The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 4th September 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 Apologies**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 3rd July 2014	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 3rd July 2014	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	D Mcmahon	To Note & Discuss	10.00
	7.2 Workforce and Staff Engagement Committee Exception Report	Enclosure 5	A Becke	To Note & Discuss	10.10
	7.3 Nurse Staffing Report	Enclosure 6	D Mcmahon	To Note & Discuss	10.20
	7.4 Complaints Report	Enclosure 7	J Cotterill	To Note & Discuss	10.30
	7.5 Audit Committee Exception Report and Annual Report	Enclosure 8	J Fellows	To Note & Discuss	10.40
	7.6 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 9	D Bland	To Note & Discuss	10.50
	7.7 Quality Accounts	Enclosure 10	D Mcmahon	To Note & Discuss	11.00
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 11	D Badger	To Note & Discuss	11.10
9.	**Date of Next Board of Directors Meeting** 9.30am 2nd October, 2014, Clinical Education Centre		J Edwards		11.20

10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards		11.20

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 3rd July, 2014 at 9:30am in the Clinical Education Centre.

Present:

John Edwards, Chairman
Ann Becke, Non Executive Director
David Badger, Non Executive Director
Paula Clark, Chief Executive
Paul Assinder, Director of Finance and Information
Paul Harrison, Medical Director
Jon Scott, Interim Director of Operations

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 Support Operations
Julie Cotterill, Associate Director of Governance/Board Secretary
Elizabeth Rees, Director of Infection Control (item 7.1)
Yvonne O'Connor, Deputy Nursing Director

14/056 Note of Apologies and Welcome

Apologies were received from Richard Miner, Jonathan Fellows, David Bland and Denise Mcmahon.

14/057 Declarations of Interest

There were no declarations of interest.

14/058 Announcements

The Chairman welcomed Jon Scott to the meeting, Jon joined the Trust on 23rd June, 2014, as Interim Director of Operations.

The Chairman welcomed Yvonne O'Connor, Deputy Nursing Director, to the meeting. Yvonne was representing Denise Mcmahon.

14/059 Minutes of the previous Board meeting on 5th June 2014 (Enclosure 1)

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

14/060 Action Sheet, 5th June 2014 (Enclosure 2)

14/060.1 Patient Story – Patient Gowns

Update to be included in the Clinical Quality, Safety, Patient Experience Committee report to the September Board.

14/060.2 Infection Control – MRSA RCA

Update to be included in the Clinical Quality, Safety, Patient Experience Committee report to the September Board.

14/060.3 Patient Story – Governors New Menu Taste Test

Covered in the Catering Report to the Private Board.

14/060.4 Patient Story – Hairdressing

Covered in the Chief Executive's Report at item 6.

14/060.5 Moving Patients Out of Hours

Covered on the agenda at item 7.3.

14/060.6 Patient Story – Screen Saver and Huddle Boards

Both items had now been completed.

14/060.7 Audit Committee – Governor Tender Evaluation

This item had now been completed.

14/061 Patient Story

Board members noted that the video featured a communication issue between medics.

Liz Abbiss confirmed that the Consultant responsible for the patient had shown the video at a multi-disciplinary team meeting and had addressed the issue directly with the Registrar concerned.

Mr Badger, Non Executive Director, confirmed that communication is still a theme in our surveys and the Trust needs to widen the learning.

The Chief Executive commented that some Consultants prefer to keep their patients in a bed to ensure they keep their slot in the diagnostic queue. That practice must cease.

Ann Becke stated that the Board had also previously raised the issue of sedated patients not remembering information that they have been given. The Medical Director agreed that the type of sedation used does stop patients forming memories and repeating the information given to these patients is very important. Mr Badger stated that it is important to repeat messages but also that when appropriate families and carers are also clear about the patients care and treatment.

Mrs Becke, Non Executive Director, commented that patients should also be informed that relatives or carers can be invited to attend when medics speak to patients about their care.

The Director of Support Operations confirmed that wards can be a noisy environment at times and this makes it more difficult for patients to concentrate.

The Chairman thanked Liz for bringing a different theme of story to the Board's attention and commented that it was a powerful message and it was helpful to note the Consultants actions. The Board also noted the issue around the patient's care pathway and whether the care had been provided in an appropriate setting.

14/062 Chief Executive's Overview Report (Enclosure 3)

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

Friends and Family: Amber for Q1 for footfall. The Trust will meet the CQUIN target. ED target for Q1 also met. Maternity remains a fluctuating position. The team are now gathering data on the Friends and Family Test for staff. The Chairman stated that the ward footfall scores had previously been good and asked the reason for the drop. Liz Abbiss confirmed that this was due in part to the reorganisation and the team are working with the wards who have a low response rate.

CQC Inspection: The Trust was awaiting a response and the Chief Executive confirmed that she would contact the CQC directly after the Board meeting for an update.

Sign up to Safety: To Trust had decided to sign up to this campaign with the support of the Board. The campaign aims to reduce avoidable harm to patients by 50% over a three year period and will follow five identified pledges. The Chairman asked if there was any correlation between Sign up to Safety and the safety thermometer. The Chief Executive confirmed that they were totally separate.

Director Appointments: Anne Baines had been appointed as Associate Director of Strategy and Performance and commences in late September.

Hairdressing: Work was being progressed through the Patient Experience Group which will report up to the Clinical Quality, Safety and Patient Experience Committee and then back to Board.

14/063 Patient Safety and Quality

14/063.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Director of Infection Prevention and Control presented her report given as Enclosure 4. An updated version of the paper, to include the Trust Toxin by Directorate graphs were tabled to Board members.

C.Diff: Within Target. Board members noted that the Trust had now agreed the process with the CCG for avoidable and unavoidable cases.

Mr Badger, Non Executive Director, asked if the team were comfortable with the C.Diff algorithm. The Director of Infection Control confirmed that it was a fair process.

MRSA: 0 cases to date this year.

CPE: A draft action plan is in place. The Trust had seen one confirmed case in the previous 18 months. The Board noted that New Cross has cases and the Trust have some patients who receive shared care between organisations. The team are currently looking at undertaking screening in high risk areas.

Mrs Becke, Non Executive Director, asked about the procedure when cases are identified. The Director of Infection Control confirmed that cases are immediately isolated. The Chief Executive confirmed that good infection control practice is the key solution and asked if hand gels are effective against CPE (Carbapenamase Producing Enterobateriaceae). The Director of Infection Prevention and Control confirmed that the infection reacts very well with hand gels.

The Chairman summarised that there are three main issues, how to identify patients at risk, how to identify areas and reinforcing infection control procedures.

The Board noted the positive performance, noted the agreement of the algorithm with the CCG and the discussion around CPE and trial process in high risk areas and reinforcing of infection control procedures.

14/063.2 Workforce and Staff Engagement Report (Enclosure 5).

Mrs Becke, Non Executive Director presented the Workforce and Staff Engagement Report given as Enclosure 5. Board members noted that this was the first meeting of the new Committee and noted the following key items:

Three Red Audits: Good progress is being made and on track to turn green.

Workforce KPIs: Turnover remains consistent, however the Committee is undertaking work to look at the target and undertake benchmarking. The Board noted that the appraisal rate had slipped and this was being closely monitored and Directorates with red workforce KPIs had been invited to the Committee to present their recovery plans. Mr Badger, Non Executive Director, confirmed that appraisals are on a downward trend, month on month and this was a concern and the position needs urgent recovery.

14/063.3 Moving Patients Out of Hours (Enclosure 6)

The Director of Support Operations, presented the report on moving patients out of hours, given as Enclosure 6.

Board members noted that this was an update report following the previous discussion on this issue at Board.

An audit is taking place during August and a report will be presented back to Board with the outcome of the audits and agreed metrics.

The Chairman noted the staging report and confirmed that a further update would be presented to the Board in the Autumn.

Update Report with results of the audit and agreed metrics to be presented to the Board at either the October or November meetings.

14/063.4 Safeguarding Quarterly Report (Enclosure 7):

The Deputy Director of Nursing presented the quarterly safeguarding report, given as Enclosure 7, including the following key areas:

Concerns raised by the independent Chair of Dudley Safeguarding Board regarding restraint:	A Pan Board Reassurance Group had been established including a police review. No practices of unlawful restraint had been identified and the Pan Board Reassurance Group had found media allegations to be groundless. Two further cases were being investigated which have followed normal Trust procedures. The complete report is due to be received upon completion of the investigation.
CQC/Ofsted Assessment:	An unannounced inspection is imminent.
Do Not Attempt to Resuscitate Training:	Policy updated and circulated to staff. The Chairman asked who reviews DNAR externally, particularly for GPs as this is a health economy issue. The Medical Director confirmed that the Trust is working closely with the CCG. The Chairman asked that the Board revisits DNAR and the work being undertaken with the CCG later in the year.

The Board noted the report.

The Board to revisit DNAR and the work being undertaken with the CCG at either the November or December Board meetings.

14/063.5 Corporate Risk Register (Enclosure 8)

The Associate Director of Governance presented the Corporate Risk Register given as Enclosure 8.

The Board noted that the Executive Directors are currently managing 12 corporate risks, 6 of which score 20 or above and these will follow in the next report, the Board Assurance Framework.
The Associate Director of Governance confirmed that each risk has an identified lead Director.

Mr Badger, Non Executive Director, stated that the report was clearly set out and helpful although he was not comfortable with some of the mitigated scores.

The Associate Director of Governance confirmed that the risk will be reassessed and therefore the mitigated scores will not be reached until the target end date.

The Board noted the report and progress and noted the mitigating score process.

14/063.6 Board Assurance Framework (Enclosure 9)

The Associate Director of Governance presented the Board Assurance Framework given as Enclosure 9. Board members noted that the Framework focuses on the highest scoring risks. The update on assurance is in the format requested by internal audit and highlights visible gaps in assurance.

Mr Badger, Non Executive Director, raised the gaps in control and assurance and enquired whether more boxes should be completed at this point. The Associate Director of Governance confirmed that an empty box identifies a gap in assurance and there will be a corresponding action to address each gap.

The Board noted the Assurance Framework.

14/063.7 Francis Report (Enclosure 10)

The Associate Director of Governance presented the Francis report given as Enclosure 10.

The Board noted that we continue to monitor our progress against the Francis recommendations and a number of areas have been closed or cross referenced to the Keogh Action Plan. There are a few remaining areas that the Trust continues to work upon.

The Board noted the progress and open and closed actions.

14/063.8 Nurse Staffing Report (Enclosure 11)

The Deputy Director of Nursing presented the Nurse Staffing Report given as Enclosure 11.

The Board noted that a detailed paper on nurse staffing had been received by the Board the previous month.

Board members noted that the process had been educational as there had been no template available to follow.

The report shows staffing level by ward, day shift, night shift, registered nurse and un-registered nurse and also shows were staffing falls below an optimal level. On occasion there were areas that were operating unsafely and action put in place to mitigate risk.

The Chief Executive questioned whether unregistered nurses should be included in the report as the Trust had not been requested to provide this information.
The Director of Finance and Information agreed that the important detail for members of the public is whether staffing levels are safe and then are they at an optimum.

The Chairman suggested that there could be two separate reports produced, one for level of requirement and one for reassurance to member of the public.

The Deputy Nursing Director confirmed that the Trust will need to check definitions around registered and un-registered staff on the Unify system.

The Chairman pointed out that there was a typing error in the report that says “unsafe” instead of “safe”.

The Deputy Director of Nursing then received clarification that the guidance states that the Trust must identify unregistered staff in its report.

The Chief Executive confirmed that the team will relook at the reports format before it is published on the Trust website.

The Chairman also requested that the narrative of the report is carefully checked.

The Board noted the report.

Nurse staffing reports to be re-checked before publishing on the Trust website.

14/064 Finance

14/064.1 Finance and Performance Report (Enclosure 12)

Mr Badger, Non Executive Director presented the Finance and Performance report given as Enclosure 12, including the following key areas:

Finance: The Board had agreed a deficit budget of £6.7m. This had now moved to over an £8m deficit. The Finance and Performance Committee had discussed how the Trust moves back to trajectory and sought assurance on performance management and accountability and also the need to have an early start to 2015/16 planning.

Board members noted that the “buy-in” of staff is essential to the success. The Chief Executive confirmed that staff briefing sessions are continuing.

Mr Badger stated that there were clear signs of pace and grip but improvements were not being achieved quickly enough.

Performance: The Trust had failed the ED target in Q1. Board members noted that the Trust had achieved the 95% target in ED for the previous 3 weeks.

The Board noted that the Trust was hanging on to the RTT target but was 10% above the national average.

There had been a reduction in the level of appraisals as noted earlier in the meeting.

The Director of Finance and Information commented that the financial position is starting to be grasped by staff. The Chief Executive commented that at the briefing sessions there is a sense of shock at the situation.

The Chairman stated that the majority of the NHS has “hit a brick wall”. He asked what was the driver behind the reduced income. The Director of Finance and Information stated that this was down to a mix of work and seeing much higher emergency admissions and this reduces capacity to undertake planned elective work.

Mr Badger commented that a proportion of the deficit is represented by maternity. The Chief Executive confirmed that there may be some shift around the maternity tariff the following year.

The Chief Executive stated that it is important to create space for elective work.

The Director of Operations confirmed that there are some actions that can take place quickly and then a health economy piece of work needs to be undertaken around attendances and acuity to build capacity.

The Board noted the position, noted the need to increase income with elective work and noted the need to increase grip on the turn round programme.

The Director of Support Operations asked the Board to note that the Trust was currently working through the Urgent Care Centre business case.

14/65 Any Other Business

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

13/066 Date of Next Meeting

The next Board meeting will be held on Thursday, 4th September, 2014, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

PublicBoardMinutes3July2014

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 3 July 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	4/9/14	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	4/9/14	On Agenda
14/052.5	Quarterly Complaints Report	Director of Governance to look at how the Board can triangulate complaints, feedback and huddle boards and how the Board uses this data.	JC	4/9/14	On Agenda
14/063.8	Nurse Staffing Report	Nurse staffing reported to be re-checked before publishing on the Trust website.	DM	4/9/14	Done
14/063.3	Moving Patients Out of Hours	Update report including audit results and agreed metrics to be presented to the Board in the Autumn.	JS	2/10/14	
14/063.4	Safeguarding Quarterly Report	Board to revisit DNAR and the work being undertaken with the CCG later in the year.	PH	2/10/14	

Enclosure 3

The Dudley G
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 4th September 2014

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Test Performance
- Monitor Roundtable Meeting
- DNARs – Court of Appeal's decision following the Tracey Case:

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 – September 2014

Friends and Family Test Performance:
RAG ratings have been updated for Friends and Family Test scores to benchmark top 20 per cent and top 30 per cent of trusts (based on March 2014 (year end) data).

Inpatients and A&E Friends and Family Test
Preliminary data for August shows a continued drop in response rates from the high rates seen in the second half of 2013/14. Areas have been reminded of the requirements and meetings held with new lead nurses following changes in staff. Inpatient scores remain green for July and August. A&E scores have now also moved from red to green during July and August.

	Apr-14	May-14	Jun-14	Q1	Jul-14	Aug-14
	01.04.14	01.05.14	01.06.14	01.04.14	01.07.14	01.08.14
Date range	30.04.14	31.05.14	30.06.14	30.06.14	31.07.14	27.08.14
Number of eligible inpatients	1886	2023	1951	5860	2073	1696
Number of respondents	644	519	483	1646	577	420
Ward FFT score	82	86	85	84	81	81.6
Ward footfall	34%	26%	25%	28%	28%	25%
Number of eligible A&E patients	4258	*4605*	4679	13542	4843	3859
Number of respondents	686	*614*	1159	2459	1712	1696
A&E FFT Score	64	53	57	57	70	69
A&E footfall	16%	13%	25%	18%	35%	19%
TRUST FFT Score (A&E/Inpatient)	73	68	66	68	73	73.6
TRUST footfall	22%	17%	25%	21%	33%	21%

Inpatient FFT Score	82+	A&E FFT Score	68+	FFT Scores key	Top 20% of Trusts (based on March 14 scores)
	79-81		65-67		Top 30% of Trusts (based on March 14 scores)
	<79		<65		Below top 30% of Trusts (based on March 14 scores)
Response rate:					
Response rate A&E	<15%	15-20%	20%+		
Response rate Inpatients	<25%	25-30%	30-40% +	40%+ *	

Maternity Friends and Family Test
Preliminary August data shows some pleasing scores but still fluctuating response rates. Managers have discussed this with leads and have been provided with a breakdown of individual areas.

		Apr-14	May-14	Jun-14	Jul-14	01/08/14 - 26/08/14
Maternity - Antenatal	Score	64	80	78	79	68
	Response rate	14%	18%	13%	21%	22%
Maternity - Birth	Score	62	85	83	90	94
	Response rate	44%	33%	34%	30%	28%
Maternity - Postnatal ward	Score	57	85	79	87	94
	Response rate	43%	31%	32%	29%	28%
Maternity - Postnatal community	Score	86	90	85	85	81
	Response rate	16%	9%	15%	13%	14%
Combined	Score	63	85	81	86	88
	Response rate	32%	24%	25%	24%	24%
% of footfall (response rate)		<15%	15%+			
Antenatal		80+	76-79	<76		FFT
Birth		89+	86-88	<86		Scores
Postnatal ward		81+	75-81	<75		key
Postnatal community		90+	84-89	<84		

Top 20% of Trusts (based on March 14 scores)
Top 30% of Trusts (based on March 14 scores)
Below top 30% of Trusts (based on March 14 scores)

NB: August data is preliminary only (as at 26.08.14) and will change as additional entries and validation are still to take place.

Monitor Roundtable Meeting:
A meeting was held by Monitor with the Trust, CCG and Local Area Team to discuss the Trust's financial situation and Five Year Plan. As our Regulator, Monitor wanted to ensure that all partners were fully conversant with the two year plan and the the fact that the Trust was planning a deficit in the first year as part of the turn round actions.

DNARs – Court of Appeal's decision following the Tracey Case:
The Court of Appeal's decision requires practitioners involved in end of life care to ensure that the appropriate people are consulted, detailed records are kept and that organisational policies comply with the law.

Key points for providers:

- Appropriate training of staff is key to ensure that they understand that the decision to withhold CPR is a clinical decision and this should be communicated to patient (and their relatives if they lack capacity). This will allow a patient/their family to seek a second opinion.
- Consideration needs to be given to training doctors to have these conversations.
- Earlier consultant involvement is likely to be required
- Not consulting will only be appropriate in the exceptional circumstance where a clinician feels that to do so will cause physical or psychological harm. It should be recognised however, that, while these discussions can be stressful, merely causing distress is not enough to exclude a patient from the process. A team discussion should take place first where this may be a concern.
- Where a patient lacks capacity, providers are obliged to consult with the patient and those involved in their care about the decision (subject to confidentiality).
- Properly recording a note of the discussion is imperative. As with any clinical decision, doing so will assist if the decision later comes into question. A note of the discussion should include a record of the discussion in relation to:
  - What CPR is and what it is expected to achieve.
  - What a DNACPR is and what happens if CPR is not provided.
  - The views of the treating team, patient and, as appropriate, their family.
  - What information was provided to the patient in written form.

- The outcome of the discussion and any further action points.

- Handovers between shifts are of critical importance. Communication with the treating team and the patient are key.
- Communication between primary and acute care providers may be important. For some patients, the issue of a DNACPR might be raised at an initial stage with their GP. If an issue is raised before CPR might be called into question, this can enable informed discussions before acute assistance is required. It may also provide the opportunity for a patient to make their wishes regarding treatment clear, draft an Advance Decision or create a Health and Welfare Lasting Power of Attorney (LPA).
- Providers must be alert to the existence of Advance Decisions. Where a patient has lost capacity, a valid and applicable Advance Decision will stand, unless it can be shown that the patient has withdrawn it, acted inconsistently with it or appointed a health and welfare LPA afterwards. An attorney can only consent to or refuse life-sustaining treatment on behalf of the donor (the patient in question who has been assessed as lacking capacity) if, when making the LPA, the donor has specifically stated in the LPA document that they want the attorney to have this authority. As with all decisions, an attorney must act in the donor's best interests when making decisions about such treatment. The attorney must not be motivated by a desire to bring about the patient's death. If you have doubts about whether the attorney is acting in the donor's best interests, seek legal advice.
- Providers should ensure that their policies and written information are both available and directed at patients and their families, as well as to staff.
- There is no obligation to offer to arrange a second opinion where the whole Multi Disciplinary Team are of the view that a DNAR notice is appropriate.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors September 2014 - PUBLIC

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

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:

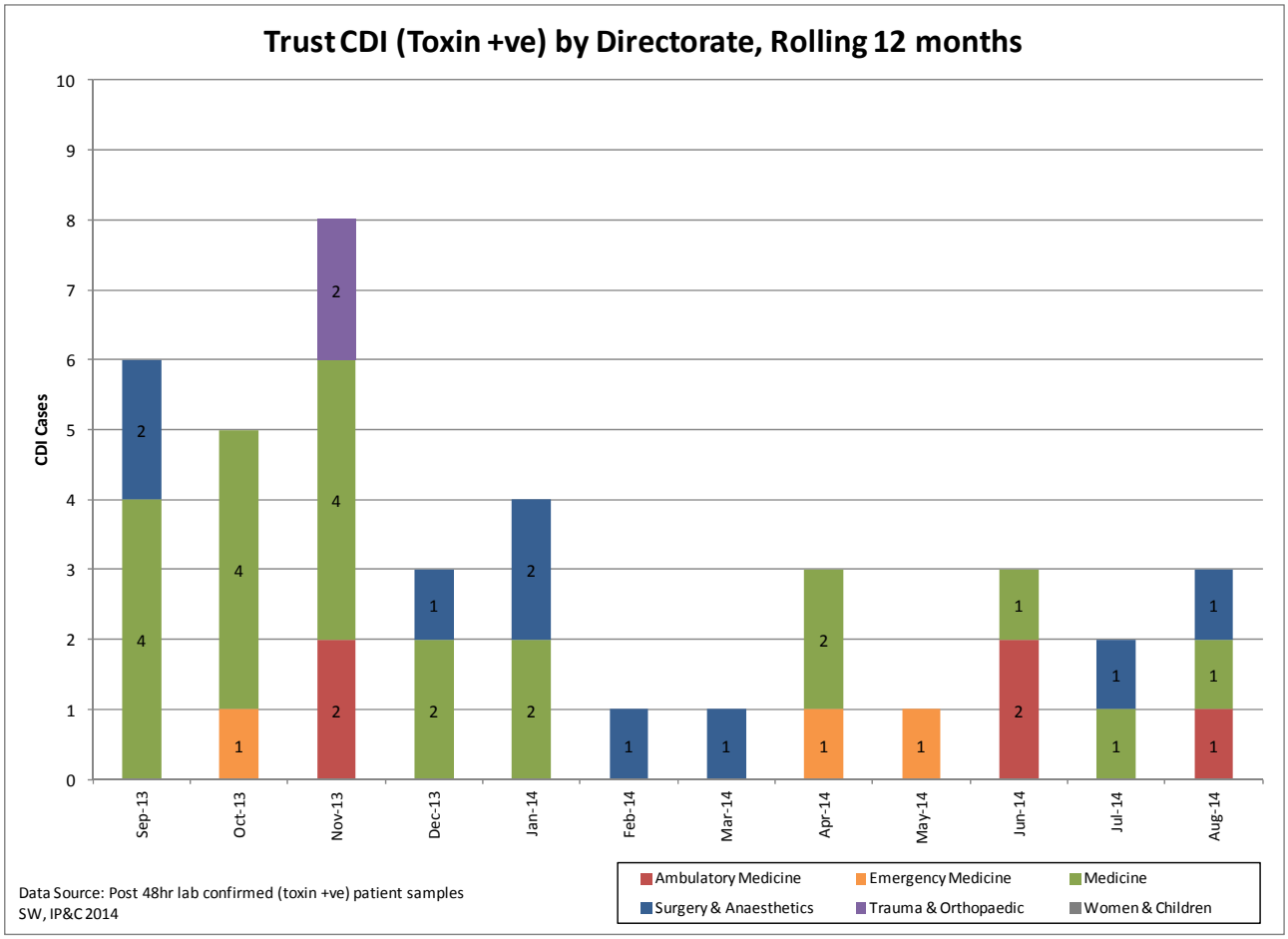
Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

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 (18/08/2014) we have 3 post 48 hour cases recorded in August 2014 against a trajectory for the month of 3 cases.



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

CPE – A draft action plan is in place. The key actions are to commence with developing a screening programme for high risk clinical areas (oncology and renal), to commence a training programme of awareness and clinical skills for staff in relation to screening for CPE infections and to update the antimicrobial prescribing guidelines to include specific advice for patients with CPE.

Norovirus – There are no wards currently affected.

Ebola – There has recently been a significant number of cases of Ebola virus in Africa. As a result, with the potential risk of cases being imported into the UK, Public Health England (PHE) has issued advice to Trusts around identification and management of suspected cases. The Trust has modified the PHE diagnostic algorithm to ensure that cases presenting to DGFT would be identified and appropriate management instituted. We have also confirmed that we have supplies of appropriate Personal Protective Equipment (PPE) in the Trust to enable staff to meet the infection control requirements advised. We are also instituting further training to extend the number of staff who are available to face fit test front line staff to ensure that they can use face masks required for safe handling of suspected cases.

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 Group NHS Foundation Trust

Paper for submission to the Board on 4th September 2014

TITLE:	**Workforce and Staff Engagement Committee**		
AUTHOR:	**Annette Reeves Associate Director of HR**	**PRESENTER**	**Ann Becke Non Executive Director**

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Whistle Blowing Annual Summary
A total of 6 whistle blowing allegations have been received for the financial year 2013/14. Appropriate action has been taken in all cases which is in accordance with the Trust Whistle blowing policy. The numbers of cases is reported to the board throughout the year to the Finance and Performance committee (Workforce and Staff Engagement Committee will receive this information going forward)

Employment Tribunal Annual Summary
A total of 11 employment tribunal cases have been received in the financial year 2013/14.this breaks down as follows

- 4 have been withdrawn
- 2 successfully defended
- 1 negotiated settlement
- 4 ongoing cases

The reason for the claims are as follows

- 8 unfair dismissal
- 1 age discrimination
- 1 race discrimination
- 1 injury to feelings

The cost of defending these cases for the financial year is £138,000

Workforce KPI's

- Absence for April is 3.66% against the target of 3.5%
- Turnover is static at 7.92%
- Mandatory Training has remaining level at 77.9% this is still the highest figure the Trust has seen
- Appraisals have dropped this month and are reported at 73.1% reviews with the management teams are continuing to take place with the committee.
- Pre employment checks from the central recruitment team and medical workforce is 100% and for the Bank 89%
- Professional Registration is 100%
- Vacancies are 268.03
- Employee relations cases are 59
- Employment Tribunal cases 4

Sickness Audit
This audit is carried out twice a year. 35 files have been reviewed and the results compared to the last audit in 2013, the committee discussed the importance of using the correct paperwork as the audited has shown that this is still an issue in the Trust. A further audit will take place in September.

Appraisal Audit
A random sample of 100 files has been audited following the same methodology in the January 2014 audit. The findings have shown that we are making progress toward the full implementation of the new appraisal policy which was launched in October 2013.

Pre Employment Checks Audit
This audit was conducted to review the Baker Tilly audit recommendations that the pre employment checks for Bank works was moved to the central recruitment team to ensure consistency of implementation and give assurance to the board that the full checks had taken place. The audit has proved that this change has been successful and the committee recommended that this change be confirmed on a permanent basis. We are now looking to moving all Medical pre employment check to the central recruitment team to create on central team of experts to complete theses checks

Turnover Target
The Committee agreed to changes to the way we monitor Turnover. Firstly we will be changing the target for turnover from 11%, which was a historic target, to 9% which reflects last year's actual figure. This will then be used as an indicator for areas which are may be showing signs of employment problems. We will also be monitoring 4 area's which have previously had either high turnover or difficult to recruit into area's. These are

- Staff nurses
- Operating Department Practitioners
- Emergency Department
- Elderly Care

The committee will receive a report on these areas at the October 2014 meeting.

JNC Minutes 29th May 2014
Negotiations are continuing to increase the notice period for band 5 and 6 agenda for change contract.
The lease car policy has been agreed by the JNC, which included a salary sacrifice option
The car park group will meet in the summer with implementation of the changes in the autumn of 2014

Local Education and Training Group Minutes 24th April 2014
There are a number of concerns from the Emergency Department Quality Assurance visit. An immediate and long term action plan has been created which includes increasing the nursing cover in the Emergency Department. The inspection team requires Resus to be staffed at all times and not just when required.
A further visit will take place in the Autumn

Diversity Management Group 13th May 2014
The Annual Report has shown good progress against the Trust equality objectives for the second year in a row. The objectives and the Single Equality Scheme are due for renewal next year.
The Committee noted the Trust Membership report had no issues however we will be adding the collation of Disability statistics from the next re-print of membership forms.
The Trust Equality and Diversity Training is at 88.4% with no concerns.

Policy Group Recommendations
The Committee ratified the following

- Security Officer Assistance Guideline
- Medical Staff Appraisal Policy
- Pre-employment checks Policy
- Standard Operating Procedure for the usage of locum medical staff

Annual Workforce Plan
The primary purpose of the 'Annual Workforce Plan' is to influence educational commissioning. The Committee discussed the changing model of providing care closer to home and that the question had been asked about whether the Trusts plan reflected the health economies ambition to provide lower acute nursing needs and higher Community requirement. The committee noted that this would mean transferring skills and having to adapt the workforce to a community setting.

Women's and Children's Workforce KPI Recovery Plan
The Committee discussed the Recovery Plan and it's long term processes.

Taking the Committee forward
The Committee discussed that the previous 2 Agenda's have focused on operational matters and as we meet 6 times a year, it was suggested that the Committee discusses operational issues at 4 of the meetings and 2 of the meetings could focus on strategic workforce issues, discussing a medium/long term impact on employees. This proposal was welcomed by the members of the committee and therefore the august meeting will focus on a strategic agenda.

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

To receive the report

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

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 4th September 2014

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

CORPORATE OBJECTIVE:

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

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

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

SUMMARY OF KEY ISSUES:

As outlined in the detailed paper submitted to the Board last month, one of the requirements set out in the National Quality Board Report 'How to ensure the right people, with the right skills, are in the right place at the right time' and the Government's commitments set out in 'Hard Truths', is the need for the Board to receive monthly updates on staffing information. The attached paper provides that information for June and July 2014.

There is no set template for this information and so the intention behind the format of the attached has been to make potentially complex information as clear and easily understandable as possible. As this is a new requirement, the format will evolve as time progresses and is different to that provided for May 2014.

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

When shortfalls occurred the reasons for gaps and the actions being taken to address these are outlined and an assessment of any impact on key quality indicators has been undertaken. The attached graph indicates the monthly fall in the number of overall shifts when the actual was below the planned for both registered (RN) and unregistered (UN) staff.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

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

THE DUDLEY GROUP NHS FOUNDATION TRUST

Monthly Nurse/Midwife Staffing Position

June and July 2014

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

Following the first two reports, the attached charts have a slightly amended format. As previously indicated the information on the charts is likely to evolve initially, hopefully making complex information clearer and more easily understandable, especially in the light that this information is shared with the general public.

The charts indicate for the months of June and July 2014 when day and night shifts on all wards were and were not staffed to the planned levels for both registered and unregistered staff, with the day shift registered figures also taking into consideration the 1:8 nurse to patient ratio for general wards.

It can be seen from the chart (green) that the planned staffing levels were attained in the majority of cases. In a number of instances, despite attempts through the use of deployment of staff or the use of bank/agency staff, the number of planned staff for the patients on that shift were not reached.

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

When shortfalls have occurred the reasons for the gaps and the actions being taken to address these in the future are outlined below.

An attached graph indicates the monthly total number of shifts when the actual was below the planned for both registered (RN) and unregistered (UN) staff. A downward trend can be seen for both groups of staff.

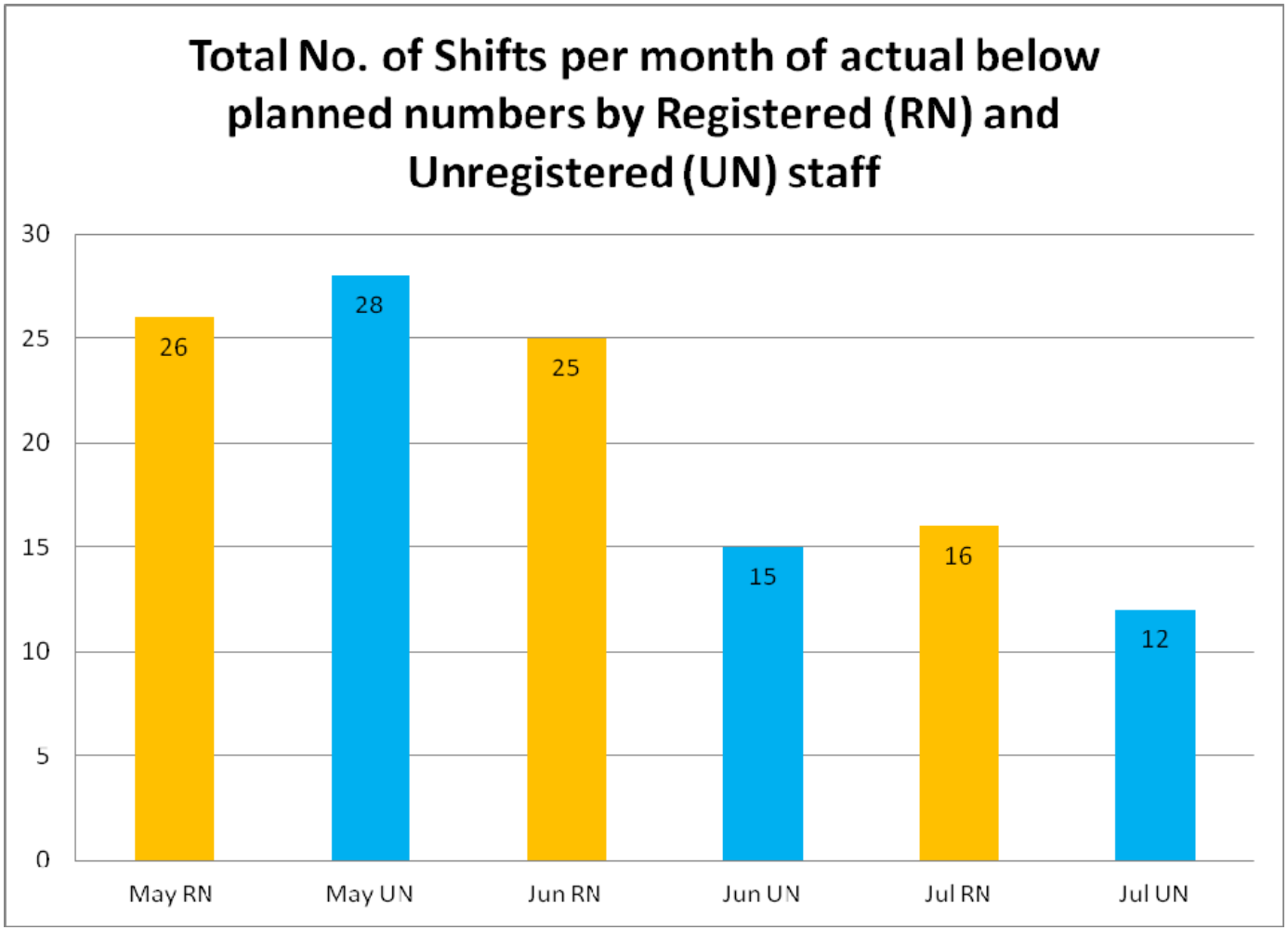
An assessment of any impact on key quality indicators has been undertaken. From as far as possible as it is to ascertain, these shortfalls have not affected the results of any of the nursing care indicator measures or other quality measures such as the number of infections. In addition, there is no evidence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

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS JUNE 2014

WARD	OCCASIONS	REG/ UNREG	REASONS FOR SHORTFALLS IN STAFFING	MITIGATING ACTIONS
B1	4 4	RN UNREG	Short term sickness and vacancy.	Bank unable to fill. On one occasion booked agency nurse cancelled. Liaised with other areas contacted for support and Site Coordinator/Matron contacted. Recruitment to vacancy on-going. Less than planned but assessed as safe with patients on the ward.
B3	1	UNREG	Short term sickness.	Bank unable to fill. Liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward.
B4	5 6	RN UNREG	Vacancy, short and long term sickness.	Bank unable to fill. On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted. Recruitment to vacancy on-going. Less than planned but assessed as safe with patients on the ward.
B6	2	RN	Sickness	Bank staff booked but did not attend. Closed ward to admissions on both nights Liaised with bank regarding the specific bank staff. Less than planned but assessed as safe with patients on the ward.
C1	2 1	RN UNREG	Sickness.	Bank unregistered staff member cancelled shift at short notice and bank unable to fill. On one occasion specialling unregistered staff member assisted with other patients. Liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward.
C6	1 3	RN UNREG	Sickness and on one occasion ward did not book bank in error.	Bank unable to fill. Booked agency nurse did not arrive on one occasion. On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward.
C7	11	RN	Vacancies and sickness	Bank and agency unable to fill. On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward. Recruitment to vacancies on-going with interviews for two Band 6 posts taking place in September (at shortlisting stage) and two Band 5 new graduates allocated for September.

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS JULY 2014

WARD	OCCASIONS	REG/ UNREG	REASONS FOR SHORTFALLS IN STAFFING	MITIGATING ACTIONS
A3	1	UNREG	Sickness	Bank staff booked but unable to fill. Liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward
A4	2	UNREG	Short and Long Term Sickness	Bank staff booked on both occasions but unfortunately staff member cancelled. Liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward.
B2 T	1 3	RN UNREG	Sickness and vacancy	Liaised with other areas contacted for support and Site Coordinator/Matron contacted and an Unreg available when RN short. Recruitment to vacancy on-going. Less than planned but assessed as safe with patients on the ward.
B5	1	UNREG	Sickness	Liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward.
B6	2	UNREG	Sickness and vacancy	Liaised with other areas contacted for support and Site Coordinator/Matron contacted. On one occasion booked agency nurse did not turn up. Recruitment to vacancy on-going. Less than planned but assessed as safe with patients on the ward.
C1	5 1	RN UNREG	Sickness and vacancy	Bank and agency unable to fill. On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward. Recruitment to vacancy on-going.
C6	1	RN	Sickness	Agency nurse booked did not turn up then liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward.
C7	9 2	RN UNREG	Vacancy and sickness	Bank and agency unable to fill. On all occasions liaised with other areas contacted for support and Site Coordinator/Matron contacted. Less than planned but assessed as safe with patients on the ward. Recruitment to vacancies on-going with interviews for two Band 6 posts taking place in September (at shortlisting stage) and two Band 5 new graduates allocated for September.


Total No. of Shifts per month of actual below planned numbers by Registered (RN) and Unregistered (UN) staff
30
25
20
15
10
5
0
26
28
25
15
16
12
May RN
May UN
Jun RN
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Jul RN
Jul UN

Jun-14		SHIFT																																																												
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WARD	STAFF	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
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Key — Red: Unsafe staffing; Amber: Registered nurse shortfall; Blue: Care Support Worker shortfall

* Critical Care has 6 ITU beds and 8 HDU beds

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

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

**** Midwifery registered staffing levels are assessed as the midwife: birth ratio and is compliant with the 'Birthrate +' staffing assessment

Jul-14

SHIFT

		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16	
WARD	STAFF	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
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WARD C8	Reg																																
WARD C8	Unreg																																
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WARD C7	Unreg							5/4																							
WARD C8	Reg																														
WARD C8	Unreg																														
CCU	Reg																														
CCU	Unreg																														
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NEONATAL	Reg																														
MATERNITY ****	Reg																														
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Key: Unsafe staffing (red) — Registered nurse shortfall (amber) — Care Support Worker shortfall (blue)

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**** Midwifery registered staffing levels are assessed as the midwife: birth ratio and is compliant with the 'Birthrate +' staffing assessment

The Dudl
NHS Foundation Trust

Enclosure 7

Paper for submission to the Board on 4th September 2014

TITLE:	Quarterly Complaints & Claims report - Q1, April to June 2014		
AUTHOR:	Maria Smith Customer Service & Claims Manager	**PRESENTER:**	Julie Cotterill Associate Director of Governance/Board Secretary

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

SUMMARY OF KEY ISSUES:

Customer Service and Claims report for quarter ending 30 June 2014.

- Total complaints received during the quarter were 16% **less** than the previous quarter ending 31 March 2014
- **100%** of complaints received were acknowledged within 3 working days
- **80%** of complaints received and closed during the quarter were answered within 30 working days (the Trusts internal working target)
- **50%** of complaints received and answered during the quarter were upheld/partially upheld.
- **5** of complainants expressed dissatisfaction with their response
- **14** Complainants met with senior staff to discuss concerns prior to or following the investigation into concerns raised
- **1** Rule 28 (formerly rule 43) - report on 'Action to Prevent Future Deaths' was received from the Assistant Coroner
- **No** adverse Inquest conclusions were reached by the Coroner in the period

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 3 complaints accepted for investigation by Ombudsman during the quarter

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			x

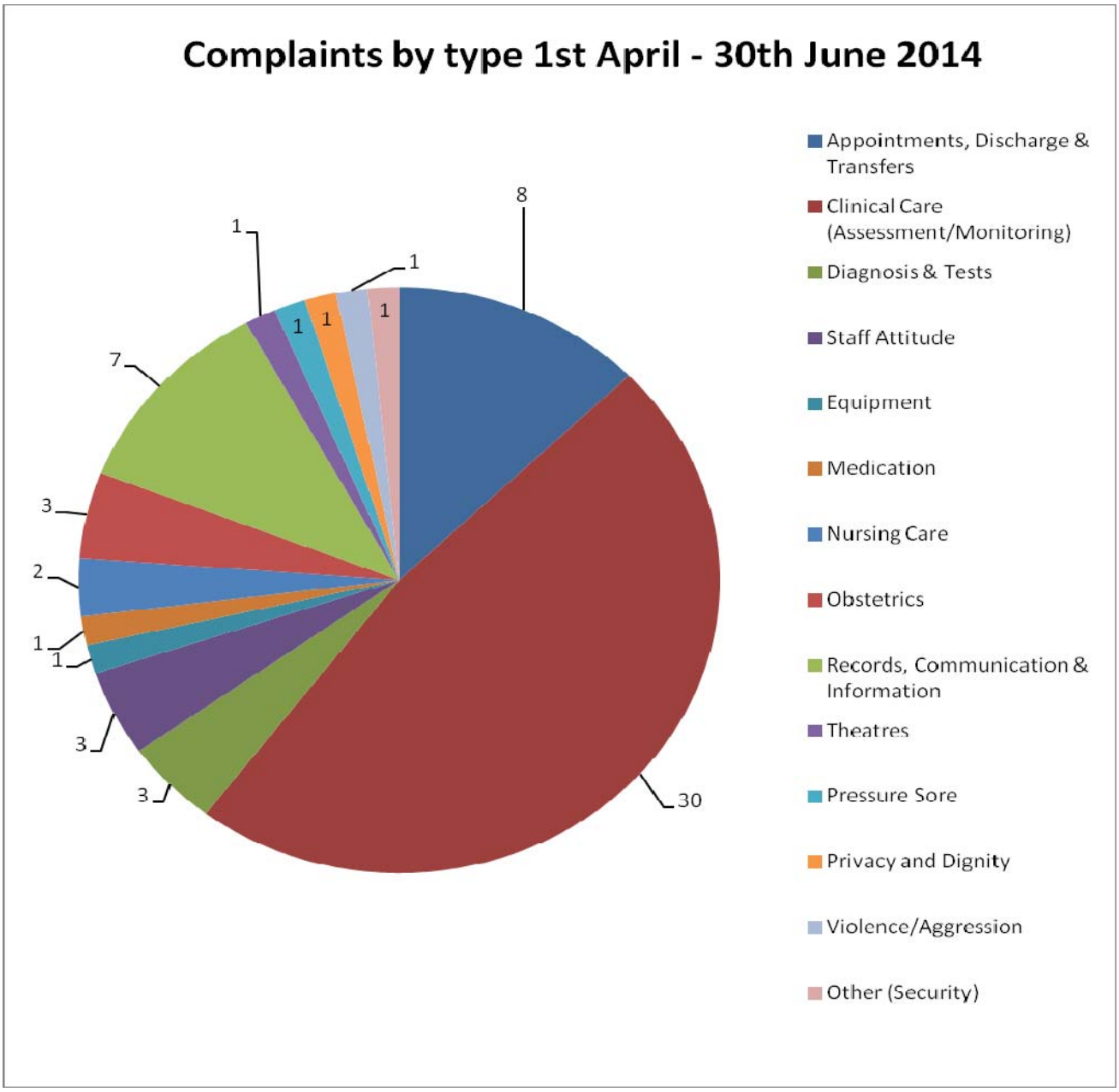
RECOMMENDATIONS:
To receive the customer care manager's quarterly report and note the position relating to the number of complaints received.

Key Facts – complaints, claims & inquests

Key facts	Qtr 4 ending 31 March 2014	Year ending 31 Mar 2014	Qtr 1 ending 30 June 2014
Total number of complaints received -	**72** 7 - high 43 - mod 22 - low	**330** 17 - high 190 - mod 123 - low	**63** 2 - high 34 - mod 27 - low
% Complaints acknowledged within 3 working days	100%	99%	100%
% Complaints answered within 30 working days (internal target only)	46%	46% (data coll comm'd in 4th qtr)	80%
Number of upheld/partially upheld complaints received & closed during quarter	**64 (60%)**	**252 (66%)**	**20 (50%)**
Complaints accepted for investigation by Ombudsman	2	5 (2 upheld and compensation paid)	3
Privacy/dignity included as a concern in complaint	1	2	1
Complaints referring to shared accommodation	0	0	0
Number of meetings held with complainants	20	87 (26% of complaints rec'd)	14
Total number of dissatisfied complaints received	14	51 (15% of complaints rec'd)	5
Total number of CCG/CSU led complaints received in quarter	1	6	2
New Claims (CNST & Personal injury) opened in quarter	20	63	15
Personal injury/Public liability claims closed/settled in quarter	3 (nil damages paid)	12 (Damages paid = £19,790)	3 (damages paid = £14,022)
Clinical negligence claims closed/settled in quarter	15 (Total damages paid = £423,603)	40 (Total damages paid = £963,853)	12 (total damages paid = £2,833,803
New Coroner's cases opened	3	25	2
Coroner's Inquests held/closed	6	13	5
Coroner's Rule 28 (was rule 43) received in quarter	0	0	1
Complaints received where safeguarding concern raised	1	0	0
Compliments and thanks received (incl on-line feedback)	**1129**	**2108**	**1746**

Complaints by category and theme

Category	Qtr 3 ending 31/12/13	Qtr 4 ending 31/03/14	Year ending 31/03/14	Qtr 1 Ending 30/06/14
Clinical Care (Assessment/Monitoring)	24 (29%)	22 (31%)	93 (28%)	30 (47%)
Diagnosis & Tests	18 (21%)	19 (26%)	76 (23%)	3 (4%)
Records, Communication & Information	15 (18%)	13 (18%)	53 (16%)	7 (11%)
Appointments, discharge & Transfers	8 (9%)	8 (11%)	53 (16%)	8 (13%)
Staff attitude (previously included in Records, communication & information	(see above)	(see above)	(see above)	3 (4%)
Obstetrics	7 (9%)	2 (3%)	17 (5%)	3 (4%)
Nursing care (incl District Nurses)	0	0	0	2 (3%)
Medication	5 (6%)	2 (3%)	15 (4%)	1 (2%)
Patient Falls, Injuries or Accidents	5 (6%)	2 (3%)	15 (4%)	0
Equipment	2 (2%)	2 (3%)	5 (1%)	1 (2%)
Safeguarding	0	1 (1%)	1 (1%)	0
Theatres	0	0	1 (1%)	1 (2%)
Privacy & dignity	0	0		1 (2%)
Pressure Sore	0	1 (1%)	1 (1%)	1 (2%)
Violence, aggression	0	0		1 (2%)
Other (security)	0	0		1 (2%)
Total:	**84** (100%)	**72** (100%)	**330** (100%)	**63** (100%)



At the end of the third quarter in 2013, complaint coding was reviewed to reflect more accurately the main complaint issues/concerns raised by complainants.

The reduction in complaints (15% less during this quarter than in quarter 4) is pleasing and reflects the increased presence by matrons and lead nurses on the wards, when issues and concerns can be raised and resolved very quickly, without recourse to a formal complaint. Notwithstanding this, many complaints received can be extremely complex and may involve a number of areas, requiring an extensive investigation and/or meetings to be undertaken prior to preparing a letter of response.

The Trust is committed to learning from complaints and is reviewing the learning opportunities from these and adverse events.

The internal complaints review group is now established and three meetings have been held. Members receive and review complaints to ensure learning is shared across the Trust and selected senior staff are invited to explain actions taken following complaints received

Percentage of complaints against activity

ACTIVITY	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 Qtr 1 ending 30/6/14
Total patient activity	185,113	181,539	186,084	181,503	734,239	181,132
% Complaints against activity	0.05%	0.04%	0.04%	0.04%	0.04%	0.03%

Coroner – Rule 28 report to prevent future deaths

Following an inquest held in March 2014, the Assistant Coroner wrote to the Trust to raise concerns about a patient's emergency department attendance in April 2013. On the first attendance, a one degree rise in temperature after Paracetamol had been administered was not reported to medical staff. On the second attendance there was a delay following arrival in the emergency department until the first assessment by a medically qualified member of staff.

Response

- A written guideline will be developed to include routine checking of INR for all patients presenting after a fall who are receiving vitamin-K antagonist anticoagulants, such as Warfarin.

- The emergency department will continue to monitor vital signs within nationally recognised guidelines, and a prompt has been incorporated in the clinical electronic information system to indicate the need to communicate abnormal observations to senior staff. Regular board rounds are now in place to ensure that each patient is discussed regularly with senior medical staff.

- The emergency department will develop an audit process to review the appropriate referral of patients for consultant review when presenting to the emergency department. Additionally, the electronic clinical information system used by the emergency department will be reconfigured to create a visible alert to the consultant in charge, when a patient's vital signs fall outside normal parameters.

- All the above actions will facilitate a reduction in the delay highlighted.

Review of Actions

The lead nurse and consultant in the emergency department will be responsible for ensuring actions/changes are implemented. The first three actions will be carried out within two months and the fourth within four months.

Complaints upheld by Ombudsman

In this quarter three complaints were upheld by the Ombudsman:

Complainant A - Admission in July 2013 – complaint raised regarding delay in prescribing pain relief

The Ombudsman upheld the complaint

The Trust acknowledged and apologised for the delay in providing pain relief and for the distress this caused the complainant. It was acknowledged that the treatment chart was not written up in a timely manner, which in turn led to the delay. Matron and the lead nurse discussed the circumstances leading to the complaint and reminded staff of the escalation policy and the need to adhere to this at all times.

During the Ombudsman's investigation it was found that the complaint response contained some incorrect information, when reference was made to an earlier admission. The Trust acknowledged this error and offered apologies to the complainant. It was confirmed that all complaint responses are now double checked against base documents, including health records, clinical results etc.

Complainant B – Admission in May 2012 - complaint regarding service failures/shortfalls in care

Ombudsman upheld the complaint

The Trust acknowledged and apologised to the complainant and outlined changes made since 2012 which included:

- reduction in size of the 70 bedded ward
- daily assessment of elderly patients
- MDT meetings
- Daily ward meetings
- Arrangements made for twice daily delivery of medical records
- Improved communication – lead nurse spending more time speaking and listening to each patient and, where possible, including carers/relatives
- Huddle boards introduced, containing photographs and details of ward staff, results of surveys, audits, etc.
- Matron/lead nurse meetings twice daily to discuss any unresolved issues or to escalate concerns
- Older people mental health team established and dedicated nurse now available on each ward with specific role to assess patients within 72 hours of admission and to refer them to be team for in-depth assessment when issues are identified
- Ward has specific discharge facilitator who liaises with social services and ward manager

Complainant C – admission in March 2010 - complaint received regarding care and treatment

Ombudsman upheld complaint and asked the Trust to pay compensation to the complainant

The service failure in respect of the care and treatment provided was acknowledged and the following actions were taken as a result of the complaint –

- Nursing care indicators introduced in late 2010, including audit of patient observations, nutrition, pain, tissue viability, medication, bowel care and fluid balance
- Pressure ulcer bundle introduced in February 2011, for the prevention and management of pressure ulcers, including education, training audits on tissue viability
- Falls bundle, introduced in September 2013, for the prevention and management of falls including daily risk assessment of every patient, and weekly audits
- Improved care bundle documentation including increased patient involvement in care plans
- Monitoring of patient fluid and food intake through monthly audits
- Regular audits of staffing levels & reduction in number of agency staff used by the Trust
- Patient experience surveys, national (friends and family) and local survey
- Information booklets introduced and provided to all patients
- Increased matron/lead nurse rounds to check cleanliness, uniforms, communication, health & safety, infection control and to speak with patients/relatives or carers present.

Action taken as a result of complaints

Community Services

- Complaint raised regarding breach of patient confidentiality and rude attitude displayed by member of staff

  Staff attended equality and diversity training and internal customer care courses
  Client satisfaction surveys to be undertaken annually
  Service comment forms on display in reception for clients to complete

Emergency Medicine

- Complaint about the treatment a relative received when attending department after suffering a suspected stroke

  Complainant's comments regarding communication shared with staff and staff reminded of need to assess individual patients' needs

Specialty Medicine

- Patient questioned whether stopping medication, as requested by doctor, would cause any damage

  Member of staff will reflect and learn from complaint

- Deceased patient's relative raised concerns regarding her care and treatment for liver cancer.

  Patients with rapid access clinic appointments now receive a telephone call as well as a letter to confirm receipt of appointment

  Staff reminded of importance of maintaining a courteous and helpful manner on telephone.

  Patients now provided with a comfort pack, blankets and pillows following admission from the day assessment unit.

Surgery & Anaesthetics

- Complaint that anaesthetic had 'worn off' by the time surgery commenced

  Staff will ensure patients understand the purpose of anaesthetic cream

- After waiting nine hours in day case, patient was informed there was no bed available for post-operative care and surgery was cancelled.

  Senior staff to review the way in which patients are called for surgery, to minimise delays

- Delay in reporting results of scan

  Consultant reviewed results. Secretary contacted next of kin to report results and offer apology for delay

- Patient felt let down by the care and treatment received.

  Clinical care conducted appropriately, however action has been taken re: communication. Triage staff have been reminded to relay the appropriate follow up information to patients. Posters put up in ophthalmology reiterating importance of telephoning department if symptoms persist.

Trauma, Orthopaedics & Plastics

- Patient's outpatient appointment was delayed by 1 hour 5 minutes**.**

  New team leader appointed with focus on waiting times and communication with patients to see if patient experience can be improved

Diagnostics

- Patient complained about the way she was treated when she underwent a scan.

  Independent investigation being carried out.

Women & Children (Maternity & Gynaecology)

- Patient unhappy with some care received prior to and following birth of her daughter

  Midwifery staff will ensure all relevant helpful leaflets are containing in booking packs.

- Concerns raised following baby's still birth

  Staff to be informed that post-natal appointments with consultant will be at three months

  Bereavement study day to be set up, including input from chaplaincy

- Delay in diagnosing tongue tie and no scan performed for PV bleed

  All women seen postnatally to be given results of investigations and diagnosis

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

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 4th September 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 22nd July 2014 and considered progress reports from:

- Internal Audit
- Local Counter Fraud Specialist (LCFS)
- Clinical Audit
- Risk and Assurance Committee
- Caldicott and Information Governance Group
- Research and Development Directorate

In addition, the Committee reviewed the Charitable Funds Annual Report and Accounts for the year ended March 2014; the Annual Report of the Audit Committee; and the Terms of Reference for the Audit Leads Group.

A summary of key issues discussed and items referred to the Trust Board is shown below.

Progress Report from Internal Audit

Since the last Committee meeting 5 final Internal Audit reports have been issued, with a further 17 reviews in progress or scheduled to be completed by October. Of the 5 final reports, 1 received a **GREEN** rating, with 2 reports advisory only and 2 follow up reports.

The **GREEN** opinion related to the Governance Arrangements for the Programme Fusion Board. The advisory reports covered the Ordering, Recording, Storage, Use and Payment of Pain Management Implants; and Additional Observations Made as Part of the Follow Up of Patient Money and Property Recommendations. Together, these reports contained 1 high priority, 2 medium priority and 6 non-categorised recommendations. The high priority recommendation relates to ward staff completing Custody of Patient Property User Guidance on the date of admission, rather than on discharge as had been found to be occurring on one of the wards visited.

The follow up reports relate to Doctor Revalidation, which found good progress; and to Validation of Reported Closed High and Medium Priority and Non Categorised Recommendations which proposed 3 recommendations be reopened on the tracking system as these have not been fully actioned.

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

Other Progress Reports

As a consequence of internal changes at Baker Tilly, Ian Kennedy had taken on the role of LCFS previously carried out by Gavin Ball. Progress on proactive LCFS work was in line with plan, while 3 investigations had been undertaken since the previous Audit Committee meeting. Of these, 2 had been closed with no action necessary, while one relating to an agency worker submitting timesheets for shifts not worked had not resulted in any loss to the Trust but had led to the agency being informed that the individual concerned would not be used by the Trust in future. The Trust will also investigate the use of signature stamps for timesheets, to reduce the potential for signatures to be copied.

Clinical Audit proposed a further 27 audits to be included in the 2014/15 annual plan and these were agreed. Of 19 audits brought forward from 2013/14, only 3 have been completed to date, so a prime area of focus for audit leads is to expedite completion of the other brought forward audits. Following notification from the Healthcare Quality Improvement Partnership (HQIP), 3 national clinical audits have been removed from the plan – National UK Parkinson's Audit, National Paediatric Pneumonia Audit and National Bronchiectasis Audit – as these audits will no longer be collecting data in 2014/15. The Audit Committee also reviewed and agreed Terms of Reference for the Audit Leads Group.

Membership of the Risk and Assurance Group is now comprised of Executive Directors only, with regular updates provided to the Audit Committee. The Corporate and Divisional Risk Registers have been discussed in detail and all Directors asked to re-assess risks focussing on gaps in control and the robustness of mitigating actions. This review process will help to inform and to target the Internal Audit annual workplan.

Disappointingly, the Caldicott and Information Governance (IG) progress report showed that compliance with mandatory IG training has fallen to 79.7%, below the required 80%. The lowest compliance levels were for Emergency Medicine (64.6%), Diagnostics (72.3%) and Specialist Medicine (74.6%). There had also been 2 instances of IG breaches, both involving patient notes being given to the wrong patient. The reviews of both breaches identified that they had arisen due to individual failures to properly follow procedures, rather than any systemic problems.

The Research & Development progress update is intended to report to the Audit Committee the number of research studies undertaken and also advise the Committee of any serious adverse events that occurred to patients enrolled in research studies. Since January 2014, there have been 19 site specific reviews (i.e. where Dudley Group is the host organisation) and a further 7 full scientific reviews. There had been 7 serious incidents reported that could potentially be linked to the research trials and these have been reported to the chief clinician overseeing the trial for review and escalation as necessary. To date in 2014 there have been 1,016 patients recruited to take part across 71 studies.

External Audit Update Report

Deloitte confirmed that both the Trust Annual Report and Trust Accounts for 2013/14 had been submitted in accordance with Monitor's deadlines, also that the audit of the subsidiary company Dudley Clinical Services Limited had been completed and an unmodified (i.e. clean) audit opinion issued.

The audit of the Charitable Funds had largely been completed and subject to receiving the Representation letter, Deloitte anticipated issuing an unmodified audit opinion.

The Audit Committee considered the Annual Report, Accounts and Representation letter for Charitable Funds and agreed to approval them all under delegated authority from Trustees. The Audit Committee also noted that the Charitable Fund had achieved its objective of expenditure for the year exceeding income, with expenditure of £0.858 million and income of £0.718 million.

As part of the early planning considerations for the 2014/15 audit, Deloitte had also undertaken an assessment of the Dudley Group performance for 2013/14 and of the Annual Plan submitted to Monitor, the comparator group being all 147 Foundation Trusts.

	No	Revenue (£'000)	EBITDA %	LY EBITDA %
Dudley Group FT		313	7.3%	8.0%
All FT Acute Trusts	83	358	4.9%	5.8%
All FT Trusts	147	284	5.2%	6.0%

Deloitte noted that although most FTs remained in surplus, there were 40 FTs (27%) reporting deficits for the year, twice the level of 2012/13. The FT sector as a whole had also seen increased debtor days, a key reason being the commissioning changes, which had resulted in a lack of clarity over whether funding for particular services rested with CCGs or NHS England, together with difficulties in charging local health authorities for public health services.

In 2013/14 Dudley Group had failed to meet the A&E 4 hour wait target and has declared this target to be "at risk" for 2014/15. Across all of the FTs audited by Deloitte, almost half are declaring at least one target at risk for 2014/15.

Across all FTs in 2013/14, C difficile cases fell by 11% overall, although 50 Trusts breached their individual targets. 18 week waiting times were achieved for the year but were on a deteriorating trend towards the end of the year, while 62 day cancer waiting time performance also deteriorated, with 26 Trusts in breach at the year end.

Dudley Group achieved CIP of 2.3% for the year, below the 3.0% achieved across all FTs. Monitor however noted the increasing percentage of non-recurrent CIP across all FTs, at 18.6% compared to 5.8% planned and 14.4% in 2012/13.

Annual plans for 2014/15 have been developed against a backdrop of considerable uncertainty. Not only will the implementation of the Better Care Fund impact on all Trusts, but many may also be affected by reconfiguration proposals. Following submission of plans, Monitor wrote to all FTs highlighting that in overall terms the forecasts for the next two years appeared relatively optimistic.

Dudley Group is planning for a reduction in EBITDA margin in 2014/15 as it implements its turnaround plan, followed by an uplift in 2015/16. This follows the trend seen across all acute and specialist FTs, although the Dudley Group assumptions appear more realistic/cautious than FTs in general. .

CIP plans across all FTs look challenging. An increasing proportion is forecast to come from pay costs, particularly in agency spend. Across all FTS there is a 40% reduction forecast in contract and agency spend. Dudley Group saw agency costs as a percentage of total staff costs exceed the overall FT average in 2013/14 and are forecasting the percentage will remain higher than average in 2014/15 before falling below the average in 2015/16.

Annual Report of Audit Committee

The Audit Committee annual report, which details the activities undertaken by the Audit Committee in 2013/14 together with the opinion of the Committee as to whether the Trust's risk management, control and governance processes are adequate and effective and may be relied upon, appears as a separate item on the Board meeting agenda.

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 the approval of the Charitable Funds Annual Report, Accounts and Representation letter, under delegated authority on behalf of the Trustees.**

b) **Note that the annual report of the Audit Committee is presented separately for the Board to consider.**

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

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board on 4th September 2014

TITLE:	**Audit Committee Annual Report 2013-14**		
AUTHOR:	**Jonathan Fellows**	**PRESENTER**	**Jonathan Fellows**

CORPORATE OBJECTIVE: Quality

SUMMARY OF KEY ISSUES:

Audit Committee annual report and opinion.

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	**No**	**Details:**
	Equality Assured	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

The attached report details the activities undertaken by the Audit Committee in 2013/14 together with the opinion of the Committee as to whether the Trust's risk management, control and governance processes are adequate and effective and may be relied upon. The Board is asked to note the report and opinion.

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
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The Dudley Group NHS
NHS Foundation Trust

ANNUAL REPORT OF THE AUDIT COMMITTEE FOR THE YEAR 2013/14

1. Introduction

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.

The purpose of this report is for the Audit Committee to account to the Trust Board of Directors on its activities relating to the financial year 2013/14. In practice this covers the period up to the approval and sign off of the Trust's Annual Report and Accounts, which took place on 22nd May 2014.

After each of its meetings during the year, the Audit Committee provides a written report to the Trust Board that details the matters discussed, key issues identified and any items requiring referral to Trust Board. This annual report draws from the information contained in these regular reports.

The Committee's chief functions are to support the Trust Board by critically reviewing:

a) the governance, risk management and assurance processes on which the Trust Board places reliance, including the risk and performance management systems and the Board Assurance Framework; and

b) all risk and control related disclosure statements, including the Annual Report and Accounts, 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; and

c) the findings, implications and management responses to the work of the External Auditors, together with ensuring that there is an effective Internal Audit function and that the organisation has adequate arrangements in place for countering fraud.

Although financial scrutiny remains vitally important, Audit Committees have increasingly recognised that there is a widening range of activities which require comprehensive and effective controls and which should therefore fall within the remit of the Audit Committee. For NHS organisations, this typically includes clinical governance issues, such as the collection and reporting of performance and quality data, the preparation of annual clinical audit plans and processes and the measures taken to combat fraud.

In order to discharge its key functions, the Audit Committee prepares an Annual Report for the Trust Board and the Chief Executive as Accounting Officer of the Trust and expresses its considered opinion based upon the evidence placed before it.

2. Audit Committee's Responsibilities

During the year, the Audit Committee operated in accordance with its responsibilities as set out in its Terms of Reference, which are:

a) To review the establishment and maintenance of 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;

b) To ensure that there is an effective Internal Audit function that meets Government Internal Audit Standards and that provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board;

c) To review the work and findings of the External Auditors and consider the implications of and management's responses to their work;

d) To review the findings of other significant assurance functions, both internal and external to the Trust and including in particular local and national clinical audit activity and outcomes and consider the implications for the governance of the organisation;

e) To satisfy itself that the organisation has adequate arrangements in place for countering fraud and to review the outcomes of counter fraud work;

f) To receive and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee also requests specific reports from individual functions within the organisation (for example, clinical audit) where these are appropriate to the overall arrangements;

g) To monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance;

h) To ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review in order to establish the completeness and accuracy of the information provided to the Trust Board;

i) To review the Annual Report, Quality Report and financial statements before submission to the Trust Board focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in and compliance with accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements and significant judgments used in the preparation of the financial statements
- Significant adjustments resulting from the audit
- The letter of management representations
- Qualitative aspects of financial reporting
- Contents of the Quality Report

3. Audit Committee Membership

The Audit Committee is constituted as a sub-committee of the Trust Board with approved terms of reference that are aligned with the *Audit Committee Handbook 2005* published by the HFMA and Department of Health. The required quorum for meetings is two Non-Executive Directors.

It is recommended that the Chair of the committee is a suitably (CCAB) qualified accountant and as a Fellow of the Association of Chartered Certified Accountants, the current Chair meets this requirement.

Certain individuals were required to attend Audit Committee meetings. These included the Trust Director of Finance & Information, senior representatives of the External Auditors of the Trust, senior representatives of the Internal Auditors of the Trust and the Local Counter Fraud Specialist (LCFS).

The table below records attendance at each meeting during the 2013/14 cycle:

Date of Meeting	Audit Chair	Other NEDs	Finance Director	External Auditors	Internal Auditors	LCFS
23rd July 2013	Yes	1	Yes	Yes	Yes	Yes
15th October 2013	Yes	2	Yes	Yes	Yes	Yes
21st January 2014	Yes	2	Yes	Yes	Yes	Yes
13th May 2014	Yes	2	Yes	Yes	Yes	Yes

Other individuals from the Trust are invited to attend meetings. The Director of Nursing, who is the Trust Director responsible for Risk and Governance, attended three meetings during the year, while the Chief Executive attended two meetings. In addition, the Associate Director for Governance attended one meeting and the Deputy Director of Finance – Reporting attended all four meetings.

The Committee is able to draw on the independent advice of the Trust's auditors and any other officers or outside agencies it considers necessary. The Committee also met with both the External and Internal auditors in private during the year in order to ensure that they had the freedom to raise any issues of concern. These meetings centered primarily on the auditors assessment of business risks and the management of these; transparency and openness of working relationships with management; and confirmation that management had not attempted to place any restrictions on the scope of their audit work. There were no matters to report as a result of these meetings.

The Terms of Reference for the Audit Committee are reviewed annually and the most recent review by the Trust Board took place in February 2014. Whilst all Non-Executive Directors can attend meetings of the Audit Committee should they wish to do so, two specific Non-Executive Directors have been appointed to serve on the Audit Committee, in addition to the Chair of the Committee. The selection process was designed to provide the Audit Committee with a skill set that includes understanding of the organisations objectives, structure, culture and governance; experience in organisations of similar size or complexity, or operating in the same environment; and knowledge of accounting, risk management and technical specialist areas pertinent to the organisation including Information Technology.

4. Internal Audit

Internal Audit services for the 2013/14 year were provided by Baker Tilly. Internal Audit supports the work of the Audit Committee in two key areas:

a) by providing an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's strategic objectives; and

b) by providing an independent and objective service to help improve risk management, control and governance.

As is normal, a risk based approach was taken to establish the internal audit plan for 2013/14. This took account of the strategic and operational risks relating to quality and safety issues; service delivery standards and targets; workforce; finance and business, as identified by both management and the Committee, as well as the need to review key financial systems to ensure that External Audit could continue to place reliance on the work of Internal Audit.

Internal Audit issues assurance ratings for audits as follows:

GREEN	the Trust Board can take significant assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective
AMBER	the Trust Board can take some assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective
RED	the Trust Board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective

A total of 26 internal audit reviews were undertaken in the year. In summary:

- 6 were advisory reviews
- 3 were follow up audits
- 8 were rated **GREEN**
- 3 were rated **AMBER/GREEN**
- 2 were rated **AMBER/ RED**
- 4 were rated **RED**

The details of the various internal audit reviews and their respective ratings are shown in the table overleaf.

GREEN	AMBER/GREEN	AMBER/ RED	RED	FOLLOW UP	ADVISORY
Transformation Board and ICT Services Project Board Governance Arrangements	Claiming and Processing of On Call Payments	CIP – Identification, Monitoring and Reporting	Compliance with Appraisal / Personal Development Review Policy	Validation of reported Closed High and Medium Priority Recommendations	Business Planning
Data Quality – 62 Day Cancer Wait	Patient Advice and Liaison Service (PALS) Consideration of Concerns Received and their Escalation to Complaints	Nursing Care Indicators	Compliance with European Working Time Directive (EWTD)	Follow up of in year RED opinion reports on Appraisal Policy Compliance and Bank Workers Pre-Employment Checks	Distribution of Payslips
Data Centre Review	Data Quality – Pressure Ulcers		Bank Workers – Pre Employment Checks and Induction Attendance	Follow up of in year RED opinion reports on EWTD and Safety Thermometer	Local Understanding and Application of Patient's Property and Money Policy and Procedure on the Emergency Assessment Unit and Ward B2
General Ledger			Safety Thermometers		Doctor Revalidation
Financial Reporting					Adherence to Trust Policy when Compiling Theatres On-Call Rota
Debtors					Information Governance Toolkit
Cash Receipts and Treasury Management					
Charitable Funds					

For the first three of the four **RED** rated 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. The follow up work undertaken in the year on these four areas identified reasonable progress had been made by management in addressing the issues raised.

In total there were 83 recommendations issued by Internal Audit across all of the reviews – 17 High priority, 38 Medium priority and 28 Low priority – all of which were accepted by management with plans agreed for implementation.

Internal Audit operates a recommendation tracking system which identifies any recommendations made which have not been actioned by their due date, or where recommendations are considered to have received inadequate management attention. Regular reports are provided to the Audit Committee, with the most recent report showing that out of 100 recommendations due to have been actioned by 31st March, 74 had been actioned and 26 had not been implemented by the agreed date. Internal Audit considered this demonstrated the Trusts positive approach to the recommendations emanating from their work.

The Audit Committee was pleased to note that Internal Audit issued positive opinions in respect of the majority of the work undertaken in 2013/14 and, in particular, found that a consistently high level of sound internal control continued to be demonstrated within the operation of the Trust's key financial systems.

The Audit Committee received progress reports from the Internal Auditors throughout the year and a final report in May 2014. 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). This opinion is based on:

a) an assessment of the design and operation of the underpinning Assurance Framework and supporting processes;

b) an assessment of the range of individual opinions arising from the risk based audit assignments reported throughout the year. This assessment takes account of the relative materiality of these areas and management's progress in addressing control weaknesses;

c) an assessment of any reliance placed upon third party assurances.

Internal Audit noted that although four **RED** rated 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.

In May 2014, Internal Audit presented the proposed Internal Audit plan for the 2014/15 year to the Audit Committee. The plan links to the strategic goals and risks of the Trust and in addition to audits of core financial systems and controls, also includes 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 common with 2013/14 – for the 2014/15 year the Trust had again requested Internal Audit to audit some potentially challenging areas, so it would not necessarily be surprising to see the issuing of **RED** opinions in some instances.

The Audit Committee considers that:

- **The strategy for Internal Audit covers the Trusts key risks as recognised by the Committee**
- **The detailed plan for 2014/15 reflects the areas that the Committee believes should be covered as priority**
- **Sufficient assurances are being received by the Trust to monitor the Trusts risk profile effectively**
- **The level of audit resource is agreed as appropriate**

Accordingly the Audit Committee recommended to the Trust Board that the Internal Audit Plan for 2014/15 be adopted by the Trust Board and this took place at the Trust Board meeting in June 2014.

5. Clinical Governance

The core business of every NHS organisation is healthcare and consequently it is appropriate and necessary for the Audit Committee to consider the clinical objectives and risks in the Assurance Framework and report to the Trust Board on the controls and assurances relating to these. The Director of Nursing regularly attends the Audit Committee to report on risk and governance issues. The Audit Committee also receives regular updates on progress against the clinical audit plan from the Trust Clinical Audit Lead, Clinical Audit Team Leader and Clinical Audit Officers.

In May 2014, the Nursing Director presented the Clinical Audit annual report to the Audit Committee. 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 considers that the Clinical Audit plan for 2014/15 includes the appropriate national and mandatory audits, meets the needs of the Trust and addresses specific risks. Accordingly the Audit Committee recommended to the Trust Board that the Clinical Audit plan for 2014/15 be adopted by the Trust Board and this took place at the Trust Board meeting in June 2014.

6. Counter Fraud Services

In May 2014, the LCFS presented to the Audit committee 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

Key activities undertaken included meetings with Senior Executive staff in the Trust to provide updates and discuss fraud risks within the NHS; liaison with the Trust Head of Procurement to provide advice on anti bribery measures in relation to tenders; providing fraud awareness pack at induction events held during the year resulting in 425 new members of staff receiving fraud awareness training; preparation and circulation of newsletters and fraud alerts; reviewing and fraud proofing Trust policies; and three proactive reviews targeting Change of Bank Account Details, Declarations of Interest and Pharmacy Procurement. No instances of fraud were identified from the proactive reviews, although three Medium and two Low priority recommendations were made that were accepted and implemented by the Trust.

A staff survey was also carried out to gauge levels of fraud awareness amongst staff and to gain an understanding of possible areas within the Trust that may require further awareness training. The results of the survey indicated that the staff surveyed were fully aware of the LCFS role, what constituted fraud and how to make a referral.

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

The LCFS also completed the NHS Protect Self Review Tool, which compares the Trusts fraud workplan and tasks completed against the standards set by NHS Protect. The Trust was rated as **GREEN**, indicating that the Trust was compliant with the standards set.

Also in May 2014, the LCFS presented to the Audit Committee the proposed workplan for the 2014/15 year. This again included 80 days of proactive work to develop fraud awareness, to manage fraud risk and to ensure compliance, governance and reporting. The intention was to build upon the existing fraud awareness and ensure there was a clearly demonstrable and embedded anti-fraud culture, with the plan 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 considers that the LCFS workplan for 2014/15 meets the needs of the Trust and addresses the Trust's specific fraud risks. Accordingly the Audit Committee recommended to the Trust Board that the LCFS workplan for 2014/15 be adopted by the Trust Board and this took place at the Trust Board meeting in June 2014.

7. External Audit

The Trusts External Auditors Deloitte presented their report on the 2013/14 audit to the Audit Committee in May 2014. Deloitte reported that they would be issuing an unmodified audit opinion on the Trust Annual Accounts for 2013/14 and that the Annual Governance Statement complied with the guidance issued by Monitor. The audit process had once again gone smoothly, with all deadlines achieved The timetable for preparation of accounts continued to shorten, with only 36 working days this year between the end of the financial year and the sign off of the approved and audited accounts.

All key risks had been reviewed as part of the audit process. Deloitte drew attention to the overall deficit for the year of £2.3 million, resulting from the provision of £2.6 million relating to the termination costs of the IT services contract. Deloitte also noted that the Trust did not achieve its CIP target, achieving £9.4 million against a target of £12.4 million. Going forward, CIP achievement would become increasingly challenging and the Trust had formally placed itself in turnaround and was working on a £30 million CIP programme to be delivered over the next two years.

In addition, the Trust had failed to meet both the A&E four hour wait and C Difficile targets for 2013/14 and was in regular dialogue with Monitor regarding the actions being taken to address these performance shortfalls and to achieve the targets in 2014/15. Deloitte noted that performance against both targets had been fully reflected in disclosures made in the Annual Report and consequently would not be reporting any matters within the audit report in respect of the Trusts arrangements for securing the economy, efficiency and effectiveness of the use of resources.

Deloitte also noted that the 2013/14 accounts included for the first time the results of Dudley Group Clinical Services Limited, a limited company subsidiary set up to drive efficiencies in out-patient medicine dispensing, together with the consolidation of the Dudley Group NHS Charity, for which the Trust was the corporate trustee. The analysis of revenue and expenditure by segment in the Annual Accounts now disclosed both Dudley Group Clinical Services Limited and Dudley Group NHS Charity as separate business segments.

Deloitte also tabled the draft Letter of Management Representations for the Audit Committee to consider. Much of this followed a standard format, with Trust specific issues including collection of outstanding balances from commissioners, appropriateness of the £2.6 million provision for early termination of the IT services contract, income accruals and that the Trust had not been declared to be in breach of its authorisation conditions by Monitor and was not the subject of any regulatory action being taken by either Monitor or the Care Quality Commission.

Also presented to the Audit Committee in May 2014 were the findings and recommendations from the Deloitte external assurance review of the 2013/14 Quality Report. This review covered two aspects:

a) firstly, an examination of the content of the Quality Report to ensure that it complied with Monitor's published guidance as set out in the Monitor's Annual Reporting Manual (ARM) and to ensure that it was not inconsistent with other specified information; and

b) secondly, a programme of work to test three selected performance indicators.

In relation to the first aspect of the review, Deloitte confirmed that based on the results of the procedures undertaken, nothing had come to their attention that caused them to believe that, for the year ended 31st March 2014, the content of the Quality Report was not in accordance with criteria set out in the ARM, nor was there any indication that the content of the Quality Report was inconsistent with other specified information.

Deloitte undertook detailed data testing across three key quality indicators of 62 day cancer waits, Clostridium Difficile and Nutritional Assessments. The review was carried out in accordance with Monitors six dimensions of data quality, namely accuracy, validity, reliability, timeliness, relevance and completeness.

All three indicators received the highest possible rating of **GREEN** – signifying that all key standards were met – across all six dimensions, with the exception of Nutritional Assessments, where data validity was rated as **BLUE** - signifying satisfactory with only minor issues. Deloitte had made recommendations for improvement in this area including amending the current process to include capture of Hospital ID numbers for patients included in monthly audits of Nursing Care Indicators (NCIs) and also using raw data to calculate performance against the Nutritional Indicator targets, rather than an average of each month's performance. These recommendations had been accepted by the Trust and actioned.

Deloitte confirmed they would be issuing an unmodified (i.e. clean) opinion on the Quality Report.

The Audit Committee is also required to consider the effectiveness of External Audit and also the independence of the external auditor in the light of any additional non-audit work undertaken during the year.

In assessing the effectiveness of the external audit process the Audit Committee takes account of the lead audit engagement partner, the audit team, planning and scope of the audit and identification of areas of audit risk, execution of the audit, communications by the auditor with the Audit Committee, the support provided by the auditor to the work of the Committee, how the auditor contributes insights and adds value and the independence and objectivity of the audit firm and quality of the formal report.

The engagement partner has a detailed understanding of the sector and of the Trust, together with a sound professional working relationship with the Trust management and provides appropriate challenge to the Trust. The audit team is well resourced, also with a good understanding or the Trust and with appropriate experience. The planning of the audit is proactive, involving early discussion with Trust management and early identification of key risk areas. Any issues or queries that arise during the audit process are dealt with promptly and there is a quality control process for the audit in place. The External Auditor provides regular reports on best practice developments and briefings on accounting and governance changes.

Independence and objectivity of the External Audit function is safeguarded by limiting the nature of non-audit services and only approving any additional non-audit service on the basis that it does not compromise independence, is a natural extension of the audit and that there are business and/or efficiency reasons that make the external auditors most suited to provide the service. These criteria were fulfilled for the reviews of Board and Quality Governance undertaken by Deloitte during 2013/14.

The Trust Annual Accounts, Annual Report, Annual Governance Statement, Quality Report and Letter of Management Representations were each considered in detail by the Audit Committee and it was agreed to recommend to the Trust Board that they all be approved and this took place at the Trust board meeting in June 2014.

8. Review of Board Committee Effectiveness

Following on from the recommendations of the detailed review of the Trust undertaken by the Keogh review panel in May 2013, the Trust commissioned Deloitte to carry out an independent review of both Board and Quality Governance arrangements.

The key findings of these reviews included that:

a) the Trust Board is capable, demonstrates unitary board behaviours, has a strong focus on patient safety and service quality issues and is committed to delivering quality care in all of its services;

b) there is a productive, open and honest relationship with the local Clinical Commissioning Group (CCG) with proactive engagement on quality issues;

c) there is a well developed repository of information for reporting the Trusts key performance measures and some aspects of reporting that demonstrate good practice;

d) there is a history of good quality outcomes, with the achievement of the majority of key National priorities and compliance with the CQC standards reviewed.

Amongst the recommendations for improvement made by Deloitte were:

a) increasing the level of strategic focus at the Trust Board;
b) adding independent clinical expertise at Trust Board level;
c) considering senior management and Trust Board level capacity;
d) establishing the Risk & Assurance Committee as an Executive led sub-committee of the Trust Board with monitoring of the process of identification and escalation the responsibility of the Audit Committee;
e) considering the establishment of a Workforce Committee;
f) reviewing the Quality Strategy following consultation with internal and external stakeholders;
g) extending the Staff Engagement Strategy to a broader Communications and Engagement Strategy to support engagement with staff, key stakeholders and the public;
h) adopting a variety of innovative methods of communication to ensure that staff are engaged on the quality agenda.

Many of the recommendations arising from the reviews have already been implemented and work continues to address those still outstanding.

Also, as part of its commitment to continuously reviewing effectiveness, a self-assessment audit was undertaken by all Trust Board members in May 2013 to establish their understanding of ands satisfaction with the Board Assurance Framework.

The result of the self assessment were considered by the Audit Committee in July 2013 and reported to the Trust Board in September 2013. In summary, the results showed there was general satisfaction with the current assurance arrangements, although a number of actions were identified from the responses, including:

a) ensuring that discussions on risk management form part of all clinical directorate performance review meetings;
b) including updates on risk management processes and outputs in all matrons and clinical directors presentations to the Trust Board;
c) the Associate Director of Governance working with each clinical directorate to ensure consistency of risk management across directorates.

9. Tender Process for External and Internal Audit

Under Monitor's Audit Code for NHS Foundation Trusts it is recommended that a market testing exercise for the appointment of the External Auditor should be undertaken at least once every five years. Both the Trusts External and Internal Auditors were appointed from April 2010 and so will have provided audit services to the Trust for five years by March 2015. It is therefore the intention of the Trust to tender for both External and Internal audit services for five year contracts commencing from April 2015.

As the Council of Governors has responsibility for appointing the External Auditor, the Council has been invited to nominate two Governor representatives to join the Chair of the Audit Committee, Director of Finance and Information and Deputy Director of Finance – Financial Reporting on a panel to carry out the External Audit tender process, evaluate responses and make recommendations to the Council of Governors.

The Trust Board is responsible for appointing the Internal Auditor. A panel comprising the Director of Nursing, Associate Director of Governance, Chair of Audit Committee, Director of Finance and Information and Deputy Director of Finance – Financial Reporting will carry out the Internal Audit tender process, evaluate responses and make recommendations to the Trust Board.

10. Conclusion and Audit Committee Opinion 2013/14

The Committee once again wishes to express its sincere gratitude and appreciation to everyone who has supported the work of the Audit Committee during the year and contributed to the effective functioning of the Audit Committee.

The Audit Committee considers it has obtained adequate assurance that the key controls and processes within the Trust to ensure corporate and financial governance continue to operate effectively and that this conclusion is supported by the reports of the Internal and External Auditors received by the Committee during the year.

As a result, the Audit Committee is able to provide reasonable assurance to the Trust Board that there are no major weaknesses in the Trust's risk management, control and governance processes. The Trust Board should however recognise that assurance given can never be absolute.

The opinion of the Audit Committee, based on the evidence placed before it during the year, is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Trust Board, although work must continue to ensure that these are embedded throughout the whole organisation. In addition, there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Jonathan Fellows
Chair of Audit Committee
July 2014

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 4th September 2014

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 12th June 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			

This meeting was not quorate but papers received were discussed by those present.

'Feel more like you' service for cancer sufferers - the Committee heard about this exciting initiative which is funded from the 'St Agatha' Trust Fund and offers breast cancer patients cosmetic advice whilst they are undergoing Chemotherapy treatment.

Quality Dashboard for Month 1 (April) 2014/2015 - the Committee received the report which excluded CDiff, MRSA and Maternity as these targets had been met.TAL – Appointment booking within 4 days, had worsened to 38.75% in April, against the 80% required target . Issues were also identified with Ophthalmology which had achieved only 16% of bookings in 4 days. It was agreed that this would be referred to the Finance and Performance Committee to understand the reasons why and to request an action plan. Both maternity targets: Increase in breast feeding initiation rates and Smoking in pregnancy were on target. It was also agreed that a concern about the Saving Lives: Renal Dialysis Ongoing Care outcome would be monitored and reviewed again next month. The Head of Nursing would be invited to update the Committee on the current position regarding this target. The clinical indicators listed for April under NHS Choices were within the acceptable range with the exception of the day case rate for patients who had surgery for Dupuytren's Contracture where there was a medium likelihood of the patients staying overnight.

Dudley and Wolverhampton Breast Screening Visit - the Trust had recently received a QA Visit looking into Breast Cancer Grading. Dr Allan outlined the format of the visit and advised that there were no recommendations requiring a response but a re-visit would be scheduled. It was noted that visits were undertaken every three years and a report was completed annually in between visits. Concerns about Pathology were discussed together with the time commitment required to address these. Overall the results were very good for performance. The Committee received the report and noted the current position and the work in progress.

Infection Prevention and Control Forum (minutes from 12th March 2014) - The Committee was advised of an MRSA case that Dr Rees (Consultant Microbiologist/Director of Infection Prevention and Control) had raised with CQRM concerning data matching and the process used at other Trusts. The Committee was also advised of a concern about Junior Doctors reporting needle stick injuries which was improving.

Quality and Safety Group - this was a newly established group that had met once. The Group had established a number of reporting groups, the chairs of which had met to consider their Terms of Reference.

Patient Story - The Committee heard a patient story about patient gowns and the lack of privacy and dignity experienced by patients. The Director of Nursing confirmed that work was progressing in this area.

Mortality Report - The Committee received the Quarterly Mortality Report Action Log and noted the current position with regard to the overall SHMI and HSMR performance which was encouraging. The report highlighted the SHMI Top 20 highest variance of "observed above expected by condition group" – October 2012 to September 2013 which indicated that congestive heart failure nonhypertensive had the highest rate. The Trust had received an alert from the CQC on the Skin and Subcutaneous Conditions group. The CQC had accepted the Trusts response to this and the alert had now been closed.

Policies -The Committee considered 5 new policies/ guidelines and supported ratification of these subject to the agreement of absent members.

Serious Incident Monitoring Report (May 2014) - There were 10 new incidents reported (1 safeguarding adult - vulnerable adult in care setting, 1 disruption to services, 1 Health & Safety, 1 unexpected admission to SCBU (neo-natal), 1 aggressive, intimidating or inappropriate behaviour- patient to patient, 1 attempted suicide, 1 cord prolapse, 1 patient fall resulting in fracture, 1 DGH ward outbreak - other organism and 1

confidentiality breach - records/information).

There were 46 open general SI's in total (18 RCA/investigations in progress, 24 awaiting assurance that all actions had been completed and 4 recommended for closure). The Committee also discussed the Trust Red Incident Matrix and noted that there were no significant trends. The Committee **noted** the current position and **supported** the recommended closure of the Serious Incidents.

Aggregated Incident Report - the Committee were advised that 3,583 incidents were reported in 2010/2011 and 15,786 in 2012/13. The 'National Reporting and Learning Service (NRLS) Organisation' state that "Organisations that report more incidents usually have a better and more effective safety culture". Nationally 67.5% of incidents were reported as no harm (DGH 66.0%), 0.5% as severe harm (DGH 0.2%) and 0.2% as death (DGH 0.2%). During 2013/2014, 12,492 patient incidents and 3,294 non clinical incidents were reported. The Committee considered a breakdown of these incidents by type. The top incident types were: Clinical Care (Assessment/Monitoring); Medication; Patient Falls, Injuries or Accidents, Records, Communication & Information and Pressure Sores.

Patient Experience Group - the Group had met twice but one meeting was not quorate. The Patient Experience Strategy was introduced and the terms of reference for the two reporting groups were reviewed at the first meeting in April. A Patient Story will be shared with the group at each meeting. The Group had received reports on:

- **Patient Led Assessment of the Care Environment (PLACE) -** A report was presented outlining the background and process for the PLACE assessments which took place on two days in April with participation from nine patient assessors, including representation from Healthwatch Dudley. The assessments included the building and food.
- **Patient Experience data report - Q4/Year end 13/14 -** The group received a comprehensive data report for 13/14 which included information on the Patient Experience CQUIN, new CQUIN requirements for 14/15, Quality Priorities and NHS Choices/Patient Opinion.

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 12th June 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 4th September 2014

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 17th July 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			

SUMMARY OF KEY ISSUES

Patient Experience Strategy Action Plan - the Patient Experience Group had met twice and considered the progress against the action plan. A variation order had been received for work relating to the discharge lounge and red rated on the action plan. The patient experience lead had also worked closely with the Patient Catering Group to ensure interventions were monitored closely to map patients likes and dislikes and alter food provision accordingly. "Noise at night" was highlighted in patient feedback and a bid had been made to Charitable Funds for £5k for quiet closing bins to support the "quiet at night" protocol. The group also discussed the funding of Customer Care Training for all Trusts across the Black Country.

National Care of the Dying Audit for Hospitals, England - 90% of Trusts had participated in this audit which linked to the national initiative 'One chance to get it right'. The Trust had achieved one out of seven key performance indicators. Improvement actions were progressing including the provision of training slots and the development of an e-learning package. The Committee discussed the report recommendations and local actions identified and noted that referrals to the team had increased from 400 three years ago to 1100 and now included both cancer patients and others. The Committee recorded their thanks and discussed the resource requirements and funding options to support the service.

Peer Review Visit – Black Country Specialist Skin MDT - the Trust together with Wolverhampton had formed a Specialist Skin Care Multidisciplinary Team (SSMDT) known as the Black Country Specialist Skin MDT. The report outlined the recommendations and planned actions arising from a peer review undertaken in March 2014. Two immediate risks and three serious concerns were made. The immediate risks related to the referral of appropriate patients at the specialist MDT and a lack of histopathology attendance at the MDT meetings. The Committee **received** the peer review report and action plans.

National Chemotherapy Survey Action Plan Update - this action plan is discussed bi-monthly at the Clinical Chemotherapy Group. When benchmarked against other organisations, the Trust was comparable with national figures for many areas but some improvements were required and various teams were progressing these. Patients were not offered an end of treatment summary but following the peer review, patients were advised how and where to request this. E-chemo prescribing has now been introduced and the Pharmacy team will offer a home delivery service. Community colleagues at Brierley Hill will be undertaking some work for the Trust to help patients receive treatment closer to home. The Committee **received** and discussed the National Chemotherapy Survey Action Plan and progress of actions.

CCG Appreciative Visit on Care of Elderly - an announced visit took place on 5th February 2014.The final report was received on 7th May and an action plan drafted by the 10th June 2014. The visit findings confirmed that there were no significant areas of concern. It was evident to the visiting team that the Trust was seeking out best practice and ideas for improvement. There were a number of joint actions that the Trust should take with either Dudley CCG, Dudley Metropolitan Borough Council or both in order to improve the efficiency and effectiveness of services. This included the establishment of a joint clinical development meeting to review the pathway for frail elderly urgent referrals to the hospital and a proposal to the Dudley Urgent Care Working Group for consideration on how both parties (Trust and Council) could work together to improve the discharge planning processes. The Committee **approved** the action plan.

Actions Arising from External Audit of Quality Accounts - this review was a statutory requirement and would be circulated to Governors and presented at the Council of Governors Meeting in September. The content of the Quality Report and data consistency and data testing all met the key national standards and no significant issues were raised. Three recommendations relating to data testing had been actioned. The Committee **noted** the contents of the report and the actions taken.

Culture of Learning CQUIN Q1 - This CQUIN was worth £670,000 and related to demonstrating improvement through organisational learning. The report focussed on the Top 5 categories by incident type and date for Serious Incidents, Serious Red Incidents and Complaints. The themes identified covered clinical care, diagnosis and tests and communication. The report summarised the learning from these and actions taken.

Learning Disability Strategy Quarterly Update - the Committee received the update and was advised that an action plan had been developed to embed the Strategy following the launch in March 2014. It was noted that some actions were for the Trust and some were for external organisations. All actions were in progress. The Committee **noted** the key issues arising from the Learning Disability Strategy Action Plan.

Quality Dashboard for Month 2 (May) 2014/2015 - The Committee received a summary of the key issues and **noted** the quality dashboard for May 2014:

- TAL – Appointment booking within 4 days was raised at the Finance and Performance Committee which had requested an action plan and recovery trajectory.
- There was an issue with the Stroke Swallowing Assessment which appeared to be due to a vacancy in the department.
- NHS Choices data was released shortly before the meeting and the clinical indicators showed that Dupuytren's Contracture was dropping. Mastectomy without reconstruction had been added this month.

Policy Group Recommendations - the Committee supported the ratification of seven guidelines.

Serious Incident Monitoring Report - 8 new incidents were reported this month. There were 72 open general SI's in total (16 RCA/investigations in progress, 34 awaiting assurance that all actions had been completed and 22 recommended for closure). The Committee was advised of a Datix problem where it appeared that Incident Managers had been closing incidents before they had been presented to the Committee. The Committee received assurance that all actions had been taken. There was little movement in terms of incident trends and no correlation with incidents reported previously. From the 1st July 2014 the Tissue Viability Team would be reporting all stage 3 or 4 pressure ulcers, acquired within hospital or community care, within the national 48hrs reporting timescale. Avoidable and unavoidable pressure ulcers would be recorded. The Trust did not previously report unavoidable pressure ulcers.

Three incidents were reported to the Trust Red Incident Matrix in June 2014; 1 for Clinical Care (Assessment/Monitoring) and 2 for Records, Communication and Information. These did not meet the Serious Incident recording requirements and no serious harm occurred. The Committee **noted** the current position and **supported** the recommended closure of 22 Serious Incidents.

Quality and Safety Group 17th June 2014 - The Committee received a summary of the key issues arising:

- **Reduction in Falls** of 344 on the rolling total. Bed and chair alarms had been delivered.
- **DNACPR-** Discussions required on how decisions taken in the Community are shared with clinical teams on admission through the Emergency Department from the Community or a Nursing home with a DNACPR .This was being progressed by the CCG.
- There was an unresolved concern about trailing wires on B1 and B2. Committee members believed this had been raised and addressed previously and referred it to the Finance and Performance Committee.

Internal Safeguarding Board - The Committee received a summary of the key issues arising from the meetings held on 4th June and 26th June 2014:

- **PAN Board Review meeting -** the Police Protection Unit had reviewed 2 cases and interviewed a number of Trust staff. The Trust was awaiting a report and final conclusion.
- **Safeguarding Training compliance -** training figures had decreased slightly in May and June for all Safeguarding training except Maternity.
- **DNAR training for Medical staff and senior nursing staff -** training sessions facilitated by the Trusts solicitors had been held for Medical and Senior nursing staff.
- **Safeguarding CQUIN-** the requirements for this were identified and discussed.

Terms of Reference - The Committee **approved** the Terms of Reference for the following Reporting Groups.

- Patient Experience Group
- Quality and Safety Group
- Infection Prevention and Control Forum
- Internal Safeguarding Board
- Trust Children's Services Group

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 17th July 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 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 4th September 2014

TITLE:	**Quarterly Quality Account Report (2014-15) (First quarter up to the end of June 2014)**		
AUTHOR:	Derek Eaves Quality Manager	**PRESENTER:**	Denise McMahon, Nursing Director

CORPORATE OBJECTIVE:

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

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

SUMMARY OF KEY ISSUES:

The attached paper indicates the Trust's position at the end of the first quarter with the five Quality Priority target areas and the National Clinical Audits/Confidential Enquiries for 2014-15. The paper shows the actions being taken to achieve the targets. With regards to the five specific quality priority areas:-

Patient Experience - There are two hospital and two community targets for this topic, however, the latter two are based on an annual survey and so these cannot be reported on at this stage. Both of the hospital targets are on track to be met and greater emphasis is being placed by the Matrons on the call bell answering.

Pressure Ulcers - Both the two hospital and the two community end of year targets are on track to be achieved with no grade 4 ulcers reported so far and a reduction in the grade 3 ulcers in the hospital, although a number of investigations are still ongoing for the period and so these figures may increase..

Infection Control – Both the MRSA and C. Difficile targets are being met so far with no bacteraemias and seven C.Difficile cases (against a target of 11 for the quarter) being reported.

Nutrition/Hydration – Both targets are on track but continual emphasis on these issues is needed and continues.

Mortality – Improvements in the timings of reviews is occurring which indicate that the end of year target will be met.

With regards to the **National Clinical Audits and Confidential Enquiries -** It can be seen that staff are participating in all of those relevant to the Trust's services.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details**:
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Quality Report requirements
	Equality Assured:	**Y**	**Details:** Better Health Outcomes Improved Patient Access and Experience
	Other	**Y**	**Details**: DoH Quality Account requirements

ACTION REQUIRED OF COMMITTEE:

Decision	**Approval**	**Discussion**	**Other**
		✓	✓– Comment

RECOMMENDATIONS FOR THE COMMITTEE: To note the position with regards to the quality priority targets and with regards to the national clinical audit/confidential enquiry participation at the end of the quarter.

THE DUDLEY GROUP NHS FOUNDATION TRUST

QUALITY ACCOUNT UPDATE - JULY 2014

QUALITY PRIORITY 1: PATIENT EXPERIENCE. TARGETS: Hospital: a) Maintain an average score of 8.5 or above throughout the year for the patients who report receiving enough assistance to eat their meals. b) By the end of the year, at least 90 per cent of patients will report that their call bells are always answered in a reasonable time. **Community:** a) Equal or improve the score of patients who state they were informed who to contact if they were worried about their condition after treatment. (2013/14: 8.8 out of 10). b) Equal or improve the score of patients who state they know how to raise a concern about their care and treatment if they so wished. (2013/14: 8.3 out of 10)

Planned Actions	Who	By When	Progress at end of June 2014
Hospital			
Continue to recruit volunteer mealtime assistants.	Mandy Green	March 2015	35 volunteer mealtime assistants recruited at first dedicated recruitment event in March 2014. In April to June 38 more volunteer mealtime assistants recruited.
Newly recruited mealtime assistant volunteers to be trained and in place on the wards where needed	Mandy Green	March 2015	First training session 26th June 2014.
Targeted patient experience surveys to be undertaken with patients requiring mealtime assistance to ensure that patients are getting the help they need	Mandy Green	June 2014	COMPLETE New process commenced in May. When patient experience assistant is undertaking surveys, if he sees someone else in the bay is on a red tray he asks the individual survey question.
Call bell data included on the new ward huddle board (prominent boards on each ward that include important safety and patient experience information for patients, relatives and staff) to maintain the focus on this important issue and to let staff and patients know how their ward is performing	Mandy Green	June 2014	COMPLETE. Call bell scores now included on the huddle boards and updated each month.
Review and further develop the pilot carried out on surgical wards in 2013/14 and roll out to all wards	Lesley Leddington	October 2014	In progress
Develop postcard style information to give to patients finishing their treatment advising who to contact if they are worried and how to raise a concern	Carrie Spafford	September 2014	In progress
Utilise the single point of access telephone number for patients to contact	Carrie Spafford	September 2014	Single point of access telephone number in place – will be communicated to all patients via the mechanisms outlined
Refresh posters in clinic settings advising patients how to raise concerns	Carrie Spafford	September 2014	In progress
Review appointment and discharge letters to ensure patients receive information on who to contact if they are worried after treatment and how to raise a concern	Carrie Spafford	September 2014	In progress

Hospital

April-June 2014 data and commentary

Quality priority hospital (a)	Q1	Q2	Q3	Q4	2014/15 YTD
Maintain an average score of 8.5 or above throughout the year for patients who report receiving enough assistance to eat their meals.	8.5				8.5
Number of patients who felt that they sometimes or never get the help that they needed	5 (out of 400 surveyed)				5 (out of 400 surveyed)
Quality priority hospital (b)	**Q1**	**Q2**	**Q3**	**Q4**	**2014/15 YTD**
By the end of the year, at least 90 per cent of patients will report that their call bells are always answered in a reasonable time.	85.5%				85.5%

The hospital quality priority is on track with target (a): average target score achieved in quarter one and target (b): having a good score to build on to reach 90% by the end of the year. With regards to the patients perceiving they did not have enough assistance to eat, these were out of a total of 33 who reported that they perceived they needed help (28 stated that they were receiving the help they needed). A more effective system of monitoring these patients has been put into place, in that the surveyor will tell the nurse in charge that the patient has a concern and the nurse in charge will discuss this with the patient and report back the outcome of that conversation.
The relevant Matron is informed of the concern and outcome.

Community

April-June 2014 data and commentary

No data to report for quarter one as this is an annual survey.

Board Sponsor: Denise McMahon, Director of Nursing
Operational lead: Mandy Green, Deputy Head of Communications and Patient Experience

QUALITY PRIORITY 2: PRESSURE ULCERS: Hospital: a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2014/15 does not increase from the number in 2013/14 **Community:** a) Ensure that there are no avoidable stage 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable stage 3 pressure ulcers acquired on the district nurse caseload in 2014/15 does not increase from the number in 2013/14

Planned Actions	Who	By When	Progress at end of June 2014
Continue to support hospital staff in the effective use of new mattresses	C Carter Direct Health Care	July 14	Ward walks continue weekly, all wards using mattresses appropriately. Any issues identified immediately and dealt with as needed.
Utilise the equipment co-ordinator to monitor current practice in all wards. This will include checking that SKIN bundles are completed effectively and ensuring patients are all nursed on the appropriate equipment	C Carter	July 14	Training has begun with regards to understanding how to check SKIN bundles and identify any issues.
Develop and embed the use of a new equipment selection flow chart for the community service supported by education sessions	L Turley D Hartill D Flavell	End June 2014	New chart is complete and piloted. Company has agreed to produce. Awaiting proof copy. Date agreed to launch on 17th July to all community teams
Continue weekly meetings with the pressure ulcer group to review any stage 3 or 4 ulcers that may develop while the patient is under the care of the Trust	L Turley C Carter	Apr 2015	Weekly meetings continue – common themes identified and actions put in place to improve standards.
The Tissue Viability team will continue to work with private care agencies and organise education sessions and updates as required	L Turley	Aug 2014	Regular sessions ongoing
The team will support nursing homes with regular link nurse meetings	L Turley	Aug 2014	Link nurses are identified and regular 3 monthly meetings in place
Following the success of a first newsletter sent out to nursing homes, the team intend to send a regular newsletter to update nursing home staff and practice nurses	L Turley K McBride	July 2014	First newsletter completed. TV is working with company to develop next edition
Education sessions to continue for all staff with practical sessions	C Carter	Apr 2015	Several sessions booked – one session cancelled due to lack of interest, more advertising and awareness of future dates has been pushed.
Play a role in working with national groups to agree standard definitions for wounds that are diabetic foot ulcers or related to circulation problems compared to pressure ulcers	L Turley	Oct 2014	Draft copy of poster developed.

April-June 2014 Data

Hospital

The quarterly figures are shown below for incidents of pressure ulcers:

Period	2013/14	Apr- June 14+	Jul-Sep 14	Oct-Dec 14	Jan-Mar 15
No. of stage 3	41	4			
No. of stage 4	0	0			
Total	41	4			

+Please note than these figures may change dependant on the outcomes of RCA investigations as to whether reported pressure ulcers are avoidable or unavoidable.

Community

The quarterly figures are shown below for incidents of pressure ulcers:

Period	2013/14	Apr- June 14+	Jul-Sep 14	Oct-Dec 14	Jan-Mar 15
No. of stage 3	4	0			
No. of stage 4	0	0			
Total	4	0			

+Please note than these figures may change dependant on the outcomes of RCA investigations as to whether reported pressure ulcers are avoidable or unavoidable.

April-June 2013 Commentary

It is pleasing to note that the targets are being very well met in the first quarter (with the proviso as indicated below the tables above). It has now been agreed that any patients who are discharged from hospital with a pressure ulcer stage 1-2 will be seen by a community nurse within 48-72 hours and a patient with a stage 3-4 or multiple pressure ulcers will be seen within 24-48 hours. As we have been seeing a trend in hospital RCA's of qualified staff not reviewing patient's skin condition at least once per 24 hours we have now included this in the weekly audit questions – it is expected that all areas will make improvements in this. As it has been identified that pressure ulcer RCAs do not follow the same pathway as other RCAs that are completed at the Trust, it has now been agreed that the pressure ulcer group will meet to discuss this and look at improving the quality and overall time to completion. Moisture lesions that deteriorate into pressure ulcers/combined lesions have been a theme this quarter and it has been noted that there seems to be some confusion over when to increase repositioning and upgrade equipment and so the tissue viability team have agreed to look at providing some guidance for this.

Board Sponsor: Denise McMahon, Director of Nursing
Operational Lead: Lisa Turley, Tissue Viability Lead Nurse

QUALITY PRIORITY 3: INFECTION CONTROL TARGETS: Reduce our MRSA and Clostridium difficile rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is to have no post 48hr cases; C. difficile is no more than 48 post 48hr cases in 2014/15.

Planned Actions	Who	By When	Progress at end of June 2014
Working with our hydrogen peroxide vapour (HPV) 'fogging' contractor to agree a rolling programme of decontamination services to assist in the prevention of cross infection	Lead Nurse, IC	Oct 2014	Meetings with company in July and discussion planned with new Matron (Infection Control) on commencement in August.
Providing further training around specimen collection and utilising the specimen checklist relating to C. difficile	Lead Nurse, IC	June 2014	COMPLETE
Develop further education programmes and competencies that can be utilised across the Trust for Infection Control	Lead Nurse, IC	Oct 2014	Infection control competencies have been rolled out across the link practitioners once they are completed they will be rolled out to the rest of the nursing teams. To assist with this work we have enrolled the assistance of the practice development nurses for medicine, surgery and Trauma & orthopedics and the graduate nurse programme as well as the programme organizer for Novices and CSW`s. All training session power points are continually being reviewed and updated as required.
Working with community nursing teams to enhance their knowledge around specimen retrieval, infection prevention and control and data collection	Lead Nurse, IC	Oct 2014	Initial meetings held to identify scope of work
Developing an agreement with the principal commissioner (Dudley CCG) on local actions, including an algorithm to differentaite between avoidable and unavoidable cases, based on NHS England's publication: C. difficile infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation	Director of Infection Prevention and Control	June 2014	COMPLETE
Publish the numbers of avoidable and unavoidable C. difficile cases on the Trust website	Nursing Director	Quarterly	This process has now been agreed with the CCG for rollout in Summer/Autumn 2014.

April-June 2014 Commentary

It can be seen (below) that the Trust is achieving both targets in the first quarter with no MRSA bacteraemia cases and seven C. difficile cases against a target of eleven for the quarter.

April-June 2014 Data

Clostridium difficile infections

	Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	Cumulative % Over/Under Target	Trust Total	Health Economy
Monthly number of C.diff cases	Apr-14	3	4	-25.0%	3	4	-25.0%	5	9
	May-14	1	4	-75.0%	4	8	-50.0%	7	9
	Jun-14	3	3	0%	7	11	-36.4%	7	8
	Jul-14		4			15			
	Aug-14		3			18			
	Sep-14		4			22			
	Oct-14		4			26			
	Nov-14		5			31			
	Dec-14		5			36			
	Jan-15		5			41			
	Feb-15		4			45			
	Mar-15		3			48			
	FY 2014-15	7	48	-85.4%				19	26

The Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours. The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

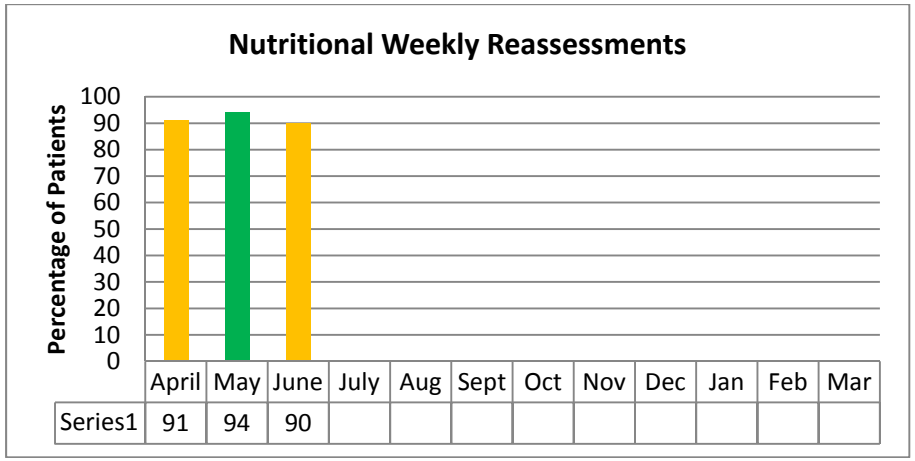
There have been no MRSA cases.

Board sponsor: Denise McMahon, Nursing Director
Operational lead: Dr. E Rees, Director of Infection Prevention and Control

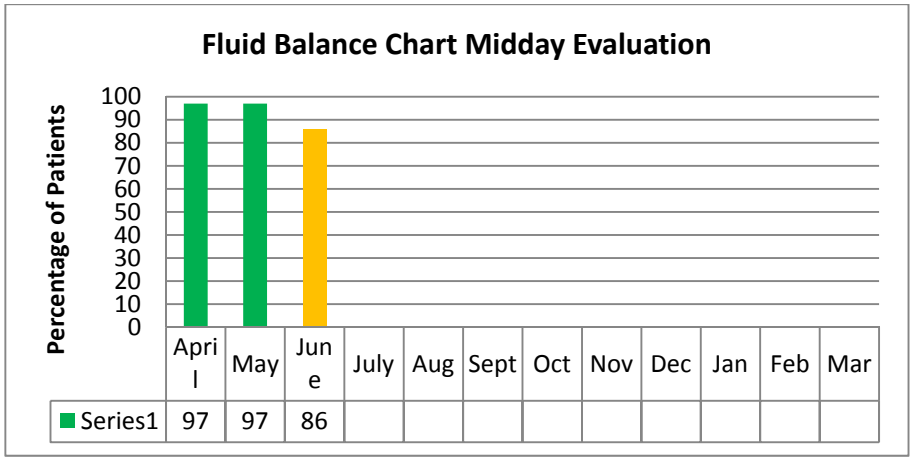
QUALITY PRIORITIES 4 AND 5: NUTRITION/HYDRATION: **Nutrition;** Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Through the year on average at least 90% of patients will have the weekly risk assessment completed and this will rise to at least 93% by the end of the year (March 2015). **Hydration:** Ensure that on average throughout the year 93% of patients' fluid balance charts are fully completed and accumulated at lunchtime.

Planned Actions	Who	By When	Progress at end of June 2014
The present process of monthly mealtime audits will be reviewed to develop a more robust system of ensuring appropriate action is taken dependant on the audit results	S Phillips Karen Broadhouse	August 2014	Strategy meeting with S Philips and K Broadhouse has taken place. Initial processes explored, currently under review prior to implementation.
A more automated system of ensuring that patients and staff are forewarned about mealtimes rather than relying on the use of the hand bells will be introduced	S Randall D Aston	March 2015	A meeting with the call bell supplier has occurred and the Trust has obtained the relevant information to change the system. S Randall will review options by the end August 2013
An electronic learning package will be implemented	A Marsh	Sept 2014	Awaiting assurance that Trust IT system will support program.
A formalised strategy will be developed to ensure that Nutrition/Hydration is a priority issue	A Marsh P Deel - Smith	Sept 2014	In progress
All current menus will be reviewed to ensure greater choice for patients	A Marsh H Standish Bevan	April 2014.	COMPLETE. Menus has been developed; trials have commenced awaiting final sign off of new meal choices.
All nutrition based policies will be reviewed and amended to ensure that they reflect up-to-date practice at the Trust	A Marsh P Deel – Smith A Fairhurst	March 2015	There are currently numerous guidelines available, which are under review to combine together with community dietetics guidelines.

April-June 2014 Data - Nutrition



April-June 2014 Data - Hydration



Key: Green – 93% and above
Amber – 92-75%
Red – 74% and less

April-June 2014 Commentary

Initial start to this financial year has proved promising with good scores being recorded for both assessments. Although there has been a drop in the hydration target score in the third month, the average of the three months reaches the target. The Matrons are addressing the third month score.

Board Sponsor: Denise McMahon, Director of Nursing
Operational Leads: Dr S. Cooper, Consultant Gastroenterologist, Sheree Randall, Matron, Karen Broadhouse, Quality Project Lead

QUALITY PRIORITY 6: MORTALITY Ensure that 85% of in hospital deaths undergo specialist multidisciplinary review within 12 weeks by March 2015.

Planned Actions	Who	By When	Progress at end of June 2014
Directorate mortality and action plans will be reviewed quarterly	Roger Callender	Quarterly	Delayed due to trust reorganisation. A report would be provided to each new division for quarter 2
Monthly mortality meeting will be held by the Medical Director, Information staff and Dudley CCG staff to review: o Mortality Indices, o Mortality Tracking System Performance o Review action plans o Provide exception reports where necessary to board.	Teekai Beach	Monthly	Monthly meetings have been held. No exceptions to be reported to board. Q2 exception: Reduction in SHMI

April-June 2014 Commentary

Our Mortality Tracking Process includes clinical coding, validation, multidisciplinary specialist audit and where necessary senior medical and nursing review led by our Deputy Medical Director. This process takes up to 16 weeks in total to ensure that each and every death occurring in hospital is understood and that we are responsive to the information we gather from the process. Therefore results are available for the previous quarter,Q4 of 2013-14 on this occasion, and for that period 78.1% of in-hospital deaths across the trust have had specialist multidisciplinary reviews within 12 weeks, an improvement from an average of 70.6% for Q 1-3 2013/2014. The details by specialty are below. At this time, we can however estimate the results for Q1 which show a Trust average of over 95%, which shows a significant improvement since the introduction of the target in April 2014.

Over 1/3 of the specialties have exceeded the 85% target and have improved their performance from Q3. There are actions in place with those specialties currently averaging below 50%, for example Vascular Surgery and Oncology work across multiple sites and organisations and although they undertake regular multidisciplinary review of deaths, there are inevitable delays in obtaining validation and feedback from a inter organisational team. Similarly, very small numbers of deaths are recorded in some specialties such as urology and haematology that require multi-specialty input into audits. As such MDT coordinators are being given access to the Mortality Tracking System where necessary to minimise the delays caused by multispecialty/cross site working.

Data for April-June 2014 (January-March 2014 Data)

Meeting 85% Target **At or above Trust Average** **Below Trust Average** **N/A – No deaths**

Specialty	% audited within 12 weeks	Specialty	% audited within 12 weeks
Cardiology	75	Clinical oncology	83.3
Gastroenterology	67.5	Haematology	0
General Medicine	72	Medical oncology	50
Medical Assessment	94	Care of the Elderly	94.7
Orthogeriatrics	N/A	ENT	N/A
Rehabilitation	88.9	General Surgery	92.6
Respiratory	91.7	Urology	0
Stroke Medicine	65	Vascular Surgery	31.2
Diabetes	N/A	T&O Rehabilitation	100
Endocrinology	66.7	Trauma and Orthopaedics	87.5
Renal	24	Neonates	100
Rheumatology	100	Gynaecology	N/A
Trust Overall	**78.1%**		

Board sponsor: Paul Harrison, Medical Director **Operational lead:** Teekai Beach, Directorate Manager to Medical Director

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES

There are 35 National Clinical Audits currently listed on the DH Quality Account (QA) in which the Trust is eligible to participate and accordingly the Trust is registered to participate in all of these. The number of audits is not static in that the Healthcare Quality Improvement Partnership (HQIP) which co-ordinates the national audit programme continues to revise the list throughout the year and audits may be added to and deleted from the list as necessary. Also included on the QA is the National Confidential Enquiries (NCEPOD) programme which currently consists of 3 studies for which the Trust has submitted data and is awaiting publication of the national reports. A further 2 NCEPOD studies are planned for December 2014 and May 2015.

Contributions from: K. Obrenovic, M.Green, S. Randall, C. Carter, E. Rees, L. Dimmock-Evans, K. Broadhouse, T. Beach. Compiled by D. Eaves. July 2014

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On 4th September 2014

TITLE	**Performance Report April – July 2014**		
AUTHOR	**Paul Assinder Director of Finance and Information**	**PRESENTER**	**David Badger Committee Chairman**
CORPORATE OBJECTIVE: SG06 Enabling Objective			
SUMMARY OF KEY ISSUES: • Surplus of £711,000 in July • Deficit of £3.2m for year to date, £0.7m over plan • Deficit budget for 2014-15 of £6.7m likely to be exceeded, with a forecast of £10m deficit now declared • A&E 4 Hours waiting time met in July and for Quarter 2 to date • Some RTT waiting time pressures but targets being met • Mortality indices continue to improve and are better than expected for the Trust.			

RISKS	**Risk Register**	**Risk Score Y**	**Details:** **Risk to achievement of the overall financial target for the year** **Failure to achieve the 4 hours A&E target in Q1 and risk for remainder of the year. Monitor has notified the Trust that it is investigating A&E performance in the Trust.** **Financial deficit above Monitor plan now forecast**
COMPLIANCE	**CQC**	**Y**	**Details:** **The Trust is awaiting a report from the Chief Inspector of Hospitals following an inspection in the Spring. This is subject to appeal.**
	NHSLA	**N**	
	Monitor	**Y**	**Details:** **The Trust has rated itself 'Amber' for Governance & '3' (good) for Finance (CoS) at Q1. The Trust**

			remains on monthly monitoring by Monitor. **Monitor has notified the Trust that it is investigating A&E performance in the Trust and its long term business viability.**
	Other	**Y**	**Details:** **Significant exposure to performance fines by commissioners**

ACTION REQUIRED OF COUNCIL

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the report

The Dudley Group NHS
NHS Foundation Trust

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

Report on Finance and Performance for April to July 2014

1. Background

The Finance & Performance Committee of the Board met on 28th August 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 Board will wish to note the following matters:

2. Financial Performance for the 4 months period April to July 2014 (Appendix 1-2)

The Trust has had a difficult start to the year following the Board of Directors agreement to a 24 months balanced budget, with a planned deficit of £6.7m in 2014-15.

The first quarter showed a trading deficit of £3.9m which was £1.3m worse than plan. However a £711,000 surplus was realised in July and the cumulative deficit for the 4 months period to date is £3.2m, £0.7m worse than the period plan.

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

- **Our inability to meet elective activity targets, resulting in significant loss of income from commissioners (Appendix 1)**
  For the period to date planned elective in patient activity is some 11% lower than in 2013-14.

- **Significant increases in emergency activity levels above plan (Appendix 1)**
  Of note is that despite significant investment in primary based care in the Borough, A&E attendances this year are 8% higher than 2013-14 and Emergency Admissions to the Hospital are 6% higher than last year.

- **Continued spending above budget on agency & locum front line medical & nursing staff**
  In spite of an active UK and overseas recruitment drive, the Trust has incurred additional expenditure of £3m on agency and locum staff during the period. The Board will also be aware that a principal component of the planned deficit in 2014-15 is a £3.1m investment in additional registered nurses, thus increasing vacant posts.

- **A slower than anticipated start to turnaround savings.**
  The Trust has set itself a very ambitious programme of savings which need to be delivered in 2014-15 (even to deliver a planned overspend of £6.7m). Whilst plans are mainly 'back ended' to deliver greater contribution later in the year, there is already significant slippage of £0.7m. The Board of Directors will need to pay particular attention to the achievement of much higher monthly savings targets in future months if budgets are to be met.

  The Committee considered a report from Steve Davies, Turnaround Director, on the activities of the Turnaround Team. Progress on the following schemes, referred to Level 1 Escalation was considered:

  - Length of Stay
  - Out Patients
  - Managed Services
  - Coding
  - Workforce

  None were considered likely to have to be escalated further. Forecast outturn of turnaround in 2014-15 was stated as £9.8m (90% of Plan) of which £3.5m c30% had been achieved to date.

The Trust is now forecasting a deficit of £9.8m for 2014-15.

At 31st July 2014 the Trust had cash reserves of £23.5m and 13.2 days liquidity.

Capital spending for the period was £1.8m (£0.5m Medical Equipment, £0.2m IT, £0.5m PFI Lifecycle), some £0.4m below plan.

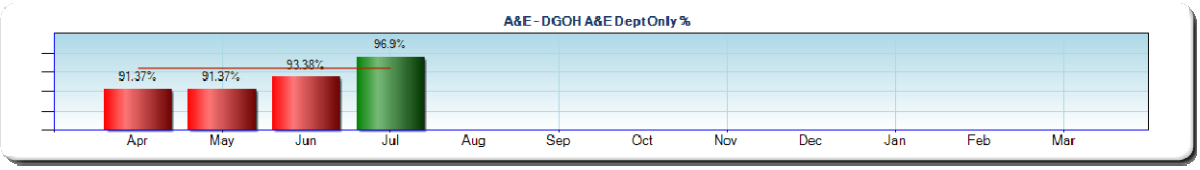
3. Performance Targets and Standards (Appendix 3)

The Trust's non financial performance for the period remains relatively strong. Performance against the Monitor Governance KPI set is given at Appendix 3.

Council will wish to note the following matters:

a) A&E 4 Hour Waits

Quarter 2 has started off very strongly with July's performance coming in at 96.9%, with the new quarter currently standing at 96.6% as at 17th August.



b) Never Events

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

c) Referral to Treatment Waiting Times

Once again the Trust only just achieved the RTT for admitted patients due to the pressure of increased emergency admissions, performance of 90.03% against a 90% target. However, the operational Divisions are confident that all specialties apart from Urology will be back within target by September. For July the specialties that were still under target were Urology, T&O, Ophthalmology, Paediatric Surgery and Oral Surgery.

It is worth highlighting that both the RTT non-admitted and incomplete pathways KPIs are both well within their thresholds, with performances of 99.2% and 96% respectively

d) Mortality Indices (Appendix 4)

The Committee noted that the Standardised Hospital Mortality indicator had improved once again for period Q3 2013-14 (December 2013) from 1.11 previously to 1.08 and now falls well below the expected range. This indicator includes deaths in the wider community and not merely deaths in hospital.

4. CQuIN

The Committee considered exception reports in respect of the following CQuIN targets:

- Pressure Ulcers
- Dementia
- Out Patients GP letters

5. Monitor Q1 Submission

Under delegated authority this submission was approved by the Finance & Performance Committee:

Financial Rating (CoS) Q1 ; 3 (good)

Governance Rating Q1: Amber (A&E breaches)

PA Assinder
Director of Finance & Information

Appendix 1

Activity trends for April to July 2014

Table 1 Actual 2014-15 v Actual 2013-14

The table below highlights the movement in activity between Quarter 1 of 2013-14 and 2014-15 by key points of delivery. The non-elective and outpatient figures exclude maternity.

Q1 Activity 2013-14 to 2014-15

	Volume Variance	%
A & E Attendances	1,808	7.56%
Day Cases (Spells)	361	3.59%
Elective In Patients (Spells)	-201	-10.69%
Referrals	-2,097	-4.85%
Non Elective In Patients (Spells)	569	5.68%
Maternity (Births)	5	0.44%
Outpatient First Attendances	-762	-2.29%
Outpatient Follow Up Attendances	-2,340	-2.80%
Outpatient Procedures	155	1.19%
Community Attendances	-4,446	-4.24%

Q1 Activity 2014-15 to Plan

	Volume Variance	%
A & E Attendances	1,694	7.05%
Day Cases (Spells)	-35	-0.33%
Elective In Patients (Spells)	-210	-11.09%
Non Elective In Patients (Spells)	434	4.27%
Births	-11	-0.95%
Outpatient First Attendances	140	0.45%
Outpatient Follow Up Attendances	-3,804	-4.48%
Outpatient Procedures	-353	-2.62%
Community Attendances	-7,473	-6.92%

Appendix 2

THE DUDLEY GROUP NHS FOUNDATION TRUST

INCOME & EXPENDITURE SUMMARY 2014/15 as at JULY 2014

Current Month Plan £000	Current Month Actual £000		Annual Plan £000	Plan to Date £000	Actual to Date £000	Variance to Date £000
		Income				
25,789	26,488	NHS Clinical Revenue	288,893	97,103	97,522	419
5	3	Private Patient	57	19	21	3
576	600	Other Non Mandatory	6,296	2,428	3,451	1,022
51	140	Research & Development	704	295	534	239
754	660	Education & Training	8,908	2,905	2,825	(80)
41	48	Car Parking	489	163	192	29
11	11	Accommodation	84	42	43	1
308	310	Non Patient Services to Other Bodies	3,470	1,199	1,245	46
287	288	Miscellaneous Other	3,395	1,129	1,173	44
27,822	**28,547**	**Total Income**	**312,296**	**105,284**	**107,006**	**1,722**
		Expenditure				
(2,283)	(2,841)	Drug Costs	(26,703)	(9,114)	(10,197)	(1,083)
(2,282)	(2,564)	Clinical Supplies	(27,358)	(9,127)	(9,440)	(313)
(322)	(505)	Non-Clinical Supplies	(3,816)	(1,389)	(1,665)	(276)
0	0	Secondary Commissioning	0	0	0	0
(15,639)	(14,908)	Employee Benefits (Permanent)	(190,421)	(62,760)	(59,929)	2,831
(138)	(735)	Employee Benefits (Agency/Locum)	(1,551)	(546)	(3,549)	(3,003)
(76)	(100)	Research & Development	(961)	(350)	(388)	(38)
(39)	(63)	Education & Training	(618)	(194)	(170)	25
(80)	(201)	Consultancy Expense	(662)	(318)	(496)	(177)
(1,902)	(1,739)	Miscellaneous Other	(21,992)	(7,647)	(7,367)	280
(2,930)	(2,930)	PFI Unitary Payment	(39,267)	(13,089)	(13,089)	0
1,311	1,311	IFRIC12 PFI Adjustment	17,571	5,857	5,857	0
(780)	(764)	Other PFI Expenses	(7,110)	(2,375)	(2,309)	67
(800)	0	CIP Requirement	6,729	818	0	(818)
(25,961)	**(26,040)**	**Total Expenditure**	**(296,159)**	**(100,236)**	**(102,742)**	**(2,506)**
1,861	**2,508**	**Surplus/(Deficit) EBITDA**	**16,137**	**5,048**	**4,264**	**(784)**
		Other				
20	0	Profit/(Loss) on Disposal	20	20	20	0
0	0	Impairment	0	0	0	0
(750)	(749)	Depreciation	(9,137)	(3,004)	(3,045)	(42)
0	116	Donated Assets	0	0	116	116
12	11	Interest Receivable	140	47	44	(2)
(1,170)	(1,170)	Interest Payable	(13,888)	(4,657)	(4,656)	1
(1,889)	**(1,792)**	**Total Other**	**(22,865)**	**(7,594)**	**(7,521)**	**73**
(27)	**716**	**Net Surplus/(Deficit)**	**(6,728)**	**(2,546)**	**(3,257)**	**(711)**

Appendix 3

Dudley Group FT

Governance Targets and Indicators

Monitor
Independent Regulator of NHS Foundation Trusts

	Threshold	Weighting	Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements							N/A
INFECTION CONTROL (SAFETY)							
HCAI - Clostridium Difficile - meeting the C Diff objective	48	1.0	7	2			**9**
CANCER WAIT TARGETS (QUALITY)							
Max waiting time of 2 weeks from urgent GP referral to date first seen for all urgent suspect cancer referrals	93%	1.0	96.9	96.2*			**96.9**
Max waiting time of 2 weeks from urgent GP referral to date first seen for symptomatic breast patients.	93%		97.3	93.5*			**97.3**
Maximum waiting time of 31 days from diagnosis to treatment for all cancers	96%	1.0	99.7	99.2*			**99.7**
Maximum waiting time of 31 days for second of subsequent treatments – Anti Cancer Drug Treatments	98%	1.0	100	90.9*			**100**
Maximum waiting time of 31 days for second of subsequent treatments – Surgery	94%		98.2	100*			**98.2**
Maximum waiting time of 31 days for second of subsequent treatments – Radiotherapy	94%		N/A	N/A	N/A	N/A	N/A
Maximum two month (62 days) wait from referral to treatment for all cancers – Urgent GP Referral to Treatment	85%	1.0	88.1	85.6*			**88.1**
Maximum two month (62 days) wait from referral to treatment for all cancers – From National Screening Service Referral	90%		100	100*			**100**
**Contains un-validated data for July*							
A&E (QUALITY)							
% Patients Waiting Less than 4 hours in A&E	95%	1.0	92.1	96.9			**93.3**
REFERRAL TO TREATMENT – RTT (PATIENT EXPERIENCE)							
RTT – Admitted % Treated within 18 weeks	90%	1.0	90.1	90.0			N/A
RTT – Non-Admitted % Treated within 18 weeks	95%	1.0	99.2	99.2			N/A
RTT – Incomplete pathways % waiting within 18 weeks	92%	1.0	94.7	96.0			N/A

Community Services (Effectiveness)							
Referral to treatment information	50%	1.0	98.0	99.1			N/A
Referral information	50%		64.9	65.9			N/A
Treatment activity information	50%		99.5	100			N/A

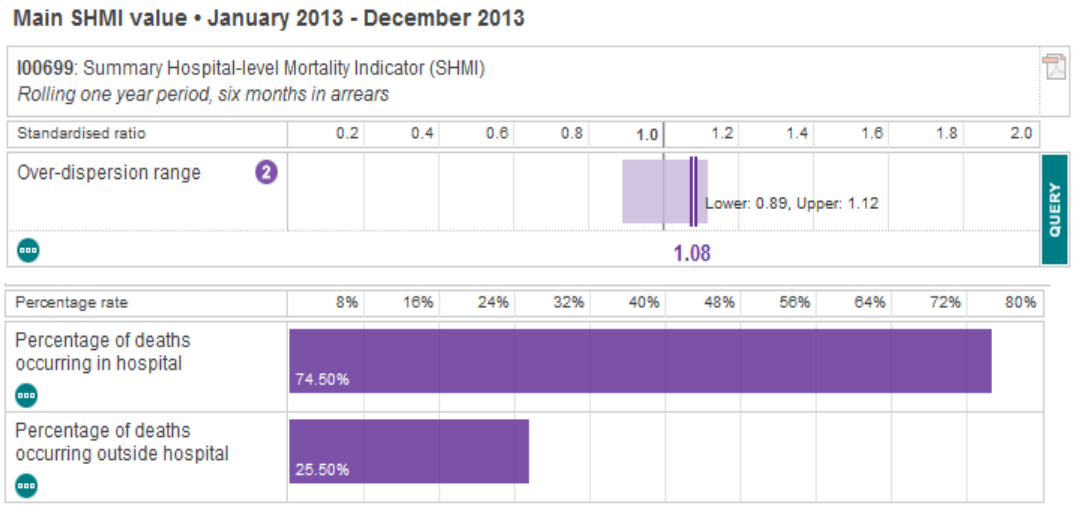
Dudley Group FT

Governance Targets and Indicators

	Threshold & Weighting	Q1	Q2	Q3	Q4	Year To Date
Trust's Governance Risk Rating – All Elements						N/A
PATIENT EXPERIENCE						
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Yes/No 0.5	Yes	Yes			N/A
Risk of, or actual, failure to deliver mandatory services	Yes/No 4.0	No	No			N/A
CQC Compliance action outstanding	Yes/No 2.0	No	No			N/A
CQC enforcement notice currently in effect	Yes/No 4.0	No	No			N/A
Moderate CQC concerns regarding the safety of healthcare provision	Yes/No 1.0	No	No			N/A
Major CQC concerns regarding the safety of healthcare provision (Review of Compliance December 2011 – Outcome 08: Cleanliness and Infection Control)	Yes/No 2.0	No	No			N/A
Unable to maintain a minimum published CNST level 1.0 or have in place appropriate alternative arrangements	Yes/No 2.0	No	No			N/A

Dudley Group FT MORTALITY - SHMI
Quarterly KPI Report

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR - ***Please note that this is pre-release data and not to be shared outside of the organisation until they are published on NHS Choices on the 30th July 2014.***



Source: NHS Choices

SHMI	Source	2013/14 Q1		2013/14 Q2		2013/14 Q3	
	NHS Choices	1.13		1.11		1.08	

Within over dispersion range

Outside of both Poisson and over dispersion range

Graph showing the impact of the 2012/13 Quarter 3 & 4 winter period and the associated increase in death on the last three publications of the SHMI.
Looking at the quarterly SHMI figures for the 2013/14 Quarters 1 to 3 we would expect the SHMI to return back with the expected range within the next one or two reporting periods.