The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 3rd October 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	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 5th September 2013	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 5th September 2013	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**	Video	D Mcmahon	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 4	D Bland	To Note & Discuss	10.00
	7.2 Infection Prevention and Control Exception Report	Enclosure 5	D McMahon	To Note & Discuss	10.10
	7.3 Keogh Review Progress Update	Enclosure 6	P Clark	To Note & Discuss	10.20
	7.4 Francis Report	Enclosure 7	P Clark	To Note & Discuss	10.30
	7.5 Organ Donation Half Yearly Report	Enclosure 8	D Badger/ R Timmins	To Note	10.40
	7.6 Revalidation Report	Enclosure 9	P Harrison	To Note	10.55
8.	**Finance**				
	8.1 Finance and Performance Report including list of potential fines	Enclosure 10	D Badger	To Note & Discuss	11.05
9.	**Date of Next Board of Directors Meeting** 9.30am 7th November, 2013, Clinical Education Centre		J Edwards		11.15

10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards		11.15

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 5th September 2013 at 9:30am in the Clinical Education Centre.

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

In Attendance:
Helen Forrester, PA
Richard Cattell, Director of Operations
Annette Reeves, Associate Director for Human Resources
Elizabeth Rees, Director of Infection Prevention and Control
Mandy Green, Deputy Head of Communications and Patient Experience
Jackie Dietrich, Communications Manager

13/043 Note of Apologies and Welcome

Apologies were received from the Director of Nursing, Denise McMahon. The Board welcomed Jackie Dietrich, Communications Manager, who was in attendance for Liz Abbiss. The Chairman also welcomed Auditors from Deloitte who were in attendance as part of the Trusts Governance Review.

13/044 Declarations of Interest

There were no declarations of interest received.

13/045 Announcements

There were no announcements to be made.

13/046 Minutes of the previous meeting on 4th July, 2013 (Enclosure 1)

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

13/047 Action Sheet 4th July, 2013 (Enclosure 2)

13/047.1 LiA Update Report.

Jules Perks has been appointed as Staff Engagement Lead and is working with Jackie Dietrich on LiA.

13/047.2 Patient Story

Positive Feedback is being collected through the Friends and Family Test and a forum is being arranged for sharing best practice.

13/047.3 Francis Report

This action had been completed

13/047.4 Audit Committee Exception Report

On the agenda at item 7.5

13/047.6 Charitable Funds Committee Report

This action will be carried forward to the October Board Meeting.

Charitable Funds Committee Chair to meet with Georgina Unit Fund Chairman Re: their activities.

13/047.7 Mid Staffs report

On the agenda at item 7.2

13/048 Patient Story

Mandy Green presented the Patient Story video of a gentleman's experience of Ward C8, the Acute Medical Unit. She added that the main points raised by the patient were that he liked the food and was happy with the medical care he received. Other points raised by the patient with regards to the entertainment have drawn Mandy Greens attention to the fact that the Trust needs to ensure radio stations are available on all wards. An audit of televisions is also being undertaken.

The Chief Executive raised concerns around the cost of televisions to the Trust and asked what the installation costs were.

Mandy Green informed the Board that Interserve quote anything from £500 to £1000 for the installation of televisions on wards.

Ann Becke, Non Executive Director asked how far we had reached with the development of the 'meet and greet' initiative as this would be a good opportunity to explain the entertainment options for patients whilst staying on a ward.

Richard Beeken, Director of Performance Strategy and Transformation informed the Board that the Volunteers are actively helping with the 'Meet and Greet' service.

Ann Becke asked if Charitable Fund monies could pay for the installation of televisions on wards.

Richard Beeken confirmed that Charitable Funds Monies are used for this in some areas and would continue to pay for any additional televisions; he went on to explain that the patient entertainment system within the Trust is currently being evaluated.

David Badger asked if the Board could receive a breakdown of costs around Interserve quotes for the installation of technology.

The Chairman pointed out that the Board will need a business case for the wired and wireless technology within the Trust. He added that the wards should be challenged to ensure they have a supply of earphones.

Paul Harrison mentioned that ‘meet and greet’ would not work for emergency patients.

John Edwards asked if the bedside packs contain information on ward entertainment.

Mandy Green confirmed that a poster at the side of the bed already contains this information.

The Board noted that this patient was comfortable with the clinical care received despite finding it difficult being on their own in a side room. It was also noted that this patient liked the food although one meal was not hot.

Mandy Green pointed out that the temperature of food comes up often in patient feedback, with many patients complaining the food is not hot enough.

The Chairman noted it was good to see a generally positive experience.

Richard Beeken questioned how good the Trust was at managing patients’ expectations of their care as the modern medicine process is very different to how it used to be.

Richard Cattell, Director of Operations mentioned that this was a role for the Nursing Team.

Paul Harrison, Medical Director pointed out that it is difficult for patients to understand different hospital areas and therefore staff must ensure they communicate well with patients throughout their care.

Mandy Green informed the Board that in EAU there are signs in the cubicle explaining where the patient is.

The Chairman noted issues around the ‘meet and greet’ process, patients being in side rooms, food presentation/temperature and general communication to patients.

Business Case for wired and wireless solution to the Finance and Performance Committee.

13/049 Chief Executive’s Report (Enclosure 3)

The Chief Executive presented her report including:

Patient Food: A recent media report stated The Dudley Group, despite being one of the highest spenders on food provision, is rated as one of the worst for the quality of its patient food. A response is awaited from the PFI providers about the options available.

Richard Beeken, Director of Performance Strategy and Transformation pointed out that the Trust had demanded an improvement plan using Amadeus recommendations.

David Badger notified the Board of the Finance and Performance Committees discussions on food including:

- The Trust still does not have clarity from Interserve on costs of food including the details around Steamplicity.

The Chairman asked for a food options paper to be brought to the Private Board meeting in October, due to commercially sensitive information being included in the paper. The Interserve General Manger will be invited to the October Board meeting to discuss the current provision of food.

ED Performance: The Trust is currently at 96.4% for this quarter, it is critical we hit the target for Q2.

Richard Cattell, Director of Operations explained that the West Midlands Ambulance Service predictions are usually helpful however lately has been less so. The team are reviewing successful and non successful days to try and identify any patterns. He explained ED struggle particularly when Resus patients occupy senior staff that have the ability to make decisions, this will slow down the passage of patients through the department. .

The Chief Executive pointed out that the Intensive Support Team recommendations are being implemented in ED, this team will be returning in October to look at pathways.

The Chairman asked if the ED planning work, when complete, could be included in the Chief Executives Report.

Deloitte Governance Review: This is currently in progress.

AQuA: The Advance Quality Alliance team is visiting the Trust the following day to scope the patient safety and quality work the Executive Team are undertaking with them.

Friends and Family Test: We have received good results on this CQUIN

Inpatient cancer patient experience survey: The Results state we have not performed well.

Mandy Green, Communications Manager explained that the Trust is currently working closely with the White House to look at providing an in house cancer information pod.

Paul Harrison, Medical Director explained to the Board that this option was looked at several years ago however did not go ahead due to various reasons.

Paul Assinder, Director of Finance and Information asked why we did not know we were poor in this area.

Mandy Green explained that the team were aware of the issues and is working with the Citizen's Advice Bureau to give more information to patients.

Ann Becke, Non Executive Director pointed out that she had attended a patient safety walkround on the Georgina Unit and an issue was raised on the environment.

Mandy Green clarified that this had been addressed and improvements are being made to make Georgina Unit a better environment for patients.

The Chairman noted that the inpatient experience survey results were as a result of a lack of information provided and were not as a result of poor quality care.

A2 Publicity: It was one bad score that placed this ward in the table, Margot James; MP is picking this issue up.

The Chairman pointed out the issues of consistency around the A&E Friends and Family feedback. He asked if the token system is accepted nationally.

Mandy Green confirmed that it was and some Trusts are already using it. The token system will begin next week.

Patient Food: Discussion around whether to invite the Interserve General Manager to attend Board.

Outcome of Georgina Unit Patient Experience Review to be presented to Board.

Include outcome of work into ED patterns in Chief Executives Report.

13/050 Quality

13/050.1 Clinical Quality, Safety and Patient Experience Committee (Enclosure 4)

David Bland, Committee Chair, presented the Exception Report given as Enclosure 4. The Board noted the following key issues:

- **C-diff:** We have exceeded the quarter one target by one; there is no specific pattern across the wards.

The Chairman noted that Liz Rees will explain this in more detail when she joins the meeting.

- **Patient Safety Group:** 65 red incidents were flagged and there are concerns around volume and timeliness, this was raised and flagged in July. Sharon Phillips is undertaking a bigger piece of work to re assess this.

The Chief Executive explained that additional resource is being put into the Governance Team.

- **Walkrounds:** Four outstanding actions from these are being reviewed by Julie Cotterill and more information will be provided at the next Clinical Quality, Safety and Patient Experience Committee.

The Chairman pointed out that a lot of outstanding Patient Safety Walkround issues were PFI related.

The Chairman went on to ask for clarity around a phrase from the NHS Choices website that states 'the Trust is well in range of Clinical Indicators'

Paul Harrison, Medical Director explained that this is collected from a wide variety of information he signs off each month, any outliers are highlighted to clinical managers and are dealt with appropriately.

The Board noted the report and the issues arising.

13/050.2 Francis Report (Enclosure 5)

The Chief Executive presented the report on the Francis action plan, given as Enclosure 5.

The Chief Executive explained that at the last Board meeting the full Francis action plan was received and the Board agreed to bring it back to this Board meeting and bimonthly thereafter. The updates provided have been shown in yellow and the completed actions have been closed down and are shown in bold. The Board are asked to note the closed actions so these can be removed from the action plan. A number of actions are to be linked to the Keogh action plan and the remainder will be progressed bi monthly at Board.

David Badger, Non Executive Director asked if there were action plans within Directorates for the open actions that were specific to them

The Chief Executive confirmed that there were.

David Badger asked if the Keogh and Francis action plans could be merged.

The Chief Executive assured that they could, however they will remain as two distinct plans at present.

Paul Harrison, Medical Director explained that we have used action plan methodology however Francis was keen that recommendations were not delivered through an action plan, some processes are ongoing and will never be closed down.

The Chairman added that a lot of actions are about the culture of the organisation and are never ending making them difficult to measure or progress.

Completed and closed actions to be removed from the plan. A number of actions to be linked to the Keogh Plan and the remainder of action to be presented to Board bi-monthly.

13/050.3 Infection Prevention and Control Exception Report (Enclosure 6)

Liz Rees, Director of Infection Prevention and Control, presented the Infection Prevention and Control Exception Report given as Enclosure 6**.** Board members noted that following areas:

MRSA: No Confirmed Cases.

Norovirus: No Confirmed Cases.

C.Diff: 15 post 48 cases against a target of 18, meaning we are within trajectory.

Neonatal Pseudonomas: 2 babies found with Neonatal Pseudonomas, one baby was transferred from another unit.

Liz Rees, Director of Infection Prevention and Control explained that the Lead Nurse for Infection Prevention and Control has resigned and there is currently a Specialist Nurse acting as lead.

Richard Cattell, Director of Operations asked if the transfer of patients puts us at risk of inheriting infections without knowing.

Liz Rees assured the Board that most units would let us know if a baby had a known infection. Babies from other units are isolated on arrival and screened.

Paul Harrison, Medical Director pointed out that the Trust is not doing as well as hoped around antibiotic prescribing,. an electronic prescribing system is key to improving this.

Paul Harrison noted that Basildon Trust has recently been fined for Legionella cases and asked if we should be reviewing within our own Trust.

Liz Rees assured the Board that she attends the Trusts Water Safety Committee that meets monthly and undertakes an annual risk assessment of the site. There are some risks however these are managed well. The Trust has employed an engineer to scrutinise the building maintenance programme.

Paul Assinder, Director of Finance and Information noted that the C-diff target was challenging, previous annual profiles show a mixture of peaks and troughs, he asked if the Trust was doing enough to ensure we meet the target.

Liz Rees made the Board aware that the fogging is being carried out pro-actively rather than reactively and a band 7 pharmacist is in place looking at high risk patients.

The Chief Executive commented that it would be helpful if there was more headroom on occupancy levels for isolation.

The Chairman asked why the usual July spike for C-diff had happened in June.

Liz Rees explained that that there was not any clear reason.

13/050.4 Risk and Assurance Committee Exception Report (Enclosure 7)

Ann Becke, Chair of the Risk and Assurance Committee presented the report given as enclosure 7.

The Board were notified that the Diagnostics directorate had attended the last Risk and Assurance Committee, it was a good meeting and Diagnostics found it highly supportive to embed risk into their directorate. Diagnostics have some risks they are responsible for that they have no control over therefore the Committee is working closely with them to provide support for managing this.

Ann Becke, Chair of the Risk and Assurance Committee notified the Board that the corporate risk register had 25 risks, all lead by the Directors.

The Board noted the CQC Quality Risk profile exceptions report had shown no major issues.

The Chief Executive informed the Board that Kevin Shine, Deputy Director of Information will be attending the new CQC Risk Profile meeting in the next couple of weeks, this Committee will look at the Trusts risk profiles against the new regime, Kevin will report the findings back to the Board.

Paul Harrison offered to share the draft range of criteria.

The Chairman said this would be helpful.

The Chief Executive assured the Board they would receive the criteria.

Ann Becke, Chair of the Risk and Assurance Committee added that she would ask Julie Cotterill, Governance Manager to include a summary.

The Chairman asked for Kevin Shines report to go to the Finance and Performance Committee first.

Paul Assinder replied that Kevin will be giving a full briefing to the Finance and Performance Committee.

Paul Assinder, Director of Finance and Information pointed out that the Monitor rating was not consistent with the CQC governance rating.

Kevin Shine to produce a full briefing on CQC Risk Profile for the Finance and Performance Committee.

13/050.5 Audit Committee Exception Report (Enclosure 8)

Jonathan Fellows presented the exception report including the following issues:

- **Risk and Assurance Exercise:** The good results were encouraging to the Committee.

- **Local Counter Fraud:** The Committee has identified 1 individual who was working at another Trust whilst claiming to be off sick, this has been dealt with through the Human Resources process.

- **Deloitte Modified Opinion** – The Representation Letter and charitable funds accounts have been approved.

- **Results of PbR Audit**: Need to ensure coding recourses are put into the service.

- **Audit of Sickness Absence:** This was referred to the Finance and Performance Committee to discuss.

- **Annual Report:** This is attached within the report at page 11, the opinion of Committee is positive.

The Chairman asked if the sickness absence audit showed the Trusts processes are sound and robust.

Jonathan Fellows notified the Board that they were not; sometimes paperwork is not always completed or filed correctly.

Annette Reeves, Associate Director for Human Resources pointed out that the last audit showed we were green for policies/ process and amber/red for implementation. The increasing trend is that we have robust policies and procedures however we need to improve the implementation down the line.

David Badger, Non Executive Director assured the Board that the Finance and Performance Committee were looking at sickness absence and had asked Annette Reeves, Associate Director for Human Resources and Richard Beeken, Director of Performance, Strategy and Transformation to do a piece of work looking at specific clinical directorates, he added that it was critical that the information coming through is correct for that piece of work.

The Chairman commented that it would be interesting to see if this is leading to under or over reporting of sickness absence.

The Chairman noted that the results of this audit are better than previous and therefore improvements are being made. He asked if the Director of Finance and Information was happy about less financial auditing.

Paul Assinder, Director of Finance and Information confirmed that he was and the External Auditors are also comfortable with it.

The Chairman supported the recommendations noted and approved the Charitable Funds Representation Letter, referred sickness absence for discussion at the Finance and Performance Committee and note the Annual Report and opinion of the Committee.

Audit of Sickness Absence to be presented at the Finance and Performance Committee.

13/050.6 Corporate Risk Register

The Chief Executive presented the Risk Register which had been reported to the Risk and Assurance Committee, recommended to the Board to receive and approve the report, noting recommendations on key risks and gaps in assurance.

Richard Miner, Non Executive Director notified the Board that he had visited Maternity a year ago and again recently and had a sense that things had improved significantly, he asked if the risk score would reduce once the processes are embedded.

The Chief Executive said she had discussed reducing risk with Yvonne O Connor, Deputy Nursing Director and Steph Mansell, Head of Midwifery; they are comfortable they can and are looking at how we can lift the cap, they believe the new Midwives who now have a years experience will improve the situation.

The Chairman asked the Chair of the Audit Committee if he was content with the risk register driving the audit plan.

Jonathan Fellows, Chair of the Audit Committee confirmed he was.

The Board approved the Corporate Risk Register and took note of the assurance and gaps in content.

13/050.7 Keogh Review Progress Update (Enclosure 10)

The Chief Executive presented the update on the action plan which had been given to the CCG and LAT and had been sent to Ruth May. It will also go to the Overview Scrutiny Committee later this month. The Board are asked to receive the report and note the identified actions. The yellow parts show the urgent actions from the original plan; further work is being done on the action plan for Monitor.

David Badger, Non Executive Director drew the Boards attention to the action at the top of page 9, asking how the Trust was progressing with the AUKUH tool.

The Chief Executive informed the Board that The Director of Nursing is moving forward looking at using a different proforma for 12 hour shifts.

The Chief Executive informed the Board that Ruth May came for an invited visit this week and they had a positive conversation regarding nursing numbers.

The Chairman asked for Audit and the AUKAH tool to be reported to Board in October. He added that there was still a debate in the press about mandated levels of nursing.

The Chief Executive agreed there was not any clarity over the correct numbers of nurses that should be employed.

The Chairman asked if the closed items could be shown on the plan.

The Chief Executive confirmed that this had been picked up by monitor and will be actioned.

The Board received the report and took note of the actions. The Chairman asked that this is brought back to the October Board.

13/051 Finance

13/051.1 Finance and Performance Report (Enclosure 10)

David Badger, Chair of the Finance and Performance Committee presented the overview report from the previous two meetings including:

- **Performance:** The Trust continues to maintain good performance against targets and have maintained a 'sea of green' on the dashboard, it is noted that ED are on target for Quarter 2 however we must keep our focus on this as it is a volatile area.

- **C.Diff:** It has been the Trusts best ever performance however we are still hovering around trajectory, this has been referred to the Clinical Quality, Safety and Patient Experience Committee.

- **Diagnostic Waits:** There were concerns around this as they marginally missed the target.

- **Sickness, Mandatory Training and Appraisals:** The Committee continue to pay close attention to these areas, mandatory training has significantly improved however it has reached a point that is difficult to move forward.

- **Mortality:** The Trust is within all the expected ranges.

- **Money:** The Trust is performing above contract. There was a high run rate on expenditure in the 1st Quarter in particular agency staffing. There is a lot of volatility in budgets and CQUIN are affecting this which is offsetting the improved income. CIP is falling behind and the Committee are looking into this. The Trust received a small deficit of £229k at end of year. The Cash holding has dropped below £30m for the first time, a number of business cases are coming forward, financial position and risk rating are good but we need to step up action on CIP and plan for next year a lot earlier.

Jonathan Fellows pointed out that the Governance rating at point 13 states Amber/Red however it should read Amber/Green

David Bland, Non Executive Director asked why there had been deterioration in the run rate and increase in agency staffing.

The Chief Executive clarified that this had been down to higher level of activity and Keogh. It has been seen that controls have been circumvented by staff, straying controls have been put back into place and each area has been asked to bring their workforce plans to performance meetings.

Paul Assinder, Director of Finance and Information commented that a perfect storm is brewing, everything cannot be delivered next year in context with the current work profile, he predicted very challenging and turbulent time ahead with no headroom in the system.

Paul Harrison added that Keogh has had a huge impact for Nursing.

The Chairman asked with regards to paragraph 11 on the financial performance and volatility in the system if it was worse this year.

The Director of Finance and Information confirmed it is significantly worse, there were huge changes in the commissioning landscape half way through the year but no invoice values have been agreed yet.

Jonathan Fellows, commented that this is particularly down to data protection systems at the CCG.

The Chairman endorsed comments about starting to plan for CIP earlier.

The Chief Executive added this should be a constant process.

The Chairman asked where we are with the Allocate business case.

Paul Assinder, Director of Finance and Information assured the Board this was actively being piloted and rolled out; the indications so far are good.

13/052 Any Other Business

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

13/053 Date of Next Meeting

The next Board meeting will be held on Thursday, 3rd October, 2013, at 9.30am in the Clinical Education Centre.

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

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

Enclosure 2

The Dudley Group NHS
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Action Sheet
Minutes of the Board of Directors Public Session
Held on 5 September 2013

Item No	***Subject***	***Action***	***Responsible***	***Due Date***	***Comments***
13/027.2	Charitable Funds Committee Report	Charitable Funds Committee Chair to meet with Georgina Unit Fund Chairman Re: their activities.	RM	3/10/13	R Miner has made contact. Meeting to be held imminently.
13/038.2	Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry	Board to continue to receive a monthly exception report until October and then bi-monthly thereafter.	DM	3/10/13	On Agenda
13/050.2	Francis Report	Completed and closed actions to be removed from the plan. A number of actions to be linked to the Keogh Plan and the remainder of action to be presented to Board bi-monthly.	PC	3/10/13	On Agenda
13/039.1	Finance and Performance Report	List of potential fines to be presented to the October Board.	DB	3/10/13	On Agenda
13/040.1	Food and Nutrition Report	Complete Food and Nutrition Report including market testing options to be presented to the October Board.	RB	3/10/13	On Private Agenda
13/049	Chief Executives Report	Patient Food: Discussion around whether to invite the Interserve General Manager to attend Board to take place outside of the Board meeting. Outcome of Georgina Unit Patient Experience Review to be presented to Board. Include outcome of work into ED patterns in next Chief Executives Report.	RB RB C	3/10/13 7/11/13 3/10/13	On Private Agenda In CEs Report
13/048	Patient Story	Business Case for wired and wireless solution to the Finance and Performance Committee. Volunteers to check that wards have a supply of headphones.	JT MG	31/10/13 31/10/13	

13/050.4	Risk and Assurance	Kevin Shine to produce a full briefing on CQC Risk Profile to the Finance and Performance Committee.	KS	31/10/13	
13/050.5	Audit Committee	Audit of Sickness Absence to be presented at the Finance and Performance Committee.	AR	31/10/13	
13/038.6	Quarterly Safeguarding Report	Report on the Winterbourne Report findings to be presented at a future Board meeting.	DM	7/11/13	

Enclosure 3

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 3rd October 2013

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- ED Performance Q2
- Learning from Performance - ED
- Friends and Family Test
- Cancer Survey 2012/2013 Update
- Patient Experience
- Patient-Led Assessments of the Care Environment (PLACE)
- Integrated Care Pioneer Bid

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

Chief Executive Update – October 2013

ED Performance – Q2 to date:

As at 26th September 2013, we are at 96.62% for Quarter 2 to date, the Q2 outturn will be available verbally at the Board meeting.

We are currently having less attenders than the same period last year (40,000 in Q2 2013/14 compared to 42,000 in Q2 2012/13) but the age profile and major / minor mix would indicate some increase in patient complexity. We have also identified a change in time of arrival, particularly of ambulances, with early evenings becoming busier.

Preparations for winter / Q3 are well underway. We await any funding settlement for our winter bids from the CCG.

Learning from Performance - ED

To further learn from our successes and failures, we have analysed several variables associated with capacity management on two days when we achieved 100% and two days when we achieved <90%. We have yet to complete the analysis but the headlines would indicate that early escalation of ED capacity issues, early morning availability of ED, EAU and medical ward space, and escalation of nursing staff issues when they arise are associated with better performance against this target. We are also noting a considerable increase in emergency surgery and trauma. The learning from this performance is being fed into our winter plan and 4hr recovery plan.

Friends and Family Test:

Latest Figures

	April 13 Overall	May 13 overall	June 13 overall	April to June cumulative	July 13 overall	Aug 13 overall	Sept 32 Wk 1	Sept 13 Wk 2	Sept 13 Wk 3
	01.04.13	01.05.13	01.06.13	**01.04.13**	01.07.13	01.08.13	02.09.13	09.09.13	16.09.13
Date range	30.04.13	31.05.13	30.06.13	**30.06.13**	31.07.13	31.08.13	08.09.13	15.09.13	23.09.13
Number of eligible inpatients	*1930*	*1962*	*1929*	*5821*	*1987*	*1968*	*472*	*472*	*482*
Number of respondents	*408*	*573*	*505*	*1487*	*500*	*549*	*123*	*94*	*102*
Ward FFT score	66	75	74	**72**	71	73	69	73	74
Ward footfall	21%	29%	26%	**26%**	25%	28%	26%	20%	21%
Number of eligible A&E patients	*4206*	*4380*	*4194*	*12800*	*4652*	*4488*	*995*	*980*	*961*
Number of respondents	*17*	*62*	*353*	*432*	*265*	*153*	*86*	*73*	*11*
A&E FFT Score	53	71	59	**60**	55	43	68	79	64
A&E footfall	0%	1%	8%	**3%**	6%	3%	9%	7%	1%
TRUST FFT Score	65	74	68	**70**	65	66	69	76	73
TRUST footfall	7%	10%	14%	**10%**	12%	11%	14%	12%	8%

Scores for inpatients remain level with the national average, but response rates have seen a slight dip in September weeks 2 and 3 across a number of wards.

A&E scores have increased for September following a decrease in July and August, but response rates remain low with the positive increase in September weeks 1 and 2 not being sustained. The token system has now been installed in A&E and we expect to see a marked increase in the response rate from September week 4.

Friend and Family National Benchmarking

Trust scores					
	April	May	June	**Quarter**	July
A&E	53	71	59	**61**	55
Inpatients	66	75	74	**71**	71
Combined	65	74	68	**69**	65
National scores					
	April	May	June	**Quarter**	July*
A&E	49	55	54	**53**	54
Inpatients	70	70	71	**70**	71
Combined	62	64	63	**63**	64

*latest available data at 25/9/13

Cancer survey 2012/13 update

At the last Board meeting, it was requested that an update be brought back to aid understanding of the environment and information issues relating to the cancer survey.

Environment

Two specific environment issues have been struggling to progress for some time.

Firstly swapping two rooms on C4 – the drug store (in the link area between the ward and isolation area) and the seminar room (located on the ward). This will provide a better storage environment for the controlled drugs and mean that staff do not have to leave the main ward area to access drugs, as happens at present. The Leukaemia Appeal Fund has agreed to fund this work which will on site before the end of October 2013.

Secondly, and a big patient experience issue for patients waiting for clinics/chemotherapy, is improvements to the ‘pod’ just outside C4. This would provide an additional (and more comfortable) waiting area and incorporate a small clinical area. The variation for this is now being amended to include the addition of a sink for the clinical work; once the variation amount is known final agreement can be reached with the Leukaemia Appeal Fund to complete these works.

Work is expected start in approximately two months’ time subject to agreeing a price with the contractor who is currently undertaking the works to the first floor pod as the two pods are almost identical in work required.

Information

The Trust has scored poorly on questions surrounding the provision of information to patients diagnosed with cancer. This was a little surprising following a raft of work undertaken during the year on the Information Prescription which provides tailored information to patients on their own condition and circumstances. Work has also been undertaken to set up a financial advice programme with the Citizens Advice Bureau – which is underway and is generally fully subscribed.

To further improve cancer information The White House charity are proposing to set up a patient information hub by the Georgina Unit and met with the suppliers on site on 26th September to start this project off.

Following the recent survey the Trust Cancer and Palliative Care Group has set up a sub-group to look at the provision of patient information throughout the cancer journey and consider a secondary information pack to follow the Information Prescription as a reminder and to give additional information. They have also agreed to ensure that the full range of MacMillan booklets are available to patients and that Free Prescriptions posters are on display in applicable areas.

MacMillan is also currently running an advertising campaign on our Hub to provide staff with resources to aid their discussions about employment issues with patients affected by cancer.

A full action plan is being drawn up to address all issues in the cancer survey and will be reported through the Clinical Quality, Safety, Patient Experience Committee.

Patient Experience Event

The Keogh Review team requested – *The board should review its approach to developing a patient experience strategy and ensure it is clear how its priorities in this area will be measured and monitored*. It was agreed to hold a patient experience event on 10th July 2013 to allow testing of the key themes in the patient experience strategy approved at Board in March 2013 and listen to the priorities of patients, the public and our partner organisations in an open forum.

The event was successful and well received with over 60 people attending, from patients, public, governors, board members, staff and partner organisations. The Listening into Action format was used to encourage participants to be as precise and clear about changes the Trust can make to help improve its patients' experiences. The following key themes came out of the session:-

Appointments
Behaviours and attitude
Listening to patients
Information and advice
Patient flow/ capacity
Time and resources

There were some new 'gems' from the event, but for the main part similar themes came from this event to those thousands of patient feedback comments we receive each year. This will help to strengthen our action planning under the three key themes in the patient experience strategy of people, places and processes. It also produced some very useful feedback on which actual improvements would mean the most to patients. We are finalising the action plan which will go to Clinical Quality, Safety, Patient Experience Committee in October and have fed back to all attendees the key themes.

Patient-Led Assessments of the Care Environment (PLACE)

The new national inspection regime for hospital environments was launched earlier this year (replacing PEAT). The results were published on 18th September and it is pleasing that The Dudley Group has scored higher than the national average for three out of the four areas; cleanliness of wards, including bathrooms, furniture, fixtures and fittings, the condition, appearance and maintenance of sites, and our patients' privacy and dignity. However food and hydration was below the national average and below our local peers by some margin. See table below for comparison of scores and more info can be found at The Health and Social Care Information Centre.

Inspection area/criteria	The Dudley Group NHSFT	Sandwell & West Birmingham NHS Trust	The Royal Wolverhampton NHS Trust	Ramsey Healthcare UK	National average
Cleanliness of wards, including bathrooms, furniture, fixtures and fittings	97.87%	98.40%	98.19%	95.95%	96.00%
Condition, appearance and maintenance of sites including decoration, signage, linen and car-park access	90.46%	95.29%	94.57%	89.45%	89.00%
Patients privacy, dignity and wellbeing, including their changing and waiting facilities, appropriate separation of single sex facilities, telephone access and appropriate patient clothing	90.92%	96.46%	89.34%	88.62%	89.00%
Patients' food and hydration (including assessment of choice, taste, temperature and availability over 24 hours	78.36%	91.81%	94.67%	89.21%	85.00%

Integrated Care Pioneer Bid

On 15th July 2013, all Board members received by email for information, the joint Dudley health and social care economy bid for "Pioneer" status on integrated health and social care. The Pioneer process is being sponsored directly by the Department of Health and is being personally driven and overseen by Norman Lamb, the Care Minister.

The intention behind the Pioneer programme is to support the development of integrated health and social care service provision. Whilst the national context of integration of services is now more complex as a result of the Health and Social Care Act 2012, nevertheless there is a national trend towards councils divesting themselves of direct service provision of social care and an ongoing desire to integrate care services to enhance the opportunity to ensure pathways experienced by patients and carers are as seamless as possible.

The programme of work being overseen by the Dudley Health & Wellbeing Board has clearly identified service user's desires to see more integration of care services to meet the more complex and changing demographic in the borough. This has since become one of the key joint strategic aims of both DMBC and the CCG, as commissioning organisations.

In practical terms, becoming one of the "Pioneer sites" may not yield more than national focus, benchmarking/best practice support and OD assistance. However, it has nevertheless been agreed to progress the forming of integrated health and social care teams as a key priority. In service terms, integration in Dudley would involve the creation of a smaller number of more resilient locality community nursing teams, integrated with social care professionals and "wrapped around" the CCG's new localities of primary care provision. There are no further practicalities agreed between the organisations about future form or function, however, it is expected that, if organised correctly and focused on health maintenance of the older people in the borough, the effect of the new approach on health economy sustainability could be significant. Clearly, the awarding of Pioneer status may give us additional support in determining the form, function and financial arrangements of such an intention.

On 16th September 2013, the Director of Strategy & Transformation represented the Trust at a final stage selection event for the Pioneer programme, at the Department of Health in London. Dudley CCG, DMBC and Dudley CVRS were also represented. 106 applications were made nationally and 25 have made it through to the final selection stage. 15 final Pioneer sites will be chosen.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 3rd October 2013

<table>
<tr><td>TITLE:</td><td colspan="3">Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 8th August 2013</td></tr>
<tr><td>AUTHOR:</td><td>Julie Cotterill
Governance Manager</td><td>PRESENTER:</td><td>David Bland (NED)
CQSPE Committee Chair</td></tr>
<tr><td colspan="4">CORPORATE OBJECTIVES:
SGO1: Quality, Safety & Service Transformation, Reputation
SGO2: Patient Experience
SGO5: Staff Commitment</td></tr>
</table>

SUMMARY OF KEY ISSUES:

Serious Incident Monitoring Report - 5 new incidents were reported in July (4 general serious incidents and 1 pressure ulcer). 1 of the incidents was categorised as a never event. The patient was unharmed but the incident was fully investigated. The Committee discussed the incident in detail and the advisory role of the CCG in confirming the assessment and downgrading of this.

There were 36 open general SI's (12 undergoing investigation, 14 awaiting assurance that all actions identified from the RCA had been completed). 2 extensions were granted by the CCG and 8 SIs were recommended for closure. There were no breaches in the 2 day reporting from date of identification and no breaches in the completion of the RCA within the agreed time scales. The Committee **noted** the current position and supported the closure of the 8 SI's recommended.

Aggregated Incident Report - there was an upward trend in the number of incidents reported in some categories. Of the 310 incidents reported in Quarter 1, 248 were in the subcategory "Clinical – Treatment Failures/Delays" which showed a quarter on quarter increase. 54 were due to a "Failure to Monitor Health Care Needs" showing a 48% increase in the number of incidents reported from the previous quarter. A review of these incidents identified that 28 related to pressure ulcers and of these all 9 community incidents were pressure ulcers. There was also an increase in "Medication incidents" over the last 3 quarters. The largest category was "Prescribing" accounting for 2348 of the 3011.

Patient Falls, Injuries and Accidents - This category continued to be an area of consistently high reporting. 285 of the 382 incidents (79%) were due to Slips, Trips and Falls. Of these 153 had no harm/near misses, 121 minor harm and 11 moderate harm. Of the 11 with moderate harm 5 sustained a fracture. These incidents were reported externally as Serious Incidents and a full Root Cause Analysis investigation was undertaken and subsequent action plans initiated. There was also a quarter on quarter increase in the number of equipment incidents reported with quarter 1 2013/14 showing a 60% increase in incidents reported from the previous quarter (42 increased from 25). 29 of the incidents were due to an "Actual Fault/Defect". A full review of all the incidents showed that 14 (33%) had been coded incorrectly and although they were equipment they were not medical devices e.g. mobile phones, computers. This has now been corrected. Of the remaining incidents one trend was identified. Five incidents related to nasogastric feeding tubes. The batches were removed from stock and this was reported to the MHRA. Of the remaining incidents there were no identifiable trends.

Quality Dashboard Report for Month 2 (June 2013/14) - the report confirmed 5 cases of CDiff in June, bringing the quarter 1 total to 11 cases. This was below the de-minimus figure of 12 set by Monitor. There were 3 C diff cases in July which meant that the Trust had exceeded the de-minimus limit for the year and now needs to ensure it does not exceed the in-year Monitor trajectory.

Maternity Smoking in Pregnancy –for the first time since December 2012 the Trust was in the green for June.**TAL Appointment booking within 4 days** – the Trust remains at around 54%, well below the target of 80% with Ophthalmology, Pain Management and ENT having the most. Key indicators highlighted two areas of poor performance. The Trust was amber for "Think Glucose" and there were three wards in the red; B1, B4 and C8.

Nursing Care Indicators - escalation process changes have been made to ensure that wards are challenged monthly on their results utilising revised escalation levels. Following the Keogh review and concerns raised by the Trust Resuscitation Officer, a new question has been added to the NCIs to ensure the daily resuscitation trolley checks are completed.

Safety Thermometers - the report showed an improving picture. The Trust reported 22 new pressure ulcers for the period April – June 2013 demonstrating a gradual reduction in incidents. The "falls with harm" figures continue to fluctuate. A new 'falls bundle' has been trialled on specific wards since January, the results of which will be reviewed by the Matron lead and it is expected that the 'falls bundle' will then be implemented in all clinical areas. Catheter acquired urinary tract infection (CAUTI) figures continue to reduce possibly as a result of the raised awareness of clinical staff on the use of urinary catheters and challenges to established practice being made in the clinical areas.

Mortality Report - the Committee was advised that the crude mortality trend line showed a slight increase following the bad weather in the winter quarter and dropped subsequently thereafter. The HSMR was under 100 and remained in the "normal" range. The SHMI had increased since September 2012 but was still within the over-dispersion range. Future Committee reports would also include Chair and Chief Executive M&M meeting notes. Attendance at the Chairman & Chief Executives M&M meeting had been expanded to include a senior coder and the relevant matron. Minutes of these meetings would in future be included in this report. All papers would go to Board.

CQC Exception Report - the CQC had not completed a full review against all 16 Essential Standards of Quality and Safety since February 2013 but made an unannounced visit on the 16th July 2013. The review looked at Management of Medicines and was completed by one Inspector. The Trust was found to be **fully compliant.** The Committee noted the data sources used to assess and compare compliance with the Essential Standards and considered the key issues arising from the assessments and comparative data sources and confirmed any further action required.

Reports from Reporting Groups:

- **Safeguarding Group -** The Learning Disability Liaison Nurse commenced on 29th July. PFI partners were now compliant with Adult and Children Safeguarding Training at Level 1 but it was noted that Porters required Level 2 training. Recent RCAs relating to the management of patients with learning disabilities had identified a gap in the knowledge base of staff in relation to the Mental Capacity Act.
- **Dudley Safeguarding Adult Board –** The meeting discussed the approval of a new competency based training package. The Learning and Development subgroup were informed that without significant investment from the Board, the Trust would not be able to implement this in view of the large number of staff involved and the resource required to deliver the training and assess competence.
- **Children's Services Group** (16th July 2013 :
    - **Joint APLS (Advanced Paediatric Life Support) -** The development of an in house course was being explored.
    - **West Midlands Quality Review of Standards for the Critically Ill/Injured Child -** The Trust was awaiting confirmation of the dates of the peer review. There were concerns about the time commitment required to prepare for the review. Matron P Smith was coordinating this.
    - **Safeguarding Children** - There was a further 'section 11' audit co-ordinated by the Dudley Safeguarding Children's Board. This was a self assessment of compliance with safeguarding children procedures.

Complaints PALs and Compliments Report - four complaints were categorised as 'high' risk on receipt of the complaint, "Delay in diagnosing neck fracture", "Alleged lack of care resulting in falls", "Inappropriate scan performed" and "Delay in diagnosing tumour".

Quality Account Update - Quarter 1 2013/2014 - Patient Experience - There were two hospital and two community targets for this topic. One hospital target was on track one was not. The relevant Matrons were taking action to improve assistance for patients at mealtimes. **Pressure Ulcers -** Both the two hospitals and the community end of year targets were on track to be achieved with large reductions in grade 3 and 4 ulcers in both sectors. An e-recording system was in use. **Infection Control -** the MRSA target was being met but the Trust was over trajectory by 2 cases against the C.difficile target at the end of June. **Nutrition/Hydration** - 2 of the 3 targets on these topics were missed slightly in the first quarter.

Clinical Audit Findings - 47 clinical audits were carried forward from the 2012/13 Clinical Audit Plan to the 2013/14 audit year. Several of these were in progress and 9 had been completed. Additionally good progress had been made with the completion of 8 audits from the 2013/14 Annual Plan.

NICE Guidance - there were 15 NICE Guidance in the 'not yet assessed' category. One guidance regarding DG 3 Computed tomography (CT) Scanners for cardiac imaging remained red and could not be implemented.

Patient Safety Group (11th June 2013) highlighted the following:

- **Cleanliness** – The group received the first combined cleaning scores from cleanliness audits undertaken by the Trust's FM Audit Team between 29 December 2012 and 9 May 2013. All scores indicated a good general standard of cleanliness.
- **Blood Transfusion** –competency training was improving gradually.
- **Point of Care Testing -** The POCT Supervisor presented a report on Staff Banding requirements for Point of Care Testing which aimed to establish which bands of staff could use what POCT device and areas where exceptions might apply.
- **Patient Safety Leadership Walk rounds -** since 1 April 2013, there had been six Patient Safety Leadership Walk rounds. Action plans had been developed for each. 24 actions had breached the completion date and remained outstanding. Of these 7 actions related to Minor Works/Estates Issues.
- **Staffing Levels** – Concerns were raised by Matrons about bank staff including hours worked, quality of work, inappropriate dress and the system for monitoring these and addressing concerns.

Friends and Family Survey Results – Survey results for July 2013 (1st to 24th only) were considered. A&E take up continued to be low and a token system was on order. New issues raised in the month related to the heat wave. A national FFT publication on 30th July identified that Dudley achieved a trust wide combined score of 69 for the quarter against the national score of 63. The inpatient FFT score had consistently remained above 70 since May and was 71 for July (1st to 24th). The Trust had been 'black listed' based on 1 complaint about Ward A2.

NHS Choices - the Trust was rated as 4 stars. 53 comments had been posted on NHS Choices.

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 8th August 2013 and refer to the full minutes for further details.

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

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd October 2013 - PUBLIC

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

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

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

GLOSSARY OF INFECTIONS

MSSA

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

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

MRSA

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

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

E Coli

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

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

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

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

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

C difficile

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

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

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

SUMMARY OF WARDS AND SPECIALTIES

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

Report to: Board of Directors

Subject: Infection Prevention & Control Report

Summary:

Clostridium Difficile - The target for 2013/2014 is 38 cases; at the time of writing the report 21 cases have been recorded.

C. Difficile Cases Post 48 hours – Ward breakdown:

Ward	Totals for 12/13	April '13	May '13	June '13	July '13	August '13	As of 23rd September '13	Totals so far 13/14
A1	2	0	0	0	0	0	0	0
A2	12	0	1	0	1	1	1	4
A3	0	0	0	0	0	0	1	1
A4	0	0	0	0	0	0	1	1
B1	0	0	0	0	0	0	0	0
B2	1	0	1	0	0	0	0	1
B3	4	0	0	0	0	0	1	1
B4	3	0	0	0	0	0	1	1
B5	0	0	0	0	0	0	0	0
B6	2	0	0	0	0	0	0	0
C1	7	1	1	0	0	0	0	2
C3	6	0	1	1	1	0	1	4
C4	4	0	0	0	0	0	0	0
C5	1	0	0	2	0	0	0	2
C6	3	0	0	0	0	0	0	0
C7	7	0	0	0	0	0	0	0
C8	2	0	0	0	0	1	0	1
MHDU	0	0	0	1	1	0	0	2
CCU/PCCU	0	0	0	1	0	0	0	1
Critical Care	0	0	0	0	0	0	0	0
EAU	1	0	0	0	0	0	0	0
SHDU	1	0	0	0	0	0	0	0
Total	**56**	**1**	**4**	**5**	**3**	**2**	**6**	**21**

See Appendix 1 – Board Report (2013/2014)

C. difficile – We have reported 21 post 48 hour toxin positive cases against a trajectory of 18 cases so far this year (annual target no more than 38 cases). The Trust has held a 72 hour meeting to review and establish an action plan to bring the number of new cases back within trajectory.

MRSA – Annual Target 2 (Post 48 hrs) - There have been no cases in the last month and no cases so far this financial year.

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

Board Report 2013/14 **Appendix 1**

(N13) Clostridium difficile infections

Monthly number of C.diff cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-13	1	3	-66.7%	1	3	-66.7%	5	7
May-13	4	3	33.3%	5	6	-16.7%	10	11
Jun-13	5	3	66.7%	10	9	11.1%	6	6
Jul-13	3	3	0.0%	13	12	8.3%	9	11
Aug-13	2	3	-33.3%	15	15	0.0%	8	11
Sep-13	6	3	100.0%	21	18	16.7%	9	9
Oct-13		4			22			
Nov-13		3			25			
Dec-13		4			29			
Jan-14		3			32			
Feb-14		3			35			
Mar-14		3			38			
FY 2013-14	21	38	-44.7%				47	55

The CCG target for Cdiff is 38 cases for the financial year. The vital signs reporting framework has indicated that samples taken during the first 48 hours of admission to hospital should not be considered as hospital acquired.
The Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours.
The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

(N1) MRSA infections

Monthly number of MRSA cases

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

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

MSSA infections		
Month / Year	Total	Cumulative
Apr-13	6	6
May-13	6	12
Jun-13	-	12
Jul-13	6	18
Aug-13	7	25
Sep-13	1	26
Oct-13		
Nov-13		
Dec-13		
Jan-14		
Feb-14		
Mar-14		
FY 2013-14	26	

Monthly number of MSSA cases

E.coli infections		
Month / Year	Total	Cumulative
Apr-13	25	25
May-13	13	38
Jun-13	14	52
Jul-13	22	74
Aug-13	29	103
Sep-13	1	104
Oct-13		
Nov-13		
Dec-13		
Jan-14		
Feb-14		
Mar-14		
FY 2013-14	104	

Monthly number of E.coli cases

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on October 3rd 2013

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

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

SUMMARY OF KEY ISSUES:

The attached report confirms the progress made against the local actions arising from the recommendations of the Francis Inquiry Report.

Updates provided are shaded in yellow. Completed and closed actions are shown in bold.

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD

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

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

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.					
4	Clarity of values and principles	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21	Board	Whilst the NHS Constitution underpins the core values and principles of the Trust, these will be re-visited and re-considered in light of the report and recommendations made.	**Open**
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions					
75	Enhancement of role of Governors	The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	10	Council of Governors and Chairman	The Board and Council of Governors will work together to progress these recommendations. Governors have committed to evaluate their current role in the monitoring of clinical quality within the Trust and strengthen this where necessary. This report will be produced by the Governor Development Group for consideration by the full Council in November 2013.	**Continue to Monitor and progress**
76		Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	10	Council of Governors and Chairman	The Board and Council of Governors will work together to progress these recommendations. Governors now attend patient safety walkabouts in ward areas to meet patients.	**Continue to Monitor and progress**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
79	Accountability of providers' directors	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	10	Chairman	Directors are currently required to comply with individual professional codes of practice and professional registrations. Any recommendations to comply with a prescribed code of conduct for directors that is not currently part of directors contracts will be complied with. The Department of Health has announced that it is currently developing an NHS wide assessment model for application in 2014.	**Open**
81		Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.	11	Board		**Open**
84		Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	10	Human Resources/ Board Secretary	This situation has not arisen in the Trust. However should this ever be the case then the Board Secretary together with the Director of HR would make the necessary referrals. The Department of Health has announced that it is currently developing an NHS wide assessment model for application in 2014.	**Open**
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings					
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13	Director of Transformation and Performance	The Health and Safety Manager role is currently vacant and is being considered as part of a restructuring of the F&E function within the Trust. Whilst arrangements for reporting RIDDOR incidents remain sound, the review of this recommendation will have to be deferred until the appointment of a new Health and Safety Manager for the Trust.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13	Director of Nursing	We will work with the HSE to meet any new requirements.	**Open**
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.					
174	Candour about harm	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	22	Medical Director	On 14th May the Medical Director advised all Consultants (inc Locums) and Trust Non-Consultant Medical Staff, of these requirements and confirmed that the Trust would not support any approach that was not consistent with these recommendations. Medical Director exploring the possibility of including a clause of openness and candour in all new medical staff contracts and retrospectively in all current medical staff contracts. **The duty of candour is included in the proposed contract which is subject to negotiations.**	**Open**
175		Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	22	Medical Director		

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Nursing					
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the:	23	Director of Nursing and Human Resources		
		– Possession of the appropriate values, attitudes and behaviours;			An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation.	**Open**
					Interviews for novice programme – entirely on values.	**Open**
		– Ability and motivation to enable them to put the welfare of others above their own interests;			To include in competencies for novices and new graduates.	**Open**
		– Drive to maintain, develop and improve their own standards and abilities;			All nursing staff/CSW have appropriate competencies and training programme, required to achieve before promotion to next grade – shortlisted for National Award 2013.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		• Leadership which constantly reinforces values and standards of compassionate care;			Developing Appraisal questions based on "The Way We Care" and Codes of Conduct The Trust runs 3 Leadership programmes • Clinical leadership in conjunction with the Hay Group aimed at CDs, MSHs and aspirant Clinical leaders. • A Trust Leadership programme which links to the NHS Leadership competency framework • A Trust Leaders Tool kit, aimed at people who are new to leading and are looking to again basis level technical skills in people management.	**Open**
		• Involvement in, and responsibility for, the planning and delivery of compassionate care;			Nursing strategy launched May 2013. 'The Way We Care' based on 6 C's and incorporating Trust Values of Responsibility, Care and Respect. KPI will be reported quarterly to Board.	**Open**
		• Constant support and incentivisation which values nurses and the work they do through: – Recognition of achievement;			Appraisals are managed as per the Trust's appraisal policy and cover both the technical part of any job together with the Trust values and the way the tasks are carried out by the employee. Recognition of good performance is made via "Committed to Excellence "and the Roll of Honour. The Trust also makes regular nominations to external awards	**Open**
		– Regular, comprehensive feedback on performance and concerns;			Nurses referred to NMC report to be taken to the Board.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	23	Associate Director of Human Resources	An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation.	**Open**
	Caring for the elderly - Approaches applicable to all patients but requiring special attention for the elderly					
236	Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	25	Medical Director	Email from Medical Director to all CDs on 14th May 13) requesting assurance on this issue. Assurance received from multiple CDs and Medical Service Heads. Responses being chased following MD/CD/MSH meeting on 7/06/13. The Medical Director issued a further email to CDs and Medical Service Heads on 25/06/13 requesting assurance that all patients admitted to Dudley Group were at all times under the care of a named consultant and that appropriate systems were in place at directorate level to ensure this happens.	**Open**
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations	i) MDTs currently form a vital part of care at DGNHSFT. ii) A review, initially in care of the elderly, will be undertaken to ensure that the contribution of all staff involved in the care of patients is included (particularly linking different teams, PFI partners etc), and the lessons of Francis applied where appropriate	**Open**

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

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

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

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		• Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. • Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.				
255	Using patient feedback	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	26	Director of Nursing	1. New web pages for patient experience being developed. 2. Patient experience results posters currently displayed on wards – this are being refreshed and improved.	**Open**
256	Follow up of patients	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	26	Director of Nursing	The Friends and Family Test follows patients up on discharge/shortly after. The new website will host more online surveys – awareness will be raised via the ward leaflets	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
262	Enhancing the use, analysis and dissemination of healthcare information	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatments	26	Director of Finance and Information	The Trust had adopted robust manual information sharing arrangements. At present real time information is not available	**Open**

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Organ Donation Committee (ODC)

Dr Julian Sonksen

Clinical Lead –Organ Donation

Rebecca Timmins

Specialist Nurse-Organ Donation

dgnhs
FOUNDATION TRUST

ODC Report Oct 2013

- Background
- National and Local Progress
- Donor Recognition Project
- Seek on going support

Organ Donation: the last 5 years

- Historical UK picture
- Special circumstances when OD can occur
- Making OD discussion ‘usual’
- 50% increase over 5 years: Achieved

- Organ Donation (OD) Taskforce 2008

Organs for Transplants

A report from the Organ Donation Taskforce

Working in partnership with

Our actions

- Engagement, education, challenge, publicity, audit and feedback
- Within Trust and across Dudley
- Supports the philosophy:

"If donation is possible then every family, or those close to the patient, should have the opportunity to consider what their loved ones end of life donation wishes were"

- Maximise comfort
- Avoid regret....

A missed Opportunity

- In 2011, my 16 year-old son was involved in a road crash, where he sustained fatal head injuries. He was hit at just after 5 pm on 2011 and his father and I turned off his life support machine at at just after midnight on the . Aaron was a kind and loving child, who had often spoken about organ donation, Obviously we never expected in a million years to be faced with the situation that occurred on that night, but ***one thing that sticks out in my mind is that we were never asked about donation***. I have requested an explanation since then as to why we were never asked and was promised that this would be investigated, but have never heard from the person "investigating" the issue.
- I raise this issue as a pointer to the service for the future. I utterly regret that I was not given the chance to "share" Aaron with someone else, to give life from his death. At the time, ***I needed someone to raise the issue. I simply didn't have the fortitude to do so and in the context of difficult decisions that night, the decision to donate organs would have been the easiest of all***.
- I trust this is of interest to you and I would ask that you pass it on to the Donation Team. I would be more than happy to speak to them.
- Thank you,

Local Data

- 2009/10
  - 0 consents: 0 donors
- 2012/13
  - 3 consents: 2 donors: 5 organs
- 2013/2014 (so far)
  - 2 consents: 2 donors: 5 organs

- DCD referral rate
  - 2009: 30%
  - 2013: 100%

Donor Recognition Project

Organs for Transplants

A report from the Organ Donation Taskforce

Working in partnership with

- Recommendation 12 of the 2008 Taskforce report has still not been achieved.
- "Appropriate ways should be identified of personally and publicly recognising individual organ donors, where desired. These approaches may include national memorials, local initiatives and personal follow-up to donor families."

Our Actions

- Only trust in West Midlands to Address recommendation 12
- Provide families with artwork recognising the selfless act given
- Upholding this act of altruism with high regard and publically displaying this

Our Actions

- Funding
- Expert advice
- 2 tier competition
- Advertising on Trust Website and Artists Website
- 29 applicants
- 5 commissioned to do further work
- Panel to choose winner Oct/Nov 2013
- Completion Spring/Summer 2014

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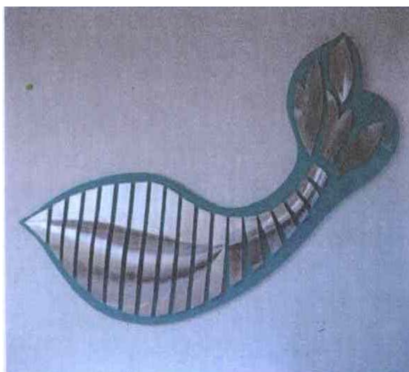
Entrants work

- Various materials used
- Abstract and figurative
- Connections with Dudley and Black Country

International Donor Recognition examples



Site of the artwork

Raising awareness

- Donor recognition project
- Transplant Week
- Internal/external Comms
- AGM
- Dudley MBC Partnership with NHSBT

Next steps...

- Continue all current work streams

- Train and support staff to ensure when we discuss Organ Donation...
  - We don’t just have conversation, but we do it well.

- Help us, help our community
- Campaign for organ donation so that life can go on

- Joining is very easy
- Join online www.organdonation.nhs.uk
- DVLA
- Facebook
- TEXT save to 84118
- Telephone 0300 123 23 23

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 3rd October 2013

TITLE:	**Organan Donation Committee Report.**		
AUTHOR:	**Dr Julian Sonksen, Clinical Lead Organ Donation. Dr Rajan Paw, Clinical Lead Organ Donation. Miss Rebecca Timmins, Specialist Nurse Organ Donation**	**PRESENTER**	**David Badger Dr Julian Sonksen Rebecca Timmins**

CORPORATE OBJECTIVE:

Quality Strategy

SUMMARY OF KEY ISSUES:

This is the third report from the Organ Donation Committee to the trust board outlining the Trust's organ donation data, and progress with Dudley Group NHS Foundation Trust Annual Organ Donation Plan 2013-14.

Section 1 - Organ Donation Data
Section 2 - CQC Data
Section 3 - Issues arising from data and actions planned
Section 4 - Donor Recognition Project
Appendix 1 - National Context and progress
Appendix 2 - Progress with 2013-14 Annual Organ Donation Plan
Appendix 3 - DGNHSFT 2012-13 Organ Donation Data

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

RISK			**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**1, 4, 6**	**Details:**
	NHSLA		**Details:**
	Monitor		**Details:**
	Equality Assured		**Details:**
	Other		**Details:**

ACTION REQUIRED OF COMMITTEE:			
Decision	**Approval**	**Discussion**	**Other**
	√	√	

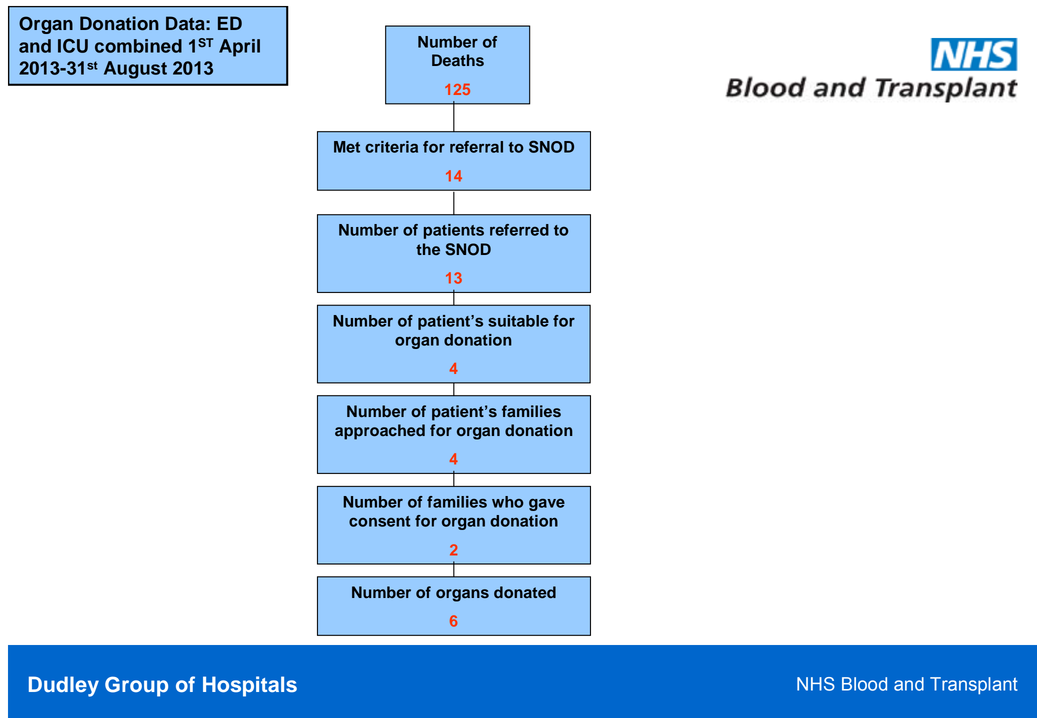
RECOMMENDATIONS FOR THE BOARD

(a) Support action plans to address Organ Donation data.
(b) Support actions planned as part of 2013-14 Annual Organ Donation Plan and Donor Recognition Project

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

Section 1: Organ Donation Data

Below is all organ donation activity for ICU and ED combined from 1st April 2013 to 31stAugust 2013.



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

Chief Executive's of Trusts will receive a separate Trust Organ Donation report of PDA activity from NHSBT 4 months after the time frame that the data reports.

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

- **Neurological Death Testing (NDT);** The trust is currently achieving a 100% NDT rate. The national average is currently 77%.

- **Referral to the Specialist Nurse- Organ Donation (SN-OD) for consideration for Donation after Brain Death (DBD) donation**; The trust is currently achieving 100% referral to the SN-OD for DBD donation. The national average is 91%.

  Approach to the family for consent for DBD donation; The trust has achieved 100% approach rate to the family for DBD Donation, the national average is 93%.

- **Obtaining consent for DBD donation;** Consent was obtained for organ donation on 1 out 1 occasion. The consent rate for DBD Donation is therefore 100%. The national average is 68%.

- **Number of Organ's donated from DBD donors;** 4 organs were donated from 1 DBD Donor at the Trust.

- **Referral to the SN-OD for consideration for Donation after Cardiac Death (DCD) donation**; The referral rate to the SN-OD for DCD donation is 93%. The national average is 62%.

- **Approach to the family for DCD donation;** There were 3 out of 3 approaches to the family for DCD donation. The approach rate in the trust is therefore 100%. The national average is 58%.

- **Consent for DCD donation;** Out of the 3 approaches to the family for DCD donation, consent was given on 1 occasion. The consent rate in the trust for DCD donation is 33%. The national average is 51%.

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

- **Number of people in Dudley on the Organ Donor Register:** The last 12 months has seen a 6.8% increase in people registering to join the Organ Donor Register from Dudley, the national average increase is 4% per year.

Section 2 – CQC Data

The below CQC data demonstrates the performance of both the ED and ICU departments combined. The data shown demonstrates the Trust's performance from the 1st April 2013 to 31st August 2013

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

Section 3: Issues arising from audit data

Actions planned to improve organ donation data

- Improve/optimize consent rate for DCD Donation. Actions carried out have been to implement NICE guidelines (CG135) in to local policy and deliver training (e-learning package) on best practice.

- Continue to monitor and deliver actions planned as per Organ Donation Plan 2013-14.

Actions planned to meet CQC target

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

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

Section 4: Donor recognition project

Artists brief formulated and advertised on Trust Website and 5 major Artist Websites on recommendation by Steve Field. Ongoing communication with Steve Field suggests that there has been a lot of interest in the competition.

Meeting held on the16th September to identify 4 artists that will be commissioned to do further artwork. Selection panel included: Steve Field (Artist), John Franklin (Governor), David badger (Non Exec Director, Organ Donation Committee member), Dr Julian Sonksen (Clinical Lead Organ Donation), Rebecca Timmins (Specialist Nurse-Organ Donation), apologies for meeting from Mark Stobart (Chaplin and Arts Committee member), and Matt Eskdale (Donor family member). The panel viewed the work of 29 applicants proposing artwork using a range of materials. The panel chose 5 artists to commission further work.

Exhibition of chosen artists artwork at Annual General Meeting (AGM) not be possible because meeting to identify chosen artists occurred after the AGM (the AGM was on the 12th September), work was exhibited however on the progress and background to the project at the AGM.

Discussions with Robert Graves indicates that Pharmacy new build will not take place in the area hoped for the Donor Recognition Project, further discussions with Summit planned.

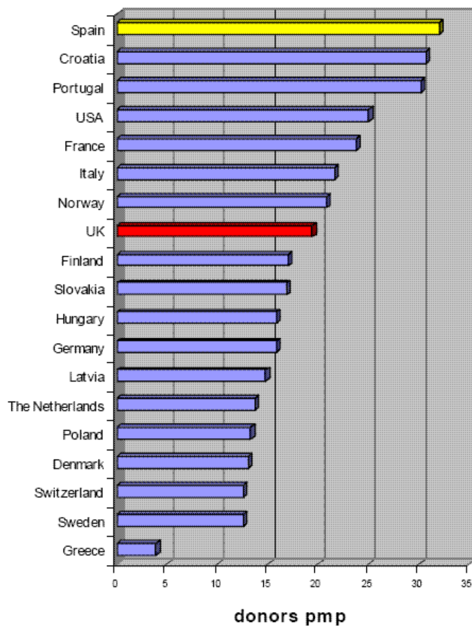
Foundation costs are estimated to be in the region of £1000 to £4000 depending on the

Action	Deadline	Progress
Budget secured	March 2013	Achieved
Artists brief agreed and advertised	May 2013	Achieved
Artists/Entrants respond to competition	July 2013	Achieved
4 artists picked to produce further artwork	July 2013	5 artists chosen to commission further work
Exhibition to be held at Annual General Meeting	September 2013	Achieved
Final artists work chosen and this is starting to be made	October 2103	Schedule to be achieved in November
Artwork made and grand opening planned	May 2014	Schedule to be achieved April-May 2014

Appendix 1: National context and progress

During 2012-13 a 50% increase in the number of deceased donors was achieved through the hard work and commitment of NHS Trusts and their staff, donating families, and NHS Blood and Transplant. The 50% increase therefore met the Organ Donation Taskforce target set in 2008.

As a result of the generosity of 1,212 organ donors in 2012-13, a 30% increase in life saving organ transplants occurred and saved even more lives.



In 2008 the UK had a donor per million population (pmp) rate of 13pmp, 5 years on we now have a donor pmp rate of 19pmp. The world leaders with the highest rates are Spain at 33pmp and our long term strategy is that we adopt best practices so that we become one of the top few countries with the highest donation rates.

To do this NHSBT strategy is to work collaboratively with NHS Trusts to develop and embed NICE Guidance in to policy and practice, and develop timely identification and referral of donors to the SN-OD by clinical staff to ensure that all families are given the option of donation.

NHSBT 2020 strategy aims to:

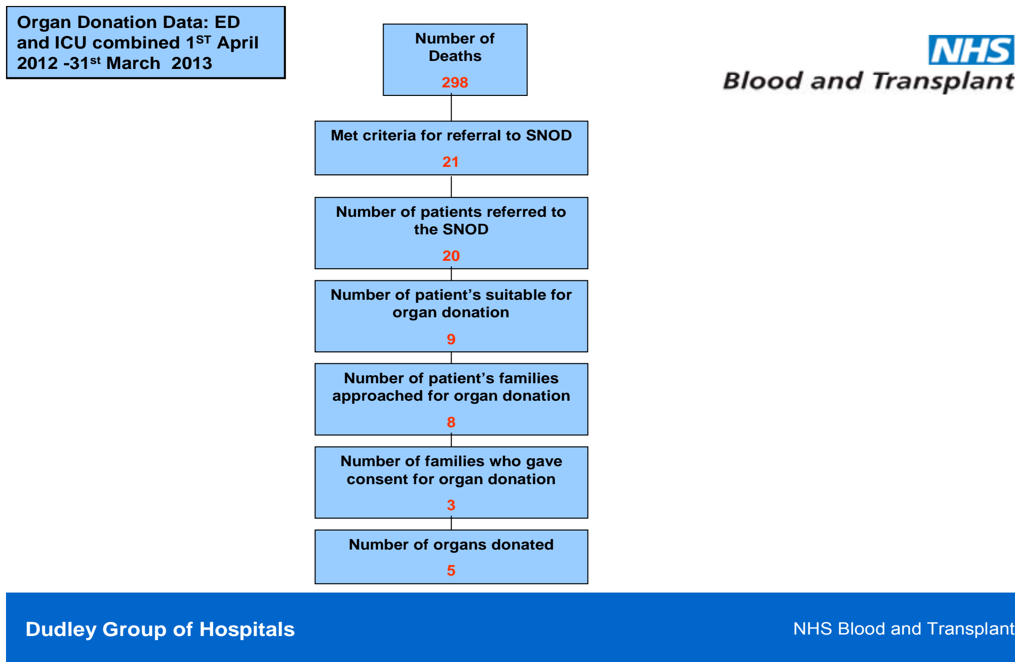
- Improve consent/authorisation rates to organ donation to above 80% (currently 57%)
- Bring the UK deceased donor rate up to 26 per million of the population (currently 19pmp)
- Transplant 5% more of the organs offered from consented, actual donors (currently 92% of actual donors result in at least one organ transplant)
- Increase the number of patients receiving a transplant to 74 per million of the population (currently 49pmp)

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

Action Plan	Progress	Outstanding actions
1) To achieve 100% Neurological Death Testing rate in ED/ICU Combined when Neurological Death is suspected.	Achieving 100%	DBD Guideline is agreed with key stakeholders and is accessible on trust intranet
2a) In over 65% of cases where the patient either had BSD confirmed or a decision was made to withdraw active treatment in patient's with a catastrophic neurological injury; The Specialist Nurse will be present with the Doctor and Nurse for the discussion with the family about donation. 2b) The specialist Nurse will also be present for at least 65% of discussions with the family about donation (non catastrophic neurological injured) with Doctor and Nurse also present as per DCD local MNC.	Achieving 100% Achieving 33%	No funding secured to facilitate Nursing and Medical Staff to undertake mandatory training on Organ Donation. The SNOD team to be involved in all approaches to the family for organ donation.
3) Referral of at least 50% of neurological injured DCD to the SN-OD and 100% of patients where ND testing is suspected.	Achieving 100% DCD Achieving 100% DBD	
4) Donor recognition project at DGNHSFT	Progress to plan	Artist is appointed by ODC and Trust Board (November 2013) Planning of project will take place with key stakeholders
5) Annual E Learning package will be developed and implemented for DGNHSFT staff working on ICU and on organ donation	Not achieving	No funding secured, reapply funding in 2014-15
6) Increase organ donation awareness and registration on the organ donor register	Achieved 6.8% increase of registrants from Dudley on the ODR this year between 2012-13 National average increase is 4%	

Appendix Three: DGNHSFT 2012-13 Organ Donation Data

The Potential Donor Audit (PDA) is an audit of all deaths in Emergency Department's and Intensive Care Unit's where the patient was under the age of 76. The upper age limit for audit was increased to 80 years of age from 2013-14. The current upper age limit for organ donation is 85 years of age and therefore we would like to report to the Trust Board all donation data in the trust, at which the PDA does not capture.



NHS Blood and Transplant

CQUIN Trust data to date

N1; No of deaths where the diagnosis of ND was suspected and patient met criteria for ND Testing and had ND tests performed	Target set 80%	Achieving 75%
N2; Number of cases where ND testing was planned and the SNOD was informed	Target set 90%	Achieving 100%
N3; Number of cases where there was a decision to WOT in a patient with a catastrophic Neuro Injury and the SNOD was informed before WOT	Target set 50%	Achieving 42%
N4; Number of cases where ND was confirmed or a decision to WOT as per N3, and an approach was made to the family for organ donation	Target set 65%	Achieving 66%
N5; Number of times that donation activity if formally considered by committee and progress with annual plan	At least quarterly	Mitigating circumstances for meeting targets in Business Plan

Dudley Group of Hospitals NHS Blood and Transplant

Enclosure 9

Paper for submission to the Board of Directors on 3rd October 2013

TITLE:	**Revalidation Update Report**		
AUTHOR:	Dr. David Perks, Assistant Medical Director Teekai Beach, Directorate Manager to Medical Director	**PRESENTER**	Paul Harrison, Medical Director

CORPORATE OBJECTIVE: SG05: Staff Commitment

SUMMARY OF KEY ISSUES:

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

- The Trust currently has an appraisal rate of 97% with generally positive feedback on the quality of appraisals.
- 22 doctors have been revalidated as of September 2013 with a single deferral compared to a 10% national average
- A review of the current appraisal structure is planned to increase the pool of medical appraisers and ensure good governance arrangements are in place.
- The Trust is rated green following the publication of the September 2013 Organisational Readiness Self Assessment Report (ORSA)

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
			Information

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:
The board is asked to note the content of this report and the recorded actions.

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

REPORT OF THE MEDICAL DIRECTOR TO THE BOARD OF DIRECTORS

3rd October 2013

Medical Revalidation & Appraisal Update

Introduction

This report provides an update to the Board on Medical Revalidation further to the paper presented to board on 7th March 2013.

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Medical revalidation is a legislative requirement governing the competence of doctors outlined in the Good Medical Practice Framework for Appraisal and Revalidation (GMC March 2011). The Responsible Officer's role was set out in The Medical Profession (Responsible Officers) Regulations 2010 The background to Revalidation was outlined in the previous paper presented to Board (July 2012).

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

This paper will outline the progress against plan for Medical Revalidation in the last quarter, against the issues set out in the previous report and our performance in the Organisational Readiness Self Assessment (ORSA) supported by the NHS Revalidation Support Team and an external audit which was undertaken in September 2013.

Summary of Results

.

The full ORSA Report is enclosed as an appendix.

Revalidation Governance:

Audit results whilst generally positive have revealed a number of minor inconsistencies in the governance arrangements for medical appraisal and revalidation. The Medical Appraisal Policy although presented at board May 2013 was noted but not formally ratified. The policy should be revised and returned via the policy group and Risk and Assurance Committee.

The Dudley Medical Appraisal met for the first time in August 2013. The committee should report via an appropriate committee to the board. This should be considered as part of the trust governance review.

Performance:

Revalidation:

Year 0: (Jan 2013 – April 2013) all ROs to be revalidated

Medical Director revalidated as Responsible Officer.

Year 1: (April 2013 – March 2014) 10% national deferral rate.

As of 24/9/13 22 doctors revalidated one deferred due to lack of evidence.

Appraisal:

Appraisal to year 31st March ORSA shows out of all medical staff who should be appraised (280) 272 were appraised by end March

Exceptions are all a result of long term sickness, sabbaticals, maternity leave and one sudden family bereavement. Almost all doctors now engaged in electronic PReP appraisal system

Feedback on appraisers was largely positive with one negative rating. However this was confirmed to be a commentary on the electronic system rather than the appraiser.

IT:

The electronic appraisal system meets the required specifications. The Edgecumbe 360 peer & patient feedback is now embedded within the system and working well There have been some requests for addtional support in using the appraisal system and auditors have highlighted the need for better information on the system on doctor induction which will be updated to reflect those recomendations.

Training:

Following a successful bid for additional funding, a further 20 doctors had received strengthened medical appraisal training. A review of the current appraisal structure; the intention being to consider whether to move towards a separate cohort of appraisers not linked to Medical Service Head roles as a way forward. This would, of course, require recognition within their job plans and this would have to be funded. The pros and cons of moving from a line manager appraisal process to an independent team of appraisers will be discussed in full at the next medical appraisal committee and be subject to review.

Recommendations/Actions

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

NHS

Revalidation Support Team

Our ref: RST / 3453
6th September 2013

Dr Paul Harrison
The Dudley Group NHS Foundation Trust
Russells Hall Hospital
Dudley
WEST MIDLANDS
DY1 2HQ

Dear Dr Harrison

ORSA Comparator Report for The Dudley Group NHS Foundation Trust

Thank you for submitting a response to the Organisational Readiness Self-Assessment (ORSA) exercise in April/May 2013. This report aims to provide comparative feedback on the readiness of your organisation using the information which was submitted to help in planning your next steps. It compares your organisation's submission with that of other designated bodies in England.

It is important that every designated body, irrespective of the overall RAG rating, produces an action plan to address all the development needs identified through this exercise. The action plan may need to include specific actions to improve appraisal rates, to ensure sufficient resources are available and to ensure the successful development and implementation of policies and procedures. The results of the self-assessment exercise and the resulting action plans should be presented to the board or the equivalent governance structures in non-NHS organisations.

The RST will be decommissioned in March 2014 and the on-going implementation of revalidation will be overseen by NHS England and the Department of Health. The report of the final ORSA exercise will be published in the next few weeks. Over the last three years ORSA has set clear expectations about the standards that organisational systems and processes need to meet to fulfil the requirements of revalidation. As we move through the implementation phase of revalidation, quality assurance becomes increasingly important and a management audit will be designed to provide assurance about the quality of the systems supporting the responsible officer role.

Following the first ORSA exercise, Sir Bruce Keogh highlighted the importance of the following:

- strong clinical leadership and effective local action planning
- ensuring all designated bodies have been identified
- ensuring all responsible officers have the resources to carry out their role
- providing support for responsible officers through networks
- ensuring all doctors have an annual appraisal.

It is clear that substantial progress has been made in these areas but there is still much more to be done to ensure these principles are fully implemented and embedded in all designated bodies so that the potential benefits of revalidation are realised.

If you no longer work for this organisation, or you are no longer the responsible officer, it is important that this report is immediately passed on to the new responsible officer, or to the chief executive of the organisation. If there are any changes to notify, or you have any queries, please contact the revalidation team in your region using the details below:

Your region	Midlands and East
Your regional revalidation lead	Genevieve Dalton
Your regional revalidation lead contact details	england.revalidation-midlandsandeast@nhs.net

Further information on revalidation can be found on the NHS Revalidation Support Team (RST) website: www.revalidationsupport.nhs.uk

Yours sincerely

Dr Martin Shelly
Director of Implementation
NHS Revalidation Support Team

YOUR ORGANISATIONAL READINESS REPORT

Analysis is based on the total of 621 returns to the 2012/13 Organisational Readiness Self Assessment (ORSA) exercise for the year ending 31 March 2013, which had been received by the RST by 7 June 2013.

Name of designated body	The Dudley Group NHS Foundation Trust
Region	Midlands and East
Sector	Hospital Secondary Care Foundation Trust
Name of responsible officer	Dr Paul Harrison

Your organisation's RAG rating	Green		
Distribution of RAG ratings for organisations in the same sector	Red	Amber	Green
	0.00%	0.00%	100.00%

See appendix 1 for details of RAG rating methodology

Responses to the 2012/13 Organisational Readiness Self-Assessment exercise:

2012/13 ORSA indicator (please refer to ORSA 2012/13 for full indicator definitions)	**Your organisation's response**	**In England: mean or % answering 'Yes'**	
		Same sector: n= 100	**All sectors: n= 621**
1.4.8 Total number of doctors with a prescribed connection	280	299.35	259.99
1.4.1 Consultants	186	207.69	70.12
1.4.2 Staff grade, associate specialist, speciality doctor	58	44.89	17.59
1.4.3 General practitioner (primary care trusts only; doctors on a medical performers list)	0	0.11	68.17
1.4.4 Trainee: doctor on national postgraduate training scheme (for LETBs only)	0	1.50	77.65
1.4.5 Doctors with practising privileges (for independent healthcare providers only)	0	0.00	2.85
1.4.6 Temporary or short-term contract holders	36	44.10	18.11
1.4.7 Other	0	1.06	5.50
2.1 RO nominated / appointed	Yes	100%	99%
2.2 Second RO nominated / appointed where required	No	31%	21%
2.3 Appropriate RO training undertaken	Yes	100%	97%
2.4 Local / regional support is available to the RO	Yes	100%	98%
2.5 The RO has sufficient funding / resource for the role	Yes	94%	94%
2.6.4 Total number of doctors who have had a recommendation made to GMC	0	9.15	5.36
2.6.1 Positive recommendations	0	8.60	5.03
2.6.2 Deferral requests	0	0.55	0.32
2.6.3 Notifications of non-engagement	0	0.00	0.00
2.6.5 Number of doctors who had a recommendation to GMC due but that were not completed on time	0	0.01	0.03

2012/13 ORSA indicator (please refer to ORSA 2012/13 for full indicator definitions)	Your organisation's response	In England: mean or % answering 'Yes'	
		Same sector: n= 100	All sectors: n= 621
3.1 A medical appraisal policy is in place	Yes	99%	96%
3.2.8 Total completed appraisals	272	194.33	138.77
3.2.1 Consultants	179	154.75	52.68
3.2.2 Staff grade, associate specialist, speciality doctor	58	25.53	11.24
3.2.3 General practitioner (for primary care trusts only; doctors on a medical performers list)	0	0.02	61.58
3.2.4 Trainee: doctor on national postgraduate training scheme (for LETBs only)		0.00	0.00
3.2.5 Doctors with practising privileges (for independent healthcare providers only)	0	0.01	2.83
3.2.6 Temporary or short-term contract holders	35	13.51	7.57
3.2.7 Other	0	0.51	2.87
3.3 Audit performed for missed or incomplete appraisals	Yes	68%	67%
3.4 The number of trained appraisers is sufficient	Yes	98%	94%
3.4.1 Number of appraisers	45	52.90	27.37
3.4.2 Number of appraisers who are trained	45	53.31	27.37
3.5 Appraisers are supported	Yes	98%	94%
3.6 Appraisers receive feedback on their performance	Yes	76%	81%

2012/13 ORSA indicator (please refer to ORSA 2012/13 for full indicator definitions)	**Your organisation's response**	**In England: mean or % answering 'Yes'**	
		Same sector: n= 100	**All sectors: n= 621**
4.1 Governance structure or strategy in place	Yes	99%	98%
4.2 Governance systems subject to review	Yes	99%	93%
4.3 System to monitor fitness to practise	Yes	100%	96%
4.4 Doctors receive feedback from patients and colleagues	Yes	98%	96%
4.5 Clinical audit activity in line with national guidance	Yes	99%	75%
4.6 Key items of information included in the appraisal	Yes	93%	94%
4.7 Information available about new doctors	Yes	96%	96%
4.8 Information available from all doctors roles	Yes	93%	93%
4.9 Process for investigation of concerns	Yes	100%	96%
4.10 Policy for re-skilling, rehabilitation, remediation and targeted support	Yes	75%	81%
4.11 RO monitors compliance with GMC undertakings	Yes	100%	97%
4.12 Support for doctors to keep knowledge and skills up to date	Yes	97%	90%
4.13 Relevant policies are non-discriminatory	Yes	100%	97%

Appendix 1: Methodology for calculating RAG ratings for the ORSA 2012/13 exercise

This table summarises the methodology for calculating the RAG ratings of designated bodies for the ORSA exercise. The methodology has been approved by the England Revalidation Implementation Board.

Section 1: Details of the designated body		
Number of doctors (and different doctor types) with whom the designated body has a prescribed connection		Number
Section 2: Responsible officer		
2.1 A responsible officer has been nominated / appointed in compliance with the regulations		Yes/No
2.3 Appropriate responsible officer training is undertaken		Yes/No
Sectional RAG rating	2 Yes = Green 1 Yes = Amber 0 Yes = Red	Green Amber Red
Section 3: Appraisal system		
3.1 A medical appraisal policy with core content is in place		Yes/No
3.4 The number of trained medical appraisers is sufficient for the needs of the designated body		Yes/No
Sectional RAG rating	2 Yes = Green 1 Yes = Amber 0 Yes = Red	Green Amber Red
Section 4: Organisational governance		
4.3 There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection		Yes/No
4.9 A process is established for the investigation of capability, conduct, health and fitness to practise concerns		Yes/No
4.10 A policy (with core content) for re-skilling, rehabilitation, remediation and targeted support is in place		Yes/No
Sectional RAG rating	3 Yes = Green 2 Yes = Amber 0 or 1 Yes = Red	Green Amber Red
Overall RAG rating		
Overall RAG rating	6 or 7 Yes = Green 4 or 5 Yes = Amber 0, 1, 2 or 3 Yes = Red Any individual section Red = Red No RO nominated/appointed = Red	Green Amber Red

Board of Directors Members Profile.

Paula Clark – Chief Executive

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

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

John Edwards – Chairman

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

Paul Assinder – Director of Finance and Information

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

Richard Beeken – Director Strategy, Performance and Transformation

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

Denise McMahon – Director of Nursing

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

Paul Harrison – Medical Director

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

Richard Cattell – Director of Operations

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

Annette Reeves – Associate Director of Human Resources

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

David Badger – Non Executive Director, Deputy Chairman and Chair of the Finance and Performance Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act. David is Deputy Chair of the Trust and also Chair's the Finance and Performance Committee.

David is also responsible for the following:
Member - Clinical Quality Safety and Patient Experience Committee
Member - Risk and Assurance Committee
Member - Remuneration Committee
Member - Nominations Committee
Member - Transformation Programme Board
Member and link to Trust Board - Organ Donation Committee
NED liaison - Council of Governors
Assigned - Governor Development Group
Assigned - Governor Membership Engagement Committee
Attendee - Governor Appointments Committee
Board representative - Contract Efficiency Group

David Bland – Non Executive Director and Chair of the Clinical Quality, Safety and Patient Experience Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

David is also responsible for the following:
Chair of the Clinical Quality, Safety and Patient Experience Committee
Non Executive Director Lead for Patient Experience
Non Executive Director Lead for Patient Safety
Member of Risk and Assurance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Member of Charitable Funds Committee
Member of Council of Governors Committee
Member of the Dudley Clinical Services Limited (subsidiary of the Trust

Jonathan Fellows - Non Executive Director and Chair of the Audit Committee

As a Non Executive Director it is Jonathans responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Jonathan is also responsible for the following:
Chair of Audit Committee
Member of Finance and Performance Committee
Member of Charitable Funds Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Assigned to the Governors Governance Committee
Board representative - Contract Efficiency Group

Richard Miner – Non Executive Director and Chair of the Charitable Funds Comittee

As a Non Executive Director it is Richard's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Richard is also responsible for the following:
Chair of the Charitable Funds Committee
Non Executive Director Lead for Security Management
Member of Finance and Performance
Member of Audit Committee
Assigned to the Governors Governance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Chair of the Dudley Clinical Services Limited (subsidiary of the Trust)

Ann Becke – Non Executive Director and Chair of the Risk and Assurance Committee

As a Non Executive Director it is Ann's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Ann is also responsible for the following:
Chair - Risk and Assurance Committee
Member – Audit Committee
Member – Clinical Quality, Safety and Patient Experience Committee
NED Lead for Safeguarding
Board Representative – Dudley Children's Partnership
Non Executive Director Liaison for West Midlands Ambulance Service
Member – Remuneration Committee
Member – Nominations Committee
Member – Arts and the Environment Panel
Assigned – Governor Sub Committee Membership Engagement
Assigned – Governor Sub Committee Strategy
Member – Dudley Clinical Education Centre Charity