The Dudley Group NHS
NHS Foundation Trust

**Board of Directors Agenda**
**Thursday 4th April 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** | | J Edwards | | 9.30 |
| **2.** | **Declarations of Interest** | | J Edwards | | 9.30 |
| **3.** | **Announcements**<br>3.1 Presentation to Sara Davis – Ward Sister of the Year | | J Edwards | | 9.30 |
| **4.** | **Chief Executives Overview Report** | Enclosure 1 | P Clark | To Discuss | 9.40 |
| **5.** | **Patient Safety and Quality** | | | | |
| | 5.1 Clinical Quality, Safety and Patient Experience Committee Exception Report | Enclosure 2 | D Bland | To Note | 9.50 |
| | 5.2 Francis Report | Enclosure 3 | D Mcmahon | To Note & Discuss | 10.00 |
| | 5.3 Infection Prevention and Control Exception Report | Enclosure 4 | D Mcmahon | To Note | 10.10 |
| **6.** | **Finance** | | | | |
| | 6.1 Finance and Performance Report | Enclosure 5 | P Assinder | To Note | 10.20 |
| **7.** | **Corporate and Strategic** | | | | |
| | 7.1 Dementia Report | Enclosure 6 | R Beeken | To Note | 10.30 |
| | 7.2 Board Secretary's Report | Enclosure 7 | P Assinder | To Note | 10.40 |
| **8.** | **Date of Next Board of Directors Meeting**<br>9.30am 2nd May, 2013, Clinical Education Centre | | J Edwards | | 10.50 |
| **9.** | **Exclusion of the Press and Other Members of the Public**<br>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 | | 10.50 |

# Board of Directors Members Profile.

## Paula Clark – Chief Executive

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

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

## 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 of Operations and Transformation

Richard is executive lead for the operational delivery in clinical services, estates and facilities and the transformation project. He is responsible for the operational leadership and management of all clinical services and the performance improvement of clinical and business processes. Richard also manages the performance of the Trust's contracts with PFI partners Summit Healthcare.

## Denise McMahon – Director of Nursing

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

**Paul Harrison – Medical Director**

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

**Annette Reeves – Associate Director of Human Resources**

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

**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.

**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.

**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 link - 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

Enclosure 1

The Dudley Group NHS Foundation Trust

**Paper for submission to the Board of Directors held in Public - 4th April 2013**

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

**CORPORATE OBJECTIVE:**
SG1, SG2, SG3 SG4, SG5

**SUMMARY OF KEY ISSUES:**

- Friends and Family Report
- Capacity Pressures
- Keogh Review into Mortality Indicator Outliers

**IMPLICATIONS OF PAPER:**

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

**ACTION REQUIRED OF COMMITTEE:**

| Decision | Approval | Discussion | Other |
|---|---|---|---|
| | | x | |

**RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:**

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

The Dudley Group NHS
NHS Foundation Trust

## Chief Executive Update – April 2013

## Friends and Family Report:

| | Apr-12 | May 12 overall | June 12 overall | July 12 overall | Aug 12 overall | Sept 12 overall | Oct 12 overall | Nov 12 overall | Dec 12 overall | Jan 13 overall | Feb 13 overall | Mar 13 overall |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date range | Baseline Month | 29/04/2012 – 26/05/2012 | 27/05/2012 – 30/06/2012 | 01/07/2012 – 28/07/2012 | 29/07/2012 – 25/08/2012 | 26/08/2012 – 29/09/2012 | 30/09/2012 – 27/10/2012 | 25/10/2012 – 24/11/2012 | 25/11/2012 – 29/12/2012 | 30/12/2012 – 26/01/2013 | 27/01/2013 – 23/02/2013 | 24/02/2013 – 31/03/2013 |
| **Organisation NPS - weekly** | 52 | 77* | 76* | 73* | 77* | 77* | 76* | 76* | 75* | 71* | 70 | 72 |
| **% of footfall (inpatient discharges - Min'm 10%)** | 12% | 15% | 12% | 19% | 18% | 18% | 22% | 29% | 21% | 26% | 35% | 27% |

* CQUIN upper quartile achieved

| | |
|---|---|
| NPS Score | >= 71 |
| | 52** to 70 |
| | < 52 |
| | |
| % of footfall | >= 10% |
| | < 10% |

In March the Trust achieved a score of 72 bringing the score back into the green. Footfall percentage is shown at 27% based on data at 27th March.

In line with guidance given by NHS Midlands and East the Trust ceased the 2012/13 Friends and Family Test before the end of the month (at the end of week 4) to allow time to bring in the new Test system during week 5.

The Trust participated in a national readiness review on 12th March 2013. The review looked at overall likelihood of success in implementing the new Friends and Family Test in terms of operational and submission readiness. For the wards element the Trust scored 100% on both counts. For A&E the Trust scored 85%; 100% was scored for submission readiness but the score was brought down for operational readiness as the system was not in operation at that time. The system has since been put into operation.

### Feedback
Sixty one per cent of respondents to the FFT survey in March provided additional comments.

### Issues
Two wards still need to submit their You Said We Did reports with their actions: C3 and C7.

## Capacity Pressures:
As reported last month the Trust is still under significant pressure from emergency admissions and has once again had to escalate to Level 4 (high pressure on our capacity) on several occasions. This has been recognised as a wider problem across the West Midlands and has peaked with the run up to the launch of the non urgent 111 telephone number. *(please see information on 111 at the end of this report)*. Analysis of activity has been carried out to help us understand the reason for the pressures. This has shown an increase in activity along with a shift from minor cases to major cases presenting at the Emergency Department. We are also seeing an increase in the age of our patients and this is contributing to longer lengths of stay and more complex discharge arrangements.

## Keogh Review into Mortality Indicator Outliers:
Further information has now been received regarding the forthcoming Review. We believe that it will take place during May with both announced and unannounced visits to the hospital which could be on any day of the week and at any time of the day. We are continuing to prepare evidence for the review team. Contact has been made with the Foundation Trust Network to help support us and the other Trusts involved during this process.

The Dudley Group NHS
NHS Foundation Trust

**NHS 111 service Information Sheet:**

NHS 111 is a new service that's being introduced to make it easier for you to access local NHS healthcare services. You can call 111 when you need medical help fast but it's not a 999 emergency. NHS 111 is a fast and easy way to get the right help, whatever the time.

NHS 111 is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.

## When to use it

You should use the NHS 111 service if you urgently need medical help or advice but it's not a life-threatening situation.

Call 111 if:

- you need medical help fast but it's not a 999 emergency
- you think you need to go to A&E or need another NHS urgent care service
- you don't know who to call or you don't have a GP to call
- you need health information or reassurance about what to do next

For less urgent health needs, contact your GP or local pharmacist in the usual way.

If a health professional has given you a specific phone number to call when you are concerned about your condition, continue to use that number.

For immediate, life-threatening emergencies, continue to call 999.

## How does it work?

The NHS 111 service is staffed by a team of fully trained advisers, supported by experienced nurses. They will ask you questions to assess your symptoms, then give you the healthcare advice you need or direct you straightaway to the local service that can help you best. That could be A&E, an out-of-hours doctor, an urgent care centre or a walk-in centre, a community nurse, an emergency dentist or a late-opening chemist.

Where possible, the NHS 111 team will book you an appointment or transfer you directly to the people you need to speak to.

If NHS 111 advisers think you need an ambulance, they will immediately arrange for one to be sent to you.

Calls to 111 are recorded. All calls and the records created are maintained securely, and will only be shared with others directly involved with your care.

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

**Paper for submission to the Board on 4th April 2013**

| | | | |
|---|---|---|---|
| **TITLE:** | **Summary of Key issues from the Clinical Quality, Safety & Patient Experience Committee held on 14th February 2013.** | | |
| **AUTHOR:** | **Julie Cotterill**<br>**Governance Manager** | **PRESENTER** | **David Bland (NED)**<br>**CQSPE Committee Chair** |

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

**SUMMARY OF KEY ISSUES:**

**Matters arising**: The Committee received progress updates from the meeting held in January 2013. Dr Peter Oliver (Radiology Medical Service Head) attended the meeting to provide assurance on the management of four reported serious incidents that had occurred in Radiology between July and December 2012.

**Mortality Report -**The Committee received an update on the mortality indices and the actions in progress to review mortality and ensure the best possible care of seriously ill patients. The progress of RAMI and HSMR for the last financial year (2011-12) and a rolling 12 month period from November 2011 – October 2012 was received.

The indices continued to show a downward trend. HSMR had improved on the last reporting period , RAMI was the same as the last reporting period and the depth of coding was now above the national average range. The latest SHMI had also shown a consistent improvement at 1.04 and was expected to drop further to 1.02.

The historic trends and specifically the significant downward trend in Quarter 3 in 2011 appeared to correlate to the initiatives and work in progress in the Trust. The Committee considered the actions that had been taken including the investigation of specific areas following alerts, including the review of 100's of sets of patient notes, greater involvement of the palliative care team, more Junior Doctors on the on call rotas, action following the trip to the Advancing Quality Alliance (AQuA) - North West Reducing Mortality Collaborative etc. The Committee also discussed the information available to the Trust Board identified by Mr Badger (NED).

**Transforming End of Life Care in Acute Hospital -** Dr Joanne Bowen (Palliative Medicine Consultant) updated the Committee on work in progress and requested permission to sign up to Phase 2 of the Transform Programme. In 2011 more than half of deaths occurred in the acute hospital setting and approx. 25% of all hospital beds were occupied by someone who was in the last year of life. The 'End of Life' work involved 50% of cancer patients and 50% of non-cancer patients. Dr Bowen outlined the six steps to the end of life care pathway and key enablers and shared the benefits to the Trust of joining phase two including improving quality of patient care, supporting people to die in their preferred place of care, promoting the development of a skilled workforce, effective resource management, reduction in inappropriate interventions, reducing unplanned hospital admissions and reducing complaints. The Committee **agreed** that the Trust should sign up to Phase 2 of the Programme and that Dr Bowen and Mrs Mcmahon would take the described leads.

**Emergency Department (ED) National Survey Results Update -** The results of the ED survey were positive and the department felt that they were making progress. The Friends and Family Surveys would commence in ED in April providing real time information on the service provided. The Committee **received** the supporting action plan, noted the content and highlighted areas for referral to the Executive and Operational leads.

**Safety Thermometer -** the Safety Thermometer Trust results are part of the mandatory National Safety Thermometer Audit. The Trust audits between 620 – 650 inpatients and the same number of community patients monthly. The following areas were highlighted:

- The incidence of new pressure ulcers reported had risen slightly on the November results
- **Falls with Harm** – figures showed a quarter reduction. The Trust has adopted a new "falls bundle" which is being trialled and is expected to be implemented in all clinical areas within the next three months.
- **VTE** – new definitions published by the Midlands and East Cluster show the Trust has been over reporting. A fall in the Trust figures is therefore anticipated.
- **Catheter Acquired Urinary Tract Infections** – showed a quarterly reduction. The Trust has adopted a new "catheter care bundle" which will be implemented in all clinical areas.

**Reports from reporting Groups:**

- **Patient Safety Group -** held on 9th January 2013 highlighted the following:
  - **Cleanliness report** –the Cleanliness Audits undertaken between 27th September 2012 and 28th December 2012 indicated a good general standard of cleanliness.
  - **Update on the Cardiac Catheter Lab and Pacemaker Insertion Room** – this issue had been placed on the risk register and a permanent solution was being explored.
  - **Incidents - Red Incident Assurance and Learning Group** – Assistance was sought from the Medical and Nursing Director to progress outstanding RCAs.
- **Internal Safeguarding Group –** held on 24th January 2013 confirmed the progress from outstanding issues and the actions required for the Trust.

**Serious Incident (SI) Monitoring Report January 2013 -** 15 new incidents were reported – 10 general SI's and 5 pressure ulcers. There were 25 open general SI's (15 under investigation, 7 awaiting assurance that all actions from the RCA investigation had been completed and 3 recommended for closure). The overview of general incident trends highlighted areas for further review, investigation and follow up. There were no breaches in the 2 days from identification of the incident and reporting and no breaches to complete the investigation in agreed timescales. An extension was requested for one incident. 3 SI's were recommended for closure. 1 was approved, the Committee requested additional work on the remainder. The Committee discussed the current reporting arrangements and agreed that discussions should take place outside of the meeting with the Chairman and other Board members on any changes to Committee or Board reporting arrangements.

**Aggregated Incident Report -** The incidents reported in quarter 3 of 2011/12 (October to December) and the same quarter for the current year 2012/13 had risen from 3310 to 3487, due to the improved reporting culture across the Trust. There were 2791 patient incidents and 696 non clinical incidents. The upward trends in incident reporting by categories were reviewed and would continue to be monitored. The Committee discussed the information in the report, the severity of incidents and prevalence at ward level.

**Friends and Family Survey Results-** the results showed that the Net Promoter Score (NPS) remained constant month on month. Food remained the top recommendation for improvement. Some wards were not achieving the 10% footfall. From April this would be 15%. Notable changes in trend during January were an increase in comments about staff and communication and facilities. Staff and communication issues related to communication between staff and patients and also between staff and staff/departments. Facilities issues were single issues around TV's, cleaning, bed changing, toilets and toilet handles. These issues would be dealt with at ward level.

**CQC Exceptions Report -** The Committee considered two amber areas:

- Outcome 9: Management of medicines – One of the three data sources indicated that this was an area which required moderate actions (CQC Quality Risk Profile (QRP)).
- Outcome 10: Safety and suitability of promises – One of the three data sources had shown that this was an area requiring moderate actions (Trust self assessment).

The Committee noted the data sources used and **considered** the key issues arising from the assessment and **approved** the Trusts position.

**Patient Experience Report including PALS and Complaints –** The Committee **received** the data on patient complaints, PALS concerns and patient experience feedback.

**Quality Account Update including Priority Targets -** the following were highlighted:

- Quality Priority 1 Action Plan: Hospital – with regard to patients receiving enough help from staff to eat their meals where this is needed. This had fallen to just below the 85% target this quarter. The cumulative yearly figure remained on target. Community – the target was based on an annual survey which had not yet been completed.
- Quality Priority 2 Action Plan: Pressure Ulcers – the dramatic decrease in avoidable ulcers reported in the community continued and the target was likely to be met at the end of the year while the hospital numbers had increased slightly from the last quarter. Achievement of the end of year target may be difficult.
- Quality Priority 3 Action Plan: Infection Control – the targets were being met.
- Quality Priority 4 & 5 Action Plan: Nutrition and Hydration – there was an increase in the completion of fluid balance charts but a dip in the figures for MUST. One of the targets had been met - Hydration (by September, 70% completion) however to achieve 90% in March looked unlikely. The achievement of the MUST target looked promising.

The Trust was undertaking all of the national clinical audits that it should. The Committee **noted** the position with regard to the targets and clinical audit participation at the end of the third quarter.

The Committee was advised of a Serious Incident and the action taken. The patient came to no harm and the Trust was reviewing the process.

***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<br>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 14th February 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.*

**Paper for submission to the Board of Directors to be held on 4th April 2013**

| | | | |
|---|---|---|---|
| **TITLE:** | **Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.** | | |
| **AUTHOR:** | **Paula Clark Chief Executive** | **PRESENTER** | **Denise Mcmahon Nursing Director** |

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

## SUMMARY OF KEY ISSUES:

On 9 June 2010 the Secretary of State for Health, Andrew Lansley MP, announced a full public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. The Inquiry was established under the Inquiries Act 2005 and was chaired by Robert Francis QC.

The final report of the Public Inquiry was published on Wednesday 6 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.

Robert Francis highlighted five key changes required from these:

1. **A structure of standards defined by public and patients.** Then a layer of 'enhanced' quality standards set out by monitored and managed by commissioners with their providers.
2. **Openness, transparency and candour throughout the system** – duty of candour on organisations to inform patients where harm has been caused even if a complaint has not been made. Ban 'gagging' clauses and independently audit Quality Accounts.
3. **Improved support for staff empowered to maintain standards with improved support for compassionate caring and committed nursing** – entrants to the profession assessed for aptitude to caring. Consideration of professional body and registration with uniform training and competency checks for HCAs so that no one is allowed to care for patients that doesn't have appropriate training, competency and consequences for non compliance.
4. **Strong Leadership** – common code of conduct for all senior managers/ leaders. Possibly a leadership college with affiliation that will allow disqualification. Public should expect leaders to be held to account.
5. **Good quality information** – accurate, useful and relevant information a must. All individuals should be obliged to take part in development of effective measures of what they do and of their compliance with fundamental standards.

The 290 recommendations link to each of the above. To meet the first recommendation in the report the **Trust is now required to "*consider the findings and recommendations of this report and decide how to apply them to their own work*".**

**Action to date:**

- Board members referred to the Executive Summary and key recommendations on release of report (February 2013)
- Statement of acceptance issued by the Chief Executive (February 2013)
- Press comment on Mid Staffs report and mortality (February 2013)
- Briefing paper issued to Council of Governors (March 2013)
- Key Themes Booklet prepared (for Board discussion) (March 2013)
- Schedule of recommendations (March 2013)
- Patients First and Foremost – Government response to Francis Report to Board (April 2013) (See attached Executive Summary)

| | | | |
|---|---|---|---|
| **IMPLICATIONS OF PAPER:**<br><br>**The Francis Inquiry has far reaching implications for all health organisations** | | | |
| **RISK** | **N** | | 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<br>Improved patient access and experience |
| | **Other** | **N** | |

**ACTION REQUIRED OF BOARD:**

| Decision | Approval | Discussion | Other |
|---|---|---|---|
| | | √ | |

**RECOMMENDATIONS FOR THE BOARD:**

**Board to note and discuss implications for the Trust.**

# Executive Summary

## Introduction

1. This document sets out an initial overarching response, on behalf of the health and care system as a whole, to the Mid Staffordshire NHS Foundation Trust Public Inquiry (the Inquiry). It details key actions to ensure that patients are '*the first and foremost consideration of the system and everyone who works in it'* and to restore the NHS to its core humanitarian values. It sets out a collective commitment and a plan of action to eradicate harm and aspire to excellence.

2. This is a watershed moment for the NHS and a call to action for every clinician, everyone working in health and care, and every organisation. Many thousands of committed, caring and hard working staff deliver good or excellent NHS care every day of the year. Yet in one hospital from 2005 to 2009 many patients received appalling care, and the wider system failed to identify the problem and then failed to share information and act on warning signs. This was unforgivable and must never happen again. Yet whilst the case at Mid Staffordshire NHS Foundation Trust was unique in its severity and duration, pockets of poor care do exist elsewhere and some of the features that contributed to the tragedy – patients and families ignored, staff disengaged or unable to speak up – point to wider problems.

3. Robert Francis' first independent inquiry looked at what went wrong inside the Trust and reported in 2010. Since then, we have taken action to strengthen the focus on the quality of care and the safeguards to protect patients from harm, including through the work of the National Quality Board, the Nursing and Care Quality Forum, the improved processes for Foundation Trust authorisation, and the introduction of dignity and nutrition inspections amongst many other measures.

4. But it is clear we now need to go further. This response starts from a simple premise and a simple goal – that the NHS is there to serve patients and must therefore put the needs, the voice and the choices of patients ahead of all other considerations. This response to the shocking findings of the Inquiry sets out a five point plan to revolutionise the care that people receive from our NHS, putting an end to failure and issuing a call for excellence:

A. **Preventing problems**

B. **Detecting problems quickly**

C. **Taking action promptly**

D. **Ensuring robust accountability**

E. **Ensuring staff are trained and motivated**

5. Delivering this response will end decades of complacency about poor care, by detecting and exposing unacceptable care quickly and ensuring that the system takes real responsibility for fixing problems urgently and effectively. It will drive coasting hospitals to improve and it will give greater freedom to care for the good and the excellent. It will

underpin the compassionate values of NHS staff with the right training and leadership needed to ensure consistently safe, effective and respectful care. It puts in place fair and robust systems to ensure that where organisations let patients, staff and the NHS down, there is proper accountability for those failings.

6. The recommendations of the Inquiry focussed on acute hospitals like Mid Staffordshire NHS Foundation Trust and so too does this response to the Inquiry. However, we know that many of the messages from the Inquiry are equally relevant to other health and care settings. Issues such as the culture of care and the vital importance of listening to and being open with patients, their families and advocates apply across the health and care system. These sorts of problems were identified not just in Mid Staffordshire NHS Foundation Trust but also in the terrible failures of care at the independent sector assessment and treatment unit, Winterbourne View.[1]

## A. Preventing Problems

7. Together the changes set out in this document will help to secure a consistent culture of compassionate care with patients' interests at its very heart. At local level, commissioners will work with hospitals to identify and tackle poor care. A Chief Inspector of Hospitals will shine a powerful light on the culture of hospitals, driving change through fundamental standards and national ratings which put the experience of patients at the centre of what the NHS does and the way in which its success is judged.

8. The measures in this document – radical transparency, excellence in leadership, clarity of accountability, consequences for failure and rewards for the very best – will together put in place the action needed to revitalise the culture of the NHS around a consistent focus on the needs of the patients it serves.

### Time to Care

9. But to do so, leaders need time to lead and staff need time to care. In a busier NHS, we will ensure that paperwork, box ticking and duplicatory regulation and information burdens are reduced by at least one third. With a single version of the truth in the Chief Inspector's balanced assessment, there will be a single national hub – the Health and Social Care Information Centre – for collecting information, and it will have a duty to seek to reduce the information burden on the service year on year.

### Safety in the DNA of the NHS – The Berwick Review

10. Professor Don Berwick, former adviser to President Obama, will be working with the NHS Commissioning Board to ensure a robust safety culture and a zero tolerance of avoidable harm is embedded in the DNA of the NHS.

## B. Detecting Problems Quickly

### Chief Inspector of Hospitals Making Assessments Based on Judgement as Well as Data

11. The Care Quality Commission will appoint a powerful Chief Inspector of Hospitals later this year. Armed with a sophisticated battery of information about hospitals from across the system, but, crucially, informed by expert judgements of inspectors who have walked the wards, spoken to patients and staff, and looked the board in the eye, the Chief Inspector will make an assessment of every NHS hospital's performance, drawing on the views of commissioners, local patients and the public. The Care Quality Commission will be supported by local Quality Surveillance

Groups, encompassing all the key players in the system, so that there are effective arrangements in place to identify rapidly those hospitals where there is a risk or reality of poor patient care.

### Expert Inspectors, not Generalists

12. We will bring an end to the days of generalist inspectors briefly visiting organisations who often have little specialist insight into the organisations they visit. From this year, new and thorough expert-led inspections will get to the heart of how hospitals are serving their patients, exposing the poor, spurring on the complacent and celebrating the achievements of the good and the excellent. Just as OFSTED acts as a credible, respected and independent arbiter of the best and the worst in our schools, the Chief Inspector will shine a light on how our hospitals are serving our patients. The Chief Inspector will become the nation's whistleblower – naming poor care without fear or favour from politicians, institutional vested interests or through loyalty to the system rather than the patients that it serves.

13. A 'comply or explain' approach to known good practices will be used in inspections. So, where there are well-established practices that benefit patients (for example nursing rounds, supervisory ward sisters, evidence-based staffing levels, and independent collection of patient experience data), inspectors will expect to see these being used across hospitals, or a valid explanation given if this is not the case.

### Ratings – A Single Balanced Version of the Truth

14. We intend to give the Care Quality Commission the power to conduct ratings at the earliest opportunity and will work with the Nuffield Trust to develop these proposals further. Until now there has been a confusing welter of information about hospitals and the public cannot easily tell how well their local hospital is doing. In the future the Chief Inspector will ensure that there is a single version of the truth about how their hospitals are performing, not just on finance and targets, but on a single assessment that fully reflects what matters to patients. As in education, the Chief Inspector will make a balanced assessment of hospitals and give them a single, clear rating, which could be "outstanding", "good", "requiring improvement" or "poor". Outstanding hospitals will be given greater freedom from regulatory bureaucracy. The Friends and Family Test for both patients and staff will be a vital component of the rating. Everyone in the system, whether regulator or commissioner, will use the same single set of data to judge success.

### Chief Inspector of Social Care

15. There will be a new Chief Inspector of Social Care who will adopt a similar approach to social care and will be charged with rating care homes and other local care services, promoting excellence and identifying problems.

### Publication of Individual Speciality Outcomes

16. A new spirit of candour and transparency will be essential for exposing poor care. In line with the Nuffield Trust recommendations, information about hospitals will not be limited to aggregated ratings but it will be possible to drill down to information at a department, specialty, care group and condition-specific level. As a starting point, the NHS Commissioning Board will extend the transparency on surgical outcomes from heart surgery, which has been hugely successful, to cardiology, vascular surgery, upper gastro intestinal surgery, colorectal surgery, orthopaedic surgery, bariatric surgery, urological surgery,

head and neck surgery and thyroid and endocrine surgery.

### Penalties for Disinformation, and a Statutory Duty of Candour

17. Mortality data must be interpreted with care, but it must also be accurate so that the public and patients can trust that they are hearing an honest and fair account. So there will be tough penalties and we will consider the introduction of additional legal sanctions at corporate level for organisations that are found to be massaging figures or concealing the truth about their performance. A statutory duty of candour on providers to inform people if they believe treatment of care has caused death or serious injury, and to provide an explanation, will reinforce the existing contractual duty.

### A Ban on Clauses Intended to Prevent Public Interest Disclosures

18. Contractual clauses that seek to prevent NHS staff from speaking out on issues like patient safety, death rates and poor care will come to a halt. Staff who disclose such problems should be supported, not vilified.

### Complaints Review

19. A review of best practice on complaints will ensure that when problems are raised, they are heard, addressed and acted upon, and seen as vital information for improvement rather than irritations to be managed defensively.

## C. Taking Action Promptly

### Fundamental Standards

20. The Care Quality Commission, working with NICE, commissioners, professionals, patients and the public, will draw up a new set of simpler fundamental standards which make explicit the basic standards beneath which care should never fall. This will be in language that both the public and professionals can easily understand.

### Time Limited Failure Regime for Quality as Well as Finance

21. In the past, when poor care was detected, it was too often put in a “too difficult” pile. Patients have been left with no one acting with urgency on their behalf to ensure a decent standard of care. This inaction must and will stop.

22. The Chief Inspector will identify poor care in public, a call to action to the hospital itself, its commissioners and the organisations responsible for their oversight. Where normal commissioner engagement with local hospitals has been unable to address significant concerns about patient care, a new time-limited three stage failure regime, encompassing not just finance, but for the first time quality, will ensure that where fundamental standards of care are being breached, firm action is taken until they are properly and promptly resolved.

23. In the first stage, the Chief Inspector will require the hospital board to work with its commissioners to improve, within a fixed time period, but the Care Quality Commission will not be responsible for making improvement happen. That will first be a task for the Board of the hospital, working with its commissioners. In the second stage, if the hospital with commissioners is unable to resolve its own problems, then the Care Quality Commission would call in Monitor or the NHS Trust Development Authority to take action. In the final stage, where fundamental problems in the hospital mean that its problems have not been resolved, the Chief Inspector will initiate a failure regime, in which the Board could be suspended or the hospital put into administration, whilst ensuring continuity of care.

24. The Care Quality Commission, the NHS Commissioning Board, Monitor and the NHS Trust Development Authority will be required to agree together the data and methodology for assessing hospitals. This will ensure a single set of expectations on hospitals of what is required of them which are aligned with the way in which commissioners, led by clinicians and guided by the views of local patients, ensure high quality care in the hospitals for which they are responsible. Providers will demonstrate, through annual Quality Accounts, how well they are meeting that single set of expectations.

## D. Ensuring Robust Accountability

### Health and Safety Executive to use Criminal Sanctions

25. Where the Chief Inspector identifies criminally negligent practice in hospitals, the Care Quality Commission will refer the matter to the Health and Safety Executive to consider whether criminal prosecution of providers or individuals is necessary. The Department of Health will ensure sufficient resources are available to the Health and Safety Executive for this role.

### Faster and More Proactive Professional Regulation

26. The General Medical Council, the Nursing and Midwifery Council and the other professional regulators are hampered by an outdated legislative framework that is too slow and reactive in tackling poor care by individual professionals. As part of the implementation of the Law Commission's review, we will seek to legislate at the earliest possible opportunity to overhaul radically 150 years of complex legislation into a single Act that will enable faster and more proactive action on individual professional failings.

### Barring Failed NHS Managers

27. To deal with the small numbers of managers who let their patients and the NHS down through gross misconduct, and prevent them from moving to new jobs in the NHS, we will introduce a national barring list for unfit managers, based on the barring scheme for teachers.

### Clear Responsibilities for Tackling Failure

28. At a national level, these proposals, taken together, will resolve the confusion of roles and responsibilities in the system, so it is clear where the buck stops on poor care beyond the action that providers and commissioners take themselves. The Chief Inspector will identify failing standards in NHS Trusts and Foundation Trusts. Where necessary, Monitor and the NHS Trust Development Authority will resolve them with hospitals and their commissioners. The Department of Health will ensure that everyone plays their part on patients' behalf.

## E. Ensuring Staff are Trained and Motivated

### HCA Training before Nursing and other Degrees

29. Starting with pilots, every student who seeks NHS funding for nursing degrees should first serve up to a year as a healthcare assistant, to promote frontline caring experience and values, as well as academic strength. They will also provide students with helpful experience for managing healthcare assistants when they qualify and enter practice. The scheme will need to be tested and implemented carefully to ensure that it is neutral in terms of costs. Health Education England will work with the Nursing and Midwifery Council, professional leaders and trade unions in developing the pilots. We will

explore whether there is merit in extending this principle to other NHS trainees.

### Revalidation for Nurses

30. Building on the historic introduction of medical revalidation, which offers proactive assurance of individual doctors, when the Nursing and Midwifery Council turns around its current poor performance we will work with them to introduce a proportionate and affordable national scheme to ensure all practising nurses are up to date and fit to practise.

### Code of Conduct and Minimum Training for Health and Care Assistants

31. Camilla Cavendish is reviewing how best to ensure healthcare assistants can provide safe and compassionate care to patients. We are today publishing standards of conduct and training for all care assistants. The Chief Inspectors will ensure that employers meet their registration requirements that all health and care support workers are properly trained and inducted before they care for people.

### Barring System for Healthcare Assistants

32. The Chief Inspector of Hospitals will assure, as part of inspections, that all hospitals are meeting their legal obligations to ensure that unsuitable healthcare assistants are barred from future patient care by properly and consistently applying the Home Office's barring regime.

### Attracting Professional and External Leaders to Senior Management Roles

33. The NHS Leadership Academy, in addition to its existing work to ensure that top leaders have the right skills and the right values, will initiate a major programme to encourage new talent from clinical professionals and from outside the NHS into top leadership positions. From within existing resources, working with world class universities, we will develop an elite fast track programme for talented leaders outside the NHS to attract the brightest and best to top NHS jobs. In addition we will invest in MBA style programmes to ensure that clinicians with a talent for leadership are supported in becoming the clinical Chief Executives of tomorrow.

### Frontline Experience for Department of Health Staff

34. At the centre of the system, the Department of Health will need to reconnect with the patients it serves. Within four years, every civil servant in the Department will have sustained and meaningful experience of the frontline with Senior Civil Service and Ministers leading the way.

### Next Steps

35. Key organisations across health and care will take the action needed to make this document a reality for patients and the Government will, as Robert Francis recommends, draw together a report on progress each year.

36. In addition, all NHS hospitals should set out how they intend to respond to the Inquiry's conclusions before the end of 2013.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

**Paper for submission to the Board of Directors on 4th April 2013 - PUBLIC**

| | | | |
|---|---|---|---|
| **TITLE:** | Infection Control Report | | |
| **AUTHOR:** | Denise McMahon – Director of Nursing<br>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<br>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 54 post 48 hr cases (not locked down) which falls within trajectory. The Trust has not breached the monthly C.difficile target since November 2012 and the annual target is on trajectory.

**C.Difficile Cases Post 48 hours – Ward breakdown:**

| Ward | Totals for 11/12 | Apr '12 | May '12 | Jun '12 | Jul '12 | Aug '12 | Sep '12 | Oct '12 | Nov '12 | Dec '12 | Jan '13 | Feb '13 | As of 27th Mar '13 | Running Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A1 | **1** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 |
| A2 | **6** | 0 | 0 | 3 | 1 | 1 | 1 | 1 | 1 | 2 | 0 | 0 | 1 | 11 |
| A4 | **2** | 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 | **9** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| B3 | **7** | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 4 |
| B4 | **8** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 3 |
| B5 | **1** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| B6 | **1** | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| C1 | **19** | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 2 | 1 | 0 | 0 | 0 | 6 |
| C3 | **16** | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 1 | 2 | 0 | 0 | 6 |
| C4 | **8** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 1 | 4 |
| C5 | **6** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| C6 | **3** | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 3 |
| C7 | **13** | 2 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | 0 | 1 | 7 |
| C8 | **7** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 2 |
| MHDU | **3** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CCU/PCCU | **1** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Critical Care | **6** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| EAU | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 |
| SHDU | **0** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 |
| **Total** | **117** | **5** | **4** | **5** | **4** | **2** | **2** | **7** | **6** | **8** | **6** | **0** | **5** | **54** |

See Appendix 1 – Board Report (2012/13)

**MRSA – Annual Target 2 (Post 48 hrs)** - There have been no cases in the last month.

**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**

(N13) Clostridium difficile infection

| 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 | 7 |
| 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 | -100.0% | 49 | 69 | -29.0% | 4 | 4 |
| Mar-13 | 5 | 8 | -37.5% | 54 | 77 | -29.9% | 8 | 8 |
| FY 2012-13 | 54 | 77 | -29.9% | | | | 106 | 117 |

Monthly number of C-Diff cases

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

| 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 |

Monthly number of MRSA cases

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.

MSSA infections

| Monthly number of MSSA cases | 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 | 1 | 48 |
| | FY 2012-13 | 48 | |

E Coli infections

| Monthly number of E coli cases | 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 | 18 | 186 |
| | Feb-13 | 18 | 204 |
| | Mar-13 | 11 | 215 |
| | FY 2012-13 | 215 | |

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

**Paper for submission to the Board of Directors 4th April 2013**

**Finance & Performance**

| | | | |
|---|---|---|---|
| **TITLE** | Finance & Performance Report | | |
| **AUTHOR** | Paul Assinder<br>Director of Finance and Information | **PRESENTER** | Paul Assinder<br>Director of Finance and Information |
| **CORPORATE OBJECTIVE:** SO 10 Enabling Objective | | | |

**SUMMARY OF KEY ISSUES:**

- The Trust continues to perform well against the long list of access and waiting target set by the NHS nationally and locally.
- This performance places the Dudley Group amongst the strongest performers in Birmingham and the Black Country and we are amongst the best nationally in many respects.
- The Trust is currently lying in 14th place (out of 46) in the SHA's 'league table' of NHS providers
- 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. It is planned to contribute towards the funding of capital works in the Russells Hall Emergency Department in future years.
- This additional income has resulted in the Trust posting a forecast surplus of c£3.7m for the year.

| **IMPLICATIONS OF PAPER:** | | | |
|---|---|---|---|
| **RISKS** | **Risk Register** | **Risk Score** Y | **Details:** |
| **COMPLIANCE** | **CQC** | N | **Details:** |
| | **NHSLA** | N | **Details:** |
| | **Monitor** | Y | **Details:** Monitor has rated Trust at 'Green' for Governance & '3' (good) for Finance at Q3. The Trust remains on quarterly monitoring by Monitor. |
| | **Other** | N | **Details:** |

**ACTION REQUIRED OF BOARD:**

| Decision | Approval | Discussion | Other |
|---|---|---|---|
| | | | **X** |

**RECOMMENDATIONS FOR THE BOARD:**

The Board is asked to note the report

The Dudley Group NHS
NHS Foundation Trust

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

**Finance and Performance**

## 1. Background

The Finance & Performance Committee of the Board met on 28th March 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. However, the vast majority of national and local access and waiting targets are being met or exceeded in Dudley.

Notwithstanding this excellent overall performance, the Committee noted the following areas of risk.

### a) A&E 4 Hour Waits

The percentage of patients who waited under 4 hours within A&E for February was 96.1%, which is the fifth consecutive monthly improvement in waiting performance since October. However, the Committee noted that high number of patient breaches during the start of March now means that the Quarter 4 target will not be achieved. The Trust will hit the target overall for 2012-13 however.

### b) Diagnostic Waits

Following the drop in performance below the 99% 2 weeks target last month diagnostic waits are now back within their threshold at 99.8%, as per the trajectory set in the exception report reported to the last meeting.

## 3. Mortality Indices (Appendix 4)

The Trust's Standard Hospital Mortality Indicator (SHMI) score for Quarter 1, 2012-13 (the latest published) of 1.04 falls well within acceptable statistical parameters.

4. **Monitor's Compliance Framework (Appendix 3)**

The Trust currently has no outstanding CQC Compliance Issues or concerns. Monitor has rated the Trust for Finance; '3' rating (good); and for Governance, 'Green'

**5. Income & Expenditure Position – February 2013 (Appendix 5)**

The Trust made a trading surplus of £361,000 in February, £899,000 ahead of plan and now has a year to date surplus of £2478,000 (£2.2m ahead of Plan).

Whilst the Committee noted this strong financial performance, it took due note that this is significantly being bolstered by the payment of significant one off monies by Dudley PCT. Without this additional payment, the Trust would have posted a 'break even' position and the Committee is concerned about the prospects for future financial years (when the Dudley PCT will no longer exist) and the Trust will be required to make good an underlying recurrent overspending of c£2m per year and to meet the Government's 4% efficiency savings requirements.

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

The Trust's Balance Sheet (Statement of Position) at 28th February 2013 which remains strong;

- £29m cash balance.
- 38.8 days liquidity margin.
- Debtor and Creditor days remain broadly on plan.

**7. Capital Programme**

Capital spending for April-February was £8.8m. The Trust estimates a total annual capital spend of £8.8m against the approved programme of £9m.

**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 | 96.1% | 95% | ↑ | ● |
| 5 | Cancer | | 14 Day – Urgent GP Referral to Date First Seen | 95.4% | 93% | ↓ | ● |
| 5 | Cancer | | 14 Day – Urgent GP Breast Symptom Referral | 98.1% | 93% | ↓ | ● |
| 5 | Cancer | | 31 Day – Diagnosis to Treatment for All Cancers | 100% | 96% | ↑ | ● |
| 5 | Cancer | | 31 Day – 2nd/Subsequent Treatment – Anti Cancer Drugs | 100% | 98% | → | ● |
| 5 | Cancer | | 31 Day – 2nd/Subsequent Treatment – Radiotherapy | - | - | - | - |
| 6 | Cancer | | 31 Day – 2nd/Subsequent Treatment – Surgery | 100% | 94% | → | ● |
| 6 | Cancer | | 62 Day – Referral to Treatment after a Consultant upgrade | 96.8% | 85% | ↓ | ● |
| 6 | Cancer | | 62 Day – Referral to Treatment following National Screening | 100% | 90% | → | ● |
| 6 | Cancer | | 62 Day – Urgent GP Referral to Treatment for All Cancers | 86.7% | 85% | ↓ | ● |
| 9-10 | Diagnostics | | Percentage of diagnostic waits less than 6 weeks | 99.8% | 99% | ↑ | ● |
| - | MSA | Retention of £250 per day the patient affected | Mixed Sex Sleeping Accommodation Breaches | 0 | 0 | → | ● |
| 7 | RTT | Deduction of 0.5% for each 1% under-achievement, to a max of 5%* | Admitted % Treated within 18 Weeks | 94.8% | 90% | ↓ | ● |
| 7 | RTT | | Non-Admitted % Treated within 18 Weeks | 99.5% | 95% | ↑ | ● |
| 7 | RTT | | Incomplete % waiting less than 18 Weeks | 98.3% | 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)* | 0 | 7 | ↓ | ● |
| - | 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. *Retention of monthly sums will be in the month following publication.* | | | | ● |
| - | 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

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*

| | | | | |
|---|---|---|---|---|
| 11 | Never Events | | 1 | |
| 12-13 | CQUIN – Acute & Community | | | |
| 14-16 | Monitor Summary Report | Governance Risk Rating | 0 | |
| 17 | Mortality Reports | 2012/13 Qtr 1 SHMI | 1.04 | ↑ |
| 18-19 | NHS Midland & East Ranking Table | | 14th / 46 | |
| 20-21 | MHP Health Mandate – Aggregate Quality Score | | 55th / 146 | |

↓ Position Deteriorating ↑ Position Improving →

▲ Within Target ▲ Outside Target ▲

# NEVER EVENTS

APPENDIX 2

| 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.

APPENDIX 3

# 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** | **0** | N/A |
| **INFECTION CONTROL (SAFETY)** | | | | | | | |
| HCAI - Clostridium Difficile - meeting the C Diff objective | 77 | 1.0 | 14 | 8 | 21 | 6 | **49** |
| 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 | 95.4 | **96.3** |
| 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 | 98.1 | **97.9** |
| Maximum waiting time of 31 days from diagnosis to treatment for all cancers | 96% | 0.5 | 99.3 | 100 | 99.4 | 100 | **99.1** |
| 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 | 86.7 | **89.2** |
| 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** |
| **A&E (QUALITY)** | | | | | | | |
| % Patients Waiting Less than 4 hours in A&E | 95% | 1.0 | 97.3 | 95.9 | 95.06 | 96.0 | **96.1** |
| **REFERRAL TO TREATMENT – RTT (PATIENT EXPERIENCE)** | | | | | | | |
| RTT – Admitted % Treated within 18 weeks | 90% | 1.0 | 95.9 | 96.3 | 96.5 | 95.7 | N/A |
| RTT – Non-Admitted % Treated within 18 weeks | 95% | 1.0 | 99.4 | 99.6 | 99.4 | 99.4 | N/A |
| RTT – Incomplete pathways % waiting within 18 weeks | 92% | 1.0 | 97.5 | 98.1 | 98.6 | 98.2 | N/A |
| **Community Services (Effectiveness)** | | | | | | | |
| Referral to treatment information | 50% | 1.0 | 94.2 | 97.2 | 99.5 | 99.6 | N/A |
| Referral information | 50% | | 66.7 | 66.7 | 65.9 | 65.8 | N/A |
| Treatment activity information | 50% | | 100 | 99.8 | 100 | 100 | 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 | N/A | N/A | N/A |

# Dudley Group FT

## Governance Targets and Indicators

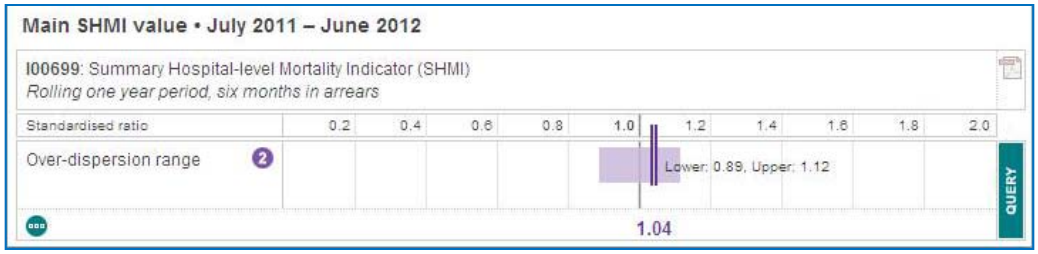
Monitor
Independent Regulator of NHS Foundation Trusts

| | Threshold & Weighting | | Q1 | Q2 | Q3 | Q4 | Year To Date |
|---|---|---|---|---|---|---|---|
| **Trust's Governance Risk Rating – All Elements** | | | **0** | **0** | **0** | **0** | 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:<br>• breaches the cumulative year-to-date trajectory for three successive quarters; or<br>• breaches its full year objective.[1] |
| Meeting the Clostridium Difficile objective | • Has greater than 12 cases in the year to date, and either:<br>• breaches the cumulative year-to-date trajectory for three successive quarters; or<br>• breaches its full year objective;[1] or<br>• Reports important or significant outbreaks of C. difficile, as defined by the Health Protection Agency |
| Referral to Treatment (RTT) waiting times | • Breaches:<br>• the admitted patients 18 weeks waiting time measure for a third successive quarter;[2]<br>• the non-admitted patients 18 weeks waiting time measure for a third successive quarter;[2] or<br>• 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:<br>• the 31-day cancer waiting time target for a third successive quarter; or<br>• the 62-day cancer waiting time target for a third successive quarter. |
| Ambulance response times | • Breaches either:<br>• the category A 8-minute response time target for a third successive quarter; or<br>• 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:<br>• referral to treatment information for a third successive quarter;<br>• service referral information for a third successive quarter; or<br>• treatment activity information for a third successive quarter. |
| Any indicator weighted 1.0 | • Breaches the indicator for three successive quarters. |

# Dudley Group FT MORTALITY - SHMI
# **Quarterly** KPI Report

## SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR - *no update since last report*



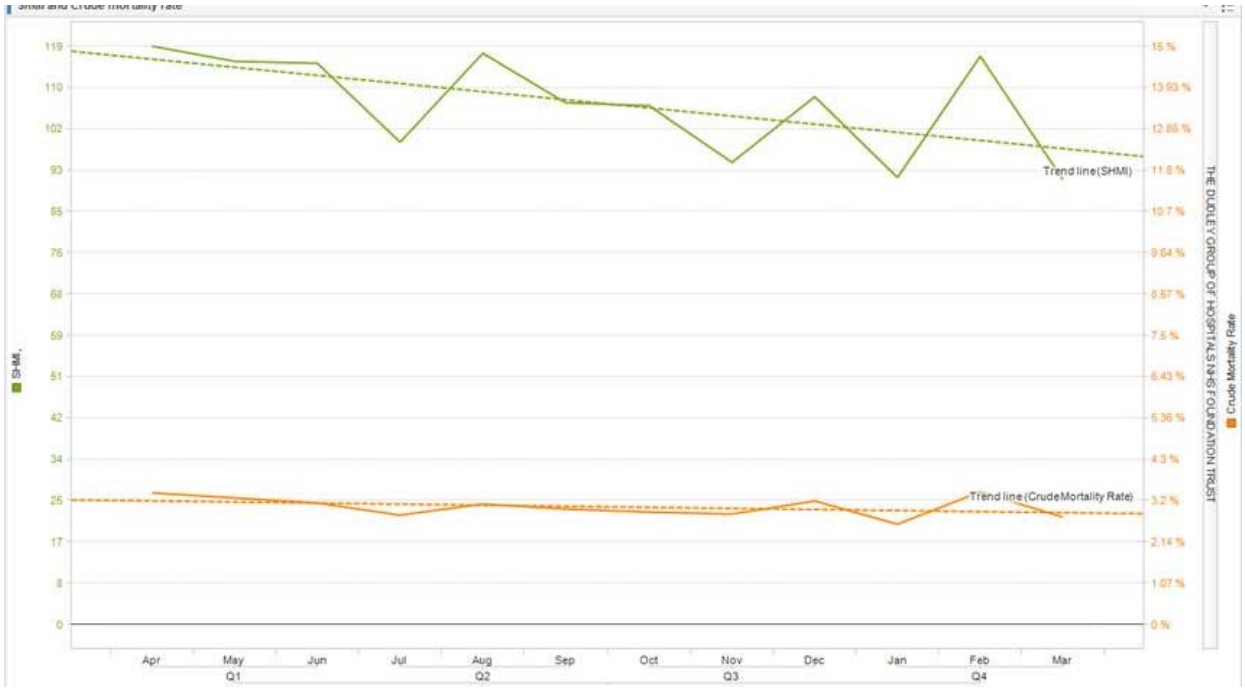

The Full SHMI is only issued by the NHS Information Centre on a quarterly basis. The SHMI intends to compare the number of deaths that actually occur against a statistical estimate of the number of deaths that might have been expected, based on the national average death rate and the particular characteristics of patients treated. The SHMI covers deaths relating to all admitted patients that occur in all settings including those occurring in hospital and those occurring within 30 days post-discharge. The In-hospital SHMI excludes the influence that the deaths that occur within 30 days post-discharge and therefore, only represents the deaths that occur within the Trust.

| SHMI | Source | 2011/12 Q3 | | 2011/12 Q4 | | 2012/13 Q1 | |
|---|---|---|---|---|---|---|---|
| **Full SHMI** | **NHS Choices** | 1.12 | | 1.07 | | 1.04 | |

*Within over dispersion range*

*Within both Poisson and over dispersion range*

In Hospital SHMI trend line against the Trust's crude mortality rate.



**THE DUDLEY GROUP NHS FOUNDATION TRUST**

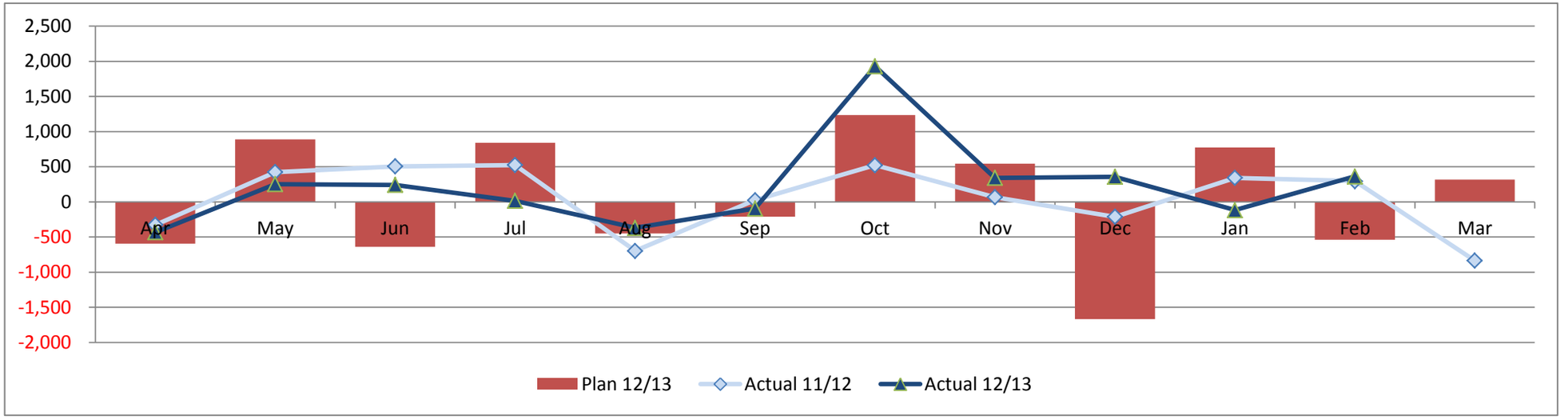
**FINANCIAL SUMMARY** **FEBRUARY 2013**

| | CURRENT MONTH | | |
|---|---|---|---|
| | BUDGET £000 | ACTUAL £000 | VARIANCE £000 |
| INCOME | £24,119 | £25,515 | £1,397 |
| PAY | -£14,833 | -£14,909 | -£76 |
| CIP | £167 | £0 | -£167 |
| NON PAY | -£8,246 | -£8,559 | -£313 |
| **EBITDA** | **£1,206** | **£2,048** | **£841** |
| OTHER | -£1,744 | -£1,687 | £57 |
| **NET** | **-£537** | **£361** | **£899** |

| | CUMULATIVE TO DATE | | |
|---|---|---|---|
| | BUDGET £000 | ACTUAL £000 | VARIANCE £000 |
| INCOME | £268,079 | £271,127 | £3,048 |
| PAY | -£158,589 | -£158,791 | -£202 |
| CIP | £340 | £0 | -£340 |
| NON PAY | -£90,162 | -£90,561 | -£399 |
| **EBITDA** | **£19,668** | **£21,775** | **£2,107** |
| OTHER | -£19,484 | -£19,297 | £188 |
| **NET** | **£183** | **£2,478** | **£2,295** |

| | YEAR END FORECAST | | |
|---|---|---|---|
| | BUDGET £000 | ACTUAL £000 | VARIANCE £000 |
| INCOME | £293,126 | £298,332 | £5,206 |
| PAY | -£172,434 | -£174,259 | -£1,824 |
| CIP | | | |
| NON PAY | -£98,917 | -£99,223 | -£306 |
| **EBITDA** | **£21,775** | **£24,850** | **£3,075** |
| OTHER | -£21,275 | -£21,106 | £169 |
| **NET** | **£500** | **£3,744** | **£3,244** |

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




**Key Comments**

£361k surplus in February (£899k ahead of plan). Cumulative position of £2.478m surplus remains £2.295m ahead of the planned position.

February income significantly above plan but may be skewed by positive month 1-6 settlements, block back of re-admissions monies and winter pressure income. The forecast reflects year end settlement offers made to all PCTs. Most have agreed full and final settlement, including Dudley.

Pay continues to rise with 41 additional staff (nursing) and highest bank spend. Other Agency increasing. Waiting list payments increased as expected.

CIP achievement below in-month plan and £340k below cumulative plan. Need to address growing non-recurrent proportion. Forecast shortfall £520k.

In-month overspend for non-pay and cumulative position marginally over plan (clinical non pay overspends offset by underspends on drugs/non clinical).

Forecast of £3.744m is due to additional income linked to contract settlements, including a positive agreement with Dudley.

Enclosure 6

The Dudley Group NHS Foundation Trust

**Paper for submission to the Board of Directors**
**On Thursday 4th April 2013**

| | | | |
|---|---|---|---|
| **TITLE:** | Dementia – Progress Report | | |
| **AUTHOR:** | **Becky Edwards**<br>Deputy General Manager, Medicine | **PRESENTER** | **Becky Edwards**<br>Deputy General Manager, Medicine |
| **CORPORATE OBJECTIVE: SGO1, SGO2, SGO3, SGO6** | | | |

**SUMMARY OF KEY ISSUES:**

The Medical Directorate Management team last presented to the Board of Directors on this subject in October 2012. This report provides the requested 6 monthly update on progress being made against the Directorate's previously articulated 3 point approach to improving dementia care within the Trust.

Improved progress against the objective of dementia screening and identification is being made and the report shows how the action plan on this objective (a 2012/13 CQUIN standard) is being managed.

With regard to the second objective of developing an improved inpatient mental health service for older people, progress has been unacceptably slow. The Director of Operations & Transformation has struggled to get a consensus with the local mental health trust on the model of care to be planned and further work with the Exec Team at Dudley & Walsall Partnership Trust is therefore required to get that consensus. The project group for this development continues to meet and develop their proposals and indeed, the potential length of stay gains from this are articulated in the Directorate's business plan for 2013/14.

The Trust has not been successful in its bid for a project lead to develop a capital proposal for the creation of a more appropriate and specifically designed dementia inpatient unit. The Trust now needs to reflect on whether they consider this enough of a priority to specifically take this forward as part of its Estate Strategy and capital plan development, in future years.

**IMPLICATIONS OF PAPER:**

| | | | |
|---|---|---|---|
| **RISK** | **Y** | | **Risk Description:**<br>OP028 – confused patient(s) becoming agitated/aggressive<br><br>OP031 – confused patient leaving ward/hospital |
| | **Risk Register:**<br>**Y** | | **Risk Score:**<br>OP028 - 12<br>OP031 - 15 |
| **COMPLIANCE and/or** | | **N** | **Details:** |
| | **NHSLA** | **N** | **Details:** |
| | **Monitor** | **N** | **Details:** |

| | | | |
|---|---|---|---|
| **LEGAL REQUIREMENTS** | | | |
| | **Equality Assured** | **N** | **Details:** |
| | **Other** | **N** | **Details:** |

**ACTION REQUIRED OF COMMITTEE:**

The Board of Directors are requested to:

1. Note the content of the report and progress being made with respect to the Directorate's 3 point plan on dementia services
2. Reflect on whether a key element of the Estate Strategy and capital planning should involve the development of a business case for the creation of a dedicated dementia inpatient facility

| Decision | Approval | Discussion | Other |
|---|---|---|---|
| | | **X** | |

**RECOMMENDATIONS FOR THE BOARD:**

N/A

The Dudley Group NHS
NHS Foundation Trust

# Dementia Progress Report

## 1.0 Background

In April 2012, Dudley Group's Trust Board received a report outlining the strategy for dealing with the increasing prevalence of dementia to ensure patients receive the most appropriate care and support when in contact with the Trust. In September 2012, a further update was provided which outlined 3 specific strands of work:

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

This paper provides an update on progress against the 3 strands.

## 2.0 Strand 1 : Improving identification (and diagnosis) of patients with dementia

2012/13 has seen the introduction of a new Dementia Commissioning for Quality & Innovation target (CQuIn), with an in year income value to the Trust of £325k. The CQuIn mandates the screening of all emergency admissions aged 75 and above for dementia (part a). For those patients whose screening indicates that they may be at risk of dementia, a full and in-depth dementia assessment must be undertaken (part b). The CQuIn also mandates that patients who are then either diagnosed or still suspected of having dementia should be referred according to the Dudley Dementia Pathway (part c).

The screening of all emergency admissions to Russells Hall Hospital aged 75 and above began on Monday 17th September 2012, following a cross-Directorate Transformation project that was initiated in May 2012.

The screening is recorded on Soarian, so that there is an electronic record of it. As the Trust rolls out the Electronic Patient Record programme beyond the Emergency Department this will be of particular benefit. Where patients are screened at risk, an electronic referral is made through Soarian to the Older People's Mental Health Team. Specialist nurses from the team then conduct an in-depth dementia assessment on the patient, before recommending the appropriate treatment, investigation and care plan. Advice is available to the nurses through the Consultant Geriatricians.

Colleagues from New Cross will be visiting the Trust in the new financial year to learn from our approach as they look to implement the CQuIn.

The Trust has now completed 6 months of screening and has seen a month on month improvement in performance against Part A since December; however this part is yet to meet the 90% target of all Emergency Admissions over the age of 75 being screened.

Results to date:

| | **A** | **B** | **C** |
|---|---|---|---|
| **October** | 64.77% | 80% | 100% |
| **November** | 71.2% | 100% | 100% |
| **December** | 61.3% | 100% | 100% |
| **January** | 69.78% | 91.20% | 100% |
| **February** | 73.72% | 100% | 100% |
| **March (To date)** | 75% | Caseload ongoing | 100% |

In order to further increase the performance of Part A and secure the associated funding, an action plan has been compiled which includes the following:

- Exploring the potential for combining VTE and Dementia screening into one process for staff to simplify the approach; this would include one daily email to all lead nurses detailing both outstanding VTE assessments and outstanding dementia screening

- Campaign planned for April to build on current communication activity which includes screensaver, Hub article and item in Chief Execs briefing. The Older Peoples Mental Health Team will be holding drop in sessions and doing ward rounds to raise the profile of screening and to address any training issues.

- Development of monitoring performance by ward to identify specific areas that may require increased support to ensure all screening is completed.

### 3.0 Strand 2 : Care and Treatment

The Trust established a RAID Transformation project group in August 2012 which included representation from Consultants, Matrons, Older Peoples Mental Health CNS and Directorate Managers. The project group was tasked with defining the team structure of a RAID service or similar, engaging commissioners and mental health trust staff in supporting the development, and constructing the business case to secure funding for it. It was anticipated that the business case would be completed by the end of Quarter 3, 2012/13, and that, if approved, the service could be implemented in Quarter 2, 2013.

Engagement with the local Mental Health Trust has progressed at a slower pace than expected, however both organisations have been involved in the ongoing evaluation of the increased investment into the Psychiatric Liaison Service which is being led by Wolverhampton University. Both Dudley and Walsall CCG's are hoping to use the evidence provided by the evaluation to increase the scope of the service substantively.

The Project team has undertaken a series of service mapping sessions with internal and external staff to understand access points to Mental Health Services within the Trust which has included, ED, Older Peoples Mental Health, Maternity and the Drug and Alcohol Liaison Team. This work has provided a better understanding of the current state and combined with the outcome of the above mentioned evaluation will enable the desired service change to progress.

When considering the current establishment of the various nursing teams providing Mental Health Services, only a small proportion of funding would be required to provide the desired coverage if single assessments could be implemented. The majority of funding would be required to provide medical input within the team.

The evaluation of the Psychiatric Liaison Service is due to be completed at the end of April 2013 which will identify additional resource to be provided and will allow the project team to progress in a way that supports and collaborates with wider health economy plans.

In late February 2013, Dudley MBC launched an Early Supported Discharge Team for patients with dementia that provides up to 4 weeks support in the community while further assessments are undertaken. Referrals are co-ordinated by the Older Peoples Mental Health Team and all patients utilising the service are then referred to the Dementia Gateways. Since the teams launch, 10 patients have benefited from the service. Social Services colleagues are now looking to further develop the service to meet the needs of both inpatients and those presenting at the front door.

## 4.0 Strand 3: Environment

In January 2013, the Trust in conjunction with Dudley MBC and Dudley CCG submitted an application to the Department of Health for funding to develop a Dementia Unit on Ward A2 and improve the wider hospital environment for patients using recognised colour schemes and signage. Unfortunately the bid was not successful.

Following the Emergency Care Intensive Support Team's visit to the Trust, support has been secured to develop the Frail Elderly Pathway in Dudley. This will provide an opportunity to explore further best practice examples and develop plans for the environment locally.

The development of any specific unit will need to form part of the Trust's wider Estates Strategy.

## 5.0 Priorities for 2013/14

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

- Fully implement the Dementia CQuIn for 13/14 which builds on the Find, Assess, Refer principles and includes a monthly survey of carers to identify how well supported they feel following a patients diagnosis of dementia and increased training for staff working in the organisation.

- Continue to work with both commissioners and Mental Health colleagues to develop a Mental Health Assessment Team that builds on the principles of RAID.

- As part of the Frail Elderly Pathway development, consider the concept of a dementia unit and changes to the environment to meet the needs of patients with dementia.

- Continue to work with colleagues from the local authority to develop further the Early Supported Discharge Team for patients with dementia and strengthen links to the Dementia Gateways.

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

**PAPER FOR SUBMISSION TO THE BOARD OF DIRECTORS ON 4th APRIL 2013**

| | | | |
|---|---|---|---|
| **TITLE:** | **Board Secretary's Report** | | |
| **AUTHOR:** | **Paul Assinder<br>Board Secretary** | **PRESENTER** | **Paul Assinder<br>Board Secretary** |

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

**SUMMARY OF KEY ISSUES:** ***(please identify key issues arising from report or minutes)***
**The report updates the Board on progress towards:**

- **Monitor approval of changes to the Trust's Constitution**
- **Monitor issuing of an Operator Licence for 2013-14**
- **Creation of a Transformation Committee (The Transformation Programme Board)**

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

| | | | |
|---|---|---|---|
| **RISK** | **N** | | **Risk Description:** |
| | **Risk Register:<br>N** | | **Risk Score:** |
| **COMPLIANCE and/or LEGAL REQUIREMENTS** | **CQC** | **Y** | **Details: Governance** |
| | **NHSLA** | **N** | **Details:** |
| | **Monitor** | **Y** | **Details: Governance / Licence** |
| | **Equality Assured** | **N** | **Details:** |
| | **Other** | **N** | **Details:** |

**ACTION REQUIRED OF COMMITTEE:**

| **Decision** | **Approval** | **Discussion** | **Other** |
|---|---|---|---|
| | X | | |

**RECOMMENDATIONS FOR THE BOARD:**

The Board is asked to note the report and consider recommendations.

The Dudley Group NHS
NHS Foundation Trust

**REPORT TO BOARD OF DIRECTORS 4th APRIL 2013**

1. **Trust revised constitution**

Directors will recall that the Board and Council of Governors approved changes to the Trust Constitution, following Royal assent of the 2012 Health & Social Care Act. The Trust has been liaising with Monitor regarding such changes and the Regulator's Legal Team has now approved a final draft of a revised constitution for Dudley Group, subject to approval of some minor changes by the Board of Directors and Council of Governors.

The Board has previously approved a number of revisions to the Constitution (October 2012 version). Monitor has requested further minor changes and these are highlighted at Appendix 1.

**The Board is asked to approve these further amendments.**

**2. Monitor provider licence 2013-14 (Ref: 120124)**

The Regulator has confirmed that it is its intention to automatically issue operator licences for foundation trusts currently operating within the terms of their authorisation. The Trust's licence was issued by Monitor on 26th March 2013 and is effective from 1st April 2013 and runs for 3 years. The Licence is attached at Appendix 2.

**The Board is asked to note the contents of the Licence.**

3. **Establishment of a new Board Committee – the Transformation Programme Board**

The Board has previously indicated its intention to establish a subcommittee to monitor the development and implementation of the Trust's Transformation Programme.

The Board is invited to consider revised terms of reference for this Committee, at Appendix 3.

4. **Recommendation**

**The Board is asked to:**

a. **Approve amendments to the Trust Constitution, as set out at Appendix 1.**

b. **Note the contents of the Trust's Provider Licence (Appendix 2).**

c. **Approve the establishment of a Committee of the Board of directors for the development and monitoring of the Trust's transformation Programme, to be called the Transformation Programme Board and approve terms of reference at Appendix 3.**

**Paul Assinder**
**Secretary to the Board**
**March 2013**

**Appendix One**

**Further changes to the Trust Constitution (October 2012 Version) requested by Monitor in March 2013**

Monitor's Legal Team has requested the following further amendment to the Draft Constitution previously approved by the Board and Council of Governors (amendments in bold italics):

- Table of Contents: Provision 35 should read "Annual Report, Forward Plans ***and non-NHS work****";*

- Interpretation and Definition: Council of Governors - the definition should read "The Council of Governors ***means the Council of Governors as constituted in this constitution which has the same meaning as 'Council of Governors' in the 2006 Act";***

- Paragraph 2.1 – please remove the footnote at the end of the sentence;

- Paragraph 35.6.2 should read "notify the directors of the Trust ***of its*** determination"

- Paragraph 35.7 – Insert a new paragraph to read ***"Where the trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the health service in England shall not be implemented unless more than half of the members of the Council of Governors of the Trust voting approve its implementation".***

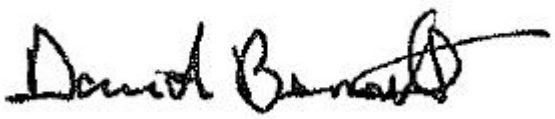
The Board is requested to approve these changes.

# The Dudley Group NHS Foundation Trust

Trust HQ Offices
C Block, Russell Hall Hospital
Dudley
DY1 2HQ

**Licence Number: 120124**

| **Date of Issue** | **Version Number** |
| --- | --- |
| 01 April 2013 | 1.0 |



Dr David Bennett, Chief Executive

Monitor

# Version History

| Version No. | Date | Comments |
|---|---|---|
| 1.0 | 26 March 2013 | Created. |

# Standard Licence Conditions

**Licence Number: 120124**

# NHS Provider Licence Standard Conditions

CONTENTS

Section 1 – General Conditions

G1: Provision of information
G2: Publication of information
G3: Payment of fees to Monitor
G4: Fit and proper persons
G5: Monitor guidance
G6: Systems for compliance with licence conditions and related obligations
G7: Registration with the Care Quality Commission
G8: Patient eligibility and selection criteria
G9: Application of Section 5 (Continuity of Services)

Section 2 – Pricing

P1: Recording of information
P2: Provision of information
P3: Assurance report on submissions to Monitor
P4: Compliance with the National Tariff
P5: Constructive engagement concerning local tariff modifications

Section 3 – Choice and competition

C1: The right of patients to make choices
C2: Competition oversight

Section 4 – Integrated care

IC1: Provision of integrated care

Section 5 – Continuity of Services

CoS1: Continuing provision of Commissioner Requested Services
CoS2: Restriction on the disposal of assets
CoS3: Standards of corporate governance and financial management
CoS4: Undertaking from the ultimate controller
CoS5: Risk pool levy
CoS6: Cooperation in the event of financial stress
CoS7: Availability of resources

Section 6 – NHS foundation trust conditions

FT1: Information to update the register of NHS foundation trusts
FT2: Payment to Monitor in respect of registration and related costs
FT3: Provision of information to advisory panel
FT4: NHS foundation trust governance arrangements

Section 7 – Interpretation and Definitions

D1: Interpretation and Definitions

## Section 1 – General Conditions

### Condition G1 – Provision of information

1. Subject to paragraph 3, and in addition to obligations under other Conditions of this Licence, the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for any of the purposes set out in section 96(2) of the 2012 Act.

2. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as Monitor may require.

3. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

   (a) in the case of information or a report, it is accurate, complete and not misleading;

   (b) in the case of a document, it is a true copy of the document requested; and

4. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

**Condition G2 – Publication of information**

1. The Licensee shall comply with any direction from Monitor for any of the purposes set out in section 96(2) of the 2012 Act to publish information about health care services provided for the purposes of the NHS and as to the manner in which such information should be published.

2. For the purposes of this condition "publish" includes making available to the public, to any section of the public or to individuals.

**Condition G3 – Payment of fees to Monitor**

1. The Licensee shall pay fees to Monitor in each financial year of such amount as Monitor may determine for each such year or part thereof in respect of the exercise by Monitor of its functions for the purposes set out in section 96(2) of the 2012 Act.

2. The Licensee shall pay the fees required to be paid by a determination by Monitor for the purpose of paragraph 1 no later than the 28th day after they become payable in accordance with that determination.

**Condition G4 – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions)**

3. The Licensee shall ensure that no person who is an unfit person may become or continue as a Governor, except with the approval in writing of Monitor.

4. The Licensee shall not appoint as a Director any person who is an unfit person, except with the approval in writing of Monitor.

5. The Licensee shall ensure that its contracts of service with its Directors contain a provision permitting summary termination in the event of a Director being or becoming an unfit person. The Licensee shall ensure that it enforces that provision promptly upon discovering any Director to be an unfit person, except with the approval in writing of Monitor.

6. If Monitor has given approval in relation to any person in accordance with paragraph 1, 2, or 3 of this condition the Licensee shall notify Monitor promptly in writing of any material change in the role required of or performed by that person.

7. In this Condition an unfit person is:

   (a) an individual;

      (i) who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged; or

      (ii) who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it; or

      (iii) who within the preceding five years has been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him; or

      (iv) who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986; or

   (b) a body corporate, or a body corporate with a parent body corporate:

(i) where one or more of the Directors of the body corporate or of its parent body corporate is an unfit person under the provisions of sub-paragraph (a) of this paragraph, or

(ii) in relation to which a voluntary arrangement is proposed under section 1 of the Insolvency Act 1986, or

(iii) which has a receiver (including an administrative receiver within the meaning of section 29(2) of the 1986 Act) appointed for the whole or any material part of its assets or undertaking, or

(iv) which has an administrator appointed to manage its affairs, business and property in accordance with Schedule B1 to the 1986 Act, or

(v) which passes any resolution for winding up, or

(vi) which becomes subject to an order of a Court for winding up.

**Condition G5 – Monitor guidance**

1 Without prejudice to any obligations in other Conditions of this Licence, the Licensee shall at all times have regard to guidance issued by Monitor for any of the purposes set out in section 96(2) of the 2012 Act.

2 In any case where the Licensee decides not to follow the guidance referred to in paragraph 1 or guidance issued under any other Conditions of this licence, it shall inform Monitor of the reasons for that decision.

**Condition G6 – Systems for compliance with licence conditions and related obligations**

8. The Licensee shall take all reasonable precautions against the risk of failure to comply with:

   (a) the Conditions of this Licence,

   (b) any requirements imposed on it under the NHS Acts, and

   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

9. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:

   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and

   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

10. Not later than two months from the end of each Financial Year, the Licensee shall prepare and submit to Monitor a certificate to the effect that, following a review for the purpose of paragraph 2(b) the Directors of the Licensee are or are not satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with this Condition.

11. The Licensee shall publish each certificate submitted for the purpose of this Condition within one month of its submission to Monitor in such manner as is likely to bring it to the attention of such persons who reasonably can be expected to have an interest in it.

**Condition G7 – Registration with the Care Quality Commission**

12. The Licensee shall at all times be registered with the Care Quality Commission in so far as is necessary in order to be able lawfully to provide the services authorised to be provided by this Licence.

13. The Licensee shall notify Monitor promptly of:

    (a) any application it may make to the Care Quality Commission for the cancellation of its registration by that Commission, or

    (b) the cancellation by the Care Quality Commission for any reason of its registration by that Commission.

14. A notification given by the Licensee for the purposes of paragraph 2 shall:

    (a) be made within 7 days of:

        (i) the making of an application in the case of paragraph (a), or

        (ii) becoming aware of the cancellation in the case of paragraph (b), and

    (b) contain an explanation of the reasons (in so far as they are known to the Licensee) for:

        (i) the making of an application in the case of paragraph (a), or

        (ii) the cancellation in the case of paragraph (b).

**Condition G8 – Patient eligibility and selection criteria**

15. The Licensee shall:

(a) set transparent eligibility and selection criteria,

(b) apply those criteria in a transparent way to persons who, having a choice of persons from whom to receive health care services for the purposes of the NHS, choose to receive them from the Licensee, and

(c) publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.

16. "Eligibility and selection criteria" means criteria for determining:

(a) whether a person is eligible, or is to be selected, to receive health care services provided by the Licensee for the purposes of the NHS, and

(b) if the person is selected, the manner in which the services are provided to the person.

**Condition G9 – Application of Section 5 (Continuity of Services)**

17. The Conditions in Section 5 shall apply:

    (a) whenever the Licensee is subject to a contractual or other legally enforceable obligation to provide a service which is a Commissioner Requested Service, and

    (b) from the commencement of this Licence until the Licensee becomes subject to an obligation of the type described in sub-paragraph (a), if the Licensee is an NHS foundation trust which:

        (i) was not subject to such an obligation on commencement of this Licence, and

        (ii) was required to provide services, or was party to an NHS contract to provide services, as described in paragraph 2(a) or 2(b);

for the avoidance of doubt, where Section 5 applies by virtue of this subparagraph, the words "Commissioner Requested Service" shall be read to include any service of a description falling within paragraph 2(a) or 2(b).

18. A service is a Commissioner Requested Service if, and to the extent that, it is:

    (a) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or before 31 March 2013, was required to provide in accordance with condition 7(1) and Schedule 2 in the terms of its authorisation by Monitor immediately prior to the commencement of this Licence, or

    (b) any service of a description which the Licensee, being an NHS foundation trust with an authorisation date on or after 1 April 2013, was required to provide pursuant to an NHS contract immediately before its authorisation date, or

    (c) any other service which the Licensee has contracted with a Commissioner to provide as a Commissioner Requested Service.

19. A service is also a Commissioner Requested Service if, and to the extent that, not being a service within paragraph 2:

(a) it is a service which the Licensee may be required to provide to a Commissioner under the terms of a contract which has been entered into between them, and

(b) the Commissioner has made a written request to the Licensee to provide that service as a Commissioner Requested Service, and either

(c) the Licensee has failed to respond in writing to that request by the expiry of the 28th day after it was made to the Licensee by the Commissioner, or

(d) the Commissioner, not earlier than the expiry of the [28th] day after making that request to the Licensee, has given to Monitor and to the Licensee a notice in accordance with paragraph 4, and Monitor, after giving the Licensee the opportunity to make representations, has issued a direction in writing in accordance with paragraph 5.

20. A notice in accordance with this paragraph is a notice:

(a) in writing,

(b) stating that the Licensee has refused to agree to a request to provide a service as a Commissioner Requested Service, and

(c) setting out the Commissioner's reasons for concluding that the Licensee is acting unreasonably in refusing to agree to that request to provide a service as a Commissioner Requested Service

21. A direction in accordance with this paragraph is a direction that the Licensee's refusal to provide a service as a Commissioner Requested Service in response to a request made under paragraph 3(b) is unreasonable.

22. The Licensee shall give Monitor not less than [28] days' notice of the expiry of any contractual obligation pursuant to which it is required to provide a Commissioner Requested Service to a Commissioner for which no extension or renewal has been agreed.

23. If any contractual obligation of a Licensee to provide a Commissioner Requested Service expires without extension or renewal having been agreed between the Licensee and the Commissioner who is a party to the contract, the Licensee shall continue to provide that service on the terms of the contract (save as agreed with that Commissioner), and the service shall continue to be a Commissioner Requested

Service, for the period from the expiry of the contractual obligation until Monitor issues either:

(a) a direction of the sort referred to in paragraph 8, or

(b) a notice in writing to the Licensee stating that it has decided not to issue such a direction.

24. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, Monitor issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then for that period the service shall continue to be a Commissioner Requested Service.

25. No service which the Licensee is subject to a contractual or other legally enforceable obligation to provide shall be regarded as a Commissioner Requested Service and, as a consequence, no Condition in Section 5 shall be of any application, during any period for which there is in force a direction in writing by Monitor given for the purposes of this condition and of any equivalent condition in any other current licence issued under the 2012 Act stating that no health care service provided for the purposes of the NHS is to be regarded as a Commissioner Requested Service.

26. A service shall cease to be a Commissioner Requested Service if:

(a) all current Commissioners of that service as a Commissioner Requested Service agree in writing that there is no longer any need for the service to be a Commissioner Requested Service, and Monitor has issued a determination in writing that the service is no longer a Commissioner Requested Service, or

(b) Monitor has issued a determination in writing that the service is no longer a Commissioner Requested Service; or

(c) it is a Commissioner Requested Service by virtue only of paragraph 2(a) above and 3 years have elapsed since the commencement of this Licence; or

(d) it is a Commissioner Requested Service by virtue only of paragraph 2(b) above and either 3 years have elapsed since 1 April 2013 or 1 year has elapsed since the commencement of this Licence, whichever is the later; or

(e) the contractual obligation pursuant to which the service is provided has expired and Monitor has issued a notice pursuant to paragraph 7(b) in relation to the service; or

(f) the period specified in a direction by Monitor of the sort referred to in paragraph 8 in relation to the service has expired.

27. The Licensee shall make available free of charge to any person who requests it a statement in writing setting out the description and quantity of services which it is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services.

28. Within [28] days of every occasion on which there is a change in the description or quantity of the services which the Licensee is under a contractual or other legally enforceable obligation to provide as Commissioner Requested Services, the Licensee shall provide to Monitor in writing a notice setting out the description and quantity of all the services it is obliged to provide as Commissioner Requested Services.

29. Unless it is proposes to cease providing the service, the Licensee shall not make any application to Monitor for a determination in accordance with paragraph 10(b):

(a) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(a) above, in the period of 3 years since the commencement of this Licence or

(b) in the case of a service which is a Commissioner Requested Service by virtue only of paragraph 2(b), in the period until the later of 1 April 2016 or 1 year from the commencement of this Licence.

30. In this Condition “NHS contract” has the meaning given to that term in Section 9 of the 2006 Act.

## Section 2 – Pricing

### Condition P1 – Recording of information

31. If required in writing by Monitor, and only in relation to periods from the date of that requirement, the Licensee shall:

    (a) obtain, record and maintain sufficient information about the costs which it expends in the course of providing services for the purposes of the NHS and other relevant information, and

    (b) establish, maintain and apply such systems and methods for the obtaining, recording and maintaining of such information about those costs and other relevant information,

    as are necessary to enable it to comply with the following paragraphs of this Condition.

32. From the time of publication by Monitor of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information broken down in accordance with those Currencies by allocating to a record for each such Currency all costs expended by the Licensee in providing health care services for the purposes of the NHS within that Currency and by similarly treating other relevant information.

33. In the allocation of costs and other relevant information to Approved Reporting Currencies in accordance with paragraph 2 the Licensee shall use the cost allocation methodology and procedures relating to other relevant information set out in the Approved Guidance.

34. If the Licensee uses sub-contractors in the provision of health care services for the purposes of the NHS, to the extent that it is required to do so in writing by Monitor the Licensee shall procure that each of those sub-contractors:

    (a) obtains, records and maintains information about the costs which it expends in the course of providing services as sub-contractor to the Licensee, and establishes, maintains and applies systems and methods for the obtaining, recording and maintaining of that information, in a manner that complies with paragraphs 2 and 3 of this Condition, and

    (b) provides that information to Monitor in a timely manner.

35. Records required to be maintained by this Condition shall be kept for not less than six years.

Section 2 – Pricing

36. In this Condition:

| | |
|---|---|
| "the Approved Guidance" | means such guidance on the obtaining, recording and maintaining of information about costs and on the breaking down and allocation of costs by reference to Approved Reporting Currencies as may be published by Monitor; |
| "Approved Reporting Currencies" | means such categories of cost and other relevant information as may be published by Monitor; |
| "other relevant information" | means such information, which may include quality and outcomes data, as may be required by Monitor for the purpose of its functions under Chapter 4 (Pricing) in Part 3 of the 2012 Act. |

**Condition P2 – Provision of information**

37. Subject to paragraph 3, and without prejudice to the generality of Condition G1, the Licensee shall furnish to Monitor such information and documents, and shall prepare or procure and furnish to Monitor such reports, as Monitor may require for the purpose of performing its functions under Chapter 4 in Part 3 of the 2012 Act.

38. Information, documents and reports required to be furnished under this Condition shall be furnished in such manner, in such form, at such place and at such times as Monitor may require.

39. In furnishing information documents and reports pursuant to paragraphs 1 and 2 the Licensee shall take all reasonable steps to ensure that:

    (a) in the case of information or a report, it is accurate, complete and not misleading;

    (b) in the case of a document, it is a true copy of the document requested; and

40. This Condition shall not require the Licensee to furnish any information, documents or reports which it could not be compelled to produce or give in evidence in civil proceedings before a court because of legal professional privilege.

**Condition P3 – Assurance report on submissions to Monitor**

41. If required in writing by Monitor the Licensee shall, as soon as reasonably practicable, obtain and submit to Monitor an assurance report in relation to a submission of the sort described in paragraph 2 which complies with the requirements of paragraph 3.

42. The descriptions of submissions in relation to which a report may be required under paragraph 1 are:

    (a) submissions of information furnished to Monitor pursuant to Condition P2, and

    (b) submissions of information to third parties designated by Monitor as persons from or through whom cost information may be obtained for the purposes of setting or verifying the National Tariff or of developing non-tariff pricing guidance.

43. An assurance report shall meet the requirements of this paragraph if all of the following conditions are met:

    (a) it is prepared by a person approved in writing by Monitor or qualified to act as auditor of an NHS foundation trust in accordance with paragraph 23(4) in Schedule 7 to the 2006 Act;

    (b) it expresses a view on whether the submission to which it relates:

        (i) is based on cost records which have been maintained in a manner which complies with paragraph 2 in Condition P1;

        (ii) is based on costs which have been analysed in a manner which complies with paragraph 3 in Condition P1, and

        (iii) provides a true and fair assessment of the information it contains.

**Condition P4 – Compliance with the National Tariff**

44. Except as approved in writing by Monitor, the Licensee shall only provide health care services for the purpose of the NHS at prices which comply with, or are determined in accordance with, the national tariff published by Monitor, in accordance with section 116 of the 2012 Act.

45. Without prejudice to the generality of paragraph 1, except as approved in writing by Monitor, the Licensee shall comply with the rules, and apply the methods, concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by Monitor in accordance with, section 116 of the 2012 Act, wherever applicable.

**Condition P5 – Constructive engagement concerning local tariff modifications**

46. The Licensee shall engage constructively with Commissioners, with a view to reaching agreement as provided in section 124 of the 2012 Act, in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications.

## Section 3 – Choice and Competition

### Condition C1- The right of patients to make choices

47. Subsequent to a person becoming a patient of the Licensee and for as long as he or she remains such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, he or she is notified of that choice and told where information about that choice can be found.

48. Information and advice about patient choice of provider made available by the Licensee shall not be misleading.

49. Without prejudice to paragraph 2, information and advice about patient choice of provider made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that, as far as reasonably practicable, assists patients in making well informed choices between providers of treatments or other health care services.

50. In the conduct of any activities, and in the provision of any material, for the purpose of promoting itself as a provider of health care services for the purposes of the NHS the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.

**Condition C2 – Competition oversight**

51. The Licensee shall not:

(a) enter into or maintain any agreement or other arrangement which has the object or which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS, or

(b) engage in any other conduct which has (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of health care services for the purposes of the NHS,

to the extent that it is against the interests of people who use health care services.

## Section 4 – Integrated care

### Condition IC1 – Provision of integrated care

52. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

53. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of health-related services or social care services by others with a view to achieving one or more of the objectives referred to in paragraph 4.

54. The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling it to co-operate with other providers of health care services for the purposes of the NHS with a view to achieving one or more of the objectives referred to in paragraph 4.

55. The objectives referred to in paragraphs 1, 2 and 3 are:

    (a) improving the quality of health care services provided for the purposes of the NHS (including the outcomes that are achieved from their provision) or the efficiency of their provision,

    (b) reducing inequalities between persons with respect to their ability to access those services, and

    (c) reducing inequalities between persons with respect to the outcomes achieved for them by the provision of those services.

56. The Licensee shall have regard to such guidance as may have been issued by Monitor from time to time concerning actions or behaviours that might reasonably be regarded as against the interests of people who use health care services for the purposes of paragraphs 1, 2 or 3 of this Condition.

## Section 5 – Continuity of Services

### Condition CoS1 – Continuing provision of Commissioner Requested Services

57. The Licensee shall not cease to provide, or materially alter the specification or means of provision of, any Commissioner Requested Service otherwise than in accordance with the following paragraphs of this Condition.

58. If, during the period of a contractual or other legally enforceable obligation to provide a Commissioner Requested Service, or during any period when this condition applies by virtue of Condition G9(1)(b), Monitor issues to the Licensee a direction in writing to continue providing that service for a period specified in the direction, then the Licensee shall provide the service for that period in accordance with the direction.

59. The Licensee shall not materially alter the specification or means of provision of any Commissioner Requested Service except:

    (a) with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service; or

    (b) at any time when this condition applies by virtue of Condition G9(1)(b), with the agreement in writing of all Commissioners to which the Licensee provides, or may be requested to provide, the service as a Commissioner Requested Service; or

    (c) if required to do so by, or in accordance with the terms of its authorisation by, any body having responsibility pursuant to statute for regulating one or more aspects of the provision of health care services in England and which has been designated by Monitor for the purposes of this condition and of equivalent conditions in other licences granted under the 2012 Act.

60. If the specification or means of provision of a Commissioner Requested Service is altered as provided in paragraph 3 the Licensee, within [28] days of the alteration, shall give to Monitor notice in writing of the occurrence of the alteration with a summary of its nature.

61. For the purposes of this Condition an alteration to the specification or means of provision of any Commissioner Requested Service is material if it involves the delivery

or provision of that service in a manner which differs from the manner specified and described in:

(a) the contract in which it was first required to be provided to a Commissioner at or following the coming into effect of this Condition; or

(b) if there has been an alteration pursuant to paragraph 3, the document in which it was specified on the coming into effect of that alteration; or

(c) at any time when this Condition applies by virtue of Condition G9(1)(b), the contract, or NHS contract, by which it was required to be provided immediately before the commencement of this Licence or the Licensee's authorisation, as the case may be.

**Condition CoS2 – Restriction on the disposal of assets**

62. The Licensee shall establish, maintain and keep up to date, an asset register which complies with paragraphs 2 and 3 of this Condition ("the Asset Register")

63. The Asset Register shall list every relevant asset used by the Licensee for the provision of Commissioner Requested Services.

64. The Asset Register shall be established, maintained and kept up to date in a manner that reasonably would be regarded as both adequate and professional.

65. The obligations in paragraphs 5 to 8 shall apply to the Licensee if Monitor has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

66. The Licensee shall not dispose of, or relinquish control over, any relevant asset except:

    (a) with the consent in writing of Monitor, and

    (b) in accordance with the paragraphs 6 to 8 of this Condition.

67. The Licensee shall furnish Monitor with such information as Monitor may request relating to any proposal by the Licensee to dispose of, or relinquish control over, any relevant asset.

68. Where consent by Monitor for the purpose of paragraph 5(a) is subject to conditions, the Licensee shall comply with those conditions.

69. Paragraph 5(a) of this Condition shall not prevent the Licensee from disposing of, or relinquishing control over, any relevant asset where:

    (a) Monitor has issued a general consent for the purposes of this Condition (whether or not subject to conditions) in relation to:

        (i) transactions of a specified description; or

        (ii) the disposal of or relinquishment of control over relevant assets of a specified description, and

    the transaction or the relevant assets are of a description to which the consent applies and the disposal, or relinquishment of control, is in accordance with any conditions to which the consent is subject; or

(b) the Licensee is required by the Care Quality Commission to dispose of a relevant asset.

70. In this Condition:

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| "disposal" | means any of the following:<br>(a) a transfer, whether legal or equitable, of the whole or any part of an asset (whether or not for value) to a person other than the Licensee; or<br>(b) a grant, whether legal or equitable, of a lease, licence, or loan of (or the grant of any other right of possession in relation to) that asset; or<br>(c) the grant, whether legal or equitable, of any mortgage, charge, or other form of security over that asset; or<br>(d) if the asset is an interest in land, any transaction or event that is capable under any enactment or rule of law of affecting the title to a registered interest in that land, on the assumption that the title is registered,<br>and references to "dispose" are to be read accordingly; |
| "relevant asset" | means any item of property, including buildings, interests in land, equipment (including rights, licenses and consents relating to its use), without which the Licensee's ability to meet its obligations to provide Commissioner Requested Services would reasonably be regarded as materially prejudiced; |
| "relinquishment of control" | includes entering into any agreement or arrangement under which control of the asset is not, or ceases to be, under the sole management of the Licensee, and "relinquish" and related expressions are to be read accordingly. |

71. The Licensee shall have regard to such guidance as may be issued from time to time by Monitor regarding:

(a) the manner in which asset registers should be established, maintained and updated, and

(b) property, including buildings, interests in land, intellectual property rights and equipment, without which a licence holder's ability to provide Commissioner Requested Services should be regarded as materially prejudiced.

**Condition CoS3 – Standards of corporate governance and financial management**

72. The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as:

(a) suitable for a provider of the Commissioner Requested Services provided by the Licensee, and

(b) providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

73. In its determination of the systems and standards to adopt for the purpose of paragraph 1, and in the application of those systems and standards, the Licensee shall have regard to:

(a) such guidance as Monitor may issue from time to time concerning systems and standards of corporate governance and financial management;

(b) the Licensee's rating using the risk rating methodology published by Monitor from time to time, and

(c) the desirability of that rating being not less than the level regarded by Monitor as acceptable under the provisions of that methodology.

**Condition CoS4 – Undertaking from the ultimate controller**

74. The Licensee shall procure from each company or other person which the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking in favour of the Licensee, in the form specified by Monitor, that the ultimate controller ("the Covenantor"):

    (a) will refrain for any action, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will refrain from any action, which would be likely to cause the Licensee to be in contravention of any of its obligations under the 2012 Act or this Licence, and

    (b) will give to the Licensee, and will procure that any person which is a subsidiary of, or which is controlled by, the Covenantor (other than the Licensee and its subsidiaries) will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to Monitor.

75. The Licensee shall obtain any undertaking required to be procured for the purpose of paragraph 1 within 7 days of a company or other person becoming an ultimate controller of the Licensee and shall ensure that any such undertaking remains in force for as long as the Covenantor remains the ultimate controller of the Licensee.

76. The Licensee shall:

    (a) deliver to Monitor a copy of each such undertaking within seven days of obtaining it;

    (b) inform Monitor immediately in writing if any Director, secretary or other officer of the Licensee becomes aware that any such undertaking has ceased to be legally enforceable or that its terms have been breached, and

    (c) comply with any request which may be made by Monitor to enforce any such undertaking.

77. For the purpose of this Condition, subject to paragraph 5, a person (whether an individual or a body corporate) is an ultimate controller of the Licensee if:

    (a) directly, or indirectly, the Licensee can be required to act in accordance with the instructions of that person acting alone or in concert with others, and

(b) that person cannot be required to act in accordance with the instructions of another person acting alone or in concert with others.

78. A person is not an ultimate controller if they are:

(a) a health service body, within the meaning of section 9 of the 2006 Act;

(b) a Governor or Director of the Licensee and the Licensee is an NHS foundation trust;

(c) any Director of the Licensee who does not, alone or in association with others, have a controlling interest in the ownership of the Licensee and the Licensee is a body corporate; or

(d) a trustee of the Licensee and the Licensee is a charity.

**Condition CoS5 – Risk pool levy**

79. The Licensee shall pay to Monitor any sums required to be paid in consequence of any requirement imposed on providers under section 135(2) of the 2012 Act, including sums payable by way of levy imposed under section 139(1) and any interest payable under section 143(10), by the dates by which they are required to be paid.

80. In the event that no date has been clearly determined by which a sum referred to in paragraph 1 is required to be paid, that sum shall be paid within 28 days of being demanded in writing by Monitor.

**Condition CoS6 – Co-operation in the event of financial stress**

81. The obligations in paragraph 2 shall apply if Monitor has given notice in writing to the Licensee that it is concerned about the ability of the Licensee to carry on as a going concern.

82. When this paragraph applies the Licensee shall:

(a) provide such information as Monitor may direct to Commissioners and to such other persons as Monitor may direct;

(b) allow such persons as Monitor may appoint to enter premises owned or controlled by the Licensee and to inspect the premises and anything on them, and

(c) co-operate with such persons as Monitor may appoint to assist in the management of the Licensee's affairs, business and property.

**Condition CoS7 – Availability of resources**

83. The Licensee shall at all times act in a manner calculated to secure that it has, or has access to, the Required Resources.

84. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.

85. The Licensee, not later than two months from the end of each Financial Year, shall submit to Monitor a certificate as to the availability of the Required Resources for the period of 12 months commencing on the date of the certificate, in one of the following forms:

    (a) "After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate."

    (b) "After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services".

    (c) "In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate".

86. The Licensee shall submit to Monitor with that certificate a statement of the main factors which the Directors of the Licensee have taken into account in issuing that certificate.

87. The statement submitted to Monitor in accordance with paragraph 4 shall be approved by a resolution of the board of Directors of the Licensee and signed by a Director of the Licensee pursuant to that resolution.

Section 5 – Continuity of Services

88. The Licensee shall inform Monitor immediately if the Directors of the Licensee become aware of any circumstance that causes them to no longer have the reasonable expectation referred to in the most recent certificate given under paragraph 3.

89. The Licensee shall publish each certificate provided for in paragraph 3 in such a manner as will enable any person having an interest in it to have ready access to it.

90. In this Condition:

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| "distribution" | includes the payment of dividends or similar payments on share capital and the payment of interest or similar payments on public dividend capital and the repayment of capital; |
| "Financial Year" | means the period of twelve months over which the Licensee normally prepares its accounts; |
| "Required Resources" | means such:<br>(a) management resources,<br>(b) financial resources and financial facilities,<br>(c) personnel,<br>(d) physical and other assets including rights, licences and consents relating to their use, and<br>(e) working capital<br>as reasonably would be regarded as sufficient to enable the Licensee at all times to provide the Commissioner Requested Services. |

## Section 6 – NHS Foundation Trust Conditions

### Condition FT1 – Information to update the register of NHS foundation trusts

91. The obligations in the following paragraphs of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

92. The Licensee shall ensure that Monitor has available to it written and electronic copies of the following documents:

    (a) the current version of Licensee's constitution;

    (b) the Licensee's most recently published annual accounts and any report of the auditor on them, and

    (c) the Licensee's most recently published annual report,

    and for that purpose shall provide to Monitor written and electronic copies of any document establishing or amending its constitution within 28 days of being adopted and of the documents referred to in sub-paragraphs (b) and (c) within 28 days of being published.

93. Subject to paragraph 4, the Licensee shall provide to Monitor written and electronic copies of any document that is required by Monitor for the purpose of Section 39 of the 2006 Act within 28 days of the receipt of the original document by the Licensee.

94. The obligation in paragraph 3 shall not apply to:

    (a) any document provided pursuant to paragraph 2;

    (b) any document originating from Monitor; or

    (c) any document required by law to be provided to Monitor by another person.

95. The Licensee shall comply with any direction issued by Monitor concerning the format in which electronic copies of documents are to be made available or provided.

96. When submitting a document to Monitor for the purposes of this Condition, the Licensee shall provide to Monitor a short written statement describing the document and specifying its electronic format and advising Monitor that the document is being sent for

the purpose of updating the register of NHS foundation trusts maintained in accordance with section 39 of the 2006 Act**.**

**Condition FT2 – Payment to Monitor in respect of registration and related costs**

97. The obligations in the following paragraph of this Condition apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

98. Whenever Monitor determines in accordance with section 50 of the 2006 Act that the Licensee must pay to Monitor a fee in respect of Monitor's exercise of its functions under sections 39 and 39A of that Act the Licensee shall pay that fee to Monitor within 28 days of the fee being notified to the Licensee by Monitor in writing.

**Condition FT3 – Provision of information to advisory panel**

99. The obligation in the following paragraph of this Condition applies if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

100. The Licensee shall comply with any request for information or advice made of it under Section 39A(5) of the 2006 Act.

**Condition FT4 – NHS foundation trust governance arrangements**

1. This condition shall apply if the Licensee is an NHS foundation trust, without prejudice to the generality of the other conditions in this Licence.

2. The Licensee shall apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

3. Without prejudice to the generality of paragraph 2 and to the generality of General Condition 5, the Licensee shall:

   (a) have regard to such guidance on good corporate governance as may be issued by Monitor from time to time; and

   (b) comply with the following paragraphs of this Condition.

4. The Licensee shall establish and implement:

   (a) effective board and committee structures;

   (b) clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and

   (c) clear reporting lines and accountabilities throughout its organisation.

5. The Licensee shall establish and effectively implement systems and/or processes:

   (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;

   (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations;

   (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;

(d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);

(e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;

(f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;

(g) to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and

(h) to ensure compliance with all applicable legal requirements.

6. The systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure:

(a) that there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;

(b) that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;

(c) the collection of accurate, comprehensive, timely and up to date information on quality of care;

(d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;

(e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and

(f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

Section 6 – NHS Foundation Trust Conditions

7. The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

8. The Licensee shall submit to Monitor within three months of the end of each financial year:

   (a) a corporate governance statement by and on behalf of its Board confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks; and

   (b) if required in writing by Monitor, a statement from its auditors either:

      (i) confirming that, in their view, after making reasonable enquiries, the Licensee has taken all the actions set out in its corporate governance statement applicable to the past financial year, or

      (ii) setting out the areas where, in their view, after making reasonable enquiries, the Licensee has failed to take the actions set out in its corporate governance statement applicable to the past financial year.

## Section 7 – Interpretation and Definitions

### Condition D1 – Interpretation and Definitions

101. In this Licence, except where the context requires otherwise, words or expressions set out in the left hand column of the following table have the meaning set out next to them in the right hand column of the table.

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| "the 2006 Act" | the National Heath Service Act 2006 c.41; |
| "the 2008 Act" | the Health and Social Care Act 2008 c.14; |
| "the 2009 Act" | the Health Act 2009 c.21; |
| "the 2012 Act" | the Health and Social Care Act 2012 c.7; |
| "the Care Quality Commission" | the Care Quality Commission established under section 1 of the 2008 Act; |
| "clinical commissioning group" | a body corporate established pursuant to section 1F and Chapter A of Part 2 of the 2006 Act; |
| "Commissioner Requested Service" | a service of the sort described in paragraph 2 or 3 of condition G9 which has not ceased to be such a service in accordance with paragraph 9 of that condition; |
| "Commissioners" | includes the NHS Commissioning Board and any clinical commissioning group; |
| "Director" | includes any person who, in any organisation, performs the functions of, or functions equivalent or similar to those of, a director of:<br>(i) an NHS foundation trust, or<br>(ii) a company constituted under the Companies Act 2006; |
| "Governor" | includes any person who, in any organisation, performs the functions of, or functions equivalent or |

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| | similar to those of, a Governor of an NHS foundation trust as specified by statute; |
| "the NHS Acts" | the 2006 Act, the 2008 Act, the 2009 Act and the 2012 Act; |
| "NHS Commissioning Board" | the body corporate established under section 1E of, and Schedule A1 to, the 2006 Act; |
| "NHS foundation trust" | a public benefit corporation established pursuant to section 30 of, and Schedule 7 to, the 2006 Act. |

102. Any reference in this Licence to a statutory body shall be taken, unless the contrary is indicated, to be a reference also to any successor to that body.

103. Unless the context requires otherwise, words or expressions which are defined in the 2012 Act shall have the same meaning for the purpose of this Licence as they have for the purpose of that Act.

Any reference in the Licence to any provision of a statute, statutory instrument or other regulation is a reference, unless the context requires otherwise, to that provision as currently amended.

The Dudley Group NHS
NHS Foundation Trust

# TRANSFORMATION PROGRAMME BOARD

## TERMS OF REFERENCE

### 1. Constitution

**1.1** The Board of Directors resolves to establish a Committee of the Board to be known as the Transformation Programme Board. The Transformation Programme Board in its workings will be required to adhere to the Constitution of The Dudley Group NHS Foundation Trust, the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts. As a committee of the Board of Directors, the Standing Orders of the Trust shall apply to the conduct of the working of the Transformation Programme Board.

### 2. Membership

Trust Chairman (Chair)
Non Executive Director
Chief Executive,
Director of Operations and Transformation,
Medical Director,
Director of Nursing,
Director of Finance and Information,

### 3. Attendance

3.1 The following members of staff will usually be in attendance at every meeting:

Associate Director of HR,
Director of Community Services and Integrated Care,
Associate Director of IT,
Head of Transformation
Head of Information,
Deputy Director of Operations (Estates and FM),
Accountable Officer / Acute Contract Lead from CCG

3.2 The Chief Officer of NHS Dudley, or his representative, shall be in attendance.

3.3 All other members of the Board of Directors shall be entitled to attend and receive papers to be considered by the Transformation Programme Board.

3.4 Other managers/staff or representatives of the Trust PFI Partners may be invited to attend meetings depending upon issues under discussion.

3.5 The Trust Secretary will ensure that an efficient secretariat service is provided to the Transformation Programme Board.

### 4. Quorum

4.1 A quorum shall be 3 members to include at least one Non Executive Director, and one Executive Director. Additionally it is expected that a member of the Transformation team and a CCG representative will be in attendance at every meeting.

### 5. Frequency of meetings

5.1 The Transformation Programme Board will meet bi monthly.

5.2 Additional meetings may be held at the discretion of the Chairman of the Board.

## 6. Authority and Scope

6.1 The Trust is facing new challenges to meet the expectations of our patients and to achieve quality and financial improvements. Large scale transformational change is required to be aligned to the Trust vision and strategy that requires Health Economy wide input and support.

Organisations and individuals often adopt low value interventions while failing to develop or introduce high value interventions, unless innovation is managed.

6.2 The Transformation Programme Board is authorised by the Board of Directors to investigate any activity within its terms of reference. The following working objectives have been set:

- Prioritisation of Trust wide transformational changes and service improvement projects (including supporting activities such as IT and Estates Strategy)
- Review the progress of the Transformation Programme through PMO reporting and determine appropriate strategies for unblocking issues and concerns
- Identification, management and progression of innovation, service improvement and transformation ideas
- Promote and sponsor the development of new ways of working and to introduce new high value ideas from elsewhere
- Promote research and evaluation and ensure that new services or interventions of uncertain value are introduced only in the context of evidence base
- Assure themselves that the Trust ensures that interventions of low value, new tests, new treatments, or new services are not introduced
- Horizon scanning to determine where we go next.
- Strategic prioritisation of the Transformation Programme for the next 3-5 years
- Ensure Trust Transformation Programme links to strategic aims and commissioning intention of CCG and local authority.

6.3 It is anticipated that the following will be delivered:

- Schedule of Transformational Change Projects
- Actions to assist in unblocking issues/concerns
- Horizon scanning, ideas generation and sharing of innovation
- Benefits realisation and evaluation

6.4 The following measures of success are expected:

- Benchmarking against Peer Group for KPI's including LOS and New:FU rates
- Improved SLR position
- A culture of innovation and idea generation
- Greater awareness of ideas that have been generated and implemented Trust wide

- Value and evidence based health provision

## 7. Duties

The duties of the Transformation Programme Board can be categorised as follows:

7.1 To oversee the development and effective implementation of the Transformation Programme including:

- Prioritisation of the Trust and Health Economy wide programme of work taking into account the wider Health Economy and Department of Health expectations
- Progress reports on the overall programme
- Oversee delivery of the programme through management and mitigation of issues and risks
- Ensure the impact on quality of services has been fully considered
- Benefit tracking and realisation
- Register of risks and clear plans for risk mitigation
- Review of supporting activity/sub groups (i.e. IT)
- Ensure that best practice and benchmarking from other Trusts and organisations has been considered in implementing changes
- Consider external impacts on the delivery of the programme and how these can be managed
- Ensure that resource requirements to deliver projects are clear and lever additional resources to support the Programme as required (this may include commissioning external advice and support)

7.2 Additionally the Transformation Programme Board will:

- Bi-monthly prioritise Trust wide service improvement projects
- Undertake horizon scanning and sharing of innovation practices to influence future strategic decision making
- Undertake benchmarking against other Healthcare providers and unblocking lack of progress and mitigation of risk to deliver

## 8. Reporting

8.1 The Transformation Programme Board reports to the Board of Directors.

## 9. Review

9.1 The Terms of Reference of the Transformation Programme Board shall be reviewed by the Board of Directors at least annually.