The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 5th June 2014 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apols. – Paul Harrison**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 1st May 2014	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 1st May 2014	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**		D McMahon	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	D McMahon	To Note & Discuss	10.00
	7.2 Clinical Quality, Safety, Patient Experience Committee, Exception Report	Enclosure 5	D Bland	To Note & Discuss	10.10
	7.3 Nurse Staffing	Enclosure 6	D McMahon	To Note & Discuss	10.20
	7.4 Audit Committee Exception Report	Enclosure 7	J Fellows	To Note & Discuss	10.35
	7.5 Research and Development Operational Capability Statement	Enclosure 8	J Neilson	To Approve	10.45
	7.6 Quarterly Complaints Report	Enclosure 9	J Cotterill	To Note & Discuss	10.55
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 10	D Badger	To Note & Discuss	11.05
9.	**Date of Next Board of Directors Meeting** 9.30am 3rd July, 2014, Clinical Education Centre		J Edwards		11.15

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

The Dudley NHS Foundation Trust

Enclosure 1

Minutes of the Public Board of Directors meeting held on Thursday 1st May, 2014 at 9:30am in the Clinical Education Centre.

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

In Attendance:
Helen Forrester, PA
Elena Peris - Cross, Administrative Assistant
Liz Abbiss, Head of Communications and Patient Experience
Annette Reeves, Associate Director for Human Resources
Richard Cattell, Director of Operations
Julie Cotterill, Associate Director of Governance/Board Secretary

14/045 Note of Apologies and Welcome

There were no apologies to record.

14/046 Declarations of Interest

There were no declarations of interest.

14/047 Announcements

Board members noted the death of John Thornbury, Associate Director of IT; they passed on their condolences to John's family for their tragic loss and asked for John's significant contribution to the trust to be noted.

The Chairman announced that this would be Richard Beeken's (Director of Strategy, Performance and Transformation) last Board meeting as he is leaving the Trust and thanked him on behalf of the Board and the Council of Governors for his hard work and dedication to the Trust. The Board wished him well in his challenging new Role as Chief Executive of the Wye Valley NHS Trust.

14/048 Minutes of the previous Board meeting on 3rd April 2014 (Enclosure 1)

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

14/049 Action Sheet, 3rd April 2014 (Enclosure 2)

14/048.1 Organ Donation

Action has been completed.

14/049.2 Francis – Awaiting Response

Monitor have responded and confirmed that they do not need to see the report.

14/049.3 Keogh

This item is on the Agenda to be discussed.

14/049.4 Patient Story

Board members noted that the vegetarian option issues have been raised with Interserve. A menu review has been concluded and a draft of the new menu is being trialled on two wards. Board members noted that customer care is being heavily focused on.

The Director of Performance, Strategy and Transformation informed Board members that there will be a taste testing session on the new menu and they are welcome to take part.

The Director of Finance and Information suggested inviting the Board of Governors to this session as they have previously shown interest in this area.

Council of Governors are to be invited to taste test the new menu.

14/050 Patient Story

The Nursing Director presented a video of a patient describing their stay in Hospital.

Board members noted the positive comments made by the Patient.

The Nursing Director informed the Board that we do run a hairdressing service for patients that is provided by local college students however it only runs on a Wednesday afternoon.

Mrs Becke, Non Executive Director explained that on a patient safety walkround she found patients hugely appreciated the hairdressing service and she suggested asking the volunteer co-ordinator if there are any volunteers with hairdressing skills that could provide a service on a more regular basis.

Head of Communications and Patient Experience to Look into the possibility of offering a hairdressing service through volunteers who may have hairdressing

14/051 Chief Executive's Overview Report (Enclosure 3)

The Chief Executive presented the report given as Enclosure 3, including the following issues:

4 Hour ED wait target: The Trust has seen a difficult start to the new financial year and failed the target in March. The team have looked back to understand the last 12 months; there has been no correlation between the numbers attending ED and performance of the department. Factors that have affected the service are availability of beds, a significant peak of Paeds cases in March which is a trend on last year and a number of over 900 patients over the age of 80 coming through ED in a month, the information team are looking closely at the length of stay and care needs of these patients.

The Board noted that the ECIST team came in again this month to look at the progress and further measures that can be implemented. The Director of Operations held a Hospital wide meeting this week to ensure delivery of the ECIST recommendations..
The Chief Executive told the Board that the Easter week had been the worst week on record in terms of performance, and colleagues are seeing the same situation across the whole of the West Midlands.

The Board noted that daily teleconferences are being held with the CCG and social care and extraordinary plans are being put in place for the upcoming bank holiday weekend.

Mr Fellows, Non Executive Director asked if it was unlikely we would hit the 95% target for quarter 4.

The Chief Executive responded that at the current stage the target has not yet been missed..

Friends and Family: The Chief Executive presented the friends and family scores which overall remain good. There have been some good return rates.

The Chairman asked if there was any news around the change of test.

The Chief Executive answered that discussion around the change of test are still taking place nationally however we are pushing on with the current testing model.

14/052 Patient Safety and Quality

14/052.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Nursing Director explained that there has been a slight change in the style of the Infection Prevention and Control Exception report. The Board were presented the report and the following points to note:

C.Diff: The target for 2014.15 is to not exceed 48 cases. We ended the month with 3 cases which are below the target of 4 per month. The team are going to look at comparing the "cases per 1000 bed days data with the other Trusts. RCA trend analysis is also being completed at the end of each quarter. The algorithm to review all post 48 hour cases is in progress, this will identify those cases that are avoidable and those that are unavoidable. A formal meeting has been planned, with the CCG, to accept the process.

MRSA: There remains to have been 0 post 48 hour MRSA cases for this year.

CPE: New National guidance has been released on the control of a group of organisms that currently do not respond to antibiotics. An action plan has been put into place that needs to be completed by June. We are looking at the screening for this group of organisms and this will become a formal part of the Infection Prevention and Control Report.

Norovirus: There is some activity within community although this is settling down and there are currently no wards closed within the Trust.

The Board were informed that an experienced senior infection control nurse has been recruited into the post of Matron in the Infection Control team.

Mrs Becke, Non Executive Director asked if there would be significant costing for the testing of the patients at high risk of CPE.

The Medical Director responded that the numbers were very low as this is being done proactively to prevent it becoming a big problem however there may be a potential cost pressure.

The Nursing Director explained that the algorithm will be included in an appendix of the next Board paper.

The Chairman noted that the Board will receive a quarterly trend report on CPE. He went on to ask if there was going to be a target for the new organism.

The Nursing Director clarified that we are awaiting national guidance.

Mr Fellows, Non Executive Director asked if the performance of this year against last year's C.Diff cases could be included in the report.

The Medical Director reminded the Board that we need to be cognisant of the changes in the national health economy.

The Nursing Director assured that she would include this information on a line graph in the next report.

The Nursing Director is to include a line graph in the next Infection Control report showing last year's C.Diff performance against this year's.

14/052.2 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 5).

Mr Bland, Non Executive Director presented the Report given as Enclosure 5 including the following points:

Patient Experience Strategy Action Plan: The Board noted that there would be an update to the Clinical Quality, Safety and patient Experience Committee every three months. The Board were also informed that the first Patient Experience Group meeting took place the previous week.

National Staff Survey Results: The Board noted the encouraging increase in the response rates to the National Staff Survey although it was still just below the national average.

Mortality Report: The SHMI was just outside of the official range however there is an improving trend and the HSMR remains within the expected range.

AHRQ Patient Safety Culture Survey Results and Actions: The Board were informed that this is a comprehensive survey that measures safety outcomes, it was a thorough piece of work which showed encouraging results.

The Medical Director informed the Board that the latest SHMI is back within the expected range as predicted.

The Chairman asked what the national average was for the national staff survey.

The Head of Communications and Patient Experience explained that the national average is 49% and therefore we are one below at 48%. This is a 10% increase from last year which is positive to note.

14/052.3 Assurance Report on Foetal Remains

The Chairman informed the Board that this report has been brought to the Board following issues appearing in the press and a letter from the NHS medical Director, Sir Bruce Keogh. The outcome of this letter is to make the Board aware of any issues.

The Medical Director assure the Board that the Trust is fully compliant with the standards and have taken this as an opportunity to look into how we can further improve the services to increase assurance.

The Chairman and the Board took note of the compliance with standards retrospectively and going forward, ethically and morally.

14/052.4 Report on moving patients out of hours (Enclosure 7):

The Director of Operations informed the Board that this report has been brought to Board in response to the second issue highlighted in Sir Bruce Keogh's letter.

The Board noted that sometimes there is either a clinical or operational need to transfer a patient out of hours and the Board has been asked to review its current practises and ensure they are in line with good practise. The Trust currently has a policy that has been updated recently and we are compliant with good clinical care. Site Co-coordinators are responsible for this policy and moving patients at night is not a consideration taken lightly.

The Chief Executive highlighted that there had been a previous patient story where a patient did not know why they had been moved and this gave us chance to review this issue back then.

Mr Badger, Non Executive Director asked if we record patient transfers on datix or anywhere else.

The Chief Executive replied that we did not as they are not an incident In the sense of datix.

Mr Fellows, Non Executive Director pointed out that the letter talked about us reviewing our practise, he suggested looking at the amount times we transfer out of hours and the reasons why in a certain time period.

The Chairman noted that it was a fair challenge to audit the adherence to the policy.

The Chief Executive agreed, she explained to the Board that operationally this is a large piece of work to look at the numbers and we need to carefully consider when we have the capacity to do this.

The Board noted that a Directors discussion it to be held to determine when this work would be picked up later in the year.

The Nursing Director suggested including this on the audit plan

The Director of Finance and Information pointed out that the audit plan was already extremely tight this year and it would be a labour intensive exercise for staff.

The Board noted the Trust's compliance with the national guidance, the policy and the need to test that this is being implemented correctly. The Chair requested that this paper is brought back to the July Board meeting along with a date that sampling will go ahead and information on discharging patients within out of hours times.

Moving patients out of hour's paper is to be brought back to the July Board meeting with a date that sampling will go ahead and information on discharging patients within out of hours times.

14/052.5 Hard Truths Report (Enclosure 8)

The Nursing Director informed the Board that this report was sent out on the 30th March and was distributed to board members after the last meeting.

The Board noted four expectations within the report, which are as follows:

- Nurse Staffing is to be reported to the Board every 6 months – The Board noted that Nurse staffing will be brought to the Board in July and then 6 monthly thereafter.
- A report is to be completed on Nurse Shifts – The Nursing Director explained to the Board that she is currently constructing the best way to present this information.
- The information mentioned in the report is the displayed in a public place. – The Board noted that this is already done with the Huddle Board on wards.
- The information also needs to be displayed on NHS Choices and the Trust website. – Board members noted that the report to Board on Nurse staffing will be posted on both websites.

The Board noted that the points on the action plan include in the appendix are either on track to be completed or are complete.

Mr Miner, Non Executive Director asked if this work fits into the Trust's assurance framework.

The Nursing Director confirmed that it did.

The Director of Finance and Information asked if the definitions in the report have been agreed to ensure that organisations are comparing like for like.

The Nursing Director reported that at the Nursing Directors' meeting last week, members discussed the issue with there currently being no guidance, however a template from NHS England is expected next week.

The Chairman pointed out that careful consideration is needed over producing a document that is most useful to the Board. He asked if a draft could be shared with colleagues before the June Board meeting.

Draft of the nursing staff numbers paper to be shared with colleagues before the June Board meeting.

14/052.6 Update on Nurse Staffing Tool (Enclosure 9)

The Nursing Director presented the update given as enclosure 9.

The Board noted that this is an evidence based tool that requires taking data for 28 days. The team are currently uploading our own data into this tool and the Board will receive this information at the next Board meeting. Minimun safe staffing levels are being completed for each ward and meetings have been held with all matrons to go through these templates.

The Board noted that the ratio of the Trust never falls below 1:8. The rate for Clinical Support Workers ranges from 1:6 to 1:10. The night ratio is down to 1:9

The Nursing Director informed the Board that the Finance team are currently working on costing.

The Board noted that the outcome will be presented at the June Board meeting.

The Nursing Director explained to the Board that there is no documented guidance for night duty ratios however this may change when NICE publish there report in July.

Board members noted that the indicative value of costing is £3m

The Director of Performance, Strategy and Transformation asked if there was a general view from Nursing Directors on what the night ratio should be.

The Nursing Director clarified that there was not, there is a lack of collaborative work between Nursing Directors. She noted however that geography of wards would be a huge contributing factor to what ratios would be correct.

The Chairman informed the Board that Nurse staffing was discussed in his interview with inspectors during the Trusts CQC review; they asked, how we would test what we are doing is working. The Chairman asked how the Nursing Director would test her own assumptions on nurse staffing.

The Nursing Director explained that she uses the PWC work as extra assurance and is working with Steve Davies, Turnaround Director and a Nursing Director in the North West to benchmark us against other Trusts nurse staffing levels.

14/052.7 Francis Report (Enclosure 10)

Mrs Cotterill, Director of Governance presented the Francis report given as Enclosure 10.

The Board noted that many actions had been closed or moved onto the Keogh Action Plan and most of the actions are embedded within normal processes and structures within the Trust.

Mr Badger, Non Executive Director asked if number 4 on the action plan around clarity of values and principles could be closed.

The Director of Governance confirmed that this has been tested and the action could now be closed.

The Board agreed to close this action.

The Board accepted and made note of the report.

Item 4 to be removed from the Keogh Action Plan

14/053 Finance

14/053.1 Finance and Performance Report (Enclosure 11)

Mr Badger, Non Executive Director presented the report given as enclosure 11.

Mr Badger thanked the Chairman for his attendance at the meeting which was very challenging.

Board members noted the positive news that the account for the end of year showed a small surplus of £350k, this was achieved with a significant sum of £9m support from the CCG.

Board members were informed that there has been further deterioration in the pay spend rate in March due to high agency spend.

CIP: 75% achieved of the original plan however 37% was non recurrent.

Performance: The Trust failed the ED target and recovery plan actions are being addressed.

RTT Admitted Waits: The Trust fully achieved this target however achieving this in April and quarter 1 of the new financial year is a risk.

Turnaround: The key to drive forward plan is going to the Board workshop later in the Month. The Trust needs to save an additional £10m, and work toward a target of £16m

Mortality: The Trust achieved figures within the expected range on all indicators

Mandatory Training: There is positive news to report with a small increase on compliance rates, we must ensure we maintain focus on this.

Monitor Q4 submission: Under delegated authority the submission was approved as a finance rating of 3 and a governance rating of green.

The Chairman and the Board took note of the positive outturn and the help and support of the CCG to avoid a deficit position.

14/043 Any Other Business

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

13/044 Date of Next Meeting

The next Board meeting will be held on Thursday, 5th June, 2014, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

PublicBoardMins1stMay2014

Enclosure 2

The Dudley Group NHS
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Action Sheet
Minutes of the Board of Directors Public Session
Held on 1 May 2014

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
14/039	Patient Story	Clinical Quality, Safety, Patient Experience Committee to discuss adopting a process for gowns that protects patients privacy and dignity and report back to Board.	DM	5/6/14	To July Board
14/030.3	Quarterly Complaints and PALS Report	Future Reports to include quarter on quarter data.	DM	5/6/14	On Agenda
14/041.1	Infection Control	MRSA RCA outcome report to be presented to the Clinical Quality, Safety, Patient Experience Committee and then back to Board.	DM	5/6/14	To July Board
14/041.9	Dementia Report	Future reports to be presented to the Clinical Qualilty, Safety, Patient Experience Committee.	RC	Ongoing	Done
14/049.4	Patient Story	Council of Governors to be invited to taste test the new menu.	MG	3/7/14	Done
14/052.1	Infection Prevention and Control	The Nursing Director to include a line graph in the next Infection Control Report showing last year's C.diff performance against this year.	DM	5/6/14	Done
14/052.5	Hard Truths Report	Draft of the nursing staff numbers paper to be shared with colleagues before the June Board meeting.	DM	5/6/14	On Agenda
14/052.7	Francis Report	Item 4 of the action plan to be removed.	JC	5/6/14	Done
14/050	Patient Story	Liz Abbiss to look into the possibility of offering a hairdressing service through volunteers who may have hairdressing skills.	LA	3/7/14	
14/052.4	Report on Moving Patients Out of Hours	Paper on moving patients out of hours to be brought back to the July Board confirming a date for sampling and information on discharging patients out of hours.	RC	3/7/14	

Enclosure 3

The Dudley Gro
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Paper for submission to the Board of Directors held in Public – 5th June 2014

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- 95% Hospital/Emergency Department 4 Hour Wait Target
- Friends and Family Test Performance
- CQC inspection update
- Parliamentary and Health Service Ombudsman

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

The Dudley Group NHS
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Chief Executive Update – June 2014

95% Hospital/Emergency Department 4 Hour Wait Target:

The Trust continues to have capacity and flow problems. This has resulted in a poor performance during May and the failure of the Q1 target. We continue to work through the recommendations made by the Emergency Care Intensive Support Team.

Friends and Family Test:

Inpatients and A&E Friends and Family Test

Preliminary data for May shows a drop in response rate for both inpatients and A&E. CQUIN requirement for quarter one is to achieve an inpatient response rate of 25% and A&E response rate of 15%. The table below shows that we are close to achieving this and need additional effort in June to ensure it is reached.

	Apr-14	Preliminary May 2014	Preliminary Q1	
	01.04.14	01.05.14	01.04.14	
Date range	30.04.14	28.05.14	28.05.14	
Number of eligible inpatients	1886	1821	3707	
Number of respondents	644	352	996	
Ward FFT score	82	87	84	
Ward footfall	34%	19%	27%	
Number of eligible A&E patients	4258	4181	8439	
Number of respondents	686	510	1196	
A&E FFT Score	64	56	61	
A&E footfall	16%	12%	14%	
TRUST FFT Score	73	69	71	
TRUST footfall	22%	14%	18%	
Inpatient FFT Score	80+	A&E FFT Score	70+	
	72-79		60-69	
	<72		<60	
Response rate:		Q1	Q4	Mar-15
Response rate A&E	<15%	15-20%	20%+	
Response rate Inpatients	<25%	25-30%	30-40% +	40%+ ✸

Maternity Friends and Family Test

Preliminary May data shows an increase in scores but a drop in response rates for antenatal and postnatal community. Low response rates have again been brought to the attention of managers. No CQUIN requirements for maternity in 2014/15.

		Apr-14	Preliminary May 2014	
Maternity - Antenatal	Score	64	79	
	Response rate	14%	12%	
Maternity - Birth	Score	62	84	
	Response rate	44%	30%	
Maternity - Postnatal ward	Score	57	88	
	Response rate	43%	29%	
Maternity - Postnatal community	Score	86	93	
	Response rate	16%	6%	
Combined	Score	63	86	
	Response rate	32%	21%	
% of footfall (response rate)		<15%	15%+	
Antenatal		80+	76-79	<76
Birth		89+	85-88	<85
Postnatal ward		78+		<78
Postnatal community		84+	79-83	<79

NB: May data is preliminary only (prepared 28.05.14) and will change as additional entries and validation are still to take place.

CQC Inspection Update:
The release of the report has been delayed and the Quality Summit will now be held in late June.

Parliamentary and Health Service Ombudsman:
We have been informed that the Parliamentary and Health Service Ombudsman plans to publish anonymised extracts from completed investigations to help as many organisations as possible to learn lessons from their investigations. This will start in July.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on June 2014 - PUBLIC

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

CORPORATE OBJECTIVE:
SG01: Quality, Safety & Service Transformation Reputation – To become well 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
	✓	✓	

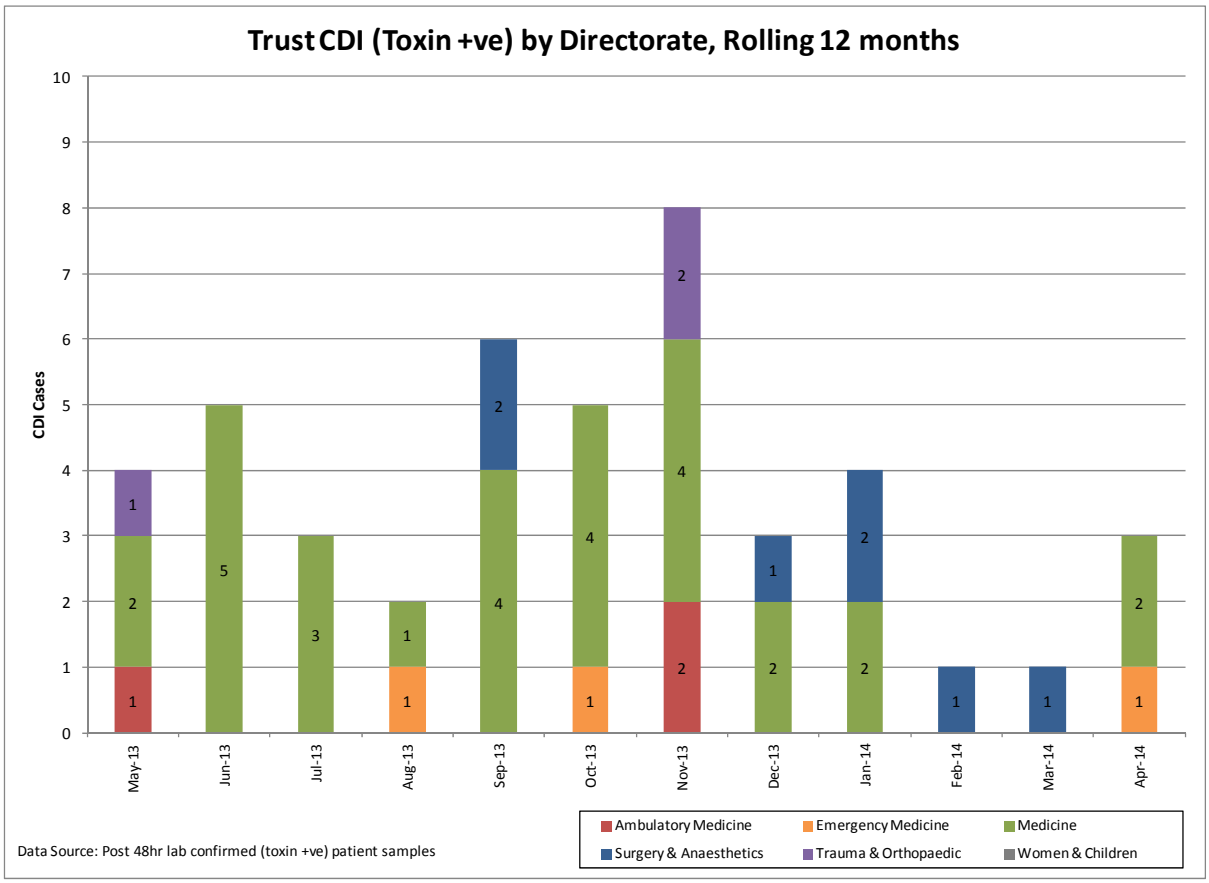
RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

Subject: Infection Prevention & Control Report

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 we have 1 post 48 hour cases recorded in May 2014 against a trajectory for the month of 4 cases. An algorithm to review all post 48 hour cases will be presented to the CQRM on 3rd June 2014. Below is a graphical representation of last years' figures and location of cases by current directorate descriptions.



MRSA – Annual Target 2 (Post 48 hrs) – There have been no post 48 hour MRSA bacteraemia cases so far this year.

CPE – A West Midlands regional meeting has been held to discuss the practicalities of the implementation of the CPE guidance and an action plan is being developed to reflect local practice. A summary of the key actions will be included in the next board report.

Norovirus – There are no wards currently affected.

Glossary of new terms:

1. CPE- Carbapenamase producing enterobacteriaceae- the carbapenems are a powerful group of broad spectrum beta-lactam (penicillin related) antibiotics which, in many cases, are our last effective defence against multi – resistant bacterial infections. Carbapenamase are enzymes produced by some bacteria and this term is used to describe any beta – lactamase that breaks down carbapenems. Of clinical concern, many carbapenamases confer resistance to all members of the beta-lactam class. There have been outbreaks in the UK with these organisms particularly in the North West, becoming endemic in pockets. Therefore early detection and prevention of nosocomial spread of these organisms is essential to prevent the rapid spread of these organisms seen in other countries in Europe.[1]

References:

1. Public Health England. Acute trust toolkit for the early detection, management and control of carbapenamase – producing Enterobacteriaceae. December 2013.

Enclosure 5

The Dudley Gr
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Paper for submission to the Board on 5th June 2014

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 10th April 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:

Quality Dashboard for Month 11 (February) 2013/2014 - The Committee received the quality dashboard noting the following:
There was 1 confirmed C.Diff incident in February 2014.

- The TAL indicator had increased to 65.67% against the 80% required performance
- The Maternity Breast feeding target was near the target at 58.02%.

The Committee discussed the appropriateness of the targets and the Trusts ability to deliver these.

There were no red rated Nursing Care Indicators (NCIs) or Protected Mealtime measures. Three wards were red for "Think Glucose" and four wards were red for "Protected Mealtime: Assistance". The NCIs at ward level showed that Paediatrics had 4 reds, 2 ambers and 1 green and Critical Care had 4 reds. These wards are on escalation level 3 and the Director of Nursing has met with the Leads to discuss progress against action plans. They were also reviewing the audit tool to ensure that it was fit for purpose in this area.

The Trust was back within range for Dupuytren's contracture.

Mortality Report - The Committee received the Quarterly Mortality Report Action Log and reviewed the work in progress and red rated action. The Committee also reviewed the actions from the Directorate Performance Reviews for Q3 2013/2014.

The Committee discussed the future reporting arrangements for the Mortality Group and Mortality Panel and agreed that these should report to CQSPE. The Committee **received** the Mortality Report and **approved** the action plan and **noted** the progress on the agreed actions

Serious and Adverse Incident Monitoring Report (March 2014) - 10 new incidents were reported (1 Violence, Aggression & Self Harm, 1 DGH Acquired Infection Post 48 hr MRSA, 1 Unexpected admission to SCBU (Neo Natal), 4 Patient Falls resulting in Fractures, 2 Confidentiality Breaches and 1 Deterioration in Health). There were 44 open general SI's in total (23 RCA/investigations in progress, 18 awaiting assurance that all actions identified from the RCA investigation had been completed and 3 recommended for closure). There were no breaches in the 2 days from identification of the incident and reporting but 1 breach to complete the investigation in agreed time scales.

The Committee considered general serious incidents recommended for closure and compliance with CCG Contractual requirements for March 2014 and supported the closure of 3 Serious Incidents

The Red Matrix Incident Trends for Clinical Care Assessment/Monitoring and Obstetric related incidents showed an overall downward trend when reviewed over the last 3 months. No other trends were identified.

Quality Priorities 2014/2015 - The Committee discussed the quality priorities for 2014/2015 and the Hospital and Community patient experience targets achieved for 2013/14. Mortality had been added to the quality priorities for the year following the Keogh review.

Friends and Family Report dates - The Friends and Family Test Report score for Quarter 4 was 36% which would achieve the CQUIN. The maternity scores had improved, except for postnatal community which scored 95 in February but didn't sustain this for March. Preliminary benchmarking data showed that the Trust was top in three areas; A&E, Maternity Postnatal Ward and Maternity Postnatal Community and joint top for Maternity Antenatal in the region. The Trust was top for A&E scoring 72. The CQUIN target would be reached.

National Survey of Adult Inpatient Results 2013 - The survey was undertaken in July 2013.The Trust performed about the same as other Trusts. Overall the results showed an improved position. The Trust had scored worse in two sections (emergency department and waiting to get a bed on a ward). The Trust had a red score (worse) for just one question which was food and was third bottom in the Country. The presentation of the results and improvements that could be considered for the future was discussed. The Committee approved a proposal to refresh the questions in the real-time inpatient surveys.

Internal Safeguarding Board held on 20th March 2014 – PAN Board Review Meeting: The section 11 audit action plan had been submitted to the Safeguarding Children's Board. The DNAR policy and practices were under review. A restraint review was in progress. The Committee expressed their thanks to Matron Smith and her team for the work they had done for the Learning Disability Strategy Launch.

Safeguarding Adults Report - There were currently two serious cases under investigation. The Police would be looking at some patients notes on the 14th April. There were no concerns with the cases they had selected.

Terms of Reference - In view of discussions throughout the meeting the Committee asked the Board secretary to review the Terms of Reference for the Committee and the reporting groups and report back.

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 10th April 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.

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th June 2014

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 8th May 2014		
AUTHOR:	Julie Cotterill Governance Manager	**PRESENTER:**	David Bland (NED) CQSPE Committee Chair

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

Cancer Patient Experience Survey Action Plan Update - the Committee was advised that waiting times for Chemotherapy patients had reduced and was now less than one hour and that the longest waits were all under 2½ hours. Staff morale was high and only two complaints had been received in April. A Chemotherapy Clinical Nurse Specialist (CNS) had been recruited on a pilot for three to four months.

Patient Information had been reviewed and work continued on this. The Breast Care Team had launched a "Breakthrough Pledge "developed in partnership with Breakthrough Breast Cancer Charity. A local Service Pledge Booklet had been produced where the Trust committed to implementing identified changes.

Approval had been received to proceed with the refurbishment of the POD to provide a phlebotomy room and extra waiting area.

A survey was in progress and patients who underwent their first treatment from September to November 2013 were sampled. The overall national response rate was 57% as at 25th April 2014. The response rate for the Trust was 55%.

Major Internal Incident Plan - The Emergency Planning Officer presented two plans for approval; the Major Internal Incident Plan and the Business Continuity Plan. The key changes to the Major Incident Plan were highlighted as:

- Improved Action Cards for the Clinical Site Coordinator
- Removal of a redundant section (Incident Medical Teams which is now undertaken by the ambulance service).
- Amendments to the plan to reflect management changes for example ERMA to Local Area Team for NHS England.

Additionally a successful exercise (EMERGO) had taken place in June. The Committee **approved** the updated plans.

Quality Dashboard for Month 12 (March) 2013/2014 – The Committee discussed the figures for C.Diff and MRSA. C.Diff had shown improvement however an MRSA was reported in March.

The TAL indicator had decreased to 22% in March, against the 80% required target. This was the lowest score ever and was believed to be attributable to a significant increase in TAL referrals and the resulting impact on the clinics. The yearend annual leave was also thought to be a contributory factor.

The Committee discussed the action taken and requested a report on the barriers to meeting the target and clarifying the level of fines associated with this for the next Finance and Performance Committee.

The Maternity: Increase in breast feeding initiation rates had increased to 61% for March and the Maternity: Smoking in pregnancy had scored 16% for March which had increased slightly but was still red.

There were no red rated Nursing Care Indicators for Protected Mealtime or Think Glucose measures and the Trust overall was rated amber for both. Two wards were red for Think Glucose – C7 and EAU Trolley area. B6 was red for Protected Mealtime: Assistance. The Trust was red for Saving Lives: Reducing Ventilation associated pneumonia as Critical Care scored 40%. The remainder were green and amber.

The Committee **noted** the quality dashboard looking at the performance trends and variances against target for NCIs for March 2014.

Mortality Report – The Committee received the Quarterly Mortality Report Action Log and a response from CQC to a mortality outlier alert relating to skin and subcutaneous skin infections issued to the Trust in September 2013. The CQC had accepted the information provided by the Trust and concluded that they would make no further enquiries regarding this.

Nursing Care Indicators Q4 Report - the Committee received the report noting a reduction of 7% in comparison with previously reported scores for Ward C7. This ward had other problems including staffing issues but had previously performed well. Ward C2 (Paediatrics) was showing sustained improvement.

Safety Thermometers Q4 Report as at 30th March 2014 - There were 18 new pressure ulcers reported, 4 falls with harm and 16 catheter acquired urinary tract infections. The Investigation Manager is monitoring falls with harm and reviewing the provision of 1:1 nursing care. These would be reviewed in the Quality Accounts and Saving Lives.

Policy Group Recommendations - the Committee **ratified** four guidelines:

- Urinary Tract Infections (UTI) in infants and children Guideline
- Respiratory Failure Guideline
- Non-Invasive Ventilation for Acute Respiratory Failure Guideline
- Anaesthetic Lubricating Gel Use for Urinary Catheterisation Guideline.

Serious and Adverse Incident Monitoring Report for April 2014 - 7 new incidents were reported (1 Wrong Result given, 1 Patient Fall resulting in a Fracture, 1 DGH Acquired Infection C.diff, 1 DGH ward outbreak C.Diff, 1 Stillbirth (pre-delivery), 1 Wrong procedure/Guidelines followed and 1 Sharps injury – Patient (Non Needlestick)). There were 43 open general SI's in total (19 RCA/investigations in progress, 21 awaiting assurance that all actions had been completed and 3 recommended for closure).

There was a consistent trend in Patient Falls resulting in Fracture but these were decreasing with 4 in March and 1 in April. No Confidentiality breaches were reported in April 2014. The CCG had commented on the timeliness of reporting of pressure ulcers.

The Overview of the Red Matrix Incident Trends was discussed. It was noted that Clinical Care Assessment/Monitoring and Records, Communication and Information related incidents both showed an overall upward trend when reviewed over the last 2 months. No other trends had been identified. These were not externally reportable. The Committee **noted** the current position and **supported** the recommended closure of the Serious Incidents.

Friends and Family Report - A&E response rates had fallen but were within the required level for next year's CQUIN which had reduced to 15% in quarter 1 increasing to 20% in quarter 4. The ward huddle boards had helped to promote the results and raised public and staff awareness of these. Trauma and Orthopaedics were running a pilot which would go live in October.

With regard to National/Regional Benchmarking the Trust remained above national average for all areas in March and top in three areas: Inpatients, A&E and Maternity antenatal.

Comparisons of actions taken by other Trusts were discussed including the introduction of soft closing bins for inpatient areas, different call bells for meal time and free car parking for bereaved families. Details about the various data collection methods used by other Trusts were also considered.

Complaints and PALs Q4 Report - the number of Complaints received had dropped from 373 last year to 330 this year. The number of meetings held with complainants had increased.

The Ombudsman had attended the Trust to review the learning from a complaint and had confirmed that he was satisfied with the progress made. The Trust was using this incident as a learning opportunity and Matron Pain had provided feedback to Matrons on how she and her lead nurse had felt, during this visit. The Ombudsman had required the Trust to make a compensation payment to the complainant.

A monthly Internal Complaints Review meeting had been established to review complaint trends.

The Committee **received** the quarterly/annual Complaints and PALs report and **noted** the position relating to the number of complaints received which was comparable to the previous quarter.

Internal Safeguarding Board held on 24th April 2014 – the Board discussed the PAN Board Review Meeting which confirmed that the Police had visited the Trust to review 13 sets of case notes where adult patients had been restrained in the Trust. Initial verbal feedback was that there did not appear to be any concerns regarding unlawful practice. 2 cases were under investigation.

Trust Children's Services meeting held on 10th April 2014 - the following issues were highlighted:

- **WMQRS Peer Review Standards Critically Ill/Injured Child** – the verbal feedback was quite positive. An action plan would be drafted
- **Paediatric Diabetes Review** – A peer review of Paediatric Diabetes was scheduled for 12th September 2014. A working group led by Ms Smith had been set up to review the Standards and benchmark existing practice.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 8th May 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 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th June 2014

TITLE:	**Audit Committee Exception Report**		
AUTHOR:	**Jonathan Fellows**	**PRESENTER**	**Jonathan Fellows**
CORPORATE OBJECTIVE: Quality			

SUMMARY OF KEY ISSUES:

The Trust Audit Committee met on 13th May 2014 and considered:

- The draft Trust Annual Accounts, Annual Governance Statement (AGS), Quality Report, and Annual Report for the year ended 31st March 2014, together with the findings and conclusions of the external auditors Deloitte following completion of the audit;
- The year end reports from Internal Audit, the Local Counter Fraud Specialist (LCFS) and Clinical Audit;
- The proposed workplans for the 2014/15 year from Internal Audit, LCFS and Clinical Audit;
- A briefing on the proposed approach to the tender process for External and Internal audit services, both of which are due for renewal in April 2015.

In addition, the Terms of Reference for the Audit Committee were reviewed. A summary of the key issues discussed and items referred to the Trust Board is shown below.

Trust Annual Accounts, Annual Governance Statement (AGS), Quality Report and Annual Report

Deloitte had completed the audit of the Trust Annual accounts and AGS and the review of the Trust Quality report and Annual report.

Deloitte confirmed that the audit process had once again gone very smoothly and that subject to receiving management representations in certain areas, notably in relation to the appropriateness of the provision for termination of the IT contract with Siemens and of the levels of income accruals with commissioners, Deloitte were prepared to issue an unmodified (i.e. true and fair) opinion on the Accounts.

Deloitte also confirmed there were no maters to report in respect of the Trust's arrangements

to secure economy, efficiency and effectiveness in the use of resources (i.e. value for money) although in this respect Deloitte also noted that the Trust reported an overall deficit of £2.3 million for the year due to the recognition of a provision of £2.6 million for the termination costs of the IT services contract; also that the Trust did not fully achieve its CIP programme, achieving £9.4 million against a target of £12.4 million. The Trust had also failed to meet national performance targets in respect of Accident and Emergency 4 hour waits and C Difficile. However, since the Trust was not the subject of any regulatory action from either Monitor or the CCG, plus had made appropriate disclosures in relation to all these issues in the AGS, Deloitte had no matters affecting the value for money opinion to report.

Deloitte had also completed the Assurance Review of the Quality Accounts in line with the procedures specified by Monitor and confirmed they would be providing a limited assurance (i.e. clean) opinion.

After detailed review, the Audit Committee agreed to recommend to the Board that the Annual Accounts, AGS, Quality Accounts, Annual Report and management representation letter all be approved.

Year End 2013/14 Report and Proposed 2014/15 Internal Audit Plan

Baker Tilly presented the Internal Audit annual report. For the year as a whole, 26 audits had been undertaken, with the summary being:

GREEN rated	8
AMBER/**GREEN** rated	3
AMBER/**RED** rated	2
RED rated	4
Advisory only	6
Follow up audits	3
	26

RED opinion	The Board CANNOT take assurance that controls are suitably designed, consistently applied or effective
AMBER/**RED** opinion	The Board can take SOME assurance that controls are suitably designed, consistently applied or effective
AMBER/**GREEN** opinion	The Board can take REASONABLE assurance that controls are suitably designed, consistently applied or effective
GREEN opinion	The Board can take SUBSTANTIAL assurance that controls are suitably designed, consistently applied or effective

The four **RED** rated audits were:

- Compliance with the Appraisal/Personal Development Review Policy
- Compliance with the European Working Time Directive
- Bank Workers – Pre-Employment Checks and Induction Attendance
- Safety Thermometers

For the first three of these four **RED** rated audits, audits, Internal Audit had identified weaknesses in the application of controls, rather than in their design and a lack of adherence

to policy requirements at a local level was the main reason for the opinions given. On Safety Thermometers, inconsistencies were identified between the data gathered at source and that entered onto the online data sets. Follow up work was undertaken in the year on these reports and the Internal Auditors identified reasonable progress had been made by management in addressing the issues raised.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion on the overall adequacy and effectiveness of the organisations risk management, control and governance processes (i.e. the system of internal control). Baker Tilly noted that although 4 **RED** opinions had been issued during the year, taking into account the actions undertaken by the Trust in response to these opinions and the improvements identified through follow up work, there was nothing that would lead to the HoIA providing a negative opinion. Accordingly, the HoIA opinion was that:

"based on the work undertaken in 2013/14, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently."

Internal Audit also presented the proposed Internal Audit plan for the 2014/15 year. The plan linked to the strategic goals and risks of the Trust and in addition to audits of core financial systems and controls, also included audits in areas such as:

- Turnaround plan
- A&E recovery plan
- Lessons learnt from claims, complaints and incidents
- Whistleblowing
- Deprivation of Liberty Safeguards
- Bed Capacity Management
- Complex Discharge Management
- Mortality Review Process
- Consultant Job Planning
- Ward Staffing Ratios
- IT Business Continuity
- Board Governance Review

Internal Audit noted that in 2013/14 and again in the proposals for the 2014/15 year, the Trust had requested Internal Audit to audit some potentially "difficult" areas, so it would not be surprising to see the issuing of **RED** opinions in some instances.

The Audit Committee considered that the proposed Internal Audit workplan reflected the areas that the Committee believed should be covered as a priority and consequently agreed to recommend the plan to the Board for approval.

Year End 2013/14 Report and proposed 2014/15 LCFS Plan

Baker Tilly presented the LCFS annual report. The workplan agreed at the start of the financial year had been delivered on time and on budget, with all tasks completed. A total of

80 planned days had been spent on proactive work, analysed as:

Strategic Governance	12
Inform and Involve	33
Prevent and Deter	12
Hold to Account	23

In addition, a further 57 days had been spent on reactive activity comprising investigations into referrals to the LCFS. There had been 9 referrals in the year, resulting in 7 formal investigations. Of these, 5 cases were closed with no recommendations to progress; 1 investigation resulted in a disciplinary sanction being placed on file; and 1 investigation remained ongoing.

The LCFS also presented the proposed workplan for the 2014/15 year. This again included 80 days of proactive activity, targeting resources in areas considered at from fraud and bribery occurring based on:

- Findings from fraud risk assessments undertaken across the Trust in 2013/14;
- Findings derived from analysis of the reactive investigations undertaken in 2013/14;
- Benchmarking information from work across the Baker Tilly NHS sector client base;
- Fraud threats identified through sector intelligence.

The Audit Committee agreed to recommend to the Board that the LCFS workplan for 2014/15 be approved.

Year End 2013/14 Report and Proposed 2014/15 Clinical Audit Plan

The Nursing Director presented the Clinical Audit annual report. A total of 244 clinical audits had been registered in the year, of which 181 (74%) had been completed, 19 (8%) had been carried forward, 39 (16%) were incomplete and 5 (2%) had been abandoned. Audits were classed as incomplete when data collection had ended but no report or action plan had yet been produced.

A RAG rating had also been introduced to show progress on the implementation of actions identified from the completed audits. This showed that from a total of 338 actions identified:

- 77 (23%) had been completed;
- 17 (5%) were in progress
- 60 (18%) were not yet due
- 117 (34%) were overdue
- 67 (20%) had no implementation deadline

A new data base was being implemented to track actions arising from completed clinical audits, aimed at reducing the percentage of overdue actions.

The Nursing Director also presented the proposed Clinical Audit plan for 2014/15. This already included 149 audits, with rationale for audits including NICE guidelines, national audits, NHSLA, CNST, patient satisfaction, adverse incidents, compliance with national and/or local guidelines, service evaluation and clinical effectiveness. Further audits would be submitted for inclusion in the plan as the year progressed.

The Audit Committee agreed to recommend the Clinical Audit plan for 2014/15 to the Board for approval.

Proposed Approach to External and Internal Audit Tender Process

Monitor's Audit Code for NHS Foundation Trusts recommends NHT FTs undertake a market testing exercise for the appointment of the external auditor at least once every five years. Both the Trust's External and Internal auditors were appointed for five year terms on 1st April 2010 and accordingly the Trust intends to tender for both external and internal audit services for a five year contract commencing 1st April 2015.

The Council of Governors is responsible for appointing the external auditor. It is proposed that a panel be established to carry out the tender, provide evaluation of responses and make recommendations to the Council of Governors. The proposed panel is:

- 2 Governor representatives
- Chair of Audit Committee
- Director of Finance
- Deputy Director of Finance – Financial Reporting

Tender invitations are proposed to be drafted in July and issued in August, with a return date in September. Evaluation and interviews will then take place before a report and recommendation is submitted to the Council of Governors in October.

The Trust Board is responsible for the appointment of the internal auditor, which also includes the services provided by the LCFS. The proposed panel to carry out the tender, provide evaluation of responses and make recommendations to the Board is:

- Director of Nursing
- Associate Director of Governance
- Chair of Audit Committee
- Director of Finance
- Deputy Director of Finance – Financial Reporting

Tender invitations are proposed to be drafted in September and issued in October, with a return date of November. Evaluation and interviews will then take place before a report and recommendation is submitted to the Trust Board in December.

The Board is asked to note the intention to tender for both external and internal audit services and also to agree the approach proposed.

IMPLICATIONS OF PAPER:		
RISK	**Y/N**	**Risk Description:**
	Risk Register: Y/N	**Risk Score:**

COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**No**	**Details:**
	NHSLA	**No**	**Details:**
	Monitor	**Yes**	**Details: Licence Compliance**
	Equality Assured	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

To note the report and in particular:

a) Note that the Trust Annual Accounts, Annual Governance Statement, Quality Report, Annual Report and Representation Letter were all recommended to the Board for approval, which took place at the meeting held on 22nd May;

b) Note that the proposed 2014/15 workplans for Internal Audit, LCFS and Clinical Audit were also recommended to the Board for approval, which also took place at the meeting held on 22nd May;

c) Agree the proposed approach to the tenders for both External and Internal Audit.

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

The Audit Committee was established to provide assurance to the Board that there is an effective system of integrated governance, risk management and internal control across the whole of the organisation’s activities (both clinical and non clinical), that supports the achievement of the organisation’s objectives and that this system is established and maintained In particular the Committee reviews the adequacy and effectiveness of all risk and control related disclosure statements including the Annual Report, Quality Report and Annual Governance Statement, underlying assurance processes and policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification. In addition the Committee reviews the findings, implications and management responses to the work of the External Auditors, ensures there is an effective Internal Audit function and that the organisation has adequate arrangements in place for countering fraud

Enclosure 8

The Dudley Gr
NHS Foundation Trust

Paper for submission to the Trust Board on 5 June 2014

TITLE:	**Research & Development Operational Capability Statement (RDOCS)**		
AUTHOR:	**Margaret Marriott, R&D Facilitator**	**PRESENTER**	**Dr Paul Harrison, Medical Director**

CORPORATE OBJECTIVE: SO1 through to SO6 (research seeks to improve all aspects of patient care)

SUMMARY OF KEY ISSUES:

The Clinical Research Unit's Laboratory has received full Good Clinical Laboratory Practice accreditation and R&D wishes to update RDOCS to reflect this.

While updating of SOPs and policy documents continues, R&D wishes to gain Trust Board approval for this document so that a new version can be uploaded to the national Research Support Services website.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register: No		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Evidence to support compliance with Essential standards of Quality & Safety Outcome 16 – Assessing and monitoring the quality of service provision.
	Monitor		**Details:** R&D activity included in the Annual Report.
	NHSLA	**Y**	**Details:** Staff working on approved studies will be covered by normal NHS indemnity arrangements.
	Other: MHRA/CPA		**Details:** Lists facilities available at DGH for conducting research studies to ICH GCP (Good Clinical Practice) standard eg pharmacy, radiology, clinical laboratory facilities

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
	√	√	

RECOMMENDATIONS FOR THE TRUST BOARD:

To approve the updated document.

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

Standard Operating Procedures				
SOP Ref Number	SOP Title	SOP Details	Valid from	Valid to
B01	Manage R&D Operational Capability Statement	Describes the procedure the R&D office use when managing the content of the R&D Operational Capability Statement.	18/02/2013	18/02/2014
PO2	Manage Study Participating Planning Tool	Describes the procedure the R&D Office use when completing a quick assessment of a study	18/02/2013	18/02/2014
PO3	Confirm Study Approvals	Describes the procedure the R&D Office use when confirming study approvals have been completed	18/02/2013	18/02/2014
PO4	Setup and Control External Agreements	The procedure R&D Office use when setting up and controlling external agreements prior to the start of a study	18/02/2013	18/02/2014
PO5	Setup and Control Internal Agreements	The procedure R&D Office use when setting up and controlling Internal agreements with services and staff within the Trust	14/02/2013	14/02/2014
PO6	Setup and Control Study Processes	The procedure R&D Office use when setting up and controlling study processes.	18/02/2013	18/02/2014
PO7	Give NHS Permissions	The procedure R&D Office use in order to issue NHS Permissions to Trust research activity as a participating Trust.	18/02/2013	18/02/2014
PO8	Oversee Study	The procedure R&D Office use in order to establish a proportionate level of oversight of a study on behalf of the Trust.	18/02/2013	18/02/2014
PO9	Site Study Closedown	The procedure R&D Office use in managing the conclusion of a study the Trust is participating in at site.	18/02/2013	18/02/2014
SO2	Confirm Study Definition	The procedure R&D Office uses in categorising a study	18/02/2013	18/02/2014
SO3	Ensure Study Protocol in Managed	The procedure R&D Office use to ensure protocol is managed by Senior Investigator in Trust sponsored studies	18/02/2013	18/02/2014
SO4	Ensure Study Funding and Approvals are Managed	The procedure R&D Office use to ensure study funding and approvals are confirmed when the Trust is a sponsoring organisation	18/02/2013	18/02/2014
SO5	Manage Study Sponsoring Assessment and Planning Tools	The procedure the R&D Office uses to ensure a study is feasible when the Trust is the sponsoring organisation	18/02/2013	18/02/2014
SO6	Give Decision on Sponsoring	The procedure the R&D Office uses to give a sponsoring decision to the Investigator on behalf of the Trust.	18/02/2013	18/02/2014
SO7	Provide and Manage External Agreements	The procedure the R&D Office uses when providing and managing agreements with external parties when the site is acting as sponsoring organisation.	18/02/2013	18/02/2014
SO8	Ensure NHS Permisson is Received by the Chief Investigator	The process used by the R&D Office to ensure copies of the NHS Permission letters are recieved from all participating organisations when the Trust is acting as sponsoring organisation	18/02/2013	18/02/2014
SO9	Ensure Study Oversight	The process used by the R&D Office when overseeing a study throught the study period, on behlaf of the Trust when acting as a sponsoring organisation.	18/02/2013	18/02/2014
S10	Ensure Study Closedown is Managed	The process used by the R&D Office to confirm that a study has been closed appropriately when the Trust is acting as sponsoring organisation.	18/02/2013	18/02/2014
RP01 - GMCRN	Investigator Site File - Version 2	Documentation that should be kept in the Investigator Site File in order to comply with ICH Good Clinical Practice.	12/08/2011 (GMCRN SOP adopted by the Trust)	12/08/2012
RP02 - GMCRN	File Notes	The procedure where file notes should be used and what they should be used for	05/03/2008 (adopted by the Trust 08/06/2009)	31/07/2011
RP03 - GMCRN	Definition of Resposibilities of Staff at Local Sites	The use and purpose of the delegation log, who is responsible and why this is essential to the conduct of the study	27/05/2011 (GMCRN SOPs adopted by the Trust)	28/05/2012
RP04 - GMCRN	Data Entry - CRF Completion	Provides and outline as to the use and purpose of CRFs and why these are essential to the integrity of the study	18/08/2011 (GMCRN SOP adopted by the Trust)	19/08/2012
RP05 - GMCRN	Archiving and Destruction Documents	Provides details of how archiving should be kept, how long it should be kept for to comply with regulations and the legislation that it relates to.	Adopted by the Trust 08/06/2009	
RP06 - GMCRN	Audit and Inspection - Version 2	The definition and process connected with audit and inspection of research related studies	18/08/2011 (GMCRN SOP adopted by the Trust)	19/08/2012
RP07 - GMCRN	Informed Consent Procedure	The legal requirments and the process for obtaining valid informed consent from study participants.	27/05/2011 (GMCRN SOPs adopted by the Trust)	28/05/2012
RP08 - GMCRN	Adverse Events and Serious Adverse Events Reporting	The legal requirements and process for reporting and recording SAEs.	27/05/2011 (GMCRN SOPs adopted by the Trust)	28/05/2012
RP09 - GMCRN	Working File Set up	The process and uses of a working file set up in addition to the Investigator Site file.	10/07/2008 (adopted by the Trust 08/06/2009)	10/07/2011

TR01 - GMCRN	Performing and Documenting Training for Research Staff	Outlines the process in place to ensure that Trust staff involved in research are appropriately trained and their experience and training is fully documented	10/07/2008 (adopted by the Trust 08/06/2009)	10/07/2011
TR02 - GMCRN	Minumum Training Recommendations	Highlights the recommended training for Trust staff engaged in research related activities	10/07/2008 (adopted by the Trust 08/06/2009)	10/07/2011
PH01 - GMCRN	Chemotherapy Trials Prescriptions - Version 2	Describes the procedure for completing, prescribing and signing trial prescriptions acuratley within clinical trials	12/08/2011 (GMCRN SOP adopted by the Trust)	12/08/2012
Pharmacy SOP CT01	Clinical trial training manual for Assistant Technical Officers	To guide pharmacy ATOs in preparation and dispensing for clinical trials	02/01/2012	01/01/2014
Pharmacy SOP CT02	Clinical Trials training pack for Assistant Technical Officers	To guide pharmacy ATOs in preparation and dispensing for clinical trials	01/05/2012	30/04/2014
Pharmacy SOP CT03	Clinical trials re-accreditation for Assistant Technical Officers	Re-accreditation for ATOs	07/07/2012	06/07/2014
Pharmacy SOP CT04	Clinical trial training manual for Pharmacists and Technicians	To guide pharmacists and technicians in preparation and dispensing for clinical trials	22/07/2011	21/07/2013
Pharmacy SOP CT05	Clinical trials training pack for pharmacists	To guide pharmacists in preparation and dispensing for clinical trials	09/07/2011	08/07/2013
Pharmacy SOP CT06	Clinical trials re-accreditation for Pharmacists	Re-accreditation for pharmacists	09/07/2011	08/07/2013
Pharmacy SOP CT07	Clinical Trials training pack for pharmacy technicians	To guide pharmacy technicians in preparation and dispensing for clinical trials	23/06/2011	22/06/2013
Pharmacy SOP CT08	Clinical trials re-accreditation for Pharmacy Technicians	Re-accreditation for pharmacy technicians	23/06/2011	22/06/2013
Pharmacy SOP CT09	Procedure for the recording of clinical trials staff training	Procedure for the recording of clinical trials staff training	15/02/2012	14/02/2014
Pharmacy SOP CT10	Information Governance in Clinical Trials	Information Governance - what data to send	01/02/2012	30/01/2014
Pharmacy SOP CT11	Procedure for collection of Investigational Medicinal Products (IMPs) after dispensing	Collection of IMP from pharmacy	08/02/2012	07/02/2014
Pharmacy SOP CT12	Procedure for recalling Investigational Medicinal Products (IMPs) in a clinical trial	Recalling IMP	26/01/2012	25/01/2014
Pharmacy SOP CT13	Procedure for receipt of a clinical trials protocol	Receiving a protocol	21/09/2011	20/09/2013
Pharmacy SOP CT14	Procedure for assessing a new clinical trial within pharmacy	Assessing new trial	10/09/2011	09/09/2013
Pharmacy SOP CT15	Procedure for the risk assessment and risk management of clinical trials	Risk assessment and risk management	22/12/2011	21/12/2013
Pharmacy SOP CT16	Procedure for settng up a Trust research & development (R&D) approved clinical trial	Set up for R&D approved clinical trial	01/09/2011	31/08/2013
Pharmacy SOP CT17	Procedure for assigning charges for a new clinical trial	Assigning charges	08/02/2014	07/02/2014
Pharmacy SOP CT18	Procedure for preparation for a clinical trial site initiation visit	Site Initiation Visit preparation	06/09/2011	05/09/2013
Pharmacy SOP CT19	Procedure for the allocation and use of PIN numbers for clinical trials	Relabelling of IMPs	09/08/2011	08/08/2013
Pharmacy SOP CT20	Procedure for the 'Greenlight' Process - authorisation to proceeed for a new Clinical Trial	Pharmacy greenlight process	01/09/2011	31/08/2013
Pharmacy SOP CT21	Procedure for the prescribing of IMP on an in-patien chart.	In-patient prescribing of IMP	21/09/2011	20/09/2013

Pharmacy SOP CT22	Procedure for receiving Investigatinal Medicinal Products (IMPs)	Receiving IMPs	02/07/2012	01/07/2014
Pharmacy SOP CT23	Procedure for labelling of investigational medicinal products (IMPs) for a clnical trial	Labelling of IMPs	23/12/2011	22/12/2013
Pharmacy SOP CT24	Clinical trial prescription dispensing procedure	Dispensing procedure	24/12/2011	23/12/2013
Pharmacy SOP CT25	Procedure for final checking of investigational medicinal prodcucts (IMPs)	Final checking of IMPs	06/09/2011	05/09/2013
Pharmacy SOP CT26	Procedure for the dispensing of investigational medicinal products (IMPs) out of hours	Out of hours dispensing	13/12/2011	12/12/2013
Pharmacy SOP CT27	Procedure for closing down a clinical trial	Closing down of a trial	03/12/2011	02/12/2013
Pharmacy SOP CT28	Procedure for the temperature monitoring of clnical trials materials	Temperature monitoring	30/07/2011	29/07/2013
Pharmacy SOP CT29	Procedure for the safe management of an investigational medicinal product (IMP) spill	Safe management of IMP spill	04/08/2011	03/08/2013
Pharmacy SOP CT30	Procedure for relabelling of investigational medicinal products (IMPs)	Relabelling of IMPs	30/12/2011	29/12/2013
Pharmacy SOP CT31	Procedure for the destruction of investigational medicinal products (IMPs)	Destruction of IMPs	27/07/2013	26/07/2013
Pharmacy SOP CT32	Procedure for 'Code Breaking' within a Clinical Trial	Also known as unblinding of a study where it is not known what drug patient has been allocated in randomisation.	06/09/2011	05/09/2013
Pharmacy SOP CT33	Procedure for the quarantining of investigational medicinal products (IMPs)	Quarantining of IMPs	23/12/2011	22/12/2013
Pharmacy SOP CT34	Procedure for Receiving Patients Unwanted Investigational Medicinal Products (IMPs)	How to deal with patients unwanted IMPs	22/12/2011 - pharmacy	21/12/2013
Pharmacy SOP CT35	Repoting and Documenting Errors and Near Misses in Clinical Trials	Documenting errors and near misses	01/09/2011 - pharmacy	31/08/2013
Pharmacy SOP CT36	Outpatient Charges for Clinical Trials Prescriptions	Outpatient Prescription Charges	30/12/2011	29/12/2013
Pharmacy SOP CT37	Procedure for the Accountability of Clinical Trial Drugs within Pharmacy	Accountability of IMPs	24/01/2012	23/01/2014
Pharmacy SOP CT38	Procedure for the ordering of Investigational Medicinal Products (IMPs)	Ordering IMPs	20/09/2010	19/09/2012
Pharmacy SOP CT39	Procedure for Investigational Medicinal Products (IMPs) Stock Control	IMP stock control	10/03/2012	09/03/2014
Pharmacy SOP CT40	Procedure for the Use of File Notes in Pharmacy for Clinical Trials	File notes	Under review	
Pharmacy SOP CT41	Procedure for Archiving Clinical Trial Documentation/ Pharmacy Files	Archiving documentation/pharmacy files	Under review	
Pharmacy SOP CT42	Procedure for Version and Document Control for Clinical Trials	Version and document control	20/09/2010	19/09/2012
Pharmacy SOP CT43	Procedure for Professionally Checking a Clinical Trial Prescription	Professionally checking prescription	Under review	

Pharmacy SOP CT44	Procedure for receipt of clinical trial prescription into pharmacy	Receipt of clinical trial prescription	29/12/2011	28/12/2013
Pharmacy SOP CT45	Procedure for the notification of an admission of a clinical trial participant to a ward in DGNHSFT	Admission of clinical trial participant to a ward	Under review	
Pharmacy SOP CT46	Procedure for the use of IMP as patient's own drugs for in patient use	Use of IMP as patient's own drugs for in patient use	Under review	
Appendix 1	Clinical Trial Drug Destruction Certificate		09/08/2011	08/08/2013
Appendix 2	Clinical Trial Drug Recall Record		29/01/2012	25/01/2014
Appendix 3	Clinical Trial Collection Record Form		Under review	
Appendix 4	Good Clinical Practice Handout		07/07/2012	06/07/2014
Appendix 5	Clinicla Trials Presentation		01/04/2011	31/03/2013
Appendix 6	Good Clinical Practice Handout for ATOs		07/07/2012	06/07/2014
Appendix 7	Clinical Trial Set up Checklist		06/12/2011	05/12/2013
Appendix 8	Pharmacy Greenlight Authorisation Form		01/04/2011	31/08/2013
Appendix 9	Unblind Request Checklist		06/09/2011	05/09/2013
RD1	Raising an invoice	Trust procedure for requesting an invoice	18/02/2013	15/05/2014
RD2	Site specific assessment	Trust procedure for approving studies where the Trust is a participating organisation	18/02/2013	15/05/2014
RD3	Peer review before ethics	Trust procedure for approving studies where the Trust is a sponsoring organisation	18/02/2013	15/05/2014
RD4	Finance costing template	Trust procedure for using the NIHR approved costing template	18/02/2013	15/05/2014
RD5	Pharmacy approvals process - NHS Permissions	Process RD Office/ Pharmacy follows to ensure the correct processes are followed to allow for NHS Permissions	18/02/2013	18/02/2014
RD6	Training for staff administering CTIMPS	Georgina Unit	18/02/2013	18/02/2014
RD7	Dealing with radiological exposures in research	The process the R&D Office uses when setting up a study involving ionising radiation or radioactive materials	19/02/2013	19/02/2014
RD8	Amendments SOP	Process the R&D office uses when handling amendments	18/02/2013	18/02/2014
PF1	Set up and control finance	The process the R&D office uses when setting up and controlling study finance procedures	18/02/2013	18/02/2014
PF2	Oversee organisation and study finance	The process the R&D offices uses when overseeing study wide financial arrangements	18/02/2013	18/02/2014
RD90	Auditing	The process the R&D Office follows when auditing a study - participating and study-wide	18/02/2013	18/02/2014
RD91	Archiving and document destruction SOP	The process the R&D Office uses when archiving a study - both participating and study-wide	18/02/2013	18/02/2014
Policy	Procedure for prescribing, safe handling and administration of cytotoxic chemotherapy and	Trust policy for administrating chemotherapy	01/11/2008	01/10/2010
Policy	Systematic anti cancer programme education and training: A multi-disciplinary approach	Trust education and training programme for cytotoxics which can be applied to the use of investigational medicinal products	New Trust training manual as of Feb 2011	

Schedule for renewing R&D Policies & Procedures		Issue date		Review date	Planned work schedule

Trust policy for taking informed consent	17/03/2014	31/03/2017	completed Feb 2014
Trust policy for managing IP	under review		01 May 2014
Trust policy for adhering to the Research Governance Framework	01/11/2011	01/11/2014	new national RGF awaited late 2014
Trust policy to address misconduct and fraud	under review		01 September 2014
Trust policy for research passports	under review		01 August 2014
Trust procedure for reportings SAEs and SUSARs	under review		01 June 2014
Trust policy for studies involving adults lacking capacity	01/08/2011	01/06/2014	01 July 2014

Enclosure 9

The Dudley [illegible]
NHS Foundation Trust

Paper for submission to the Board on 5th June 2014

TITLE:	Complaints and PALS Report Quarter 4, January to March 2014 Annual Report for year ending 31 March 2014		
AUTHOR:	Maria Smith & Karen Jaunzems (Customer Service & Claims Department)	**PRESENTER:**	Julie Cotterill Associate Director of Governance / Board Secretary

CORPORATE OBJECTIVE: SG02 - To provide the best possible patient experience

SUMMARY OF KEY ISSUES:

- Customer Service and Claims report for year ending 31 Mar 2014 (incorporating quarter ending 31 March 2014).
- Total number of complaints for the quarter is comparable with previous quarters
- 46% of complaints are answered within 30 working days during quarter
- 66% of complaints received and answered during year were upheld or partially upheld.
- 15% of complainants expressed dissatisfaction with their response and in the majority of cases, a meeting was held to try to resolve the issues raised.
- Complainants offered a meeting to discuss concerns prior to commencement of investigation
- No rule 43 (now rule 28 - Reports on Action to Prevent Future Deaths) letters received from Coroner and there were no adverse Inquest verdicts.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** **Outcome 01: Respecting and involving people who use our services** **Outcome 17: Complaints**
	NHSLA	**Y**	**Details: Standard 2 – concerns and complaints and claims management**
	Monitor	**N**	**Details:**
	Equality Assured	**Y**	**Details: Better health outcomes** **Improved patient access and experience**
	Other **Ombudsman**	**Y**	**The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 No. 309** **2 complaints accepted for investigation by Ombudsman in quarter and 5 during the year**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS:

To receive the Customer Care Manager's Quarterly/Annual Report and note the position relating to the number of complaints received (330) which is slightly less than last year (373) and the lessons learned from these.

Key facts	Qtr ending 31 March 2014	Year ending 31 Mar 2014
Total number of complaints received - (7 – high; 43 – moderate; 22 – low) (17 high; 190 – moderate; 123 – low)	**72** 7 - high category 43 - mod " 22 - low "	**330** 17 - high category 190 - mod " 123 - low "
% Complaints acknowledged within 3 working days	100%	99%
% Complaints answered within 30 working days	46%	46% (data collection commenced in 4th qtr)
Complaints upheld/partially upheld	64 (60%) of complaints closed during **quarter** upheld/ partially upheld	252 (66%) of complaints closed during **year** upheld/ partially upheld
Complaints referred to Ombudsman for investigation	2	5 (2 upheld and compensation paid)
Complaints/PALS concerns including privacy & dignity	1 (complaints) 0 (PALS concerns)	2 (complaints) 0 (PALS concerns)
Complaints/PALS including concerns regarding shared accommodation	0 (complaints) 0 (PALS)	0 (complaints) 1 (PALS)
Number of meetings held with complainants	20	87 (26% of complaints)
Total number of dissatisfied complaints received	14	51 (15% of complaints)
Total number of CCG/CSU led complaints received	1	6
PALS Concerns	211	551
New Claims (CNST & Personal injury) opened in quarter/year	20	63
Personal injury/Public liability claims closed/settled in quarter/year	3 (nil damages paid)	12 (Damages paid £19,790)
Clinical negligence claims closed/settled in quarter/year	15 (Total damages paid = £423,603)	40 (Total damages paid = £963,853)
New Coroner's cases opened	3	25
Coroner's Inquests held and closed	6	13
Coroner's Rule 43 (now rule 28) received	0	0
PALS/Complaints relating to adult safeguarding issue received or safeguarding referral re another provider	1 (Complaint) 0 (PALS)	0 (Complaints) 1 (PALS)
Compliments and thanks received	1118	2108

Complaints Categories for Jan to Mar 2014 & Year End 31/03/144 (these have been reviewed and are now shown as follows) –

Category	Qtr 3 ending 31/12/13	Qtr 4 ending 31/03/14	Year ending 31/03/14
Clinical Care (Assessment/Monitoring)	*24 (29%)*	*22 (31%)*	*93 (28%)*
Diagnosis & Tests	*18 (21%)*	*19 (26%)*	*76 (23%)*
Records, Communication & Information (incl attitude of staff)	*15 (18%)*	*13 (18%)*	*53 (16%)*
Appointments, discharge & Transfers	*8 (9%)*	*8 (11%)*	*53 (16%)*
Obstetrics	*7 (9%)*	*3 (3%)*	*17 (5%)*
Medication	*5 (6%)*	*2 (3%)*	*15 (4%)*
Patient Falls, Injuries or Accidents	*5 (6%)*	*2 (3%)*	*15 (4%)*
Equipment	*2 (2%)*	*2 (3%)*	*5 (1%)*
Safeguarding	*-*	*1 (1%)*	*1 (1%)*
Theatres	*-*	*-*	*1 (1%)*
Pressure Sore	*-*	*1 (1%)*	*1 (1%)*
Total:	***84 (100%)***	***72 (100%)***	***330 (100%)***

Previous data is shown below for information:-

Category	Qtr 2 ending 30/9/12	Qtr 3 ending 31/12/12	Qtr 4 ending 31/03/13	Year ending 31/03/13	Qtr 1 Ending 30/6/13	Qtr 2 Ending 30/9/13
All aspects of clinical treatment	86 (84%)	88 (81%)	74 (83%)	295 (79%)	65 (69%)	40 (48%)
Attitude of staff	2 (2%)	2 (2%)	4 (4%)	14 (4%)	2 (2%)	16 (19%)
Communication/information to patient	4 (4%)	8 (7%)	4 (4%)	19 (5%)	10 (11%)	13 (16%)
Admission, Discharge & Transfer	1 (1%)	4 (4%)	2 (2%)	8 * (2%)	4 (4%)	7 (9%)
Outpatient Department appointment/cancellation	5 (5%)	3 (3%)	3 (3%)	17 (5%)	11 (12%)	-
Nursing care	-	-	-	8 * (2%)	-	6 (7%)
Delay providing service	-	-	-	-	-	1 (1%)
Other	-	-	-	-	2 (2%)	-

Percentage of complaints against activity

ACTIVITY	Total year ending 31/3/2013	Total Qtr 1 ending 30/6/13	Total Qtr 2 ending 30/9/13	Total Qtr 3 ending 31/12/13	Total Qtr 4 ending 31/03/14	Total Year ending 31/3/2014
Total patient activity	735,247	185,113	181,539	186,084	181,503	734,239
% Complaints against activity	0.05%	0.05%	0.04%	0.04%	0.04%	0.04%

Listening into Action Events for Complainants

The Chief Executive invited previous complainants to a second Listening into Action event on 20th March 2014; the first being held in December 2013.

This is now a regular event to enable the trust to listen to the experiences that patients and relatives have of the complaints process.

Following feedback received during this meeting planned improvements include:-.

- Training for front line staff on communication and empathy
- Families to share role of caring for relatives and encouraged to be more involved.
- Communicate clearly with patients regarding their planned treatment
- Single point of contact to manage complaint from receipt to closure
- Evidence action has been taken
- Matron/lead nurse to be more visible to prevent escalation of complaint
- Response letter to be made more personal
- Give feedback and confirm what action has been taken.

Complaint themes for quarter ending 31st March 2014

Following a reviewing of coding, clinical care is now 28% of complaints received during the year. This compares favourably with complaints received in 2012/13, when up to 81% of complaints were received as being in respect of clinical care.

Risk categories

A senior member of the complaints team now assesses each complaint on receipt and allocates a provisional risk category. On completion of the complaint investigation senior staff involved in responding to issues raised are asked to review the risk category and amend as necessary, dependent upon the outcome of the investigation.

There were 7 complaints received in quarter 4 which, upon receipt, were categorised as 'high risk' 43 were categorised as 'moderate' and 22 as 'low' risk.

Complaint review meetings

An Internal Complaints Review Group, which reports to the Patient Experience Group, has been established. Chaired by the Chief Executive, membership includes:

- One non-executive director
- Head of Communications and Patient Experience
- Customer Service and Claims Manager
- Director of Nursing
- Deputy Medical Director

The group will –

- oversee the implementation and review of findings and related action plans resulting from complaints investigations.
- ensure that good practice is shared across the Trust and externally.
- receive and review reports from directorates on complaints review and learning and ensure this learning is shared across the Trust.
- monitor processes continuously to improve the service user experience based on feedback to and from patients, carers and relatives.

Action taken as a result of Claims

Emergency and specialty medicine

- Fluid balance charts are now completed and intentional rounding now takes place at least hourly.

Surgery and Anaesthetics

- Risks and benefits of surgery are explained and documented and the patient's signature is obtained.

Women & Children (Maternity & Gynaecology)

- Triage arrangements have been revised for women who present with diminished foetal movement

Action taken as a result of Complaints or Concerns

Ambulatory Medicine

- Complaint related to insensitive correspondence - Style of letters amended to take account of comments made.
- Department to formally invite patients to research projects when they attend clinic.

Diagnostics

- Mobilisation of Patients - Staff have been reminded to advise patients to remain seated until assistance is offered to move or mobilise

Emergency Medicine

- Ordering of tests – Staff reminded of the need to take all factors into consideration when ordering tests
- ***Specialty Medicine***
- Responding to patients specific wishes to be seen by a male or female technician - Information leaflets to be revised and a new 'alert' placed on the local booking system to ensure that departments are aware when a patient wishes to be seen by staff of a specific gender.
- Communication on ward - Further training to be provided for staff and communication with staff and relatives discussed during ward meetings.

Surgery & Anaesthetics

- Waiting times for follow up appointments - New clinics set up to help alleviate the situation and patient sent a 'soon' appointment.
- Patient concerns re length of stay on SAU and lack of information and refreshments - New laminated signs erected in bays and side rooms to explain the reason for 'nil by mouth' and patients asked to speak to nursing staff if unsure. Theatre 'team brief' will also enable staff to offer appropriate refreshments if long delays are expected.

- Patient concerned about general pre-operative arrangements - Staff asked to keep patients better informed of any delays.

Trauma, Orthopaedics & Plastics

- Concerns raised about poor communication and transport issues - Lead nurse has asked ward staff to ensure they inform the ward clerk when transport is needed.

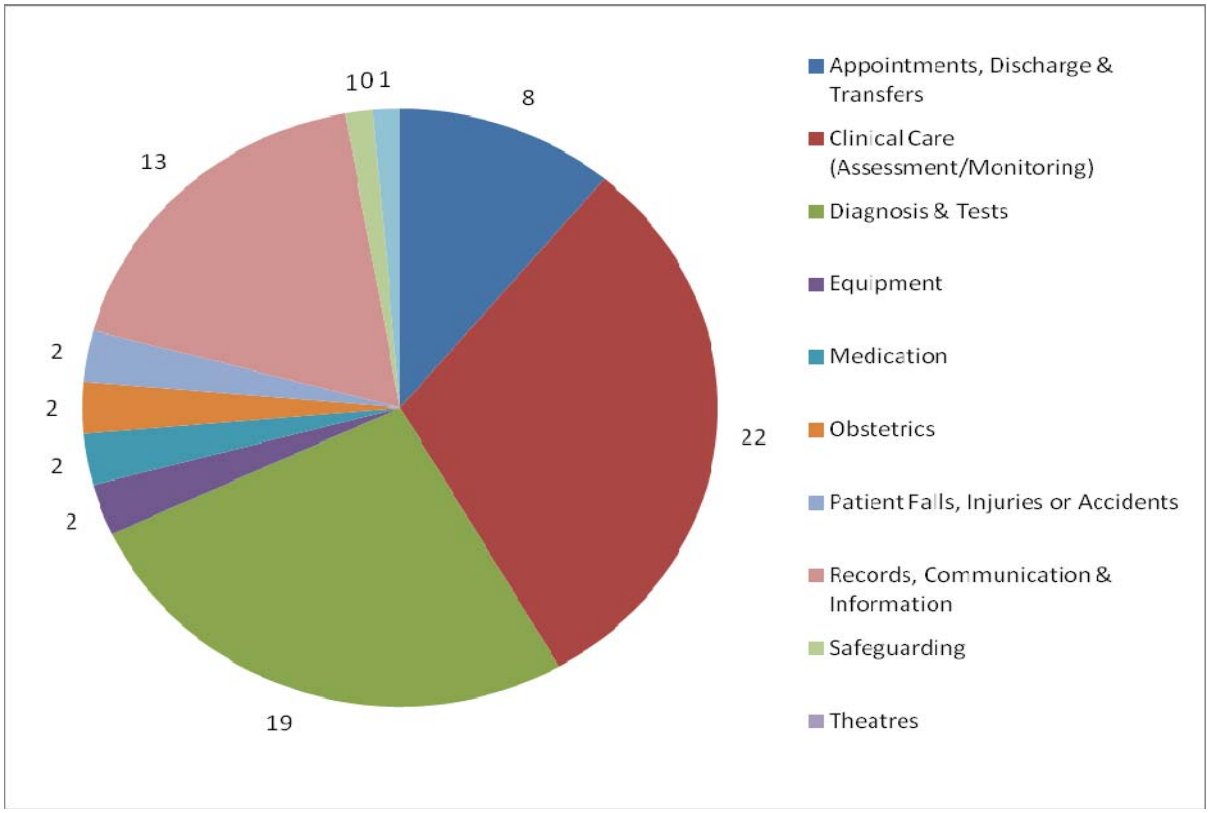
Women & Children (Maternity & Gynaecology)

- Poor communication - Staff reminded of the importance of effective communication.

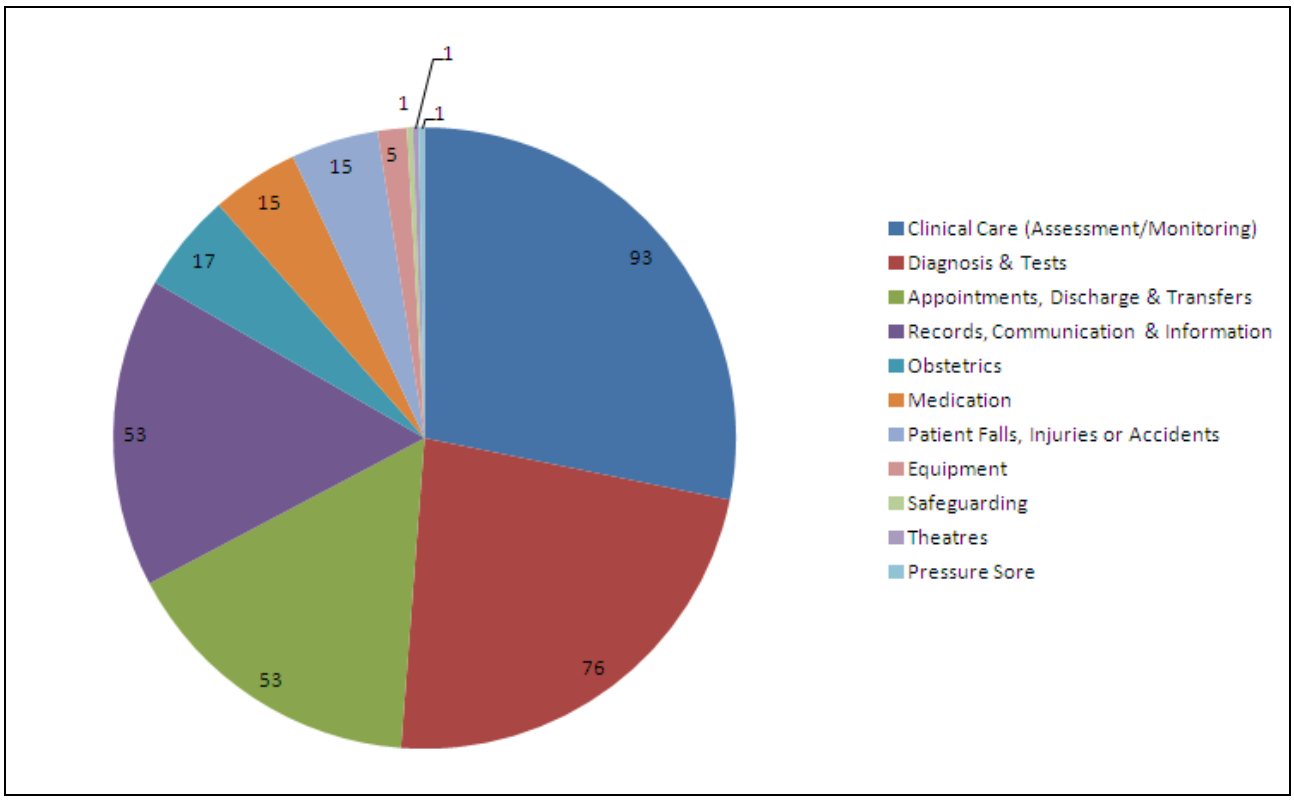
In addition, a number of individual staff members were counselled or asked to reflect on the care/treatment provided.

Pie Charts illustrating types of complaints and concerns received for January to March 2014

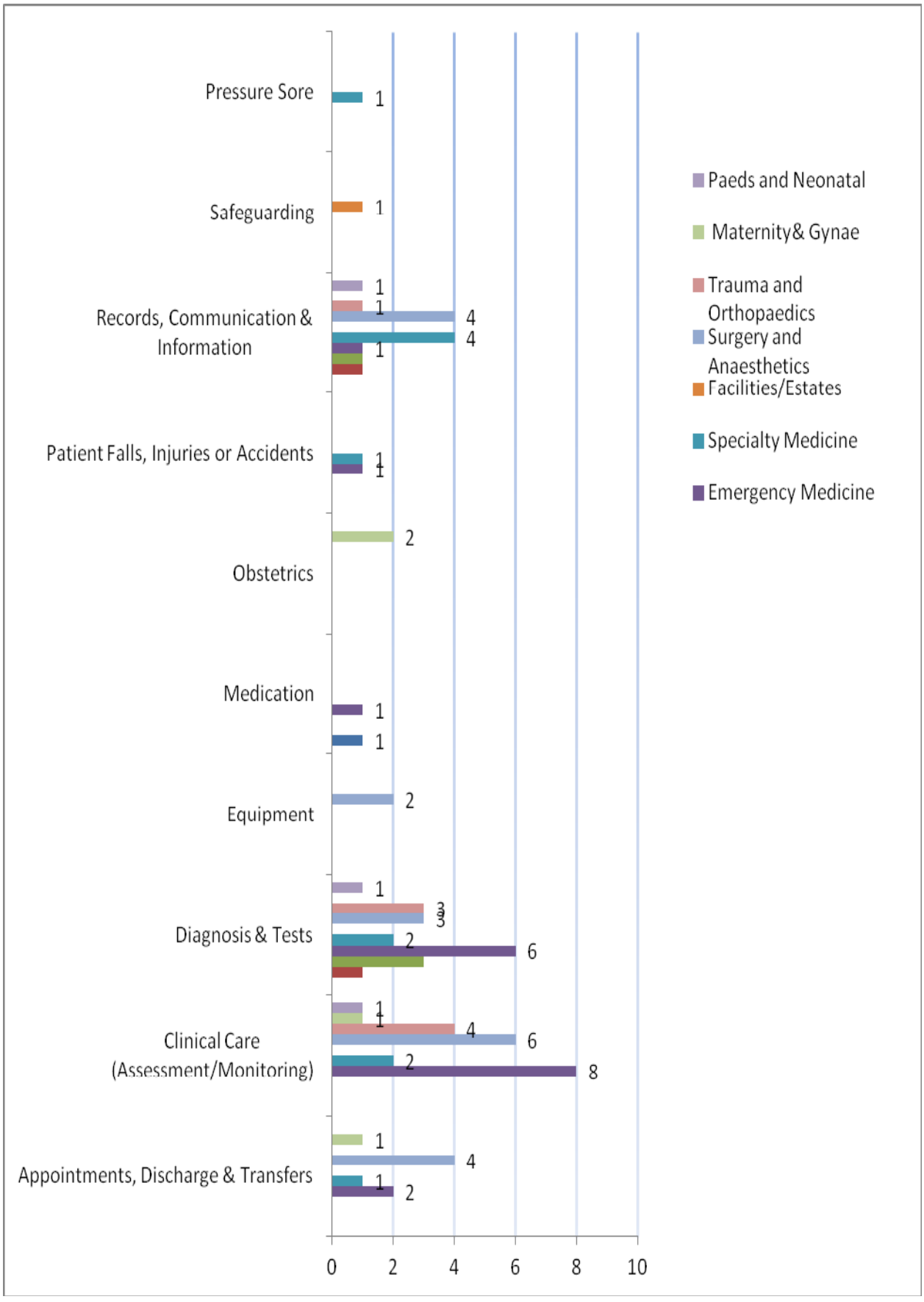
Complaints by type January – March 2014



Complaints by type April 2013 – March 2014



Bar chart illustrating Complaints by Directorate and type January – March 2014



Enclosure 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On the activities of the Finance & Performance Committee

TITLE	**Finance & Performance Committee meetings held on 29h May 2014**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**Jonathan Fellows**
CORPORATE OBJECTIVE: S06 Enabling Objective			
SUMMARY OF KEY ISSUES: • **The Trust has experienced a poor start to the new financial year both operationally with a failure of the 4 hours ED target in April and a significant budget overspend**			
IMPLICATIONS OF PAPER:			
RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Failure to achieve the 4 hours A&E target in Q1** **Risk to 2014-15 Financial Plan**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **The Trust's performance in April jeopardises itslf 'Green' for Governance & '3' (good) for Finance ratings at Q4.** **The Trust remains on quarterly monitoring by Monitor.**
	Other	**Y**	**Details:** **Significant exposure to performance fines by commissioners in 2014-15**
ACTION REQUIRED OF BOARD:			

Decision	Approval	Discussion	Other
			X

NB: Board members have been provided with a complete copy of agenda and papers for this meeting.

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the Committee's major concern about the level of overspending in the Trust which is jeopardising financial stability in 2014-15 and a continued failure to achieve the 4 hours ED target.

The Dudley Group NHS
NHS Foundation Trust

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

Finance and Performance Committee Meeting held on 29th May 2014

1. Background

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

2. Operational matters:

The Committee considered reports from the Director of Operations on :

a. 18 Weeks Referral to Treatment
Currently at 90.1%. The Committee considered issues and mitigation proposals for each clinical specialty in turn. The Committee were assured that the target is achievable for Q1. Mr Cattell reported that the main reasons for deterioration in this target were increases in emergency surgical activity and medical outliers causing elective surgical cancellations and an 8% increase in referrals. Theatre staffing issues are a further concern

Particular pressures had been analysed in Urology & T&O due to consultant vacancies. Short term waiting list sessions will correct the position with a more structured transfer of additional beds to surgery planned in 2015.

b. Non nursing & medical agency spending
The Committee considered expenditure trends for 2013-14 and current plans to reduce these in the new financial year

c. A benefits realisation report – the Ambulatory Medical Unit
The Committee were apprised of the implementation of this project and noted the achievement of proposed length of stay benefits.

d. ED 4 hours target recovery plan
The latest Trust Action Plan, inclusive of most recent ECIST recommendations, was noted and the Director of Operations reported upon progress to date.

The Committee requested regular monthly progress reports with financial and other benefits clearly articulated on a number of the above.

3. **Turnaround Programme Progress report**

Mr Davies, Interim Turnaround Director, presented the 2nd draft of the Turnaround Plan for consideration and approval and reported upon progress to date against the critical path presented to the previous Board of Directors Meeting.
The revised Plan identifies firm savings proposals of £18.8m, with an in-year impact of £10.9 (based upon a 74% delivery rate).

May has seen the formal launch of the Turnaround Programme by the Chief Executive and other Executive Directors.

Mr Davies said that the Committee would see the level of expenditure begin to fall in May (week 9-13 of the Plan).

The QIA approval process for vacant posts had commenced and started very well.

The key to success in turnaround was identified as clear accountability for the achievement of agreed actions with crisp escalation where these fail. This will be a large feature of the process being instituted across the organisation.

The Committee approved the submission of the Plan to Monitor.

4. Facilities & Estates Report

Mr Graves presented the quarterly standing report and asked the Committee to note the plans for the planned market testing of 'soft' PFI services over the next few months. The Committee also noted the extremely high levels of cleaning audit scores across all 3 sites, a situation borne out by the recent independent PLACE inspections.

5. Performance Targets and Standards

The Committee noted the following matters:

a) A&E 4 Hour Waits

The percentage of patients who waited under 4 hours within A&E for April was 91.4% (March was 91.5%) against a 95% target. The Trust has failed 4 of the last 5 quarters' targets. The Committee devoted a great deal of time to the analysis of key drivers and the Trust Recovery Plan.

b) Never Events

The Trust had no 'never events' in April.

6. Workforce KPIs

The Committee received a report from the Director of Human Resources, noting the following:

a. Absence
The Trust absence rate for the month of March is 3.63% (3.85% previously) The 2014-15 target is 3.50% and YTD performance is 3.63%.

b. Turnover
Turnover continues to remain consistent and within target at 7.87% (8.02% previously)

c. Mandatory Training and Appraisals
The compliance rates for Mandatory Training has shown a small increase on previous months to 78.1%. No red rated subjects.
Appraisals have decreased this month to 76.01% (77.26% previously and a 85% 2014-15 target).

d. Professional Registration
100% of Professional registrations checks have been performed.

The Committee noted that the Trust had 4 live ET cases submitted during the year.

7. Financial Performance for April 2014

The Trust made a poor start to the year, posting a deficit of £2.2m, £1.7m worse than plan (equivalent to the planned deficit for Quarter 1 as a whole). However the Committee noted that April showed a £1m loss of planned income which may be the result of coding and budget phasing issues that will be rectified in future months. Of greater concern was the continued high run rate in agency spending, although early indications for May show this falls sharply.

The Board of Directors has taken the unprecedented step of approving a deficit budget for 2014-15, moving back into balance next year. The Committee considered that this budget can still be achieved through the swift and thorough implementation of the Turnaround Plan.

The Trust's balance sheet and liquidity position remain relatively strong, although significant overspending is putting unnecessary strain on cash reserves.

Capital spending is broadly on plan.

The Committee noted the work of the Turnaround Director and the need for a strong delivery of identified savings if the budget is to be delivered.

8. **Matters for the attention of the Board of Directors or other Committees**

The Board is asked to note the report and to note the Committee's continued concerns about the trends in overspending and failure to achieve the 4 hours target in ED should be noted by the Board

PA Assinder
Director of Finance & Information