The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 5th February, 2015 at 9.30am
Clinical Education Centre

Meeting in Public Session
All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		D Badger	To Note	9.30
2.	**Declarations of Interest**		D Badger	To Note	9.30
3.	**Announcements**		D Badger	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 8th January 2015	Enclosure 1	D Badger	To Approve	9.30
	4.2 Action Sheet 8th January 2015	Enclosure 2	D Badger	To Action	9.30
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	D Mcmahon	To Note & Discuss	10.00
	7.2 Nurse Staffing Report	Enclosure 5	D Mcmahon	To Note & Discuss	10.10
	7.3 Estates Report on Emergency Planning and Business Continuity	Enclosure 6	R Graves	To Note & Discuss	10.20
	7.4 Food and Nutrition Report	Enclosure 7	R Graves	To Note & Discuss	10.30
	7.6 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 8	D Bland	To Note	10.40
	7.7 Revalidation Report	Enclosure 9	P Harrison	To Note	10.50
	7.8 Safeguarding Report	Enclosure 10	D McMahon	To Note	11.00
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 11	J Fellows	To Note & Discuss	11.10

9.	**Date of Next Board of Directors Meeting** 9.30am 5th March, 2015, Clinical Education Centre		D Badger		11.20
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).		D Badger		11.20

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 8th January, 2015 at 9:30am in the Clinical Education Centre.

Present:

David Badger, Chairman
Richard Miner, Non Executive Director
Jonathan Fellows, Non Executive Director
Denise McMahon, Nursing Director
Paul Taylor, Director of Finance and Information
Paula Clark, Chief Executive
Ann Becke, Non Executive Director
David Bland, Non Executive Director

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Communications and Patient Experience
Julie Cotterill, Associate Director of Governance/Board Secretary
Anne Baines, Director of Strategy and Performance
Jon Scott, Chief Operating Advisor
Jackie Howells, Learning Disabilities Liaison Nurse (Item 5)
Dr Jeff Neilson, Head of Research and Development (Item 12)
Dr Jo Bowen, Consultant in Palliative and End of Life Care (Item 14)

15/001 Note of Apologies and Welcome

Apologies were received from Paul Harrison.

15/002 Declarations of Interest

There were no declarations of interest.

15/003 Announcements

The Chief Operating Advisor confirmed that he would be required to step out of the meeting to manage capacity pressures during the course of the Board meeting.

15/004 Minutes of the previous Board meeting held on 4th December, 2014 (Enclosure 1)

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

15/005 Action Sheet, 4th December 2014 (Enclosure 2)

15/005.1 Charitable Fund Report

The Board noted that the Charitable Fund details had been circulated to Board members earlier in the week and the item could now be removed from the action sheet.

All other items appearing on the action sheet were complete or for update at a future Board meeting.

15/006 Patient Story

Jackie Howells, Learning Disabilities Liaison Nurse joined the meeting.

The Nursing Director reminded the Board that it had previously asked for a Learning Disabilities Story.

The Board watched a video that described the story of a patient with learning disabilities. Jackie Howells appeared on the video detailing the patient journey.

The Chairman asked about the other people involved in the patient's care who were mentioned in the video. Jackie Howells confirmed that they were the patients two sisters and brother in law, her care worker from the nursing home and a social worker.

The Head of Patient Experience and Communications read out some recent, very positive feedback, relating to patients with learning disabilities from the NHS Choices website.

Mrs Becke, Non Executive Director, asked about how capacity decisions are made and how this information is received by the patients carers. Jackie confirmed that decisions are well documented and normally very well received by carers.

Mrs Becke asked if the communication boxes were still in use. Jackie confirmed that wards are using communication tools and these are being adapted for different ward areas.

Mr Miner, Non Executive Director, stated that there is a very important role for charitable funds in work around learning disabilities.

The Nursing Director passed on her thanks to Jackie for her continued excellent work.

The Chairman and Board reiterated their thanks for Jackie's drive and commitment.

The Board noted the patient story, the praise for Jackie and Mr Miner's comments relating to the use of Charitable Funds.

15/007 Chief Executive's Overview Report (Enclosure 3)

The Chief Executive presented her Overview Report, including the following highlights:

Friends and Family Test Performance:

The Trust achieved the footfall target of 31% and A&E target of 22%, therefore all targets for the quarter were achieved.

The Trust is working with the CCG on the development on an "App". for the friends and family test.

Dalton Report:

This was presented for the Board's information. An Executive Summary was attached to the report.

The Director of Strategy and Performance confirmed that the next Board Development event should consider this document and how it relates to the Trust's Five Year Strategy.

The Dalton Report and how it relates to the Trust's Five Year Strategy to be considered at the next Board Workshop in February.

Planning Guidance 2015/16:

For the Board's information. Summary guidance was attached to the report.

CCG Unannounced Visit:

An action plan has been produced by the Trust and shared with the CCG who will be presenting the item at its next Board meeting.

Actions will be taken through Committees and then be presented to Board in the Committee Exception Report.

The Nursing Director confirmed that the action plan is also available on the shared drive.

CCG unannounced visit action plan to be monitored through Board Committees and presented to the Board in the Committee Exception Report.

The Chairman noted the Chief Executive's Report and noted that the Dalton Report will be discussed in detail at the Board Workshop in February.

The Chief Executive asked that her thanks be put on record for the exceptional work of staff over the Christmas and New Year period. The Chairman reiterated these comments and confirmed that it was a tremendous achievement to meet the quarter three target.

15/008 Patient Safety and Quality

15/008.1 Infection Prevention and Control Exception Report (Enclosure 4)

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

MRSA: No cases to report.

C.Diff: The Trust continues to perform well with 16 cases less this year than at this point last year.

Norovirus: Being experienced in several other local organisations and schools but no cases to note at the Trust to date.

Ebola: The Trust is up to date with national requirements.

The Chief Operating Advisor commented that he wanted to formally note his admiration towards the Nursing Director and her team for their excellent performance around infection control.

The Chairman noted the good performance and positive report and confirmed that the Board can take assurance from the consistent positive performance.

15/008.2 Nurse Staffing Report (Enclosure 5)

The Nursing Director presented the Nurse Staffing report given as Enclosure 5.

The Board noted that the Trust must undertake a six monthly national assessment of staffing levels. The Trust has used the Safer Nursing Care Tool for this exercise. There is a reasonable consistency with the Trust's own local method.

Ward areas look at the link between Nursing Care Indicators and staffing levels. The conclusion for ward B2 is that this area requires close monitoring.

The conclusion of the assessment is shown on page 22 of the report and this gives assurance from national and local levels that our staffing levels are within the pack.

The Chief Executive stated that nurse recruitment remains an issue. The Nursing Director confirmed that the Trust is currently looking at further recruitment of overseas nurses.

The Chairman commented that he was assured by the triangulation method within the report. The Board noted the actions taken and noted the Trust's recruitment intentions.

Part two of the report detailed the monthly position for November. The Nursing Director confirmed that November had been a particularly difficult month for staffing and December was expected to be even more of a challenge. The Nursing Director confirmed that she expected to see some red areas on the next report to Board.

The Chief Executive confirmed that all additional capacity has been opened and there was a real concern around how the Trust would staff these additional beds.

The Chairman noted the November staffing report. He raised the performance of ward B4 which had been previously raised at Board. The Nursing Director confirmed that there remains a focus on this area and there are a number of actions in place to improve the position. The Chairman noted the difficulties expected to be demonstrated in the December report.

15/008.3 Moving Patients Out of Hours (Enclosure 6)

The Chief Operating Advisor presented the Moving Patients Out of Hours Report, given as Enclosure 6.

The Board noted that actions have been put in place to monitor patient moves on a real time basis.

The Chief Operating Advisor asked for the Board's approval of the way the moves are currently being monitored. The Board noted that out of hours moves will be included in the daily breach report.

The Board noted that the amount of out of hours moves will increase in January due to the period of increased pressure.

The Board supported the approach detailed in the report.

The Chairman noted the update and the actions taken.

15/008.4 Complaints Report (Enclosure 7)

The Director of Governance/Board Secretary presented the Complaints Report, given as Enclosure 7.

The Board noted that the summary of key issues on the cover page should state June and not March.

The Director of Governance/Board Secretary confirmed that all complainants are now offered at least one resolution meeting and the Board noted the burden that this places on the small Complaints Team.

Inquest outcomes were noted on page 7 of the report.

The Ombudsman had accepted 3 complaints for further investigation and these are ongoing.

The end of the report details samples of action taken following complaints.

The December end of quarter report will be available for the next Board meeting.

The Director of Strategy and Performance asked how the Trust monitors the number of complaints received in areas and suggested that the Trust should use incident trends and not just the learning from complaints.

The Director of Governance/Board Secretary confirmed that it was the responsibility of Divisions to provide assurance around trends and learning.

The Chief Executive confirmed that the Trust looks at trends at its Complaints meetings.

Mr Fellows, Non Executive Director, asked if the number of unresolved complaints could be added to the summary table. The Director of Governance/Board Secretary confirmed that this will be done for the next report.

The Chief Operating Advisor asked if the number of complaints had increased because of unrealistic expectations around discharge. The Director of Governance/Board Secretary suspected that this issue would be resolved locally by PALS rather than escalating to a formal complaint.

Mrs Becke, Non Executive Director, stated that relatives will continue to have issues around Patient's home of choice. The Chief Executive confirmed that the Trust had been required to produce letters for patients notifying them of the Trust's intention to discharge.

The Chairman noted the report and noted Mr Fellows requested to include unresolved complaints on the summary table in the report.

The December end of quarter Complaints Report to be presented at the next Board meeting.

The number of unresolved complaints to be included in the summary table in the next Complaints Report to Board.

15/008.5 Board Assurance Framework (Enclosure 8)

The Director of Governance/Board Secretary presented the Board Assurance Framework, given as Enclosure 8.

The Board noted that there are 16 corporate risks currently being managed by the Trust.

The Chairman confirmed that there were no surprises in the report.

Mr Miner, Non Executive Director, asked for further clarity around the description of risk CR059 on page 9 of the report. The Chief Executive confirmed that this relates to a reduction of activity in ED when the Urgent Care Centre opens on 1st April, 2015, as this has a financial impact. The Director of Finance and Information confirmed that contract discussions are ongoing with the CCG around this issue.

The Chairman noted the Board Assurance Framework.

15/008.6 Corporate Risk Register (Enclosure 9)

The Director of Governance/Board Secretary presented the Corporate Risk Register, given as Enclosure 9.

The Board Assurance Framework is drawn from the Risk Register.

The Board noted that 4 new risks had been added since the previous report.

Of the 16 corporate risks there were 6 with a score of 20 or above. Assurance is actively monitored and mitigating actions had been identified.

Mr Fellows, Non Executive Director, asked if the delivery of the IT Strategy should appear on the register as a risk. The Director of Finance and Information confirmed that this had been discussed by Directors

The Director of Strategy and Performance commented that on page 10 of the register the Black Country Review appears twice.

The Chairman noted the Register, noted including the IT risk and removing the duplication around the Black Country Review.

15/008.7 CQC Closure Report (Enclosure 10)

The Chief Executive presented the CQC Closure Report, given as Enclosure 10.

The report gives assurance around actions taken in the areas described as requiring improvement in the CQC report, including:

- DNAR
- ED Flow
- Ophthalmology Clinic Provision
- Phlebotomy Capacity
- Documentation for the use of Compression Stockings
- Incident Recording and Reporting
- Staffing Level Reporting and Recording in Maternity
- Staffing Levels and Cover for Vacant Shifts

The Board agreed the approach set out in the report, noted the areas and received assurance around actions and monitoring.

15/008.8 Quality Accounts Report (Enclosure 11)

The Nursing Director presented the Quality Accounts Report, given as Enclosure 11.

The Board is asked to note the current quality priorities. Attendees at the AGM had been asked for ideas to include in the quality priorities. These areas must be measurable by the Trust.

At its meeting in December, the Council of Governors discussed a proposal for going forward.

The Nursing Director confirmed that the proposal was to maintain the current quality priorities. The Board also needs to agree which three quality metrics will be published in the Quality Accounts for each of the three areas of quality of Patient Experience, Patient Safety and Clinical Effectiveness.

Mrs Becke, Non Executive Director, confirmed that she was happy with the proposal but suggested that Mental Health is currently a key issue, although she was unsure how this could be monitored as a priority.

The Chief Executive and Chief Operating Advisor agreed that the Trust needs to better consider its Mental Health performance.

The Chairman suggested that including End of Life Care is also an aspect for consideration.

Mr Bland, Non Executive Director, commented that we need to consider measurability of priorities.

The Chief Executive stated that it would be helpful to understand the Trust's performance around sepsis and acute kidney injury. The Nursing Director confirmed that this information will be available for the next report.

The Board agreed the proposed account priorities provided in the report.

15/008.9 Research and Development Report (Enclosure 12)

Jeff Neilson, Head of Research and Development, presented the Research and Development Report, given as Enclosure 12.

The Board noted that Dr Neilson had taken over as lead for Research and Development from Professor Kitas in December 2014.

The Board noted that the Trust had received a small uplift in funding for Research and Development.

Recruitment activity was noted to be reasonable level.

Dr Neilson confirmed that the Trust was proud of developments in education and training and the Board noted that the Trust laboratory had been recognised and accredited.

There was enormous potential for research to be grown at the Trust and it needs to look at how to expand its research capabilities to maximise potential.

The Chief Executive asked if Dr Neilson was confident that Research and Development is a growth area for the Trust. Dr Neilson confirmed that being seen to have significant research activity makes the Trust more appealing when recruiting Consultants. There are also hidden benefits particularly around cancer drugs which are funded in trials.

The Director of Finance and Information confirmed that it would be helpful to try and show these hidden benefits in future reports.

The Chief Executive suggested that Dr Neilson may wish to present on Research and Development to the CCG Board.

Mr Bland, Non Executive Director, also underlined that Dudley is one of the only trust's to receive an uplift.

Mrs Becke, Non Executive Director, asked why some trusts receive more funding. Dr Neilson confirmed that this is based on historic activity.

The Chairman asked if there were any issues around spread of representation in specialities. Dr Neilson confirmed that there is always potential for growth and the Research and Development Directorate is a support function for specialities.

The Chairman noted the report and the potential for growth and noted the proposed presentation to the CCG Board.

The hidden benefits of Research and Development, particularly around drug costs, to be included in future Research and Development Reports to Board.

Dr Neilson to consider presenting an update on the Trust's Research and Development activities to Dudley CCG.

15/008.10 Listening into Action Report (Enclosure 13)

The Head of Patient Experience and Communications presented the Listening into Action Report, given as Enclosure 13.

The Board noted that the Trust was about to re-launch Listening into Action across the organisation. The timing of the launch will be agreed with the Executive Team.

Achievements from the last round of LiAs were also included in the paper.

The Chairman noted the report and the Board supported the re-launch.

15/008.11 Palliative and End of Life Care Report and Presentation (Enclosure 14)

Dr Jo Bowen, Consultant in Palliative and End of Life Care presented her report, given as Enclosure 14.

Dr Bowen presented a patient case to the Board relating to an 86 year old patient with multiple co-morbidities.

The report highlights some of the work of the Palliative Care Team.

The Trust is one of only 6 pilot sites awarded funding from Macmillan to look at improving palliative care and end of life services.

The Board noted the risks associated with the capacity of the team to deliver care, provide education and undertake service improvement.

The Board also noted that the Trust had been successful in recruiting to two new Consultant posts which have been funded by Macmillan and the CCG.

The Trust is required to provide an update to the Board as part of the national end of life care initiative.

The Chairman confirmed that it was helpful to note the individual end of life care factors associated with the patient case.

The Chairman thanked Dr Bowen for her work with the End of Life Care Steering Group. The Board noted that the Trust is required to have a Board level lead for End of Life Care and it is proposed that this should be the new Medical Non Executive Director.

The Board noted the report.

15/008.12 Non Executive Director Committee Changes (Enclosure 15)

The Chairman presented his report on Non Executive Director Committee changes, given as Enclosure 15.

The paper detailed the changes to Non Executive Director Committee membership.

The Chairman confirmed that Dr Doug Wulff had been offered the post of Medical Non Executive Director and this appointment will be ratified by the Council of Governors at its meeting on 22nd January, 2015.

The Board noted the report.

15/009 Finance

15/009.1 Finance and Performance Report (Enclosure 16)

Mr Badger, Committee Chair, presented the Finance and Performance Committee report, given as Enclosure 16.

The Board noted the good trading month for October, although there was still a potential deficit of £8m at year end.

A discussion around the ED target at taken place earlier in the meeting. The Trust continued to meet its RTT and cancer targets.

The back page of report details the presentation received from the Surgical Division around the issue of maternity services. The Committee will monitor actions with the Division.

The Committee had received an update on turnround and noted an additional £2m CIP schemes have been signed off by the Trust.

The Board also noted that the vacancy approval process is now seen to be having an effect.

The Director of Finance and Information confirmed that pressures in ED have led to significant premium costs.

Mr Miner, Non Executive Director, stated that following the presentation on maternity the prognosis for the service was much more reassuring.
The Chairman noted report and noted the current position.

15/010 Any Other Business

None to report.

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

15/011 Date of Next Meeting

The next Board meeting will be held on Thursday, 5th February, 2015, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 8th January 2015

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
14/106.5	Draft People Plan	Mr Wilson to use the Board's comments on the paper to adapt the draft plan.	RW	31/1/15	J Bacon updating plan
14/095.9	Food and Nutrition Report	Deputy Director of Operations to make representation to the PLACE assessors regarding patients preference for hot meals, investigate October scores and confirm if there is a downward trend and also notify the PFI partners that the Board wishes to see the new menus and trolleys in place by no later than the end of January 2015.	RG	31/1/15	Done See item 14/103 below.
14/095.10	Audit Committee Exception Report	The Board to consider when to next review its effectiveness and governance. Report back to Board from the Estates Team on emergency planning, IT business continuity and how we hold our PFI partners to account.	JC RG	5/2/15 5/2/15	To Feb Board Workshop On Agenda
15/008.4	Complaints Report	The December end of quarter Complaints Report to be presented at the next Board meeting. The number of unresolved complaints to be included in the summary table in the next Complaints Report to Board.	JC JC	5/2/15 5/3/15	To March Board
14/007	Chief Executive's Overview Report	The Dalton Report and how it relates to the Trust's Five Year Strategy to be considered at the next Board Workshop. CCG Unannounced visit action plan to be monitored through Board Committees and presented to the Board in the Committee Exception Report.	PC/AB DB	12/2/15 Ongoing	

14/103	Action Sheet	New menus to come online at the end of February 2015. The new heated trolleys will not be available at the end of January as requested at the November Board meeting due to limitations in the PFI contract.	RG	5/3/15	
14/095.5	Safeguarding Quarterly Report	Future Safeguarding Reports to include learning from patient stories.	DM	5/3/15	
15/008.9	Research and Development Report	The hidden benefits of Research and Development, particularly around drug costs, to be included in future Research and Development Reports to Board. Dr Neilson to consider presenting an update on the Trust's Research and Development activities to Dudley CCG.	PH JN	7/5/15 7/5/15	

Enclosure 3

The Dudley G
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 5th February 2015

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Test Performance
- Delayed Transfers of Care Update
- Urgent Care Centre Interim Solution – Update
- Monitor – Breach of Licence and Undertakings
- Senior Information Responsible Owner

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, give approval as appropriate, and discuss issues of importance to the Board.

The Dudley Group NHS
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Chief Executive Update – 5th February 2015

Friends and Family Test (FFT) Performance:

FFT rollout to Community, Day Case and Outpatient areas – provisional update Jan '15
Data submission to NHS England will commence in February 2015 with the first return being for community patients January FFT responses.

Up until the 21st January the trust had received 30 responses with 100% of respondents indicating they would be extremely likely or likely to recommend the service they had used to friends and family.
Data submission to NHS England for outpatients and day case will commence in May 2015 for patients responding in April 2015. We are awaiting final reporting guidance.

FFT Inpatient and A&E provisional December 2014 results 01.01.15 – 21.01.15
Inpatient FFT
The Trust continues to benchmark well both nationally and regionally. The latest published figures are for November 2014 show The Dudley Group scored 97% (increase from October score of 96%) against the national average of 95%.

The provisional response rate for January (01.01-15-21.01.15) shows a significant dip to 22% (compared to 31% at the end of quarter three) across our inpatient areas. The Patient Experience Team is working to improve this.

A&E FFT
The Trust continues to score well and is in the top 20% of Trusts with those who say they are extremely likely or likely to recommend A&E to friends and family. In the month to 21.01.15 the response rate has continued to fall from 22% at the end of quarter three to 8%.

	Q1	Q2	Q3	Jan provisional up to 21/1/15
Date range	01.04.14	01.07.14	01.10.14	01.01.15
	30.06.14	30.09.14	31.12.14	21.01.15
Number of eligible inpatients	5860	5987	5669	1324
Number of respondents	1646	1577	1756	288
Ward FFT score	84	80.8	84	80
Ward FFT score in percentage		97%	97%	96%
Ward footfall	28%	26%	31%	22%
Number of eligible A&E patients	13542	13970	12545	2731
Number of respondents	2459	3141	2709	230
A&E FFT Score	57	67.7	56	73
A&E FFT score in percentage		90%	83%	93%
A&E footfall	18%	22%	22%	8%
TRUST FFT Score (A&E/Inpatient)	68	72	67	77
TRUST footfall	21%	24%	25%	13%

FFT results Maternity provisional January 2015 results 01.01.15 – 21.01.15
The combined response rate has experienced a severe decrease for the month to date from 19% in December to 3% in January. We are continuing to work with the team involved to improve the response rates.

The Trust continues to score well and remains in the top 20% of Trusts with those who say they are extremely likely or likely to recommend our maternity services to friends and family.

	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Q2	Oct-14	Nov-14	Dec-14	Jan provisional up to 21/1/15
Maternity – Antenatal Score	64	80	78	79	66	71	72	71	69	89	No responses
Score in percentage							97%	98%	97%	100 %	
Response rate	14%	18%	13%	21 %	19%	26%	22%	16%	15%	11%	0%
Maternity – Birth Score	62	85	83	90	94	98	93	87	91	89	100
Score in percentage							100 %	98%	100 %	99%	100%
Response rate	44%	33%	34%	30 %	23%	24%	25%	14%	30%	27%	5%
Maternity - Postnatal ward Score	57	85	79	87	94	96	92	83	87	87	100
Score in percentage							100 %	98%	100 %	98%	100%
Response rate	43%	31%	32%	29 %	23%	24%	25%	14%	31%	27%	5%
Maternity - Postnatal community Score	86	90	85	85	85	76	82	70	82	100	No responses
Score in percentage							100 %	100 %	100 %	100 %	
Response rate	16%	9%	15%	13 %	12%	11%	11%	8%	10%	6%	0%
Combined Score	63	85	81	86	88	88	87	80	86	89	100
Response rate	32%	24%	25%	24 %	20%	21%	21%	13%	23%	19%	3%

Delayed Transfers of Care Update:
The Board will be aware that the high level of Delayed Transfers of Care contributed to the capacity problems over the Christmas fortnight. Although numbers did initially fall into January to around 60 they have once again started rising to around 90 which is totally unacceptable. The number of beds which are also essentially blocked in the community means that the Discharge to Assess programme initiated in the autumn has effectively been suspended. The Local Authority has just received £425k in funding the Government to tackle this problem and we have given our views to the CCG about the effectiveness of the programmes proposed by the LA to spend this money. We do seem to still have problems in getting traction on this and therefore I have been in contact with the Emergency Care Intensive Support Team (ECIST). They tried to assist the health system last autumn on this issue. They are willing to come up again in March and the CCG are supportive of taking this opportunity.

Urgent Care Centre Interim Solution – Update:
The interim solution is moving forward in terms of vacating the Clinic 3 and Phlebotomy areas of Outpatients for use by Malling Health to house the UCC. It is envisaged that work should be complete late Feb/early March ready for full implementation over the Easter fortnight. We are working with the CCG on the communications and contingency arrangements to ensure the transition runs smoothly over this busy period.

Monitor – Breach of Licence and Undertakings:
The Trust has been put formally into breach of its licence by our regulator, Monitor regarding financial performance and sustainability. Board members will have received the letter along with the undertakings required. We are required to deliver a draft plan by 10th April which is an ambitious and realistic strategy and financial recovery plan. This must lead us to long term breakeven, financial stability and organisational sustainability.

Senior Information Responsible Owner:
The Board is asked to give approval for Paul Taylor, Director of Finance and Information/Deputy CEO to take over this role on behalf of the Trust.

Talent for Care:
The Talent for Care is a strategic framework for the development of the healthcare support workforce and was approved by the Health Education England Board in October 2014.
Health Education England has created a draft pledge and action plan to assist local employers and their partners develop actions and measures of success that will deliver this improved investment and development of their healthcare support workforce.

Each local Trust is encouraged to sign up to the Partnership Pledge to deliver against the 10 strategic objectives in the Talent for Care framework. Within the pledge are a series of activities to support people to:

- Get in – Opportunities for people to start their career in a support role
- Get on – Support people to be the best they can be in the job they do
- Go further – Provide opportunities for career progression, including into registered professions

In order to support our organisation with this, Health Education West Midlands have allocated £30,000 to each Trust as one-off funding to review and map baseline activity against the strategic intentions undertake a gap analysis and develop a local action plan to be ready to move forward with the delivery of The Partnership Pledge and 10 Strategic Intentions from the 1st April 2015. The funding will be made available during January 2015.

To carry out the programme we are suggesting that we use the £30,000 allocation to recruit a fixed term Project Manager to deliver the required outputs. In the initial 12 month period we would have the following outputs:

- A baseline of current activity
- Gap analysis
- Action plan to address gaps
- Organisational strategy on Work Experience and Apprenticeships
- Learning Framework for staff
- Monitoring framework to measure impact (e.g numbers and quality of work experience, numbers of apprentices, destinations/employment of apprentices, training undertaken by existing staff).
- Increased activity on all aspects of the strategic objectives identified within the action plan

During the 12 month fixed-term period, a review of on-going activity will be undertaken to identify what plans are required on-going resource would be required to sustain the activity.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th February 2015 - PUBLIC

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

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

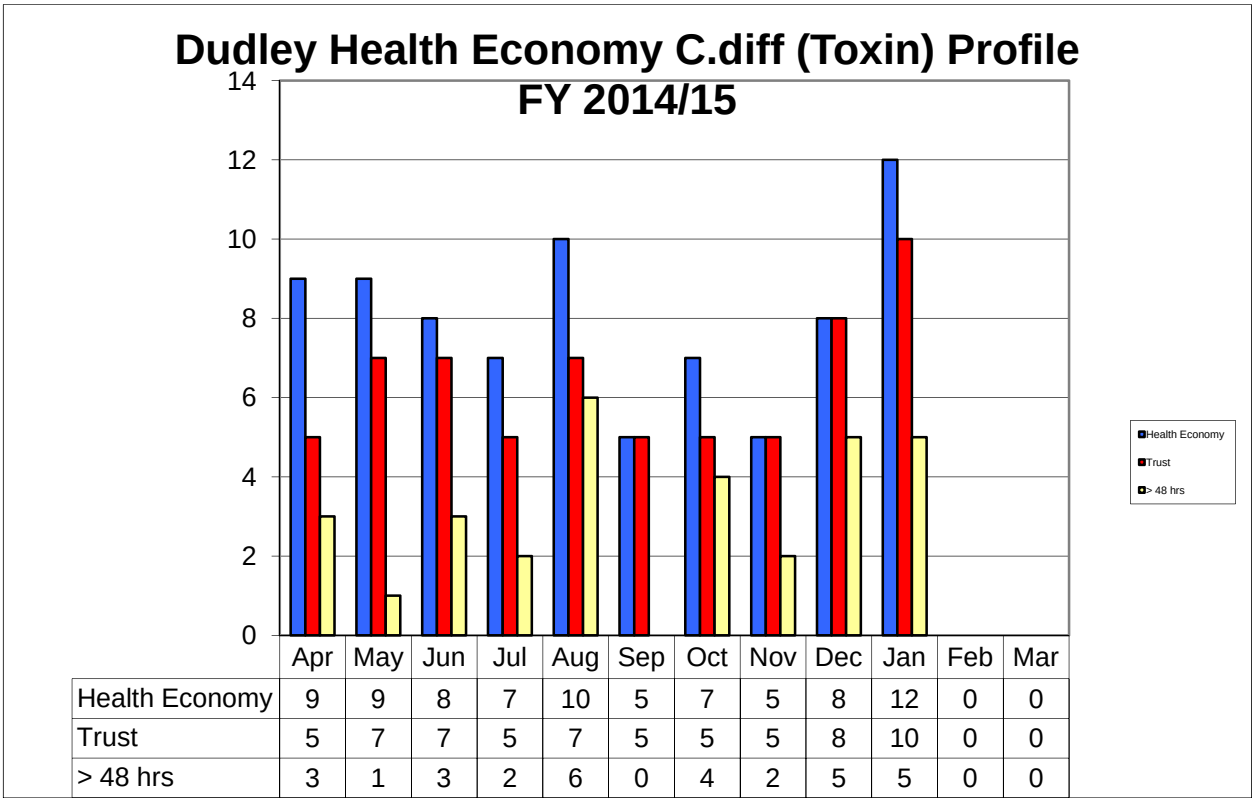
Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive the Infection Prevention and Control Exception Report and note the content.

Summary:

Clostridium Difficile – The target for 2014/15 is 48 cases, equivalent to 20.5 CDI cases per 100,000 bed days. At the time of writing (26/1/15) we have 5 post 48 hour cases recorded in January 2015 against a trajectory for the month of 5 cases.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	9	9	8	7	10	5	7	5	8	12	0	0
Trust	5	7	7	5	7	5	5	5	8	10	0	0
> 48 hrs	3	1	3	2	6	0	4	2	5	5	0	0

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], has commenced. To date 23 cases have been reviewed with the CCG of which 18 were determined as being associated with lapses in care. The main themes identified are: 7 cases were associated with poor documentation, 6 cases were associated with issues related to antibiotic prescribing, 7 cases were associated with delayed sample collection, 1 case was associated with delayed isolation, 4 case was associated with poor environmental scores and 2 case was associated with poor hand hygiene scores. As can be seen some cases had more than one lapse identified.

We have also reported a period of increased incidence on one of the surgical wards and the initial 72 hour meeting has been held.

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

Norovirus – There are no wards currently affected.

Ebola – Public Health England (PHE) have issued further advice, which the Trust is adopting, including displaying public information at entry points into the Acute Trust. A recent update of the ACDP guidance and algorithm for Viral Haemorrhagic Fevers has been released by Public Health England and this is replacing the previous guidance.

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

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th February 2015

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

CORPORATE OBJECTIVE:

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

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

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

SUMMARY OF KEY ISSUES:

Attached is the monthly information on nurse/midwife staffing.

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

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

When shortfalls occurred the reasons for gaps and the actions being taken to address these are outlined and an assessment of any impact on key quality indicators has been undertaken.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

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

THE DUDLEY GROUP NHS FOUNDATION TRUST

Monthly Nurse/Midwife Staffing Position

December 2014

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

The paper endeavours to give the Board a view of the frequency when Registered Nurse to patient ratios do not meet the recommended ratio on general wards of 1:8 on day shifts and also the number of occurrences when staffing levels have fallen below the optimum levels for both registered and unregistered staff. It should be noted that these occurrences will not necessarily have a negative impact on patient care

The attached chart follows the same format as the updated one last month. It indicates for the month of October 2014 when day and night shifts on all wards fell below the optimum, or when the 1:8 nurse to patient ratio for general wards on day shifts was not achieved.

In line with the recently published NICE (2014) guideline on safe staffing:

1) An establishment (an allocated number of registered and care support workers) is calculated for each ward based on a combination of the results of the six monthly Safer Nursing Care Tool exercise and senior nurse professional judgement both based on the number and types of patients on that ward (with the Board receiving a six monthly paper on this). The establishment forms a planned number of registered and care support workers each shift.
2) Each six weeks the Lead Nurse draws up a duty rota aimed at achieving those planned numbers.
3) Each shift the nurse in charge assesses if the staff available meet the patients' nursing needs.

Following the shift, the nurse in charge completes a monthly form indicating the planned and actual numbers and, if the actual doesn't meet the planned, what actions have been taken, if any is needed for the patients on that day. Each month the completed form for every ward is sent to the Nursing Directorate where they are analysed and the attached chart compiled.

It can be seen from the chart (green) that the number of shifts identified as amber or blue are 49. This compares to 38 in November, 53 in October and 33 in September. The number is still very small and there have been no incidents on any shifts assessed as red and unsafe. Overall the staffing available met the patients' nursing needs in the majority of cases but, in a number of instances, despite attempts through the use of deployment of staff or the use of bank/agency staff, the optimum number of staff for the patients on that shift were not reached.

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

When shortfalls in the 1:8 RN to patient ratio for day shifts on general wards or when shifts have been identified as below optimum; the reasons for the gaps and the actions being taken to address these in the future are outlined below.

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

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

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS DECEMBER 2014

WARD	No.	RN/ Unreg	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A1	2	RN	Short term sickness/Vacancy	On 1 day and 1 night shift, bank and agency unable to fill. Patient caseload shared with ward A3 and care assistant complement increased. Patient safety maintained
A3	1	RN	Vacancy	On 1 night shift bank and agency unable to fill. Additional care assistant staff employed to maintain safety
A4	1	RN	Short term sickness	On the 1 day shift the site co-ordinator assisted and the stroke bleep service was cancelled. Safety was maintained.
B1	4	RN	Vacancy/Staff sickness and staff moved to another ward to assist	On 1 day shift the ratio was 1:9 but due to low dependency of patients no action was required. On a further day shift assistance from a care assistant occurred and on one of the two night shifts day staff remained for part of the shift and on the other one station was closed.
B4	9	RN	Short and long term staff sickness	On the two night shifts both bank and agency were unable to fill and on one occasion a booked bank nurse called in sick just before the shift. On the seven day shifts the bank was unable to fill. On all seven occasions there were no identified patient safety concerns or issues and on two of these occasions the dependency of the patients was such that a nurse was able to assist another ward for part of the shift.
C1	9 1	RN Unreg	Sickness/Vacancy	On the four day and five night shifts of RN shortfall and 1 day of Unreg shortfall, the bank and agency were unable to fill. Patient safety was maintained.
C2	1	RN	Increased HDU patients	On the 1 night shift the site co-ordinator and registrar (medical) were aware. The registrar saw potential admissions in ED rather than on the ward to reduce the ward nursing workload. There was no adverse effect on patients.
C5	2 1	RN Unreg	Sickness/Vacancy	On one occasion of RN shortfall, the weekend dependency was such that safety was maintained with an extra care assistant. On the other shortfall occasion dependency was such that safety was maintained.
C6	1	RN	Staff moved to another ward	The low dependency of the patients was such that a staff member was moved to another ward to assist. Patient safety was maintained.
C7	3 1	RN Unreg	Sickness/Vacancy/ Compassionate leave	On the 2 dayshift shortfalls of RN the bank/agency were unable to fill. Patient safety was maintained. On the 1 nightshift shortfall of RN the bank and agency were unable to fill. For the other night shift, there was one unregistered short and it required two further unregistered staff but the bank or agency were unable to fill

WARD	No.	RN/ Unreg	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
C8	7	RN	Vacancy	On all seven occasions the patient complement was such that all their needs were met.
MHDU	1	RN	Sickness	Actions taken were that a patient was moved to a general ward and a nurse from the general wards assisted. Patient safety was maintained.
Maternity	5	RM	High maternity leave, sickness absence.	Bank unable to fill. Escalation process enacted. Staff redeployed to area of need.

Dec-14

SHIFT

WARD	STAFF	1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16	
		D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	Reg																							3/2									
	Unreg																																
WARD A2	Reg																																
	Unreg																																
WARD A3	Reg																																
	Unreg																																
WARD A4	Reg																																
	Unreg																																
WARD B1	Reg		2/1									4/3														4/2							
	Unreg																																
WARD B2 HIP	Reg																																
	Unreg																																
WARD B2 TRAUMA	Reg																																
	Unreg																																
WARD B3	Reg																																
	Unreg																																
WARD B4	Reg												5/3													6/4				6/5		6/5	
	Unreg																																
WARD B5	Reg																																
	Unreg																																
WARD B6	Reg																																
	Unreg																																
WARD C1	Reg							6/5				6/5						6/5					4/3		4/3								
	Unreg											8/6																					
WARD C2***	Reg																		10/7														
	Unreg																																
WARD C3A	Reg																																
	Unreg																																
WARD C3B	Reg																																
	Unreg																																
WARD C4	Reg																																
	Unreg																																
WARD C5	Reg																																
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WARD C6	Reg																																
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WARD C7	Reg		4/3									5/4														5/4							
	Unreg																																
WARD C8	Reg									4/3										4/3				4/3									
	Unreg																																
CCU	Reg																																
	Unreg																																
PCCU	Reg																																
	Unreg																																
EAU	Reg																																
	Unreg																																
MHDU	Reg																																
	Unreg																																
CRITICAL CARE*	Reg																																
	Unreg																																
NEONATAL**	Reg																																
MATERNITY ****	Reg																									15/13						15/14	
	Unreg																																

WARD	STAFF	17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
		D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	Reg																										3/2				
	Unreg																														
WARD A2	Reg																														
	Unreg																														
WARD A3	Reg														4/2																
	Unreg																														
WARD A4	Reg							3/1																							
	Unreg																														
WARD B1	Reg														2/1																
	Unreg																														
WARD B2 HIP	Reg																														
	Unreg																														
WARD B2 TRAUMA	Reg																														
	Unreg																														
WARD B3	Reg																														
	Unreg																														
WARD B4	Reg	6/5		6/5		6/5	5/3															6/4									
	Unreg																														
WARD B5	Reg																														
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WARD B6	Reg																														
	Unreg																														
WARD C1	Reg		4/3	6/5			4/3																		4/3						
	Unreg																														
WARD C2***	Reg																														
	Unreg																														
WARD C3A	Reg																														
	Unreg																														
WARD C3B	Reg																														
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WARD C4	Reg																														
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WARD C5	Reg							6/5												6/5											
	Unreg																			7/6											
WARD C6	Reg					3/2																									
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WARD C7	Reg																														
	Unreg																														6/3
WARD C8	Reg							4/3										4/3		4/3										4/3	
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CCU	Reg																														
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PCCU	Reg																														
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EAU	Reg																														
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MHDU	Reg						4/2																								
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CRITICAL CARE*	Reg																														
	Unreg																														
NEONATAL**	Reg																														
MATERNITY ****	Reg																		15/10		15/10			15/10							
	Unreg																														

Key Unsafe staffing (red) · Registered nurse/midwife shortfall (amber) · Care Support Worker shortfall (blue)

* Critical Care has 6 ITU beds and 8 HDU beds

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

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

**** Midwifery registered staffing levels are assessed as the midwife: birth ratio and is compliant with the ‘Birthrate +’ staffing assessmen

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th February 2015

TITLE:	**Report from the Estates Team on emergency planning, IT business continuity and how we hold our PFI partners to account.**		
AUTHOR:	**Robert Grave. Deputy Director (Facilities & Estates)**	**PRESENTER**	**Robert Graves. Deputy Director (Facilities & Estates)**
CORPORATE OBJECTIVE: **SG01: Quality, Safety & Service Transformation Reputation**			

14/095.10 Audit Committee Exception Report (Enclosure 13)

Action: Report back to Board from the Estates Team on emergency planning, IT business continuity and how we hold our PFI partners to account.

SUMMARY OF KEY ISSUES: Emergency planning and continuity planning.

The PFI Project Agreement makes reference to Major Incident in Schedule 5 of the Project Agreement and the Project Agreement does not make any reference to Continuity Planning. The contractual requirement for Major Incidence requires additional support from hard and soft services in addition to what else is set out in the Schedules of Services.

Continuity is covered within the PA as requirements to maintain services and facilities with deductions where this does not happen in accordance with the Performance Manage System. The Trust does not have a contractual right to Continuity Plans from ProjectCo though these are usually supplied on request.

ProjectCo may charge for any additional responsibilities or requirements set out in new Major

Incident plans as a variation to the MIP at the time of contract.

Business Continuity Planning and Audit
The Business Continuity Plans have been developed in conjunction with ProjectCo and cover failures of mains power, water, lighting, heating, lifts, medical gases, telecoms and medical devices. The business continuity plans were audited by Baker Tilly Risk Advisory Services LLP in 2014 in the report dated 23 September 2013. Two recommendations were identified relating to the PFI contract and were Continuity of Electricity and Water Supplies.

Baker Tilly Risk Advisory Services LLP Ref 3.4 - *The Trust should request a completion report from Interserve or maintain a log of all tests carried out to ensure that generator tests are being undertaken in accordance with the planned*

Baker Tilly Risk Advisory Services LLP Ref. 3.5 - *Routine checks should be undertaken on the back-up water tanks to ensure that they function and the required water levels would be delivered should there be major disruption to the normal water supply.*

Baker Tilly Risk Advisory Services LLP final report dated 13 January 2015 noted that:

Based on the results of our testing we are able to confirm that the following recommendations have been fully implemented. These recommendations have been closed on the Trust's recommendation tracking system.

IT Business Continuity
IT Business Continuity is the responsibility of the Associate IT Director and IT is no longer part of the PFI following the Siemens termination. On the Siemens IT contact termination all of the Performance Manage Specification was also terminated. The Siemens IT termination was dealt with by Trust IT and Finance.

Recommendations

To note the contents of the report.

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

RISK	**Y**		**Risk Description: That appropriate routine checks on water levels and generator testing are not in place and recorded.**
	Risk Register: **N**		
	CQC		

COMPLIANCE and/or LEGAL REQUIREMENTS	**NHSLA**		**Details:**
	Monitor		**Details:**
	Equality Assured		**Details:**
	Other		**Details: External Audit – Baker Tilley**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS

To note the contents of the report.

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th February 2015

TITLE:	**Patient Catering – Update to Board paper of 6th November 2014**		
AUTHOR:	**Robert Grave. Deputy Director (Facilities & Estates)**	**PRESENTER**	**Robert Graves. Deputy Director (Facilities & Estates)**
CORPORATE OBJECTIVE: SG02 Patient Experience			

SUMMARY OF KEY ISSUES:

The report covers:

- General update.
- Actions taken by Interserve as an update from the last report.
- What needs to happen to effect change and improvement and updated from the last report.
- Patient survey information.
- Recommendations and decisions required.

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

RISK	**Y**		**Risk Description: Poor perception of food quality, choice and serving interface can affect the patients experience and in turn local and national patient experience survey scores can be adversely affected.**
	Risk Register:		**Risk Score: 4 x 4 =16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Risk is assessed by CQC via PLACE assessment scores and inpatient survey scores on food.**
	NHSLA		**Details:**
	Monitor		**Details:**
	Equality Assured		**Details:**

	Other		**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
	X	**X**	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS

The Board of Directors is asked to discuss and note the contents of the report and:

1. That all future Patient Catering reports are joint reports from Estates covering the Project Agreement requirements, Dieticians dealing with quality and choice of food, and Nursing reporting on the success of service from the trolley to patient, feeding patients that need help, and breakfasts.

2. That representational samples of patient surveys on food are continued to be collected so that the Board are accurately advised of trends in patient catering scores.

3. That the existing focus on patient catering is maintained and that the process of development of new menus and the roll out is completed.

4. That the Trust gives access for Interserve to the Trust Wi-Fi and a decision is made if payment for access has to be made by Interserve.

5. That Nursing (with matrons) agree the length of meal service and then talking to Interserve undertake an assessment, ward by ward, to agree the number of ward staff to achieve the best possible patient experience for each meal time.

6. That Nursing assesses on a ward by ward basis the number of staff required to feed patients that need support.

7. That patient catering is treated as a dynamic and consistent continual improvement programme and regular reports continue to be received by the Board no less than annually, even when the Trust achieve significantly higher scores.

8. The Board to decide if consultation on the possible patient preference for a single hot meal per day should be undertaken now or consider the option to undertake consultation post PLACE.

The Dudley Group NHS
NHS Foundation Trust

Background
The purpose of this report is to highlight the progress made to date and to identify further work that needs undertaking to continue to improve Patient Catering as a dynamic process.

General update
Patient catering is one of the indicators on how our Trust is perceived by our public both within PLACE and National Survey for Adult Inpatients. This information is collected by Patient Experience.

Though Interserve and the PFI are responsible for the delivery of patient catering they will not make changes to the menu without the express instructions and approval of the Trust, which falls to our dieticians.

The Way Forward
There are 5 elements to developing and improving the patient catering experience:-

- The supply chain of food which is controlled by Interserve.
- The preparation and delivery of food to wards, which is undertaken by Interserve.
- The control and specification of type, nature and quality of food by Trust dieticians.
- The delivery of food to patients (and where necessary feeding) by ward staff.
- Communication and Patient Experience strategy focusing on informing our patients and visitors that we have listened to them and have made changes and then listening and maintaining or improving the standards of patient catering.

Ward staff prepare and deliver breakfasts and hot drinks. To further improve scores after the roll out of the new menus for lunch and dinner, breakfast will be assessed and recommendations made where improvements can be made in service delivery and where the patient experience scores can be increased.

The service and preparation of breakfasts are not a PFI requirement except the quality and amount of food available. Bread has been replaced with Hovis and no other issues have been raised.

1. **The supply chain**
   New menus were designed and a four week trial, with two repeat cycles, completed. Using a feedback loop from patients, staff and governors tasting amendments to the menu were made on preferences, quality and popularity of dishes. Tillery Valley (the supplier) has been heavily engaged throughout the process. Fruit has been added to the daily menu, and chips are served on a regular basis, with positive feedback from the wards and patients. Bread has been changed and margarine has been replaced with butter. Sandwich fillings have been changed and new nourishing soups have been introduced.

2. **Preparation and delivery**
   Interserve has undertaken additional training for their staff, and have produced a manual for each ward covering laying out the food trolleys, standard dress, plug in points for the trolley, standardised ward kitchen layouts etc.

3. **Trust Dieticians**
   Trust Dieticians have completed the menu review and have also completed the roll out of new dysphagia codes/descriptors and training with the roll out of the new dysphagia menu which was completed in January 2015.

4. **Ward staff**
   Breakfasts and hot drinks are both prepared and served by Trust ward staff. The terms of the PFI Project Agreement allows for materials for seven hot drinks per day, so it is assumed that is the target for ward staff to achieve.

   Breakfasts have not been audited to date and will be the next section of patient meals to be assessed. This is a mixture or ward staff and patient experience. There have been no complaints received about the quality of the basic products since the bread supplier was changed.

5. **Communication and Patient Experience Strategy**
   Following the completion of the dysphagia roll out no other action is possible until Interserve agree to move forward, which is dependent on the Trust giving access to the Wi-Fi.

Food Assessments / Surveys/ PLACE Representation
Annually there are two national indicators which include patient catering. These are the Patient Led Assessment of the Care Environment (PLACE) and the National Survey for Adult Inpatients (which is published by the CQC and is often referred to as the Picker survey).

PLACE is a moderately complex assessment and the food element looks at our processes and environment as well as the food itself. The 2014 results recorded a 6% increase on the 2013 results. This is a good improvement though the Trust is still below the median. PLACE is made up of two parts. The first part is a yes or no response by the Trust on achieving set criteria against the weighting measures. The second part is the assessors' scores which is part privacy and dignity and part quality of patient food.

Representations have been made to the PLACE (Health and Social Care Information Centre) and a written response has been received. We have agreement that our representations will be taken up on our view that our patients may prefer only one hot meal a day. This will be raised with the Hospital Caterers Association and the Department. The response outlined that the choice is ours and if we do choose only one hot meal then our score will be lower. This year's criteria are fixed. The response also outlined that substantial consultation was undertaken to set the criteria.

The Trusts options are:

- To continue with our current trajectory to upgrade the patient catering and move to pre-order and re-consider post PLACE.
- To consult with patients on the proposal to move to one hot meal.

If the second option is considered then very early consultation should be taken with Summit and Interserve, as cost savings are often very small when parts of a service are omitted. Savings may be further reduced by Interserve having already proposing to move to pre-order, which will give patients the ability to choose only one hot meal. The savings will then be made by Interserve as this is a reduction in wastage.

The National Survey for Adult Inpatients asks three questions on patient catering:

- How would you rate the hospital food?
- Were you offered a choice of food?
- Did you get help from staff to eat your meals?

These are weighted questions and the scoring is moderately complex. The Trusts 2013 'rating' score was 4.3 out of 10 taken during July 2013 and this was the third worst score recorded nationally. The current real-time scores are better and are shown in Appendix 1. Last year our actual score for July mirrored our recorded score which is unusual as looking at the last three years' scores recorded at the bed head there is a variation of 0.8 better than inpatients in the follow

up survey – which we would expect.

The information for patient catering scores is collected by Patient Experience.

The current overall score for the existing menu, with improvements, is 5.9 and is consistent with 3 months ago; however some of the representational sample sizes due to lack of resources within Patent Experience makes the scores unreliable.

Our patient experience scores for menus are shown in Appendix 1.

Records are kept on the impact that the introduction of various changes to food menus has made, showing scores for each initiative. This table is shown in Appendix 1.

In addition the score for the new menu had shown a significant increase to 7.64 for the final week of the trial menu, which is exceptionally high. Overall this score is currently 6.15 and showing a downward trend to the point that the figure is similar to the old menus. The trial menu on C2 (Children's) C5 and B4 has been maintained and the scores from these 3 wards are in Appendix 1. Governors have also had an opportunity to taste the new menus and fed back their observations through the event organised by Patient Experience.

It is believed, and in part evidenced, that auditing catering improves the score and once auditing is completed and without further intervention scores decline.

The PFI Catering Contract

The Project Agreement covers:

- The supply chain of food which is controlled by Interserve.
- The preparation and delivery of food to wards, which is undertaken by Interserve.

Ward staff cover:

- The delivery of food to patients from the trolley after having been plated up by Interserve (and where necessary feeding) by ward staff.

All three elements are mutually interrelated and must be dealt with in a holistic action plan to deliver improvement.

Interserve Actions

Interserve have not made any incremental or other improvements since the last report, and have stated that they do not wish to implement the new menus without access to the Trust Wi-Fi for ordering and stock control. Trust IT has stated that they have a resolution which they are bringing forward. Interserve also continues to make written and verbal representations on the level of ward staff in attendance at lunch and dinner. As an action this needs Nursing and Interserve to agree on a ward by ward assessment what staffing is necessary and this has the support of the Director of Nursing.

Interserve have been asked to produce a roll out programme of the new menus, including any resources and training required, however Interserve have declined to progress the role out of menus without the support of the Trust in giving access to the Trust Wi-Fi, as Interserve view access as essential to pre-ordering and waste control. Contractually NCI's can be applied; however it is very rare that a deficiency in the service is logged on the Helpdesk. Currently only a failure under patient choice would be possible to apply as a deduction, and a temperature deduction would fail under Interserve recorded observation of nurse support on ward though the mitigation would degrade subject to the ward nature, as maternity and children's wards are substantially self-sufficient through partners or parents support, in comparison with dementia or frail and elderly wards, which require significant nurse support to patients. However the temperature of food is recorded from the trolley at the end of each meal service and is compliant.

As food temperature has been a consistent complaint, Interserve had previously promised £0.5M in new trolleys, which will also include plate heating. The current account manager has confirmed he believed this will be honoured though no date has been offered by Interserve for the new trolleys and the National Director of Interserve Healthcare has been asked to a meeting to discuss the lack of progress being made on patient catering and the lack of clarity when the new trolleys will be ordered and delivered. Summit have written to the Trust stating that Interserves promise to upgrade the trolleys has been recorded and they expect the trolleys to be replaced. It is unlikely that contractually Interserve can be held to replace the trolleys.

Induction and ongoing training covering the Interserve catering service is being built into the individual ward manuals that the Trust has instructed Interserve to produce. This seeks standardised and processed methodology to increase the control and quality systems, as to date catering services is not consistent in delivery. The dynamic Interserve catering manual is being regularly reviewed and updated.

Interserve has taken action to ensure their personnel respect protected mealtimes. Currently only lunch is a protected mealtime, however Interserve will look to showing similar respect for other mealtimes. ProjectCo are reviewing the new Trust Protected Mealtime Policy, which has been agreed by the Trust but not by ProjectCo.

Interserve were costing directly delivered patient meals to the patient, however they have recently indicated that they do not wish to proceed with this possibility as Interserve consider the risks outweigh the benefits of serving directly to patients.

Interserve has proposed the use of an electronic tablet (IT) to choose, report to the central kitchen on each patient meal choice as an order, and also build up a profile of preferences over a period of time to accurately target quantities on wards on site and are waiting for approval for access to the Trust Wi-Fi to begin testing. Patient ordering would happen the day of the meal, and as there are constant admissions and discharges a limited number of additional portions would be included on the patient catering trolley for variations in choices.

This variation in procedure removes the waiting for patients to choose their food at meal times and may be a cost effective alternative to ward staff delivering this service. This process will be quicker and a better patient experience. Trust IT have agreed that Wi-Fi access can be granted and have sought payment from Interserve who have not responded in a positive manner, based on the very high level of investment that they have already made in patient catering. The use of electronic ordering and recording will also help to reduce food wastage.

Contractually this will deliver the Project Agreement output of self monitoring as long as there is real time recording of first choices of patient meals being delivered. To date there is evidence that patients are not getting first choices and this is not being recorded and no deductions are being taken. Under the current system this will only improve if ward staff actively audit and report failings on the Help Desk or an audit function is added.

Trust Actions

It is equally as important that our own Trust staff engage in ensuring the best possible patient experience in serving, protecting the protected meal times and giving very robust feedback on the quality, timeliness, temperature and accuracy of requested menu choices via the Help Desk as fed back by patients, to lever the service improvements. Our own staff must also buy into patient meals as a quality product and that is expected to require a staff engagement communication exercise, including staff in regular taste testing so they know and endorse the patient menus.

To apply contractual pressure would require significant Trust commitment to record each and every contractual failure on the Help Desk. To date this does not happen and though we are aware of contractual deficiencies, through patient questionnaires, the actual failures are not being recorded by ward staff. Whilst the evident commitment from Summit and Interserve to invest and work at

improving patient catering remains, it is not the intention to apply NCI's and Deficiency Points for other than serious breaches.

Interserve record the numbers of Trust staff assisting with the meal service, plus get the ward staff to sign off the service at the end of the meal service. It is proposed that ward staff also sign off that Interserve have provided a service in accordance with the contract. Currently Interserve mitigates their contractual liability on temperature by claiming lack of ward staff support at meal times.
As Interserve claim that lack of nursing support is slowing down the delivery of meals which then impacts on temperature and quality the Director of Nursing has decided that, in discussion with Matrons, an agreed time period in which each meal is served and this is audited. This will define the ward staff required on a ward by ward basis to achieve an agreed and efficient patient catering service. The Director of Nursing also wishes to undertake a secondary audit to follow through which will define on a ward by ward basis the number of ward staff required to feed patients.

Recommendations

1. That all future Patient Catering reports are joint reports from Estates covering the Project Agreement requirements, Dieticians dealing with quality and choice of food, and Nursing reporting on the success of service from the trolley to patient, feeding patients that need help, and breakfasts.

2. That representational samples of patient surveys on food are continued to be collected so that the Board are accurately advised of trends in patient catering scores.

3. That the existing focus on patient catering is maintained and that the process of development of new menus and the roll out is completed.

4. That the Trust gives access for Interserve to the Trust Wi-Fi and a decision is made if payment for access has to be made by Interserve.

5. That Nursing (with matrons) agree the length of meal service and then talking to Interserve undertake an assessment, ward by ward, to agree the number of ward staff to achieve the best possible patient experience for each meal time.

6. That Nursing assesses on a ward by ward basis the number of staff required to feed patients that need support.

7. That patient catering is treated as a dynamic and consistent continual improvement programme and regular reports continue to be received by the Board no less than annually, even when the Trust achieve significantly higher scores.

8. The Board to decide if consultation on the possible patient preference for a single hot meal per day should be undertaken now or consider the option to undertake consultation post PLACE.

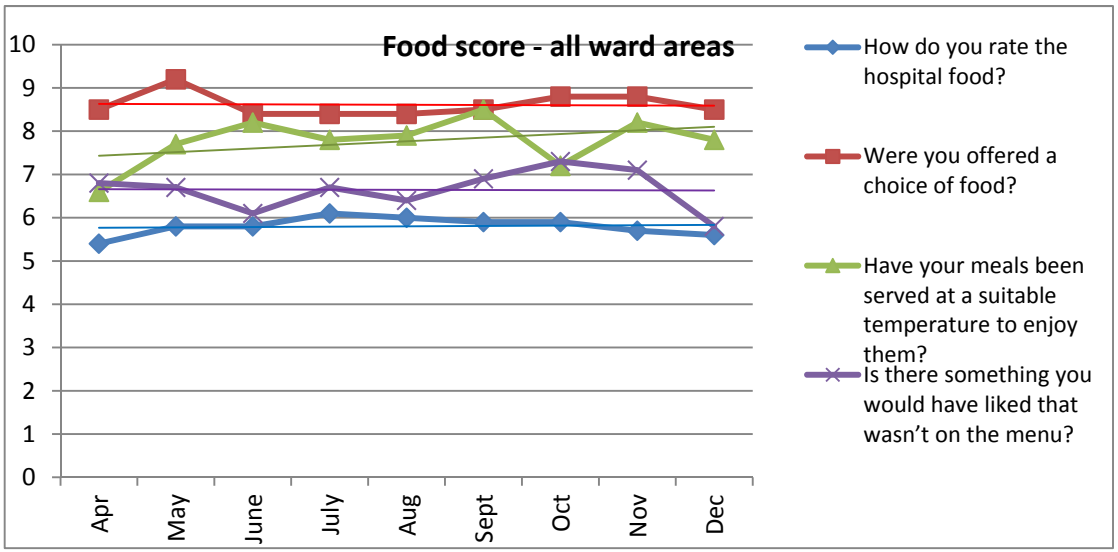
Appendix 1

Patient Experience Data Report – Board February 2015

The first two questions in the chart below track national survey questions, the following two questions have been added by the Trust to track issues highlighted by patients.

2014/15	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
How do you rate the hospital food?	5.4	5.8	5.8	6.1	6	5.9	5.9	5.7	5.6
Were you offered a choice of food?	8.5	9.2	8.4	8.4	8.4	8.5	8.8	8.8	8.5
Have your meals been served at a suitable temperature to enjoy them?	6.6	7.7	8.2	7.8	7.9	8.5	7.2	8.2	7.8
Is there something you would have liked that wasn't on the menu?	6.8	6.7	6.1	6.7	6.4	6.9	7.3	7.1	5.8
Number of Responses	260	271	250	311	214	191	129	135	140

This data charts the food scores across all wards



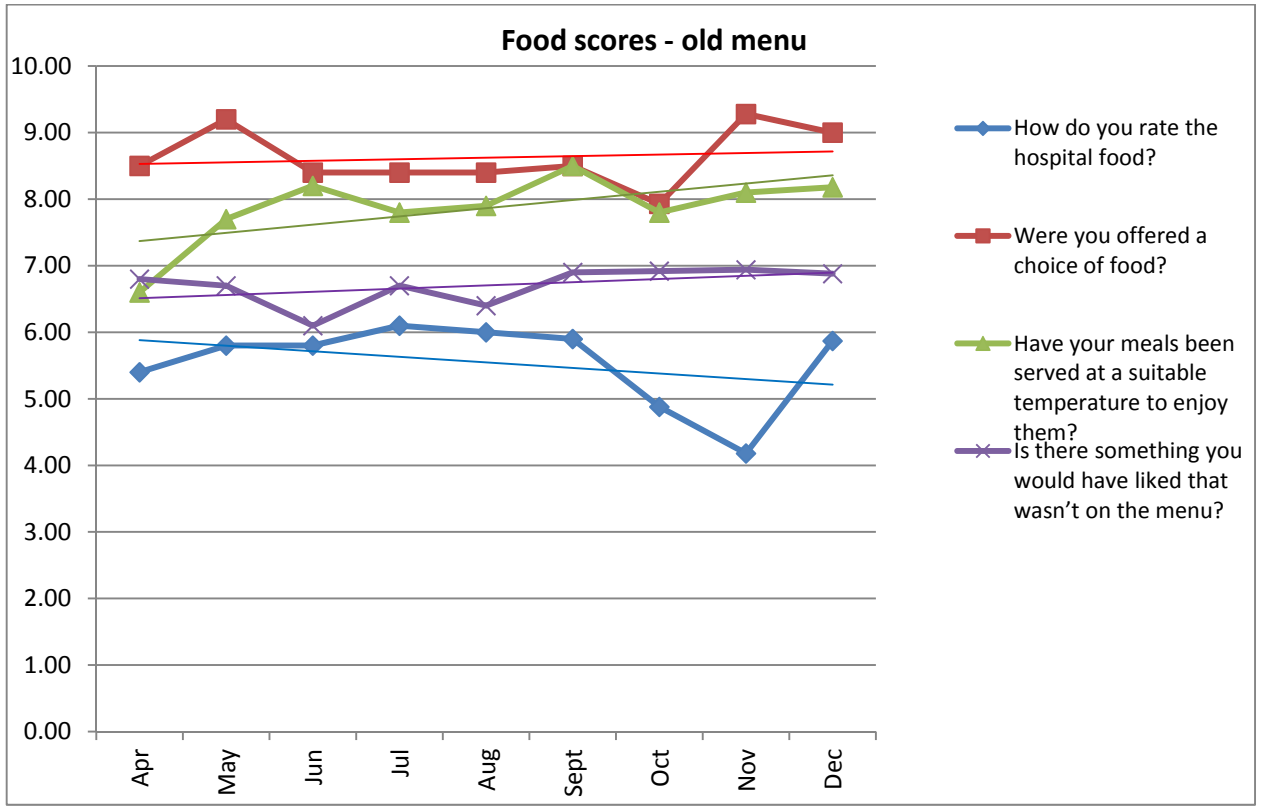
The chart opposite shows the following trends:

- The rating of hospital food is showing a sustained upwards trend.
- Were you offered a choice of food is showing a slight upward trend
- Have your meals been served at a suitable temperature – this is showing a downward trend (Interserve are doing a Business Case to provide new trolleys to try and improve this facility)
- Is there something you would have liked that wasn't on the menu – this is showing a slight downward trend (this is being addressed by asking patients what they would have liked and including popular items on the new proposed menus)

This chart shows food scores for all wards using old menus

2014/15	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
How do you rate the hospital food?	5.40	5.80	5.80	6.10	6.00	5.90	4.88	4.18	5.87
Were you offered a choice of food?	8.50	9.20	8.40	8.40	8.40	8.50	7.93	9.28	9.00
Have your meals been served at a suitable temperature to enjoy them?	6.60	7.70	8.20	7.80	7.90	8.50	7.80	8.10	8.18
Is there something you would have liked that wasn't on the menu?	6.80	6.70	6.10	6.70	6.40	6.90	6.92	6.94	6.88
Number of Responses	260	271	250	311	214	191	96	105	23

This data shows food scores for all wards using old menus



This chart shows food scores for all wards using new menus

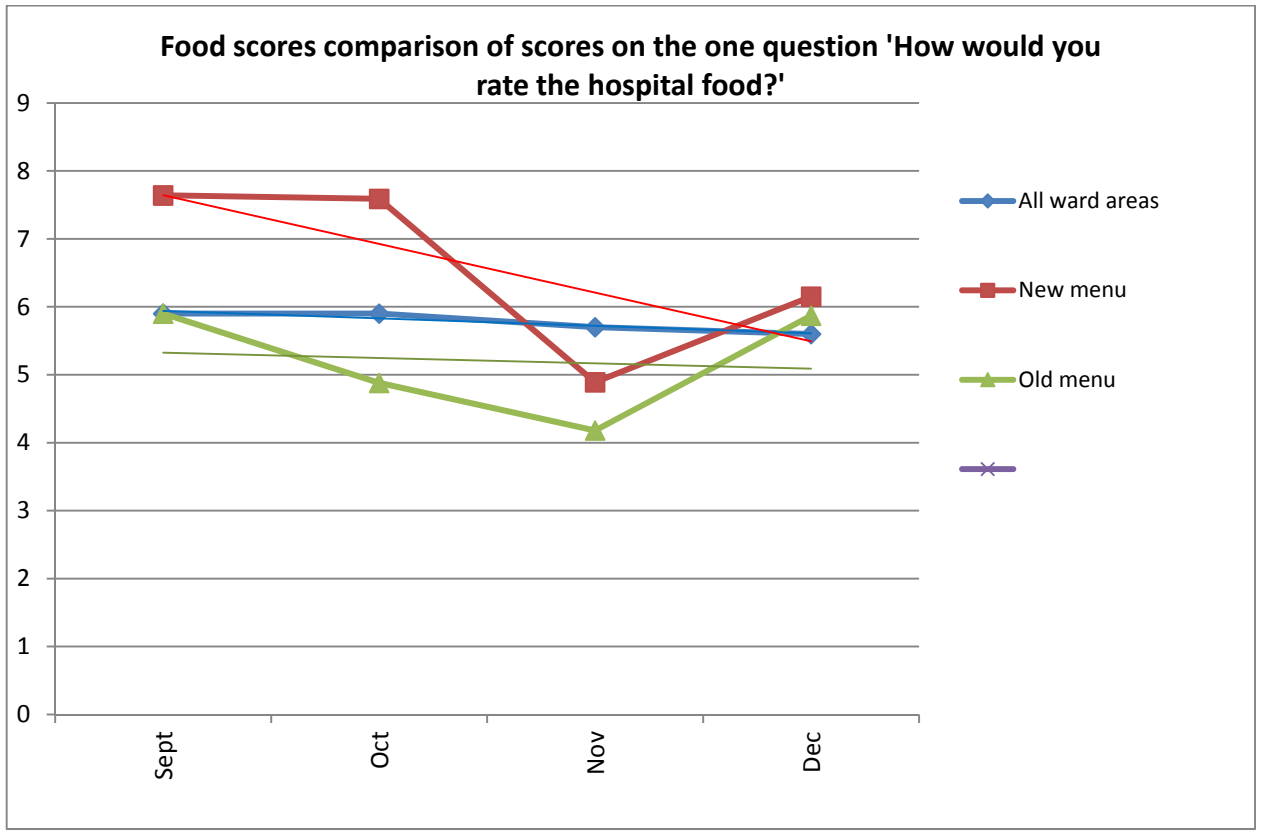
2014/15 Q3	Sept	Oct	Nov	Dec
How do you rate the hospital food?	7.64	7.59	4.89	6.15
Were you offered a choice of food?	8.79	10.00	8.00	8.07
Have your meals been served at a suitable temperature to enjoy them?	9.75	9.10	8.67	7.86
Is there something you would have liked that wasn't on the menu?	6.67	10.00	8.67	5.87
Number of Responses	89	129	15	51

This data shows food scores for all wards using new menus

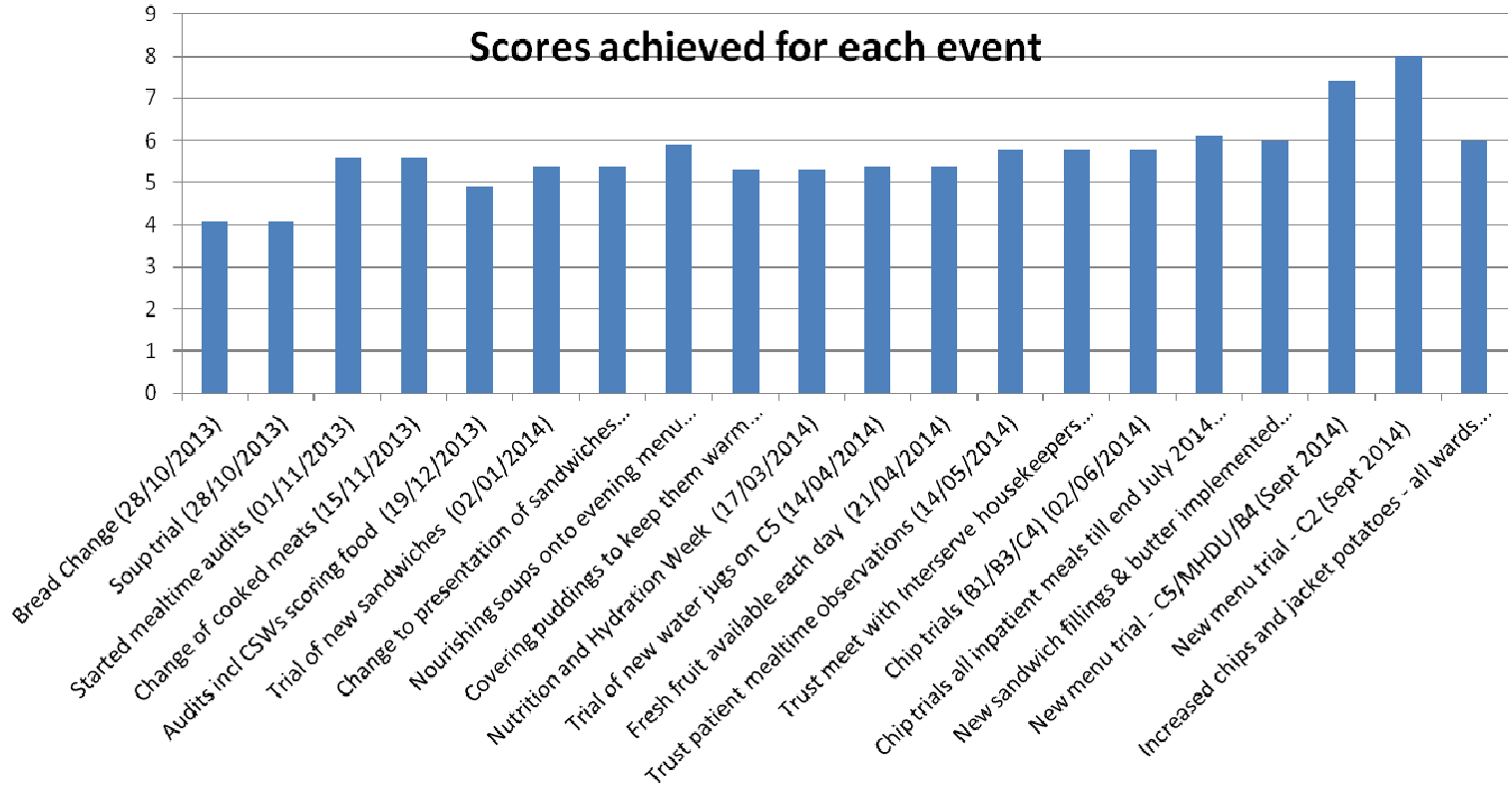
How would you rate the hospital food?

2014/15	Sept	Oct	Nov	Dec
All ward areas	5.9	5.9	5.7	5.6
New menu	7.64	7.59	4.89	6.15
Old menu	5.9	4.88	4.18	5.87

This data compares the above question across the old menu, new menu and all wards combined



The table below shows the score from the Patient Experience Data collected from July 2013, along with the actual scores following the introduction of the various initiatives.



Enclosure 8

Paper for submission to the Board on 8th January 2014

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

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

SUMMARY OF KEY ISSUES

National Cancer Survey Results - The Committee received the survey results and noted that the Trust was in the top ten improved Trusts and was aiming to be in the top 20 per cent of best performing Trusts. 53 questions out of 62 showed improved scores from previous years and 5 questions showed a slightly reduced score. Approximately 300 comments received were very positive and complimentary about aspects of care the patients had received. Patients also commented on areas where the Trust needed to improve including the waiting times for day case chemotherapy, car parking charges and specific examples around unprofessionalism, poor communication, staff smelling of smoke and patient gowns.

National Survey Results – The results were based on 32 questions and were compared with the 2012 survey results. The Trust did less well in some areas but had not worsened overall. Waiting times and a lack of suitable refreshments were commented upon. The full report would be considered at the Patient Experience Group.

Quality Dashboard for Month 6 (September) 2014/2015 - the Committee discussed the following issues:

- **C Diff -** no cases were reported in September. A process was now in place to agree which cases were avoidable. There were 5 in quarter one and 6 in quarter two.
- **Maternity KPIs -** The 'Increase in Breast feeding initiation rates' had increased. The 'Smoking in Pregnancy' was just over the target, putting the Trust in the red again.
- **Stroke -** the Trust was red for the 'Stroke – Suspected TIA Scanned within 24 Hours of Presentation' target for September and the 'Stroke - Swallowing Screen within 4 hours of clock start' was also below target in September.
- **TAL Appointment booking within 4 days -** performance continued to be poor and only 34% of patients booked via the TAL Choose & Book system received notification of their appointment within 4 days.

Additionally one Never Event was reported in September which fell under the category of Retained instruments post operatively.

Policy Group Recommendations - 11 guidelines were revised and 6 documents were returned to the Policy Group with minor amendments and had been collectively agreed. The Committee **ratified** the 17 guidelines/policies.

Patient Experience Actions Update - the following actions were either delivered in quarter 2 or were planned for quarter 3:

- **Friends and Family** - The roll out of Friends and Family in the Community and Out Patients
- **Committed to Excellence** – The Trust received 540 entries this year.
- **#hellomynameis campaign** –This campaign was launched at the Committed to Excellence Awards in October to raise awareness of the importance of excellent communication at all points in a patient's journey. This initiative encourages staff to introduce themselves to patients.

The Committee **noted** the progress and action taken in quarter two and planned for quarter three to help the Trust achieve the Patient Experience Strategy.

Quality Accounts Update - The Director of Nursing drew the Committees attention to concerns relating to Pressure Ulcers where two of the four target topics had taken a downturn in the last quarter. The work in progress was discussed. The Committee **noted** the position with regard to the quality priority targets and with regard to the national clinical audit/confidential enquiry participation at the end of the quarter.

Nursing Strategy Update - good progress had been made with regard to the action plan. One red action relating to the expansion of the use of Telehealth with the virtual ward team had not been taken forward by the CCG. The other red rated action was to 'Ensure that 80% of all staff are trained in End of Life issues by the end of the year (March 2014)'. Actions were in progress to ensure that end of life champions were

available in ward areas.

Serious Incident Monitoring Report - October 2014 - 23 new incidents were reported of which 9 were new general incidents and 14 pressure ulcer incidents. The Committee **noted** the current position and **supported** the recommended closure of 13 Serious Incidents. The following areas were discussed:

- **Falls resulting in fracture -** there were 3 incidents between April and June and 12 between July and September. All incidents had a full RCA and the falls bundles and assessments were being undertaken.
- **Confidentiality Breach -** 2 incidents were reported in October 2014. Both related to children in foster care but there was no link between them.
- **Compliance with CCG Contractual Arrangements -** there were no breaches in the 2 days from identification of the incident and reporting to STEIS, however there was a breach in completion of an RCA investigation report within the 45 day timescale. There were no Never Events in October.
- **Red Incident Matrix** - The Committee reviewed and discussed the Trust Red Incident Matrix incident trends and noted the possibility of downgrading two incidents.

Quality & Safety Group - The Committee **noted** the summary of the meeting held on 16th October 2014 and noted that Nursing Care Indicators had been reduced in number. The Safety Express audits had shown that Pressure Ulcers and Falls were below the national average and catheter care was consistent.

Internal Safeguarding Board - The Committee **noted** the key issues arising from the Internal Safeguarding Board held on 23rd October 2014 and were advised that the Safeguarding Board had published the executive summary of the investigation into Restraint Allegations on the 16th October 2014 confirming that it was now complete. The Safeguarding Annual Report 2013/14 was also complete.

Infection Prevention and Control Forum - The Committee **noted** the key issues arising from the Infection Prevention and Control Forum held on 11th September 2014 and considered the following issues:

- **Maternity** – There were concerns with the urinary catheter care audits which showed 80% for May and June due to incomplete documentation.
- **Incidents** - There was a period of increased incidents on C3 which related to 2 cases of C Diff. There was no link between these.
- **Needlestick injury** –there was increased reporting of needle stick injuries believed to be due to increased reporting.
- **Ebola** –several walkthroughs had been undertaken to ensure that processes were robust.
- **MRSA** –new guidance had been issued by the Department of Health.

International Drug Shortage –the Committee was advised of a national shortage of a drug used for patients with bladder cancer and was assured by the Medical Director that national guidance would be followed and affected patients needs would be reviewed at a meeting on 24th November 2014.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 13th November 2014 and refer to the full minutes for further details.

The Clinical Quality, Safety & Patient Experience Committee was established to provide assurance to the Board on Clinical Quality and Safety standards, (including Clinical Effectiveness, Patient Safety and Patient Experience). It sets clear quality

performance expectations and ensures the development and delivery of high quality care and continuous improvements through innovation and the use of levers such as CQUINS. It identifies and advises on quality improvement priorities and the organisational learning from these and monitors compliance with Health Standards ensuring the Trust fulfils its obligations with regard to the Health Act (2009) and Monitor in the production of an Annual Quality Account and Report.

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

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

CORPORATE OBJECTIVE: SG05 SG01

SUMMARY OF KEY ISSUES:

Revalidation for medical staff commenced in December 2012 and is required by all doctors to be given a licence to practice every five years. In order to be revalidated doctors require five satisfactory annual strengthened appraisals (although initial revalidation requires less). Revalidation arrangements have been in place within the Trust since December 2012. This report briefly outlines the progress made in Q2 2014/2015 and highlights any issues.

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
			Information

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

Paper for submission to the Board of Directors 5th February 2015

REPORT OF THE MEDICAL DIRECTOR TO THE BOARD OF DIRECTORS

February 2015

Quarterly Revalidation Report

1. Introduction

This report provides an update to the Board on Medical Revalidation further to the paper presented to board on 2nd October 2014

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

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

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

2. Governance Arrangements

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

The Trust is achieving over 90% of the mandatory and good practice standards set by NHS England in April 2014. The table below shows progress against areas of concern reported in July 2014. A more detailed report will be provided internally to the Workforce and Engagement Committee. Key areas for improvement are the implementation of learning and development programmes for medical appraisers, case investigators and case managers.

Quarterly training dates have been set for the next year to ensure that trained appraisers, case investigations and managers have sufficient professional development opportunities.

Core Standards Development Plan- Progress January 2015

	FQA Standard	Progress
2.2.6	The responsible officer ensures that medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers)	
2.2.8	The responsible officer ensures that the initial training programme is competency based and those who cannot demonstrate the competencies do not become/are not appointed as medical appraisers.	
2.2.9	The responsible officer ensures that there is an initial review of performance for appraisers covering the first three appraisals followed by an initial review.	
2.2.11	The responsible officer ensures that there is a written role description, person specification and terms of engagement for medical appraisers	
2.2.12	The responsible officer ensures that appraisers have access to regular appraiser assurance groups or networks, which will include agreement about expectations of attendance.	
3.1.28	The responsible officer co ordinates a quality assurance look back process of cases.	
3.1.29	The responsible officer ensures that there are mechanisms are in place to define the success criteria for interventions and processes and to demonstrate that the organisation learns from experience.	
3.2.4	The responsible officer ensures that individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (ref RST guidance)	
3.2.6	The responsible officer ensures that case investigators and case managers have a regular programme of updates and skills development.	
3.2.7	The responsible officer ensures that case investigators and case managers undertake quality assurance of their roles and receive feedback on their performance.	
3.2.8	The responsible officer ensures that case investigators and case managers participate in peer networks to learn and share good practice.	

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

reopened to ensure implementation of recent changes to the Appraisal and Revalidation Policy and have now been completed.

3. Appraisal and Revalidation Performance Data Q2 2014/2015

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

- 313 doctors had a prescribed connection to The Dudley Group NHS Foundation Trust for the period between 1st July 2014 and 30th September 2015.
- 64 doctors were due to hold an appraisal meeting within the reporting period of that number, 20 doctors did not complete their appraisal within 12 months.
    - 16 of the 20 overdue appraisals were completed within 15 months, the maximum time allowed by the GMC to complete annual appraisal.
    - 2 of the 20 over due appraisals were due to special circumstances such as sick leave, or moving to another jurisdiction and were acceptable to the Responsible Officer.
    - 3 doctors failed to engage with the appraisal process within the 15 month period and were discussed with the GMC liaison officer.

4.1 Appraisers

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

4.2 Revalidation Recommendations

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

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

APPENDIX 1

	Indicator	Q1 (1 Apr to 30 Jun)	Q2 (1 July to 30 Sep)	Q3 (1 Oct to 31 Dec)
1	**Name of designated body** (or NHS England Area Team or Region) Note: Please ensure your organisation's name is written exactly as it is recorded on GMC Connect	The Dudley Group NHS Foundation Trust		
2	Number of doctors with whom the designated body has a **prescribed connection**	313		
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	41	64	0
3.1	Number of those within # 3 above who **held an appraisal meeting** in the reporting period	30	44	
3.2	Number of those within # 3 above who **did <u>not</u> hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	11	20	
	Data entry checker			
3.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**	6	2	
3.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either <u>not</u> understood or accepted by the RO**	5	18	
	Data entry checker			

4	**Any Comments** you wish to raise (e.g. new RO, new appraisal lead etc.):	**15**-of those 18 doctors who did not have a reason which was not accepted by the RO for failing to complete the appraisal within 12 months have now completed their appraisal within the GMC recommended 15 months. **1** - doctor has scheduled appraisal for completion within the 15 month period and **3** doctors are overdue and are not engaged, internal procedures to manage these doctors have commenced and the RO will consider reporting to the GMC should the 15 month period be breached. **2** doctors for whom the reason for non-completion is both understood and accepted are recorded appropriately as having special circumstances

APPENDIX 2

Audit of revalidation recommendations

Revalidation recommendations between 1 July 2015 2014 to 30th September 2014	
Recommendations completed on time (within the GMC recommendation window)	76
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
Deferrals	2

Paper for submission to the Trust Board on 5th February 2015

TITLE:	**Safeguarding Report to Trust Board – January 2015**		
AUTHOR:	**Pam Smith Deputy Director of Nursing**	**PRESENTER**	**Denise McMahon Director of Nursing**
CORPORATE OBJECTIVE: SGO1, SGO2 and SGO6			

SUMMARY OF KEY ISSUES:

1. CQC/OFSTED ASSESSMENT

This unannounced inspection is still awaited. The local Authority has requested that all agencies are prepared for this. The Internal Safeguarding Board members are aware of the unannounced inspection and staff in key areas have been briefed as required.

2. SAFEGUARDING CQUIN 2014/15

The safeguarding CQUIN target for 2014/15 is to present one adult and one child case to the Board in each quarter. See appendices One and Two for further details on the cases and learning identified from the cases.

3. DUDLEY SAFEGUARDING CHILDREN'S BOARD MEETING

Concerns regarding access to CAMHS tier 4 beds remain and these were raised by the Deputy Director of Nursing. A meeting between the Independent Chair, the Deputy Director of Nursing and the Deputy Director of Nursing for Dudley and Walsall Mental Health Foundation Trust has been scheduled for February 2015.

Concerns regarding the faxing of Safeguarding referrals to social care which was identified by the Trust audit of the Children's Safeguarding policy were raised by the Deputy Director of Nursing. The Acting Divisional Lead for the local authority agreed to address the need to use the electronic referral form via a secure email with those Departments that are asking Dudley Group staff to send the referral via Fax.

The Trust has completed the Section 11 audit for 2015 and is in the process of uploading evidence of compliance. The deadline for submission for all agencies is 31st January 2015.

4. BAKERTILLY SAFEGUARDING CHILDREN POLICY AUDIT

An audit on Compliance with Sections 5.1, 6.1 and 7.1 of the Trust's Safeguarding Children Policy has been undertaken as part of the approved internal audit periodic plan for 2014/15.

The review considered specifically the practical application of the following sections of the Trust's Safeguarding Children Policy:

- Trust Board Responsibilities (Policy section 5.1);
- Referrals – Child Protection/Child in Need (Policy section 6.1); and
- Children who do not attend hospital appointments (Policy section 7.1).

The audit identified that the Board can take some assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective, action needs to be taken to ensure this risk is managed. The overall RAG rating for the audit is Amber.

An action plan has been developed. The action plan has been reviewed at the Internal Safeguarding Board and key actions are being taking forward – see Appendix Three.

5. BIRMINGHAM SERIOUS CASE REVIEW
A de-brief session has been held with supervisors of Trust staff involved in the case. A criminal case is being held in February 2015 and the final Serious Case Review will be published following this.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		Y	

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

SAFEGUARDING REPORT TO TRUST BOARD
JANUARY 2015

1. CQC/OFSTED ASSESSMENT

This unannounced inspection is still awaited; the inspection is expected imminently. The local Authority has requested that all agencies are prepared for this. The Internal Safeguarding Board members are aware of the unannounced inspection and staff in key areas have been briefed as required.

2. LEARNING DISABILITY

2.1 Learning Disability Strategy

The Learning Disability Strategy action plan has been reviewed at the end of December 2014 to evaluate progress. An update has been provided to the Clinical Quality Safety and Patient Experience Committee. All actions remain on track.

2.2 Learning Disability Toolkit

The Trust hosted the launch of a national learning Disability toolkit across the Black Country on the 3rd December 2014. The event was attended by 10 champions identified from the wards/departments to support the roll out of the toolkit within the Trust.

2.3 Learning Disability Self Assessment

The Learning Disability Self Assessment for the Trust has been completed by the acute Liaison Nurse for Learning Disability in consultation with the Learning Disability Commissioners and having considered the Learning Disability strategy launch, the development of the patient summits, the CQUIN training and the support from the Trust Board rated the Trust as Green.

The rating will be reported on to NHS England. A peer review will be undertaken in the 2015; dates to be confirmed.

3. TRAINING

3.1 Safeguarding Children compliance

Safeguarding Children Foundation training compliance is now at 85.9%. This is a decrease of 0.1% from December 2014. Intermediate training compliance is now at 71.3%. This is a 1.3% increase from December 2014.

3.2 Safeguarding Adults compliance

Safeguarding Adults training compliance is now at 85.8%. This is a 1% increase from December 2014.

3.3 Mental Health compliance

Mental Health training compliance is now at 78.1%. This is an increase of 1.5% from December 2014.This needs to reach 90% compliance by March 2015 to meet the CQUIN target. 17 additional Mental Health awareness workshops have been scheduled to achieve this.

3.4 Learning Disabilities CQUIN

The numbers of staff to be trained in Learning Disability to meet the CQUIN target for 2014/15 has been identified. 75% of staff identified to undertake training have completed this. This is within the CQUIN target identified for the end of Quarter 3.

3.5 Safeguarding Maternity Compliance

Safeguarding Adults 80%.
Safeguarding Children Foundation (level 1) 89%.
Safeguarding Children Intermediate (level 2) 85%.

4. ANNUAL SAFEGUARDING REPORT 2013/14
The annual Safeguarding Report for 2013/14 has been circulated to Dudley Safeguarding Adults Board and Dudley Safeguarding Children's Board and was presented at the Safeguarding Adults Board in December 2014. The Trust was commended by the Chair and other agencies for the progress made in 2013/14.

5. SAFEGUARDING CQUIN 2014/15
The safeguarding CQUIN target for 2014/15 is to present one adult and one child case to the Board in each quarter.

5.1 Quarter 3 – Service User Stories
Child Service User Story
This story focuses on the admission of a teenager to the Trust accompanied by the Police. The teenager had been missing for three days, this had been publicised on social media sites. The teenager stated that she had been given drugs and eventually disclosed she had been sexually abused by four men - see appendix One for further details.

The following learning was identified from the review of this story:
- Staff to complete Datix incident report and notify the named nurse for safeguarding children at the earliest opportunity.

Adult Service User Story
This story focuses on an assault on a staff member by a patient with learning disabilities whilst in Emergency Department (ED). The patient was brought to ED by ambulance after being found in the street by a passer-by. The patient lived in an adult social care home and had been reported missing by his main carer - see appendix Two for further details.

The following learning was identified from the review of this story:
- Establish clear means of communication between service providers for patients attending ED from outside of Dudley borough.
- All ED staff should be trained in mental health awareness, Mental Capacity Act and caring for patients with learning disabilities.
- Establish a process to provide emotional support to staff following traumatic incidents within ED.

5.2 Safeguarding Learning Event
The Safeguarding CQUIN target identifies that all patient user stories to be presented to front line staff and the Clinical Commissioning Group in quarter 4. A Safeguarding Learning Event has been scheduled for Friday 6th March 2015 9.00-12.00. The Event is being led by the Named Nurse for Safeguarding Adults and the Named Nurse for Safeguarding Children and is being supported by the members of the Internal Safeguarding Board. Invitations to the event are being sent out to front line staff in the Trust, the Trust Board, the Dudley Safeguarding Adults and Children's Board, and Dudley Clinical Commissioning Group.

6. CHILD PROTECTION – INFORMATION SHARING
A new system to enable professionals to look at a system nationally to see if a child is on a child protection plan. This will provide timely information by local authority and identify the key professionals involved. This is being launched jointly by Safeguarding Children's Boards and NHS England. A response on how the system will be launched within the Trust is awaited from the Associate Director for IT.

7. BIRMINGHAM SERIOUS CASE REVIEW

A de-brief session has been held with supervisors of Trust staff involved in the case. A criminal case is being held in February 2015 and the final Serious Case Review will be published following this.

8. RESTRICTIVE INTERVENTION GROUP

A Restrictive Intervention Group has been developed to review the Minimisation and Restrictive Intervention policy (Restraint Policy) following new national guidance and to review incidents associated with challenging behaviour and restrictive interventions. The group is comprised of Trust staff, Interserve staff and Olympian staff and is authorised by the Internal Safeguarding Board. The group will report to the Clinical Quality and Patient Experience Committee via the Internal Safeguarding Board.

9. DUDLEY SAFEGUARDING CHILDREN'S BOARD MEETING

Concerns regarding access to CAMHS tier 4 beds remain and these were raised by the Deputy Director of Nursing at the above meeting on 16th January 2015. A meeting between the Independent Chair, the Deputy Director of Nursing and the Deputy Director of Nursing for Dudley and Walsall Mental Health Foundation Trust has been scheduled for February 2015.

Concerns regarding the faxing of Safeguarding referrals to social care which was identified by the Trust audit of the Children's Safeguarding policy were also raised by the Deputy Director of Nursing. The Acting Divisional Lead for the local authority agreed to address the need to use the electronic referral form via a secure email with those Departments in Children's Social Services that are asking Dudley Group staff to send the referral via Fax.

The Trust has completed the Section 11 audit for 2015 and is in the process of uploading evidence of compliance. The deadline for submission for all agencies is 31st January 2015.

10. BAKERTILLY SAFEGUARDING CHILDREN POLICY AUDIT

An audit on Compliance with Sections 5.1,6.1 and 7.1 of the Trust's Safeguarding Children Policy has been undertaken as part of the approved internal audit periodic plan for 2014/15.

The review considered specifically the practical application of the following sections of the Trust's Safeguarding Children Policy:

- Trust Board Responsibilities (Policy section 5.1);
- Referrals – Child Protection/Child in Need (Policy section 6.1); and
- Children who do not attend hospital appointments (Policy section 7.1).

The audit identified that the Board can take some assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective, action needs to be taken to ensure this risk is managed.

The main findings that influence the auditors overall opinion are in respect of the following:

- In some cases the Local Authority asks for Child Protection/ Child in Need referral forms (containing sensitive/ confidential information) to be faxed to their Social Services Departments. This is not a secure method of delivery as there is potential for the forms to be faxed to the wrong numbers, not be received or collected promptly or be seen by non-authorised staff as the security arrangements for such documents at the Local Authority are not known; and
- Whilst it is a requirement for Did Not Attend letters to be issued when a child fails to attend two consecutive appointments, our testing found cases where forms were not prepared or the relevant entries on Datix had not been made. As the latter is used to produce management information on safeguarding children it cannot be accurate if cases are not recorded.

An action plan has been developed. The action plan has been reviewed at the Internal Safeguarding Board and key actions are being taking forward – see Appendix Three.

The Dudley Group NHS
NHS Foundation Trust

APPENDIX THREE

Safeguarding Children Policy Audit Action Plan

The priority of the recommendations made is as follows:

Priority	Description
High **Medium** **Low**	Recommendations are prioritised to reflect our assessment of risk associated with the control weaknesses.
Suggestion	These are not formal recommendations that impact our overall opinion, but used to highlight a suggestion or idea that management may want to consider.

Ref	Recommendation	Categorisation	Accepted (Y/N)	Management Comment	Implementation Date	Manager Responsible
2	Safeguarding should be added as a topic in the Volunteer Induction Schedule (Appendix 1b, in the Corporate and Local Induction Policy) as it is covered within the Volunteer Mandatory Induction.	Low	Y	Section to be included in the Corporate and Local Induction Policy.	February 2015	Named Nurse for Safeguarding Children/Deputy Director of Nursing
5	Staff need to complete and file Child Protection/Child in Need referral forms and update Datix in accordance with the Trust's Policy i.e.: - Place a copy on the patient's notes;	High	Y	Flow chart for actions to be taken by staff completing a Child Protection/Child in Need referral forms to be developed.	January 2015	Named Nurse for Safeguarding Children/Deputy Director of Nursing

Ref	Recommendation	Categorisation	Accepted (Y/N)	Management Comment	Implementation Date	Manager Responsible
	- Send a copy to the Named Nurse for Safeguarding Children; - Register them on the Datix system; and - Where registered electronically, a hard copy is printed and placed on the patient's notes. Where any non-compliance with Trust Policy is identified by the Named Nurse for Safeguarding Children upon matching forms received to Datix entries and patient notes, this must be immediately brought to the attention of the referring officer/ their line manager.		Y	To develop a process to cross reference referral forms received to Datix and inform referrer and their line manager	January 2015	Named Nurse for Safeguarding Children
6	Arrangements should be made with all Social Services Departments for completed referrals to be emailed to a secure email account, rather than sending any by fax.	High	Y	To inform Dudley Safeguarding Children's Board of the risk and agree an interim process for sending secure referrals pending the introduction of the Dudley Multi Agency Safeguarding Hub (MASH).	January 2015	Deputy Director of Nursing
7a	The two sets of patient notes that were not made available at the time of our review should be obtained and checked to ensure that: - a notification letter was sent by a member of the Trust's nursing staff to the Health Visitor or School Health Advisor; and - the notes were marked	Medium	Y	The two sets of patient notes not made available for the review to be requested and checked to ensure a notification letter was sent and the notes were marked appropriately	January 2015	Named Nurse for Safeguarding Children

Ref	Recommendation	Categorisation	Accepted (Y/N)	Management Comment	Implementation Date	Manager Responsible
	appropriately to show a notification had been issued and identified where it had been sent.					
7b	Staff need to be reminded that a Did Not Attend notification letter must be completed and issued where a patient is identified as having missed their second appointment with a note of this being recorded on the patient notes.	Medium	Y	Memo to be circulated to staff via safeguarding board members to remind them that a Did Not Attend notification letter must be completed where a patient is identified as having missed their second appointment	January 2015	Named Nurse for Safeguarding Children/Deputy Director of Nursing

Suggestions

Ref	Suggestion	Management Comment
1	The Safeguarding Children Policy should be updated to reflect current processes. It should include at section 7: - The current process of monitoring Did Not Attends, making reference to notification letters being issued after a child fails to attend two appointments, the timeframes for issuing such letters and including the responsibility of the Information Governance Team and the Named Nurse for Safeguarding Children.	Safeguarding Children Policy to be updated to reflect the process of monitoring Did Not Attends, making reference to notification letters being issued after a child fails to attend two appointments, the timeframes for issuing such letters and including the responsibility of the Information Governance Team and the Named Nurse for Safeguarding Children.
3	To avoid any confusion between internal and external Board responsibilities, the Trust's Safeguarding Children Policy should state that Trust staff attendance at the Dudley Safeguarding Children Board is monitored and is reported within the Dudley Safeguarding Children Boards annual report.	Safeguarding Children Policy to be updated to state that Trust staff attendance at the Dudley Safeguarding Children Board is monitored and is reported within the Dudley Safeguarding Children Boards annual report.
4	If there is a requirement for quarterly safeguarding reports to be presented to the Board, then this should be incorporated into the Safeguarding Children Policy.	Safeguarding Children Policy to be updated to identify the requirement for quarterly safeguarding reports to be presented to the Board.

Ref	Suggestion	Management Comment
7c	The Safeguarding Children Policy should refer to: • the production of a weekly update on Did Not Attends by the Information Governance Team; • that the DNA notification is issued after the second appointment has been missed; • the timeframe for the completion and issue of the DNA letters; and • state how the DNA letters should be sent to the Health Visitor or School Health Adviser (ideally by email to a secure email address).	Safeguarding Children Policy to be updated to include: • the production of a weekly update on Did Not Attends by the Information Governance Team; • that the DNA notification is issued after the second appointment has been missed; • the timeframe for the completion and issue of the DNA letters; and state how the DNA letters should be sent to the Health Visitor or School Health Adviser (ideally by email to a secure email address).

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On 5 February 2015

TITLE	**Performance Report April – December 2014**		
AUTHOR	**Paul Taylor Director of Finance and Information**	**PRESENTER**	**Jonathan Fellows F & P Committee Chairman**
CORPORATE OBJECTIVE: SG06 Enabling Objective			
SUMMARY OF KEY ISSUES: • **Deficit of £0.04m in December (£0.4m better than plan)** • **Deficit of £5.0m for year to date, (£1.0m better than plan)** • **Deficit budget for 2014-15 of £6.7m still likely to be exceeded, with a £7.5m deficit now forecast – which is an improvement of £0.5m on the previous month's projection** • **Some risks to the year-end position remain including redundancy costs; CCG income and some potential outstanding IT payments.** • **A&E 4 Hours waiting time target met in Q3 (95.0% performance)** • **Some RTT waiting time pressures, but major RTT and Cancer targets being met**			
RISKS	**Risk Register**	**Risk Score Y**	**Details: Risk to achievement of the overall financial target for the year Financial deficit above Monitor plan now forecast**
COMPLIANCE	**CQC**	**Y**	**Details: CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.**
	NHSLA	**N**	

	Monitor	**Y**	**Details:** **The Trust has rated itself 'Amber' for Governance & '3' (good) for Finance (CoS) at Q2, but 2 for Finance for the forthcoming 12 months. The Trust remains on monthly monitoring by Monitor.** **Monitor has notified the Trust that it is no longer investigating A&E performance in the Trust** **Monitor has confirmed that the Trust is in breach of its authorisation conditions regarding future financial sustainability. Undertakings being signed by Trust to resolve this position**
	Other	**Y**	**Details:** **Significant exposure to performance fines by commissioners**

ACTION REQUIRED OF COUNCIL

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the report

The Dudley Group NHS
NHS Foundation Trust

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

Report on Finance and Performance for April to October 2014

1. Background

The Finance & Performance Committee of the Board met on 29th January 2014. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered forecast year end performance reports.

Highlights of the discussion at the meeting are as follows:

2. Financial Performance for the 9 months period April to December 2014 (Appendix 1)

The Trust set itself the financial strategy from April 1st 2014 to get back to financial balance over a 2 year period, and as part of that strategy agreed a £6.7m deficit plan in 2014-15. Early months in 2014-15 were not as favourable as anticipated and the forecast year-end deficit exceeded £10m in August 2014. Since then spending has broadly stabilised and activity, and therefore income has exceeded expectations.

December 2014 continued the recent trend of the Trust's in-month and forecast year-end position improving

In December 2014 the Trust posted an in-month deficit of £0.04m, which was £0.35m better than plan.

For the 9 months period to December 2014 a cumulative deficit of £5.1m was recorded. Key variances include income at +£5.3m (+2.3%); Non Pay -£3.7m (-4.5%); CIP not achieved -£1.9m.

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

- Significant increases in emergency and other types of activity level above plan
- Continued spending above budget on agency & locum front line medical & nursing staff

- Higher than anticipated spending on drugs and devices, which are recharged to commissioners under the terms of our healthcare contracts with them
- A slower than anticipated achievement of savings.

The Trust is now forecasting a deficit of £7.5m for 2014-15 which is an improvement of £0.5m on the previous month.

At 31st December 2014 the Trust had cash reserves of £18.8m (£18.2m in November) and 9.6 days liquidity (10.5 previously).

Capital spending for the period was £7.8m (£1.1m Medical Equipment, £4.5m IT, £153m PFI Lifecycle), some £0.7m below plan.

3. Performance Targets and Standards (Appendix 2)

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

Highlights include:

a) A&E 4 Hour Waits

The December 2014 performance was 95.2% compared to the constitution target of 95%. The quarter-end performance was exactly 95% - the Trust achieving the 11th best performance in the country amongst non-specialist Trusts

b) Never Events

The Trust had no 'never events' in December 2014 or for the period to date.

c) Referral to Treatment Waiting Times

The RTT admitted waiting time standard of 90% of patients was just met again in December 2014 with an improvement in month to 93.1% of patients being seen in time. There is confidence that this will continue to be achieved for the rest of the year. RTT non-admitted and incomplete pathways KPIs are both well within their thresholds, although the performance on the incomplete pathways reduced in month.

d) Diagnostic Waits

Diagnostic waits continue to underperform compared to targets, and the position deteriorated in month. The remedial action plan is being reviewed by the Division.

4. Divisional performance Review

The Committee considered the performance presentation from the Division of Medicine and Community Services, particularly focussing on the financial and operational aspects following the presentation to the Board of Directors on their strategic plans. A number of areas for financial improvement were discussed

5. Turnaround Progress Report

The Committee considered the extent of the progress being made to date on the Turnaround Programme, and in particular on the large scale cross-organisational schemes. The forecast year-end position of £8m was discussed together with the prospects for further schemes in 2015-16.

6. IT Post Transfer Financial Analysis

The Committee considered the accounting arrangements following the transfer of IT Services from Siemens as part of the PFI deal, back to the ownership of the Trust. It also considered some contractual liabilities the Trust is negotiating regarding the termination of the arrangements for Project Fusion.

7. Operational Planning 2015-16

The Committee discussed the forthcoming budget setting and contracting process for 2015-16 identifying the risks and opportunities there-in. The consultation on the tariff proposals for 2015-16 was debated and the potential for the proposals not to be approved (this has subsequently proved to be the case)

8. Monitor Decision on Breach of Terms of Authorisation

The recent decision by Monitor to notify the Trust that it considered it to be in breach of its conditions of authorisation was debated, together with the requirements placed upon the Trust to produce an ambitious and realistic plan for the next 5 years by 10th April 2015, to be updated in July 2015 following work with the CCG and other partners on the future provision of health services in Dudley.

9. Report from IT Steering Group

The Committee received a report from the IT Steering Group following is most recent meeting (the Board have recently confirmed the governance arrangements for the IT Steering Group as a group reporting to Finance and Performance Committee) Key areas debated were:

- The need to expand the membership of the group to include an additional clinician, nurse and operational manager, together with the re-establishing of a clinical senate to support the clinicians on the Group
- Progress made in bringing the IT staff together following the transfer of services back to Trust by Siemens
- The outline plan for developing the new clinical systems in the next 2 years following the abandoning of Project Fusion. The proposed process is to initially undertake a detailed process mapping exercise to determine which clinical and operational processes would benefit from support from information technology, so that a detailed specification could be dran up with some priorities – together with a Benefits Realisation approach which would identify where savings could be made in exchange for the investment in IT

The Committee re-emphasised the need for the IT Steering Group to take an early veiw on the IT requirements of Community Services.

P Taylor
Director of Finance & Information

THE DUDLEY GROUP NHS FOUNDATION TRUST

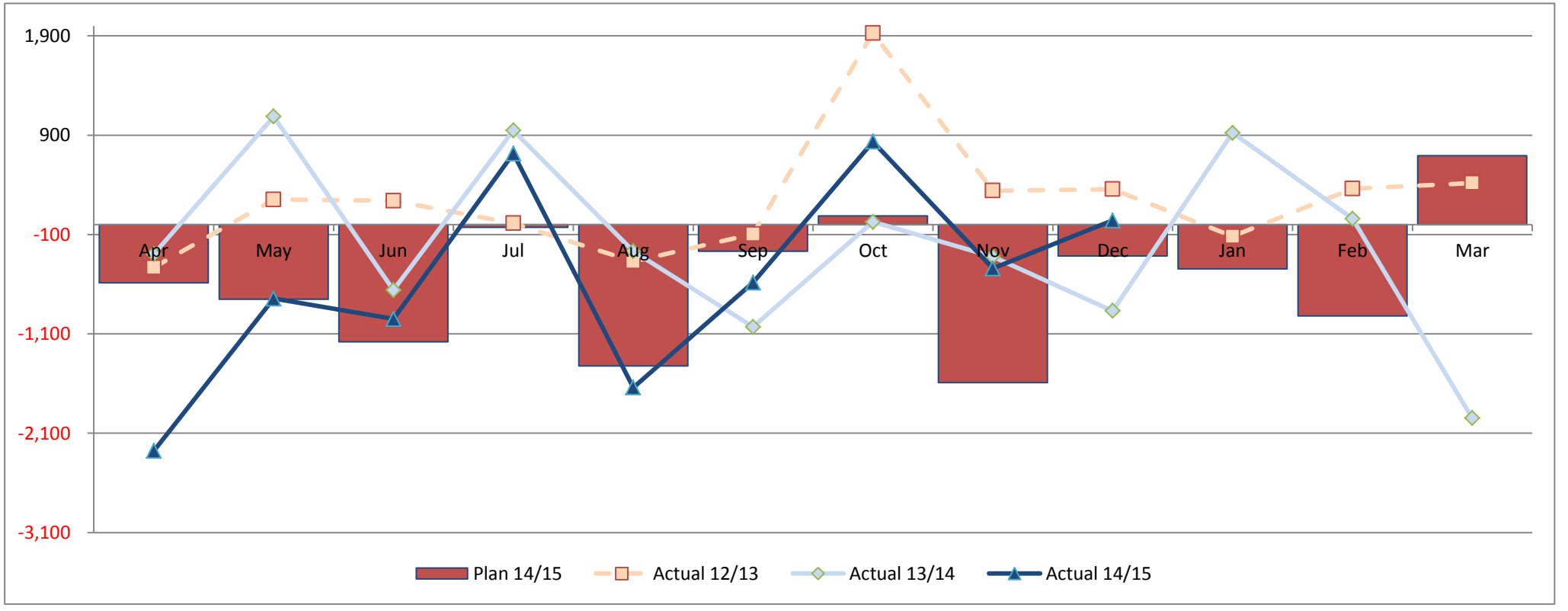
FINANCIAL SUMMARY **DECEMBER 2014**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£27,204	£27,160	-£44
PAY	-£15,999	-£15,737	£261
CIP	-£775	£0	£775
NON PAY	-£8,833	-£9,572	-£739
EBITDA	**£1,598**	**£1,851**	**£253**
OTHER	-£1,913	-£1,808	£105
NET	**-£316**	**£43**	**£358**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£237,159	£242,452	£5,293
PAY	-£143,905	-£142,784	£1,122
CIP	£1,857	£0	-£1,857
NON PAY	-£84,045	-£87,793	-£3,748
EBITDA	**£11,065**	**£11,875**	**£810**
OTHER	-£17,120	-£16,919	£201
NET	**-£6,055**	**-£5,044**	**£1,011**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£316,798	£323,215	£6,417
PAY	-£193,231	-£192,079	£1,152
CIP	£3,505	£0	-£3,505
NON PAY	-£110,935	-£116,316	-£5,381
EBITDA	**£16,137**	**£14,820**	**-£1,317**
OTHER	-£22,865	-£22,314	£552
NET	**-£6,728**	**-£7,493**	**-£765**

NET SURPLUS/(DEFICIT) 14/15 PLAN & ACTUAL **DECEMBER 2014**



Dudley Group FT

Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

	Threshold & Weighting		Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements							N/A
INFECTION CONTROL (SAFETY)							
HCAI - Clostridium Difficile - meeting the C Diff objective	48	1.0	7	8	11		**26**
HCAI - Clostridium Difficile - Avoidable Cases			5	6	Not Yet Available		**11**
CANCER WAIT TARGETS (QUALITY)							
Max waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	1.0	97.0	96.1	96.2*		**96.2**
Max waiting time of 2 weeks from urgent GP referral to date first seen for symptomatic breast patients.	93%		97.3	94.7	97.5*		**96.3**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	1.0	99.7	99.8	99.1*		**99.7**
Maximum waiting time of 31 days for second of subsequent treatments – Anti Cancer Drug Treatments	98%	1.0	100	100	100*		**100**
Maximum waiting time of 31 days for second of subsequent treatments – Surgery	94%		98.2	100	100*		**99.4**
Maximum waiting time of 31 days for second of subsequent treatments – Radiotherapy	94%		N/A	N/A	N/A	N/A	N/A
Maximum two month (62 days) wait from referral to treatment for all cancers – Urgent GP Referral to Treatment	85%	1.0	88.7	87.4	87.7*		**88.1**
Maximum two month (62 days) wait from referral to treatment for all cancers – From National Screening Service Referral	90%		100	100	95.6*		**98.5**
							**includes provisional data for December*
A&E (QUALITY)							
% Patients Waiting Less than 4 hours in A&E	95%	1.0	92.1	96.1	95.0		**94.3**
REFERRAL TO TREATMENT – RTT (PATIENT EXPERIENCE)							
RTT – Admitted % Treated within 18 weeks	90%	1.0	90.1	90.6	92.1		N/A
RTT – Non-Admitted % Treated within 18 weeks	95%	1.0	99.2	99.1	98.7		N/A
RTT – Incomplete pathways % waiting within 18 weeks	92%	1.0	94.7	95.9	95.6		N/A

Community Services (Effectiveness)							
Referral to treatment information	50%	1.0	98.0	99.0	99.5		N/A
Referral information	50%		64.9	65.4	66.7		N/A
Treatment activity information	50%		99.5	100	100		N/A

Dudley Group FT

Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

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

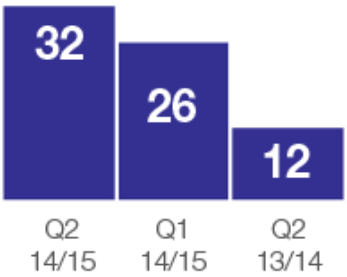
Monitor
Making the health sector work for patients

Performance of the foundation trust sector
Quarter 2: 6 months ended 30 September 2014

Healthcare targets

Cancer targets

Target breaches: 62-day wait for first treatment from GP referral



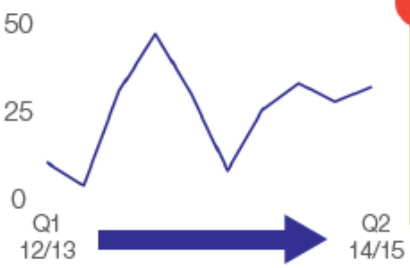
There were 19,000 cancer referrals to foundation trust hospitals during the second quarter of 2014/15

This is a c.**6%** increase on 2013/14

This was the second successive quarter the foundation trust sector has failed the cancer 62-day waiting time target

A&E performance

Breaches of the 4-hour A&E waiting time target

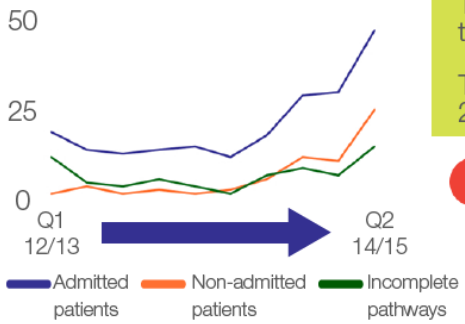


Demand for urgent and emergency care remains high:

2,700,000 patients received A&E care in NHS foundation trusts during Q2

Waiting time standards

Waiting time target breaches



The number of patients waiting longer than 18 weeks has increased by **19%**

This is up from 87,000 in September 2013 to 104,000 in September 2014

Only **88.1%** of foundation trust patients started inpatient treatment within 18 weeks of admission