The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 6th June 2013 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – P Clark, D Mcmahon, P Harrison**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 2nd May 2013	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 2nd May 2013	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**	Enclosure 3	Y O'Connor	To Note & Discuss	9.40
6.	**Chief Executives Overview Report**	Enclosure 4	P Assinder	To Discuss	10.00
7.	**Patient Safety and Quality**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 5	D Bland	To Note	10.10
	7.2 Francis Report	Enclosure 6	Y O'Connor	To Note & Discuss	10.20
	7.3 Infection Prevention and Control Exception Report	Enclosure 7	Y O'Connor	To Note	10.30
	7.4 Audit Committee Exception Report	Enclosure 8	J Fellows	To Note	10.40
	7.5 Reports Recommended by the Audit Committee for Approval	Enclosure 9	J Fellows	To Approve	10.50
	7.6 Risk and Assurance Committee Exception Report	Enclosure 10	A Becke	To Note	11.00
	7.7 Risk and Assurance Committee Annual Report	Enclosure 11	A Becke	To Note & Approve	11.10
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 12	D Badger	To Note & Discuss	11.20
	8.2 Charitable Funds Committee Half Yearly Report	Enclosure 13	R Miner	To Note & Discuss	11.30
9.	**Strategic**				
	9.1 Security Report	Enclosure 14	R Miner	To Note	11.40

	9.2 Role of Director of Strategy, Performance and Transformation	Enclosure 15	R Beeken	To Note	11.50
10.	**Date of Next Board of Directors Meeting** 9.30am 4th July, 2013, Clinical Education Centre		J Edwards		12.00
11.	**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		12.00

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 2nd May 2013 at 9:30am in the Clinical Education Centre.

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

In Attendance:
Helen Forrester, PA
Elena Peris-Cross, Apprentice
Tessa Norris, Director of Community Services and Integrated Care
Liz Abbiss, Head of Customer Relations & Communications
Richard Cattell, Director of Operations
Jackie Dietrich, Communications Manager (item 9.3)
Richard Price, Deputy Director of Finance and Information

13/009 Note of Apologies and Welcome

Apologies were received from the Director of Finance and Information and it was noted that Richard Price was in attendance in his role as Deputy Director of Finance and Information. Apologies were also received from the Associate Director for Human Resources.

The Board welcomed Richard Cattell in his new role as the Director of Operations. The Board noted that Richard Beeken was now the Director of Strategy, Performance and Transformation.

13/010 Declarations of Interest

There were no declarations of interest.

13/011 Announcements

The Chairman announced he would ask for points of clarification at the end of the agenda.

13/012 Minutes of the previous meeting, 4th April, 2013 (Enclosure 1)

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

13/012.1 Action Sheet 4th April 2013 (Enclosure 2)

Board members noted all actions were complete or on the Agenda to be discussed.

13/013 Patient Story Report (Enclosure 3)

The Board noted that negative patient stories had been presented at the previous two Board meetings and now a positive patient story will be presented.

The Nursing Director presented a thank you letter from a patient who was also a Medic, and explained that the letter had been redacted of personal information however we now have approval for this information to be released.

David Badger, Non Executive Director commented that it was good to see such a positive letter of thanks and it is important that we share these positive stories with staff.

The Medical Director notified the Board that compliment letters are shown to Medics as part of the appraisal process.

The Chairman noted the point of giving the positive feedback to relevant staff.

The Nursing Director explained that this patient story had also been presented at the CCG Board meeting.

13/014 Chief Executive's Report (Enclosure 4)

The Chief Executive presented her report given as enclosure 4 including the following items:

- **Capacity and Emergency Pressures:** The Trust has experienced a high level of escalation in capacity and emergency, the whole of the Black Country has seen the same pressures. The West Midlands Ambulance Service predicted the busiest weekend ever over the coming May Bank Holiday weekend.

The Chairman asked why the West Midland Ambulance Service predicted such a bad weekend.

The Chief Executive explained that it was a Bank Holiday and the Ambulance Service use a sophisticated modelling tool that looks at national figures and historical trends.

Jonathan Fellows, Non Executive Director asked if there had been an increase in emergency pressures due to the difficulty in obtaining GP appointments, he went on to ask if that was having an effect on our Trust.

The Medical Director confirmed there was an effect following the change of the GPs' contract with more work going into the acute sector.

David Badger, Non Executive Director asked how the local health economy responded to the emergency pressures.

The Chief Executive clarified that the health economy in Dudley has been working well together, however the pressure is extreme at the moment and we are having to cancel elective surgery.

- **NHS 111:** There have been problems nationally, the CCG and Social Services are working hard to try and manage pressure for the weekend.

- **NHS Choices:** NHS Choices has been central to the Keogh review and the CCG have the NHS choices link on their website homepage. We have included this link onto our own hub so staff can view the positive and negative comments to review and action.

- **Keogh Review Mortality Indicator Outliers:** The Board noted that the Keogh Review Team are reviewing the Trust on the following Tuesday and Wednesday. The Executive Team were given 24 hours to comment on factual accuracy of the data, this will be published on the NHS Choices website. The Agenda for the review will be agreed tomorrow. Unannounced visits will be taking place before a Risk Summit in early June, and the Chief Executive, Nursing Director and the Medical Director have been requested to attend. The final report will be published in the public domain. Communications are working on media comments however we cannot give the public information until the Keogh Review Team have confirmed we are able to do so.

  The KLOEs we have received look at – Governance, Clinical Operations, Patient Experience, Workforce and some other specific areas.

  The Review Team have requested that staff listening groups are put together for them. In addition they will also hold a public meeting on the Tuesday evening. A meeting with the Lead Governor and the Council of Governors will also be held.

The Chairman reminded the Board that there was a Council of Governors meeting that evening and they will need to be provided with an update.

13/015 Quality

13/015.1 Clinical Quality, Safety and Patient Experience Committee (Enclosure 5)

David Bland, Committee Chair, presented the Exception Report given as Enclosure 5; the Board noted the following key issues:

- **Patient Safety Walkrounds:** There had been 28 in the last 12 months; this is a good figure at 2 per month on average.

- **Nursing Care Indicators:** The Trust had shown good results for quarter 4

- **Paediatrics Quarterly Assurance Revisit:** The visit went very well, some areas of good practice noted.

The Chief Executive informed the Board that the Paediatric Trainees said they would all recommend the Dudley Group as a place to work.

The Chairman asked what had changed since the last visit.

The Chief Executive confirmed that a lot of work had been done engaging trainees and the problem was that we have a lot of different types of trainees that have very different and specific needs.

The Board adopted the report and noted the issues arising.

13/015.2 Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (Enclosure 6)

The Nursing Director presented the report given as Enclosure 6 to note and discuss.

The Nursing Director informed the Board at the last meeting it was agreed to include this report as a formal briefing paper. This report showed the beginning of an action plan. The assigned lead for each recommendation and actions will be populated for the next Board meeting.

David Badger, Non Executive Director pointed out items 75 and 76. The Role of Governors should be referred to the Governor Development Group.

The Chairman confirmed that the Fit and Proper Persons test should be assigned to himself and the Code of Conduct should be assigned to the Executive Directors and the Governors. He added it was important that the Board fully understood the Code of Conduct.

The Chairman suggested it would be helpful to have a single document drawing together the work from Francis 1 and Francis 2.

The Chairman agreed that the report would stay on the agenda monthly until later in the year and bi monthly thereafter.

- **Fit and proper person test to be assigned to the chairman**
- **Code of Conduct to be assigned to the Executive Directors**
- **Role of Governors reffered to the Governor Development Group**

13/015.3 Infection Prevention and Control Exception Report (Enclosure 7)

The Nursing Director presented the Infection Prevention and Control Report given as Enclosure 7**.**

The Nursing Director informed the Board that this report covered a formal end of year position which remains unchanged since the last Board report.

- **C. Diff:** The Trust has shown real improvements in C. Diff with a 50% reduction in April. There was 1 case of C-diff in April, the target for this year is 38

- **MRSA:** The Trust is below trajectory for MRSA, there is a 0 MRSA target for this year.

- **Norovirus:** The Trust still has no cases of Norovirus to report.

The Chairman asked if we are using the Hydrogen peroxide fogging machines effectively.

The Nursing Director assured the Board that these were used whenever possible and that more work had been put into looking where we can make further improvements such as appointing a further antibiotic pharmacist and moving to seven day working.

Ann Becke, Non Executive Director confirmed that she had read a report that closed windows aids infections and asked if we keep windows open to prevent infection.

The Nursing Director reported that an initial conversation had taken place regarding infections speading because of closed windows however there were difficulties around controlling the temperature with open windows which caused problems especially with elderly patients. Liz Rees is looking at the evidence in more detail.

The Chairman asked if there had been any changes between the Trust and the CCG around imposing of penalties.

The Deputy Director of Finance informed the Board that the CCG will not have a choice; they will have to impose a fine if we fail to meet a target.

David Badger, Non Executive Director asked if there was any tolerance on the MRSA target.

The Chief Executive said it was likely to be the same as previous years.

Jonathan Fellows, Non Executive Director asked how the CCG would impose fines.

The Chairman asked that this was reported back to the Board.

The Board noted the report, the positive outcome for this year, the investment of an Antibiotic Administrator and the move to 7- day working.

13/015.4 Nursing Strategy (Enclosure 8)

The Nursing Director presented the full Nursing Strategy given as enclosure 8 and asked the Board for approval.

The Nursing Director explained that Jane Cummings, Chief Nurse for England had produced a national strategy and after consultating with our own staff we have formed our own nursing strategy which Jane Cummings will be visiting the Trust on 7th May to launch it. The Francis report has highlighted further the importance of this strategy.

The Nursing Director presented 'The Way we Care' handouts that support the Nursing strategy and act as a summary document.

Richard Miner,Non Executive Director queried the comment over Student Nurses practising as HealthCare Support Workers for a year.

The Nursing Director clarified that we have received no details on how this will work. It is important we are robust on the training of our Healthcare Assistants and our work on this has been recognised at national awards.

The Chairman noted that the strategy will be reviewed quarterly by the Clinical Quality, Safety and Patient Experience Committee and then to the Board.

Board members noted that one 'C' of the strategy is Courage and we need to have a very robust system for reporting issues.

The Nursing Director pointed out the difficulty of this as we cannot require staff to use the strategy, only encourage them. The strategy will be reviewed to see if we can strengthen the words around having the courage to report issues.

Richard Miner, Non Executive Director asked if the Whistle Blowing policy was robust enough to encourage the staff to use effectively.

The Chief Executive explained that it was important to create a culture around open doors to support the policy and make staff feel secure and confident to raise things confidentially, it cannot just depend on what is written in policies.

The Director for Community Services and Integrated Care pointed out that on Patient Safety Walkrounds the Executive and Non Executive Directors encourage staff to contact them directly, we also have Staff Governors to whom any concerns can be raised.

Jonathan Fellows, Non Executive Director spoke with regards to page 10 of the Nursing Strategy and corrected the wording ‘matron attending each Board’’ to read ‘’every other Board’’. He also asked why the appraisal target was set at 89%.

The Nursing Director informed the Board that due to new starters, maternity leave, staff leaving and sickness we will never be able to achieve 100% on the appraisal target, however of the appraisals we can complete we achieve 100%.

David Bland, Chair of the Clinical Quality, Safety and Patient Experience Committee said he welcomed the work behind the strategy and felt assured by the comments on the Nursing Strategy Graffiti Board.

Ann Becke, Non Executive Director reassured the Board that she has had staff raise concerns with her and was comfortable we have an open culture.

The Chair noted the Chief Executive’s point over culture and commented that work had to be done to achieve this. The wording around appraisals should read ‘’100% of all eligible should receive appraisals.’’ The wording around Matrons attending Board should read ‘Matrons are to attend Board every other month.’’

The Chairman took note of the typing errors and pointed out the importance that this strategy is for all staff and not just the Nursing Directorate.

The Board approved the strategy subject to amendments.

Change the wording of the information around Appraisals and Matrons in the Nursing Strategy document

13/015.5 Quality Accounts (Enclosure 9)

The Nursing Director presented the draft Quality Accounts report given as Enclosure 9.

The Nursing Director explained that this was a draft of the report to show the Board the content of information.

Jonathan Fellows, Chair of the Audit Committee confirmed that this was an excellent document that was helpful and clearly set out despite the small time-scale to complete.

The Chairman noted the positive comments from the Chair of the Audit Committee and asked that any additional comments were reported directly to the Nursing Director.

The Nursing Director informed the Board that the document will be taken to the Audit Committee on the 15th May 2013.

The Board approved the Quality Accounts document subject to further amendments and changes.

The Chairman thanked the Nursing Director and her team for their work.

13/016 Finance

13/016.1 Finance and Performance Report (Enclosure 5)

The Chair of the Finance and Performance Committee presented the summary of papers received by the Finance and Performance Committee given as Enclosure 10.

Performance Targets and Standards: The Board were notified that the Trust had shown strong performance against targets and standards. It had met a vast majority of the targets however missed the 4hr wait target for the final quarter, achieving 92.6% against a target of 95%. We achieved the 4hr wait target in quarters 1, 2 and 3 despite the increasing number of ambulance presentations and more majors. The Trust has put a number of measures in place to address these issues. No other Trust in the region met the 4hr wait target for quarter 4.

The Board noted there were no CQC concerns.

The Chairman asked for clarification over the governance ratings and why missing the accident and emergency target tipped the governance rating to amber.

The Deputy Director of Finance and Information assured the Chairman he would clarify and report back.

Income and Expenditure: At year end for 2012/2013, the Trust has a strong surplus of £2.9 Million which reflects an underlying reccurent budget of £1.1 million **.** It has a CIP of around £4 Million that was non recurrent, this has to be covered in the budget for the new financial year. We have £12 million to save in 2013/2014.

Appraisals: We achieved over 72% this month which is a 10% increase since last month but is still not on target. The Chair of the Finance and Performance Committee informed the Board that we had received new initiatives on Mandatory training, he expressed he was comfortable that the Trust was moving in a good direction on this.

The Chairman asked that the Finance and Performance Committee looked in more detail at the compliance framework and the Board noted the report and the Trust's financial pressures for the next year.

13/ 017 Corporate and Strategic

13/017.1 Research and Development Report (Enclosure 11)

The Medical Director presented his report given as enclosure 11.

The Board were notified that Research and Development were subject to a reduction in funding. This funding cut back is not as significant as originally anticipated, however we do not know what the implications for next year will be.

The Medical Director informed the Board that a serious adverse indident in clinical trials is not the same as our other reported SUI's in the Trust. The Board noted a Research and Development facilitator had been appointed on a 2 year fixed term contract to ensure every one possible participates in trials.

The Board noted the key issues and the positive report but also noted the unclear future around funding for Research and Development.

13/017.2 Non Executive Director Lead Responsibilities Report (Enclosure 12)

The Chairman presented the report given as Enclosure 12 and informed the Board that the Non Executive Director lead responsibilities would be reaffirmed each year.

The Board approved the report.

13/017.2 Listening Into Action Update Report (Enclosure 13)

Jackie Dietrich, Communications Manager, presented the report given as Enclosure 13.

The Board were informed that all teams were on the 2nd phase.

Ann Becke, Non Executive Director asked how this was going in terms of staff engagement.

Jackie Dietrich informed the Board that the Trust had lost a little impetus and it needs to re-launch with stage 3. We now we have a new Communications assistant and more capacity can be given this in the next couple of months.

David Badger, Non Executive Director commented that he would expect this work to become embedded at some stage.

Jackie Dietrich confirmed that the process has become embedded, for example in Paediatrics the process and find it very productive.

The Chairman noted the report and the progress made and the impending re-launch.

- **Continue to push staff engagement and Re-launch process**

13/018 Any Other Business

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

13/019 Date of Next Meeting

The next Board meeting will be held on Thursday, 6th June, 2013, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

PrivateBoardMinutes2ndMay2013

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 2 May 2013

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
13/015.2	Report of the Mid Staffordshire NHS foundation Trust Public Enquiry	Fit and Proper Persons Test assigned to the Chairman. Code of Conduct assigned to the Executive Team. Role of Governors referred to the Governor Development Group.	C CE DB	With immediate effect	
13/015.4	Nursing Strategy	Wording of appraisal information in the Strategy to be revised.	ND	6/6/13	
13/017	Listening into Action Update Report	Continue to focus on staff engagement and prepare for re-launch.	JD	4/7/13	

The Dudley Group
NHS Foundation Trust

Enclosure 3

Paper for submission to the Board of Directors meeting on 6th June 2013

TITLE:	**Patient Story**		
AUTHOR:	**Mandy Green, Deputy Head of Communications and Patient Experience**	**PRESENTER**	**Yvonne O'Connor**

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

SUMMARY OF KEY ISSUES:

A story from a patient who wished to share their good experience of our services on B4, B5 and in Theatre. The patient was only frustrated that there didn't appear to be a way of making her feelings known about the good service she received and had to go via the Complaints Department. The patient explains how the staff were able to put her at ease before, during and after her surgery.

The feedback has been shared with the ward and theatre.

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	**Y**	**Details:** Better Health outcomes Improved Patient access and Experience
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS FOR THE BOARD:

To view a patient story

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 6th June 2013

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Report
- Keogh Review into Quality of Care and Treatment - update
- Designated Trauma Unit status confirmation

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

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

The Dudley Group NHS
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Chief Executive Update – June 2013

Friends and Family Report:
Additional effort is being put into the A&E Friends and Family Test to improve the uptake of the Friends and Family test. Some improvement is being seen by week four, which shows the Trust-wide completion rate now up to 12 per cent. We need to achieve 15 per cent for quarter one – action is being taken to better embed the process in A&E and text messaging options are being investigated. A token system was considered but the A&E department did not wish to persue this and felt they could improve with the current method. Current cumulative Trust-wide completion is eight per cent.

Ward completion rates remain high.

	April 13 Overall	May 13 wk 1	May 13 wk 2	May 13 wk 3	May 13 wk 4
Date range	01.04.13 30.04.13	29.04.13 05.05.13	06.05.13 12.05.13	13.05.13 19.05.13	20.05.13 26.05.13
Ward FFT score	65	75	68	83	69
Ward footfall (min'm 15% required)	19%	25%	27%	27%	31%
A&E FFT Score	53	50	40	70	80
A&E footfall (min'm 15% required)	0%	1%	1%	1%	3%
TRUST FFT Score	65	73	66	82	71
TRUST footfall	6%	9%	8%	10%	12%

Guidance has now been issued for implementing the Friends and Family Test into Materntiy by October 2013. Women are to be surveyed at three touch points:

1. Antenatal care – at the 36 week antenatal appointment
2. Birth and care – at discharge from unit/following a home birth
3. Postnatal community care – at discharge from the care of the community midwifery team

Work is underway with the Maternity unit, information department and Trust IT to meet the implementation deadlines.
The new Friends and Family Test commenced on the wards and in A&E at the end of March in readiness for 1st April 2013.

As at April 23rd, wards were reaching 20% of footfall but A&E is still struggling at <1%.

Anecdotally a low A&E response appears to be the case in many Trusts. The Clinical Quality, Safety and Patient Experience Committee has agreed that the Trust will look into a text survey option to try to increase response rates.

Keogh Review into Quality of Care and Treatment:
Both the announced and unannounced visits from the team have now taken place. The data pack produced by Price Waterhouse Coopers (PwC) was published on the NHS Choices website and the Trust worked with the team at PwC to address our concerns about factual accuracy, some of which were accepted in the final publication. The themes under review were mortality indicators, clinical and operating effectiveness, patient experience, workforce and safety. The Risk Summit takes place on 6th June after which reports on Batch 1 of trusts reviewed will be published.

Designated Trauma Unit Status:
We have now heard that we are formally designated as a Trauma Unit within the West Midlands network. We will continue to be performance managed on our achievement of the required standards and will continue working with colleagues at University Hospital Birmingham as the Major Trauma Centre for our area.

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 6th June 2013

TITLE:	**Summary of Key issues from the Clinical Quality, Safety & Patient Experience Committee held on 11th April 2013**		
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:

Blood Transfusion and Competency Training - Dr Taylor attended the Committee to provide an update on training provided for Anaesthetists. 24 staff had attended training (39%). Training sessions would continue during April following which further sessions would be provided to capture staff that had not attended. It would then be rolled out to ED medical staff. Many Anaesthetists had previously attended training but had not been competency assessed. Dr Taylor also outlined the changes that had recently been made to nurses training and indicated that this had been combined with the IV course which ran over 2 days and was completed every 3 years.

Quality Page Web Site Update - The Committee received an update on the development of the web site. Patient experience would be sited under the "Quality" tab but would link to other sections to ensure ease of use for patients. It would also be accessible via a search and via the Patients and Visitors buttons to make the pages as user friendly as possible. The Committee agreed that good news should also be shared and a link should be provided to the Governors.

Regional Screening Committee Failsafe Visit - the Specialist Midwife Screening Co-ordinator presented the Action Plan developed following a Regional Screening Committee Failsafe visit in January 2012. The report was received in November 2012 and was provided after a number of screening serious incidents occurred in a local trust. The Committee **supported** the identified action required to achieve compliance with the recommendations following the visit.

Clinical Audit Findings - The Committee received the current position on national and local audits and noted that the Clinical Audit Annual Report for 2012/13 would be received at the Audit Committee. The Committee discussed the potential to link audits to the risk register and the difficulty in ensuring that all audits were completed when junior doctors were on rotation. The use of data and risks associated with the sharing of unvalidated data presented outside the organisation was also considered.

National Institute for Health and Clinical Excellence (NICE) Guidance Update - There had been a significant reduction in '**not yet assessed overdue'** NICE Guidance, reducing by 68% from 41 down to 13 and an increase in the number that were fully compliant, rising by 38% from 39 to 63. The Committee **received** the information on current NICE Guidance and **noted** the level of compliance and actions in progress.

CQC Visit - The Committee received the Final Report from the CQC visit to the Trust in February 2013. Five wards and two departments were visited and the Trust was found to be compliant with the six standards checked. Whilst not formally required, an action plan will be developed to consider the items to be noted.

Privacy and Dignity Review - The Committee received an action plan arising from the Dudley Metropolitan Borough Council Health and Adult Social Care Select Committee (HASC) which looked at Privacy and Dignity at the Trust.

Quality Dashboard Report for Month 11 - the overall performance position was very strong for

the current list of Quality indicators. However five indicators were red in February:

- Maternity: Increase in breast feeding initiation rates
- Maternity: Smoking in Pregnancy
- Never event: Retained instrument post-operatively
- SUI: Notification of SUI incidents to STEIS within 2 operational days
- TAL Appointment - Booking within 4 days. These were down from 71.9% in January to 56.9% in February.

Rate of 'Serious Harm' Patient Safety Incidents Report - the National Reporting Learning System (NRLS) Organisation Patient Safety Incident Report (1st April 2012 – 30th September 2012) showed that although the Trusts 'Severe' and 'Death' categories were comparable with national figures the 'Moderate harm was higher than national figures. The NHS Commissioning Board had confirmed that the Trust had reported just over 4000 incidents to the NRLS during the period and were showing in the 50th percentile overall. The Committee considered the importance of learning from incidents and noted that nationally, 67% of incidents were reported as no harm and just under 1% as severe harm or death. The response to incidents was the most important aspect of the system. The Committee discussed the impact of incident reporting, expected actions and changes in practice including the impact of the integration of Community services. They **noted** the current position with regard to the number of 'Moderate' severity graded incidents and the proposed actions.

Serious Incident (SI) Monitoring Report - the following issues were highlighted: 13 new incidents were reported – 10 general SI's and 3 pressure ulcers. There were 45 open general SI's (19 under investigation, 14 awaiting assurance that all actions identified from the RCA investigation had been completed and 2 requiring additional assurance. 8 were recommended for closure). Concerns highlighted from the General SI's included falls resulting in a fracture and pre-delivery still births. There had been no breaches in the 2 day reporting from date of identification and completion of RCAs within the agreed time scales.

Health Records Group - The Committee **received** the report for information and assurance.

Friends and Family Survey Results - the Friends and Family Test Report highlighted the following issues:

- The Net Promoter Score (NPS) was Green for March.
- The Friends and Family Test had commenced in the Emergency Department.
- Food moved back to the top of the list for improvements required.
- 2013/2014 patient experience CQUIN focused on the Friends and Family Test.

The new system for 2013/14 had been introduced across wards and ED. There had been a slow start in ED as expected and some concern around meeting the baseline target of 15% in ED in Quarter 1. The possibility of using text messaging as a means of capturing the information would be explored.

National Inpatient Survey Results - The formal report will be released on 16th April 2013. In the interim the Committee received the headline position. 'Discharge' had moved from 'Worse' to 'About the same' category. There were two sections (ED and Waiting for a bed) that had moved from 'about the same' to the 'worse' category. ED had dropped to the 'worse' category despite an increase in score.

Workforce and Patient Experience Strategy – The paper provided an update on the progress of HR actions in the corporate Patient Experience Strategy and the outstanding actions from the implementation of the HR Strategy received and reviewed by the Committee throughout the year. The purpose of the original paper was to receive and monitor progress against action plans, targets and objectives for Staff Engagement, Recruitment and Leadership Development. Many actions had been achieved in 2011/2012; the remainder were transferred to the new strategy paper.

National Staff Survey Results 2012 - The Committee received the National Staff Survey Results

for 2012. The response rate for the Trust was 35.8% which had decreased since 2011 by 6.9%. The survey was completed between September and December 2012 and a sample of 850 pre-selected individuals were invited to participate. Overall staff engagement was represented as a figure out of a total score of 5 and the score for the Trust for 2012 was 3.64, compared to 3.66 last year. The National Average for acute trusts was 3.69. 51% of all questions were rated positively with 43% negative. Questions were grouped into key findings and the report considered the published top 4 findings and bottom 4 findings. These were measured against national results. A summary of all results was illustrated under 5 themes. 3 out of the 5 had increased scores compared to 2011.

The Committee reviewed the results and discussed the outcome, comparing the results with the comparisons available. It was noted that KF14 - % of staff reporting errors, near misses or incidents witnessed in the last month and KF 10 % of staff receiving health and safety training had decreased when compared to 2011.

Drugs and Therapeutics Group - the key issues arising from the meeting held in March were highlighted and discussed.

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

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

ACTION REQUIRED OF BOARD:

Decision	**Approval**	**Discussion**	**Other**
		Y	

RECOMMENDATIONS FOR THE BOARD:

To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 11th April 2013 and refer to the full minutes for further details.

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

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on June 6th 2013

TITLE:	**Francis Inquiry Table of Recommendations requiring Local Action**		
AUTHOR:	**All Directors**	**PRESENTER**	**Mr Assinder Director of Finance and Information**

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

SUMMARY OF KEY ISSUES:

At the last meeting the Board received a report proposing an approach for the management of locally identified actions arising from the recommendations in the Francis Inquiry. This focussed only on those actions that could be progressed prior to action by any related third party organisations and omitted those recommendations identified for specific external organisations/ regulatory bodies.

It was agreed that the table format presented to the Board would form the basis of future reports incorporating regular progress information. The attached table confirms the current position and the lead Directors assessment of progress.

Additionally, Directors have considered the need to raise awareness and provide training for staff across the organisation on some of the key themes/issues arising from the Inquiry which provide learning opportunities and will improve patient safety and care. These are currently being developed.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	**Approval**	**Discussion**	**Other**
	Y		

RECOMMENDATIONS FOR THE BOARD

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

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

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
	Availability for implementation of the recommendations These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.					
1	Implementing the recommendations	It is recommended that: • All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work; • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions;	Introduction	Board	The Board has received regular reports on both the Themes arising from the report and the recommendations and has agreed a process for monitoring the progress against local actions quarterly. The Chief Executive issued a formal Statement of Acceptance in February 2013. The Board has requested quarterly update reports on local actions.	G
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.					
4	Clarity of values and principles	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21	Board	Whilst the NHS Constitution underpins the core values and principles of the Trust, these will be re-visited and re-consider n light of the report and recommendations made.	A

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
	Fundamental standards of behaviour Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.					
11		Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements.	20	All	All staff have responsibilities to the public, their patients and colleagues and are expected to contribute to and comply with Trust procedures.	G
		Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary.	20	Director of Nursing / Medical Director	In place. Evidence report to Board and CQSPE	**G**
12		Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	2	Director of Nursing	Feedback and learning needs to be further enhanced	A

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
	A common culture made real throughout the system – an integrated hierarchy of standards of service No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.					
	Responsibility for, and effectiveness of, healthcare standards					
37	Use of information about compliance by regulator from: • Quality accounts	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them.	11	Director of Nursing	Quality accounts audited by Deloittes. Compliant since 2009/2010	**G**
		To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website.			On website	**G**
		Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information.			Compliant – all quality measures published.	**G**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions					
75	Enhancement of role of Governors	The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	10	Council of Governors and Chairman	The Board and Council of Governors will work together to progress these recommendations.	A
76		Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	10	Council of Governors and Chairman	The Board and Council of Governors will work together to progress these recommendations.	A
79	Accountability of providers' directors	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	10	Chairman	Directors are currently required to comply with individual professional codes of practice and professional registrations. Any recommendations to comply with a prescribed code of conduct for directors that is not currently part of directors contracts will be complied with.	G
81		Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.	11	Board		

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
84		Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	10	Human Resources/ Board Secretary	This situation has not arisen in the Trust. However should this ever be the case then the Board Secretary together with the Associate for HR would make the necessary referrals.	G
86	Requirement of training of directors	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	10	Board/Human Resources	Annual appraisals are completed with all board members and their respective line managers. This process includes a review of the previous 12 months objectives, setting the coming year's objectives and the completion and agreement of a personal development plan which is reviewed during the appraisal discussion.	G
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings					
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13	Director of Transformation and Performance	The Health and Safety Manager role is currently vacant and is being considered as part of a restructuring of the F&E function within the Trust. Whilst arrangements for reporting RIDDOR incidents remain sound, the review of this recommendation will have to be deferred until the appointment of a new Health and Safety Manager for the Trust.	R
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13	Director of Nursing	We will work with the HSE to meet any new requirements.	TBA

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
	Enhancement of the role of supportive agencies					
97	**National Patient Safety Agency functions**	Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	17	Director of Nursing	We already upload to the NRLS.	G
	Effective complaints handling Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.					
109		Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	3	Director of Nursing	• Complaints/PALS email address shown on Trust website • Leaflets available on wards and in clinic areas • Posters on all ward notice boards and in departments • Free phone telephone number to call department • Freepost address available for those who wish to write to us • Staff available to meet complainants to assist with documenting concerns	G
110	Lowering barriers	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	3	Director of Nursing	Advice given regarding patient choice to wait for conclusion of formal complaint investigation before proceeding with litigation. However, if complainants suggest legal action being taken this does not preclude a full complaint investigation and response being provided.	A

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
111		Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	3	Director of Nursing	• Posters distributed to wards and departments encourage patients/relatives to raise issues with ward staff. • All wards display photographs of matron, lead nurse and (usually) ward staff at ward entrances. • Comments made on NHS Choices website displayed on Trust's intranet hub for staff to read • Real time surveys undertaken by patient experience team who will refer individuals if appropriate.	A
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	3	Director of Nursing	• New Trust complaints web-based database will allow all staff with access to computers to have read-only access • This point to be further investigated when new database is installed	A
113	Complaints handling	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	3	Director of Nursing	The recommendations made by the Patients Association have been reviewed and will be followed	A
114		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	3	Director of Nursing	The new Trust web-based complaints database which automatically links to incidents will trigger automatic alerts when serious complaints or comments are received.	A

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
115	Investigations	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply:	3	Director of Nursing		
		• A complaint amounts to an allegation of a serious untoward incident;			All Sis have a RCA	R
		• Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion;			Process in place	G
		• A complaint raises substantive issues of professional misconduct or the performance of senior managers;			Nursing staff referred to NMC and Doctors referred to GMC. No process for managers or CSW. Disclosure and Barring used for Safeguarding issues for all staff.	A
		• A complaint involves issues about the nature and extent of the services commissioned.			Process in place	G
116	Support for complainants	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	3	Director of Nursing	The Trust's complaints leaflet (sent to all complainants when acknowledgement of complaint is sent) gives details of ICAS – i.e. telephone number and address	G
117		A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	3	Director of Nursing	Local Advocacy service is available for complainants who require specialist support. ICAS can provide expert advice to their Clients if required.	G

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
118	Learning and information from complaints	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	3	Director of Nursing	This is not currently the case complaints are not published on website. The Process needs review to include this agreement with the complainant.	**R**
119		Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	3	Director of Nursing	The process needs to be revised to obtain complainants permission to undertake this.	**R**
	Performance management and strategic oversight					
142	Clear lines of responsibility supported by good information flows	For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	8	Director of Finance and Information	The Trust has recently reviewed the composition and management of Directorate Performance meetings but will consider this in line with the wider review of overall governance structures and reporting lines.	A
143	Clear metrics on quality	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	8	Board	The Trust has developed a comprehensive set of quality metrics and will continue to monitor the effectiveness of these.	G

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.					
173	Principles of openness, transparency and candour	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	22	Board	This is fundamental to the Vision and Values of the Trust "Where People Matter". The Trust will issue a Board statement to all staff re-confirming these principles	A
174	Candour about harm	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	22	Medical Director	On 14th May the Medical Director advised all Consultants (inc Locums) and Trust Non-Consultant Medical Staff, of these requirements and confirmed that the Trust would not support any approach that was not consistent with these recommendations.	G
175		Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	22	Medical Director		

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
176	Openness with regulators	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	22	Board / Chief Executive	The Trust will continue to act with professional integrity at all times when making statements to regulators , commissioners or the public	G
177	Openness in public statements	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	22	Chief Executive		
179	Restrictive contractual clauses	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	22	Associate Director of Human Resources	We have discussed this with our legal representatives and they have assured us that this has not been part of the Trust way of working in the past. We have always taken legal advice on any contractual clauses and will continue to follow this practice to ensure that this recommendation continues to be implemented.	G
180	Candour about incidents	Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.	22	All Executives	The Trust reviewed and updated the Being Open Policy as part of the NHSLA assessment in 2012 and will monitor compliance with this.	G

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

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

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
185	Focusing on culture of care	Encouraging them to report concerns and to give priority to patient well-being			Continue to nominate for National Awards and Committed to Excellence Awards Advertised on the Hub – Fortnightly – open drop in sessions 'The Way We Care'	**A**
		Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	23	Associate Director of Human Resources	An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation.	A
		As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	23	Director of Nursing	Appraisal to include NMC Code of conduct and The Way We Care evidence. Compliments and Complaints also to be included.	**A**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
		Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	23	Director of Nursing	This is being implemented and Matrons are supervising the process. Ward round bundles also require lead nurses to know all patients and be present on rounds. Skill mix and staffing review to be commenced using AUKUH tool to ensure supernumerary status of lead nurse.	**A**
					Datix to be completed when not supernumerary.	**R**
					Appraisal process is in place with clear person responsible for each appraisal.	**G**
					Matrons should also be visible to patients and relatives and should be ward based.	**A**
199	Key nurses	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient	23	Director of Nursing	Allocation for each shift is in place.	**G**
					Wards round bundle is being rolled out.	**A**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
	Caring for the elderly Approaches applicable to all patients but requiring special attention for the elderly					
236	Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	25	Medical Director	Email from Medical Director to all CDs on 14th May 13) Requesting assurance on this issue.	G
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations	i) MDTs currently form a vital part of care at DGNHSFT. ii) A review, initially in care of the elderly, will be undertaken to ensure that the contribution of all staff involved in the care of patients is included (particularly linking different teams, PFI partners etc), and the lessons of Francis applied where appropriate	A
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:	25	Director of Nursing		
		• All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.			Matrons and Lead Nurse availability posted on ward trialled in Paediatrics being rolled out.	**A**
		• Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients			Every ward has an area that is confidential to converse with patients and visitors.	**G**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
		• The NHS should develop a greater willingness to communicate by email with relatives.			All e-mails from patients relatives and nurses are responded to by the Executive team. Ward level will require more process.	**G** **R**
		• The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered.		Director of Ops/Medical Director	The trust plans to move to an Electronic Patient Record system in the future and will include this requirement in the system specification	R
		• Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.			Care plans available at the bedside.	**G**
					Communication with relatives/visitors sheet being trialled on C7.	**A**
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25	Director of Operations	i) Late night discharge reports to be provided to clinical teams routinely to enable peer review and challenge ii) Review of the criteria for and protocol supporting patient moves at night as a requirement of managing bed capacity during periods of high escalation levels Discharge lounge is now appropriately staffed and furnished to provide care for patients awaiting discharge. Further work is being undertaken to improve the uptake of the service provided by the discharge lounge	G

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
240	Hygiene	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	25	Director of Nursing	Hand hygiene audits completed by Infection Control Team which tests this all observational audit. Posters and screen savers support this culture.	**G**
241	Provision of food and drink	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	25	Director of Operations	i) MUST assessments and subsequent red tray / food/fluid balance charts implemented for all patients, assurance is gained via nursing care indicators ii) The nursing team are responsible for providing food and drink to elderly patients. They are supported by Nutrition Support Workers (on A2 only) and IFM housekeeping staff who ensure availability on the ward iii) A multi-disciplinary team drawn from nursing teams, nutrition group and housekeeping will identify and agree best practice at DG NHS FT.	G

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
242 243	Medicines administration	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	25	Director of Operations	i) The nurse administering medicines routinely checks for all required medicines and acts on medicines which are not given ii) The medicines management policy and subsequent mandatory training includes the need to constant vigilance in ensuring medicines are given at the appropriate time iii) Medicines link nurses act as a link between the ward nurse and pharmacy, the learning programme for medicines link nurses includes checking administration	G
	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25	Director of Nursing & Medical Director	Not currently possible to record electronically.	**R**
					Paper charts are at each bedside.	**G**
					Compliance with charts is audited via Nursing Care Indicators.	**A**

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

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
		• Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. • Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.				
245	Board accountability	Each provider organisation should have a board level member with responsibility for information.	26	Director of Finance & Information	In place - Director of Finance & Information	G
247	Accountability for quality accounts	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.	26	Board secretary	Complied with	G
248		Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	26	Director of Finance & Information	Complied with	G
249		Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	26	Board secretary	Complied with	G

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	RAG
255	Using patient feedback	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	26	Director of Nursing	1. New web pages for patient experience being developed. 2. Patient experience results posters currently displayed on wards – this are being refreshed and improved.	**A**
256	Follow up of patients	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	26	Director of Nursing	The Friends and Family Test follows patients up on discharge/shortly after. The new website will host more online surveys – awareness will be raised via the ward leaflets	**A**
262	Enhancing the use, analysis and dissemination of healthcare information	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatments	26	Director of Finance and Information	The Trust had adopted robust manual information sharing arrangements. At present real time information is not available	A

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 6th June 2013 - PUBLIC

TITLE:	Infection Control Report		
AUTHOR:	Denise McMahon – Director of Nursing Dr Liz Rees - Consultant Microbiologist/ Infection Control Doctor	**PRESENTER:**	Yvonne O'Connor Deputy Director of Nursing

CORPORATE OBJECTIVE: SG01 – To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

GLOSSARY OF INFECTIONS

MSSA

What is Meticillin Sensitive Staphylococcus aureus (MSSA)?

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

What illnesses are caused by Staphylococcus aureus?

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

MRSA

What is Meticillin Resistant Staphylococcus Aureus (MRSA)?

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

Who is at risk of MRSA infection?

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

E Coli

What is *Escherichia coli* ?

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

What types of disease does *E. coli* cause?

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

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

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

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

C difficile

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

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

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

SUMMARY OF WARDS AND SPECIALTIES

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

Report to: Board of Directors

Subject: Infection Prevention & Control Report

Summary:

Clostridium Difficile – Annual Target 77 (Post 48 hrs) - The target for 2013/2014 is 38 cases; at the time of writing the report three cases have been recorded.

C.Difficile Cases Post 48 hours – Ward breakdown:

Ward	Totals for 12/13	April '13	As of 21st May 13
A1	2	0	0
A2	12	0	0
A4	0	0	0
B1	0	0	0
B2	1	0	**1**
B3	4	0	0
B4	3	0	0
B5	0	0	0
B6	2	0	0
C1	7	**1**	0
C3	6	0	**1**
C4	4	0	0
C5	1	0	0
C6	3	0	0
C7	7	0	0
C8	2	0	0
MHDU	0	0	0
CCU/PCCU	0	0	0
Critical Care	0	0	0
EAU	1	0	0
SHDU	1	0	0
Total	**56**	**1**	**2**

See Appendix 1 – Board Report (2013/2014)

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

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

Denise McMahon – Director of Nursing
Elizabeth N Rees - Consultant Microbiologist/Infection Control Doctor

Monthly number of C.diff cases

(N13) Clostridium difficile infections

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-13	1	3	-66.7%	1	3	-66.7%	4	6
May-13	2	3	-33.3%	3	6	-50.0%	3	3
Jun-13		3			9			
Jul-13		3			12			
Aug-13		3			15			
Sep-13		3			18			
Oct-13		4			22			
Nov-13		3			25			
Dec-13		4			29			
Jan-14		3			32			
Feb-14		3			35			
Mar-14		3			38			
FY 2013-14	3	38	-92.1%				7	9

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

Monthly number of MRSA cases

(N1) MRSA infections

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

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

Monthly number of MSSA cases

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

Monthly number of E.coli cases

E.coli infections		
Month / Year	Total	Cumulative
Apr-13	25	25
May-13	2	27
Jun-13		
Jul-13		
Aug-13		
Sep-13		
Oct-13		
Nov-13		
Dec-13		
Jan-14		
Feb-14		
Mar-14		
FY 2013-14	27	

Enclosure 8

The Dudley Gr
NHS Foundation Trust

Paper for submission to the Board on 6 June 2013

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

SUMMARY OF KEY ISSUES:

The Trust Audit Committee met on 14th May and considered:

- The External Auditors report on the financial statements for the year ended 31st March 2013;
- The External Auditors findings and recommendations on the NHS Quality Report review;
- The Trust Annual Accounts, Annual Governance Statement and Trust Quality Report;
- The Internal Audit Progress report and Annual Report for 2012/13 and the Internal Audit Strategy for 2013/14 to 2014/15;
- The Local Counter Fraud Specialist (LCFS) Annual Report for 2012/13 and Annual Workplan for 2013/14;
- The Clinical Audit activity report for 2012/13 and forward Clinical Audit Plan for 2013/14;
- A progress report following the Trusts version 10 submission to the Monitor Information Governance Toolkit

External Auditors report on the financial statements audit for the year ended 31st March 2013: Deloitte reported that they would be issuing an unmodified audit opinion on the Trust Annual Accounts for 2012/13. The audit process had gone smoothly, with all deadlines achieved and a tight timetable met.

All key risks had been reviewed as part of the audit process and Deloitte wished to draw attention to both the level of non recurrent CIP being carried forward into 2013/14 and also the challenge to achieve further CIP in 2013/14. Deloitte noted that the non recurrent CIP being carried forward totalled around £4m and expressed the view that around £1.5m to £2m would be a more manageable level. Deloitte also noted that the plan for 2013/14 included a further £10m of CIP together with £3m of transitional support, plus that all Trusts were finding it increasingly difficult to identify further CIP savings. The Committee identified the opportunities available from improved IT systems and from transformation as key drivers for future cost reduction.

Representation letter for year ended 31st March 2013: Deloitte tabled the draft Representation Letter for the Committee to consider. Much of this followed a standard format, with the Trust specific issues including collection of outstanding balances from commissioners, treatment of PFI in the financial statements, provisioning for bad debts and treatment of deferred income. The draft letter was considered in detail by the Committee and recommended for approval by the Board.

External Auditors findings and recommendations from the Quality Report Assurance Review: Deloitte undertook detailed data testing across four key quality indicators of 62 day cancer waits, Clostridium Difficile, incidents resulting in severe harm or death and patient experience. The first three of these were mandatory with the final one being selected locally.

The review was carried out in accordance with Monitors six dimensions of data quality, namely accuracy, validity, reliability, timeliness, relevance and completeness. Deloitte confirmed they would be issuing an unqualified opinion. All four indicators received the highest possible rating of green – signifying that all key standards were met – across all six dimensions, with the exception of 62 day cancer wait data validity which was amber rated. This was because from the 25 samples tested for this indicator, 2 were found to have errors in the recording of treatment dates, although neither had resulted in any breaches against the indicator. Deloitte had made recommendations for improvement in this area which had been accepted by the Trust.

Deloitte also commented that the across the board rating of green for the Trust was an excellent performance and in their experience not many Trusts had achieved a similar outcome.

Trust Annual Accounts, Annual Governance Statement and Quality Report: These reports were considered in detail by the Committee and it was agreed to recommend to the Board that they all be approved.

Internal Audit Progress Report: Since the last Committee meeting a total of 12 reports had been finalised:

- Service Line Management Assessment : Advisory
- Procurement Review follow up : Good progress
- Delayed Discharges follow up : Little progress to date due to delay in developing shared database
- Data Quality Community Services follow up : Reasonable progress but separate Trust and Community Services Patient Administration Systems (PAS) still need to be combined
- Equality and Diversity Compliance : GREEN opinion
- IT Health Check : Advisory
- Patient Experience and Involvement : Advisory
- Board Assurance Framework : AMBER/GREEN opinion
- CIP Quality Focus : AMBER/GREEN opinion
- Data Quality, delayed discharges : AMBER/GREEN opinion
- Care Quality Commission Compliance Monitoring : Advisory
- Reporting of Serious Incidents : GREEN opinion

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

In addition, the Internal Auditors had made a number of recommendations following a review by RSM Tenon of payroll overpayments in NHS organisations. The Trust had developed an action plan to address the recommendations made but the Committee noted that the Trust level of salary overpayments appeared to be well below the overall NHS average of £3.07 per employee per month.

Internal Audit Annual Report:

A total of 30 internal audit reviews were undertaken in the year. Of these:

- 7 were advisory reviews;
- 4 were follow up audits which all found reasonable/good progress in implementing recommendations with the exception of delayed discharges where a shared database still needed to be developed;
- 9 resulted in GREEN opinions
- 9 resulted in AMBER/GREEN opinions
- 1 resulted in a RED opinion, this relating to data quality for 18 week waits in Community Services. A follow up review found reasonable progress although the recommendations could not be fully implemented until a single PAS was in place across both the hospital and Community Services

In total there were 70 recommendations issued by Internal Audit across all of the reviews, all of which were accepted by management with plans agreed for implementation.

Based on the work undertaken the Internal Auditors did not consider that there was anything that needed to be included in the Annual Governance Statement as a significant internal control issue and the Head of Internal Audit issued the following opinion for the year:

Based on the work undertaken in 2012/13, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisations objectives and that controls are generally being applied consistently.

The Internal Auditors also concluded that the Trust had in place effectively designed systems around risk management and the Board Assurance Framework.

Internal Audit Strategy for 2013/14 to 2014/15:

The Internal Auditors presented the proposed strategy covering both 2013/14 and 2014/15. This incorporated the detailed Internal Audit Plan for 2013/14.

The Trusts objectives and Assurance Framework had been the starting point for developing the strategy.

It had been agreed to move away from annual audits of some core financial systems. These consistently achieved GREEN opinions so it was considered more appropriate to direct resource to other areas of specific risk or where assurance was needed. Accordingly, the 2013/14 plan included audits of:

- Nurse Care Indicators/Safety Thermometer
- Data Centre
- Community Focus
- Francis Report implementation of recommendations
- Business Planning priorities

Other areas for audit include claims and complaints, commissioning arrangements, appraisals, doctor revalidation, PFI monitoring, pressure ulcers and on call payments. There were also 5 contingency days included in the plan that could be used to address any issues arising in year.

The Committee considered the Internal Audit strategy and the plan for 2013/14 in detail and agreed to recommend to the Board that they be adopted.

LCFS Annual Report and Workplan for 2013/14:

The Committee considered the LCFS Annual Report and 2013/14 Workplan. The annual report showed that the level of proactive fraud awareness, compliance, governance and reporting work had totalled 80 days, in line with the agreed plan. Reactive investigative work had involved a further 72 days, with 9 investigations undertaken covering areas including misuse of Trust resources, conducting private work in NHS time, not fulfilling contracted hours and falsification of time sheets. One investigation was handed over to West Midlands Police and was proceeding to trial. Of the other investigations, 3 resulted in disciplinary action, 1 investigation was ongoing and 4 had been closed.

The Annual Workplan for 2013/14 detailed the proactive work that was proposed to be undertaken in the year ahead. This again involved a total of 80 days and after detailed consideration the Committee agreed to recommend to the Board that the workplan be adopted.

Clinical Audit activity report:

The Director of Nursing presented the Annual Clinical Audit report for 2012/13 which included a full overview of all clinical audit activity for the year.

In summary there were 290 clinical audits registered, of which 227 were completed, 47 carried forward and 16 (6%) incomplete. Within the total of 290 audits, the larger categories included CQC/NHSLA mandatory audits (78), patient surveys (47) and National clinical audits (41). The Trust participated in 100% of all National clinical audits and also 100% of all National confidential enquiries covering NHS services that the Trust provided.

Results of all mandatory audits had been RED/AMBER/Green rated and circulated to Medical Service Heads and Specialty Clinical Audit Leads for review and action plans.

The Committee noted the excellent progress that had been made and also the very small number of incomplete audits which was encouraging. The report was accepted as assurance of the clinical audit activity undertaken by the Trust. It was agreed that with recommendations from audits already being monitored, the next challenge would be for the Committee to be able to track their implementation.

Clinical Audit Plan for 2013/14:

The Director of Nursing presented the proposed Clinical Audit Plan for 2013/14. The principles on which the plan had been prepared included:

- Prioritisation of National and Mandatory audits
- Increased engagement across clinical directorates
- An increase in the number of re-audits and inclusion of incidents and risks audits
- Inclusion of all clinical audits into the plan. Previously some audits have been monitored outside of the plan, including infection control audits, mortality reviews, trigger tool audits, nursing audits and patient experience audits in the acute setting
- Continued emphasis on clinical audit topics that support organisational objectives and inform improvements in patient care
- Improved communication of outcomes across the Trust to enable shared learning

A total of 129 audits had already been identified and approved for inclusion in the plan although this number would increase as the year progressed and further audits were approved.

After considering the Clinical Audit plan in depth, the Committee agreed to recommend to the Board that it be adopted.

Information Governance Toolkit:

The Director of Finance and Information updated the Committee on progress against Monitors Information Governance Toolkit requirements. The Trust had achieved 78% compliance for the version 10 submission, up from 74% for version 9 and this maintained the "satisfactory" grading. Across all directorates, only Emergency and Specialist Medicine failed to achieve at least a 50% compliance score, although the Committee noted that some of the corporate directorates had scores between 50% and 70% and requested that these areas be pushed to improve. It was considered that 100% compliance should be the target for corporate directorates.

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: IG Toolkit**
	Equality Assured	**No**	**Details:**
	Other	**No**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

The Audit Committee recommended that the Board approve the Annual Accounts, Representation Letter and Trust Quality Report

The Audit Committee recommends that the Board adopt the Internal Audit Strategy for 2013/14 to 2014/15 and also the Local Counter Fraud Annual Workplan for 2013/14

The Audit Committee recommends that the Board approve the Clinical Audit Plan for 2013/14

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

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

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 6 June 2013

TITLE:	Reports Recommended by the Audit Committee for Approval		
AUTHOR:	Paul Assinder Director of Finance and Information	**PRESENTER**	Jonathan Fellows Non Executive Director
CORPORATE OBJECTIVE: SG06			

SUMMARY OF KEY ISSUES:

The Audit Committee received the following reports and recommends them to the Board of Directors for Approval:

- Internal Audit Strategy 2013/14 (Appendix 1)
- Local Counter Fraud Workplan 2013/14 (Appendix 2)
- Clinical Audit Plan 2013/14 (Appendix 3)

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	**Y/N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS

To approve the attached reports.

APPENDIX 1

RSM Tenon
Connected for Success

The Dudley Group NHS Foundation Trust

Internal Audit Strategy
2012/2013 – 2014/2015

Presented at the Audit Committee meeting of: 14 May 2013

Glen Palethorpe
Head of Internal Audit

1 INTRODUCTION

This document sets out the approach we have taken to develop your internal audit strategy for 2012/13 to 2014/15 and the annual plan for 2013/14.

1.1 Role of Internal Audit

> Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.
>
> *(Definition of Internal Audit: Chartered Institute of Internal Auditors)*

From 1 April 2013, internal auditors in the public sector are required to work to the *Public Sector Internal Audit Standards (PSIAS)*, which are based on the *International Standards for the Professional Practice of Internal Auditing* published by the Institute of Internal Auditors and which also adopt the institute's definition of internal auditing and code of ethics.

In line with these requirements, we perform our internal audit work with a view to reviewing and evaluating the risk management, control and governance arrangements that the organisation has in place, focusing in particular on how these arrangements help The Dudley Group NHS Foundation Trust to achieve its objectives. The opinion may also be used by the Accountable Officer, to support their Annual Governance Statement. This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee.

2 DEVELOPING THE INTERNAL AUDIT STRATEGY

2.1 Issues influencing Internal Audit coverage

The Trust's objectives and Assurance Framework are the starting point in the development of our strategy for delivery of internal audit services.

We have considered our previous work and findings on your risk management processes and consider that we can place reliance on your risk registers / assurance framework to inform the internal audit strategy.

Appendix A reflects the range of potential issues that may affect the Trust. These were used to focus our conversations along with the Trust's Assurance Framework with the Executive Directors on where our work would be most effective.

In preparing your strategy and more detailed operational plan we have met with:

- Chief Executive;
- Chairman;
- Director of Finance & Information;
- Deputy Director of Finance – Financial Reporting
- Medical Director;
- Director of Operations; and
- Associate of Human Resources.

The key areas are summarised below:

Key Areas discussed with Management and their impact on the 2013/2014 plan	
1	**Nurse Care Indicators/ Safety Thermometer** This review will look at the processes in place around the collation / production indicators included as Nurse Care Indicators and the Safety Thermometer. The review will also look to establish how current reporting triangulates with the requirements of the Safety Thermometer.
2	**Data Centre** As this arrangement develops we will provide assurance over the processes being applied within the Data Centre. The specific scope of this work will be determined with the Associate Director of IT and take into account and Data Centre client assurance expectations.
3	**Community Focus** During our audits we will ensure that the community element is included within the scope of our reviews.
4	**Francis Report** The review will determine the effectiveness of the Trust's gap analysis and action plan that was developed following the publishing of the Francis Report. The review will follow up progress made by the Trust to implement actions and consider whether there is clear evidence to support management's assessment.
5	**Business Planning** This review will look at the processes in place at the Trust around the annual Business Planning cycle and how priorities are ranked/ risk assessed. The review will focus on the procedures in place and how these are applied across the orgaisiation.

The strategy is set out in Appendix B, with the more detailed annual plan for 2013/14 set out at Appendix C.

As well as assignments designed to provide assurance or advisory input around specific risks, the strategy includes:

- a contingency allocation, which will only be utilised should the need arise, for example, for unplanned and ad-hoc work and will be subject to prior approval by the Audit Committee;
- a follow-up allocation, which will be utilised to assess the degree of implementation achieved in relation to recommendations agreed by management during the prior and current financial year and will serve to inform the adequacy of the organisation's own recommendation tracking process; and
- an audit management allocation, used at Partner and Manager level for quality control, client and External Audit liaison and for preparation for and attendance at Audit Committee.

2.2 Working with other assurance providers

We intend to meet with the Trust's External Auditors to confirm the scope of the work in the areas of financial control to ensure they can continue to place their planned level of reliance on our work for 2013/2014.

The Audit Committee are reminded that internal audit us only one source of assurance and through the delivery of our plan we will not, and do not, seek to cover all risks and processes at the Trust. We will however seek to work closely with other assurance providers, such as External Audit, Local Counter Fraud Services and Clinical Audit to ensure that duplication is minimised and a suitable breadth of assurance obtained.

3 INTERNAL AUDIT RESOURCES

3.1 Your Internal Audit Team

Your internal audit team is led by Glen Palethorpe as Head of Internal Audit.

Your Senior Manager is Shauna Mallinson supported by Alex Hire, Client Manager and Mark Coton, Assistant Manager.

We are not aware of any relationships that may affect the independence and objectivity of the team, and which are required to be disclosed under auditing standards.

3.2 Internal Audit Fees

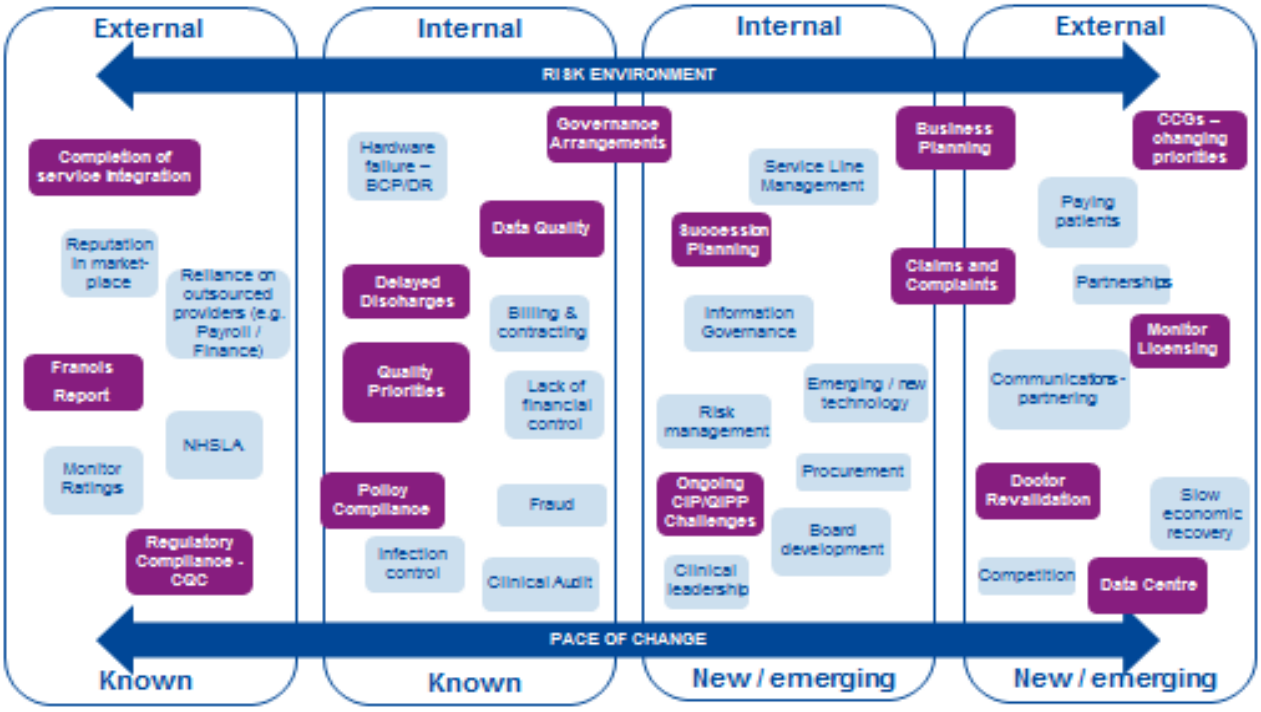
The fee for your internal audit service for 2013/14 is £77,414.40. This is for the core 252 days.

4 CONSIDERATIONS FOR THE AUDIT COMMITTEE

- Does the Strategy for Internal Audit (as set out at Appendix B) cover the organisation's key risks as they are recognised by the Audit Committee?
- Does the detailed internal audit plan for the coming financial year (as set out at Appendix C) reflect the areas that the Audit Committee believes should be covered as priority?
- Is the Committee satisfied that sufficient assurances are being received by the Trust to monitor the organisation's risk profile effectively, including any emerging issues / key risks (see Appendix A) not included in our annual plan?

APPENDIX A: ISSUES AFFECTING THE TRUST

The chart below reflects some of the current issues facing the organisation. Those topics which have been highlighted (in dark blue) are those where internal audit coverage is planned in the coming year.



APPENDIX B: UPDATED STRATEGY FOR INTERNAL AUDIT 2012/13 – 2014/15

Risk Based Assurance

Auditable Areas	Risks (from Trust's Board Assurance Framework (BAF) or Risk Register (RR))	2012/13	2013/14	2014/15
Strategic Goal 1: To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation				
Francis Report	Risk Register Reference COR048 Failure to understand the implications of the themes and recommendations arising from the Public Inquiry at Mid Staffordshire Hospitals NHS Foundation Trust and the impact on The Dudley Group	-	✔	✔
CIP	Risk Register Reference COR034 Failure to achieve the IP target. To deliver financial balance in 2013/14, the Trust is required to deliver a cash releasing CIP of £15.7m (5.5% of budget).	✔	✔	✔
Strategic Goal 2: To provide the best possible patient experience				
Pressure Ulcers	Risk Register Reference COR028 Increase in the number and grade of avoidable pressure ulcers (Trust)	-	✔	-
Nurse Care Indicators/ Safety Thermometer	Risk Register Reference COR028 Increase in the number and grade of avoidable pressure ulcers (Trust)	-	✔	-
Data Quality	Management assurance required.	✔	✔	✔
Delayed Discharges	Risk Register Reference COR007 Unable to admit emergency patients due to externally caused delayed discharge/transfer.	✔	✔	✔
Claims and Complaints	Management assurance required.	✔	✔	-
Strategic Goal 3: To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio				
Commissioning Landscape	Risk Register Reference COR013 Relationship with stakeholders deteriorates - risk to successful management of contract due to potential differing approaches to the	-	✔	-

Auditable Areas	Risks (from Trust's Board Assurance Framework (BAF) or Risk Register (RR))	2012/13	2013/14	2014/15
	management of the contract.			
PFI Monitoring	Risk Register Reference COR013 Relationship with stakeholders deteriorates - risk to successful management of contract due to potential differing approaches to the management of the contract	-	-	✔
Strategic Goal 4: To develop and strengthen strategic clinical partnerships to maintain and protect our key services				
On Call Payments Policy	Management assurance required.	-	✔	-
Appraisals	Management assurance required.	-	✔	-
Pre-Employment Checks	Management assurance required.	-	✔	✔
Doctor Revalidation	Management assurance required.	-	✔	-
Strategic Goal 5: To create a high commitment culture from our staff with positive morale and a "can do" attitude				
Business Planning	Risk Register Reference COR032 Failure to implement Business Continuity Plan during a Major Internal Incident.	-	✔	-
Strategic Goal 6: To deliver an infrastructure that supports delivery				
Governance Arrangements	Management assurance required.	✔	✔	✔
IT Audit (Data Centre Assurance)	Management assurance required.	-	✔	-

Compliance

Audit Area	Outline scope	2012/13	2013/14	2014/15
IG Toolkit	Management assurance required.	✔	✔	✔
Governance: CQC Registration and NHSLA compliance	Audit of the management processes followed by the Trust / CCG to ensure that the Trust / CCG are continuing to continually challenge its compliance with standards.	✔	✔	✔
Assurance Framework and Risk Management	Review of the Trust / CCG's risk management and use of its assurance framework.	✔	✔	✔

Financial Controls (including work allowing greater external audit reliance on our work)

Systems	Source of Requirement	2012/13	2013/14	2014/15
General Ledger	External audit will place reliance on our work to inform their audit.	✔	✔	✔
Financial Reporting		-	✔	-
Creditor payments		✔	-	✔
Cash Receipting and Treasury Management		✔	✔	✔
Income and Debtors		✔	✔	-
Payments to Staff		✔	-	✔
Asset Management		✔	-	✔
Charitable Funds		✔	✔	-

Other Internal Audit Activity

Activity	Rationale	2012/13	2013/14	2014/15
Follow Up	To meet internal auditing standards and to provide management with on-going assurance regarding implementation of recommendations.	✔	✔	✔
Contingency	To allow for additional audits to be undertaken at the request of the Audit Committee or management based on changes in assurance needs as they may arise during the year.	✔	✔	✔
Audit Management	This will include: ▪ Annual planning ▪ Preparation for, and attendance at, Audit Committee meetings ▪ Regular liaison and progress updates ▪ Liaison with external audit ▪ Preparation of the annual internal audit opinion	✔	✔	✔

APPENDIX C: INTERNAL AUDIT PLAN 2013/2014

Audit	Internal Audit Coverage	Internal Audit Approach	Audit Days	Proposed Timing	Audit Committee
Assurance and Advisory Work to Address Specific Risks					
Strategic Goal 1: To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.					
Francis Report	Our review will consider and challenge the robustness of the evidence supporting the Trust's self-assessed position against the Francis Report. It will also look at the action plans put in place to address areas that require strengthening.	Assurance/ Advisory	10	To be determined	As used
CIP	The review will consider the stages from the identification through to implementation of schemes. It will also look to establish whether a post implementation review of schemes from 2012/13 is carried out and what is learnt from this.	Compliance Testing	10	June 2013	July 2013
Strategic Goal 2: To provide the best possible patient experience					
Pressure Ulcers	A review of the application of the new grading system, being introduced from 1 April 2013, for Pressure Ulcers. The new grading system will bring the Trust in line with the SHA/ Regional reporting.	Compliance Testing	8	August 2013	October 2013
Nurse Care Indicators/ Safety Thermometer	To review the processes in place around the collation / production indicators included as Nurse Care Indicators and the Safety Thermometer. The review will also look to establish how current reporting triangulates with the requirements of the Safety Thermometer.	Assurance/ Advisory	10	August 2013	October 2013
Data Quality	Our review will seek to provide assurance with regards to the robustness of data collection and quality processes. This will involve selecting a sample of key quality indicators and tracing them back to source documentation. This will include how these assurances support the Monitor quarterly declaration process. The areas to be reviewed will be discussed with management prior to commencement of the audit to	Compliance Testing	10	September 2013	October 2013

	identify where resources could be best utilised.				
Delayed Discharges	Following on from the work on Delayed Discharges during our 2012/13 audit year, the focus for 2013/14 will be on the Memorandum of Agreement with the Local Authority. The review will look to provide an understanding of what the definitions mean in the contract to the key parties responsible for delivery of the contract.	Key Control	10	April 2013	May 2013
Claims and Complaints	Our review will look at the processes around claims and complaints. The focus will consider how the PALs Team risk assess the concerns that they receive and how these link into the Trust's 'early warning' systems.	Key Control	8	September 2013	October 2013
Strategic Goal 3: To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio					
Commissioning Landscape	To review the requirements and changing priorities of the Clinical Commissioning Groups (CCGs). The focus will be on the processes the Trust have in place and how they are assured around the quality of the information being provided.	Compliance Testing	10	December 2013	January 2014
Strategic Goal 4: To develop and strengthen strategic clinical partnerships to maintain and protect our key services					
On Call Payments Policy	Following the revised Policy being issued in 2012/13 our review will look to establish whether the Policy is being consistently applied.	Compliance Testing	5	June 2013	July 2013
Appraisals	A review of compliance with the Policy will be undertaken.	Compliance Testing	5	July 2013	July 2013
Pre Employment Checks	This review will focus on compliance with the Policy, with particular focus on the completion of pre-employment checks, including professional registration and local induction.	Compliance Testing	10	June 2013	July 2013
Doctor Revalidation	To ensure that the Trust's appraisal system is compliant with revalidation for the Trust's doctors. The review will consider compliance with the Trust's policies and procedures in relation to the conduct of appraisals for doctors including the timeliness, documentation of appraisal, documentation of actions, and the follow up of agreed actions.	Assurance/ Advisory	10	July 2013	October 2013

Strategic Goal 5: To create a high commitment culture from our staff with positive morale and a "can do" attitude					
Business Planning	This review will look at the processes in place at the Trust around the annual Business Planning cycle and how priorities are ranked/ risk assessed. The review will focus on the procedures in place and how these are applied across the orgaisiation.	Key Control	10	April 2013	July 2013
Strategic Goal 6: To deliver an infrastructure that supports delivery					
Governance Arrangements	Focus in the past has been at a Corporate level, therefore our review will extend to look at the arrangements of key committees that report to the Board Sub-Committees. This review will be completed in two phases.	Assurance/ Advisory			
	Phase 1 will look at the arrangements and Terms of Reference of the two new committees (IT Project Committee and Transformation Committee).		4	May 2013	July 2013
	Phase 2 will review the reporting and governance arrangements around the key committees that report to the Board Sub-Committees. As part of this review we will also look at how the Board gets assurance the Monitor returns can be self-certified.		9	January 2014	May 2014
IT Audit (Data Centre Assurance)	To provide assurance over the processes being applied within the Data Centre. The specific scope of this work will be determined with the Director of IT and take into account and Data Centre client assurance expectations. (Note: as the expectations of the Data Centre clients are unknown we have only a rough estimate of time in the plan).	Assurance/ Advisory	10	To be determined	As used
Compliance					
CQC	To assess the Trust's arrangements for monitoring on-going compliance across the wider Trust including a review across a sample of essential standards to ensure evidence exists and supports actions being taken.	Compliance Testing	9	September 2013	October 2013
Assurance Framework	Maintaining our understanding of the Trust's development, use and reporting of its assurance framework.	Compliance Testing	5	February 2014	May 2014

	A sample of assurances will be mapped back to source documentation. The review will also look to establish whether the assurances being provided by Clinical Audit link into the Board Assurance Framework.				
Risk Management	Maintaining our understanding of the Trust's development, use and reporting of its risk management arrangements.	Compliance Testing	5	December 2013	January 2014
IG Toolkit	This review will consider: ▪ The Governance arrangements in place for the completion and sign off of the Information Governance Toolkit return; ▪ The validity of the toolkit return based upon a review of a sample of toolkit requirements; and ▪ The robustness of the IG Toolkit improvement plans, monitoring and reporting of these.	Compliance Testing	10	October 2013	January 2014
Financial Controls					
General Ledger Financial Reporting Cash Receipting and Treasury Management Income and Debtors Charitable Funds	To test the key controls to enable External Audit to place their planned level of reliance on our work. The work across the financial systems will be on a cyclical basis, which will be agreed following discussions with External Audit.	Key Controls Testing	40	October/ November 2013	January 2014
Other Internal Audit Coverage					
Contingency	For coverage of risks and changes in assurance needs as these arise during the year. To be agreed in advance with Management.	-	5	As required	As used
Follow Up	To meet internal auditing standards and to provide management with ongoing assurance regarding implementation of recommendations.	Follow up review	14	Ongoing	Delivered to each Audit Committee
Management	This will include: ▪ Annual planning. ▪ Preparation for, and attendance at, Audit Committee meetings. ▪ Regular liaison and progress	-	25	Ongoing	As used

	updates. ▪ Liaison with external audit. ▪ Preparation of the annual internal audit opinion.				
Total			252		

APPENDIX 2

RSM Tenon
Connected for Success

THE DUDLEY GROUP NHS FOUNDATION TRUST

Annual Work-plan for 2013/2014

FINAL

February 2013

Gavin Ball / Tony Kelly- Local Counter Fraud Specialist

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RSM Tenon
Connected for Success

1. EXECUTIVE SUMMARY

1.1. BACKGROUND

1.1.1. We have an enviable and long-established reputation in providing counter fraud services to the NHS, other public sector bodies and wider markets. We are at the forefront in working with relevant stakeholders (including NHS Protect) to ensure that our services are not only 'fit for purpose' but are in-line with the latest thought-leadership and emerging methodologies, including the Government's National Fraud Strategy and CIPFA's 'Managing the Risk of Fraud'.

1.1.2. We deliver professional services in a public-sector spirited way, mindful of the general principles that underpin conduct in public life and the governance frameworks that support these.

1.1.3. We differentiate our working practices, by being innovative and output driven, ensuring that our work is focussed on a risk based approach, adding value to our clients. Because of the size of our operations, we are able to apply economies of scale and utilise days saved in terms of increased proactive exercises for our clients at no extra cost to them.

1.1.4. The National Health Service is facing challenging times, owing to the pressures on spending of public funds across the public sector, and the wider situation involving the economic climate. As a result, the emphasis of ensuring a robust counter fraud strategy is essential in protecting the limited resources which destined for providing patient care. The local counter fraud services that we deliver, can provide an effective measure to assisting in the protection of your finances and assets.

1.1.5. We are pleased to present you with our draft annual work-plan for 2013/14 and look forward to discussing this and working with you to ensure it meets your bespoke needs and addresses your specific fraud risks.

1.1.6. Specifically, this work-plan focuses on the area of further embedding the strong anti-fraud culture that exists within the organisation, to carry out fraud proofing of policies that have not been subject of review before and to carry out Local Proactive Exercises (LPE's) in key areas of risk to the Trust. In addition, risk assessments will be another feature of work for the forth-coming year, using information and highlighted risk areas from the previous year to provide a bespoke and tailored fraud work-plan for the Trust.

1.1.7. We look forward to working with you again in 2013/14 to ensure fraud is driven down to the absolute minimum allowing you to deliver the vital services you provide.

2. SUMMARY OF WORKPLAN AREAS AND RESOURCES ALLOCATION

	LCFS Recommended Number of Days 2013/14	LCFS Comments
PROACTIVE	**80**	The 80 day resource is appropriate for the size of the organisation and will provide the LCFS with sufficient resource to provide a risk based, bespoke work-plan tailored to the needs of the Trust.
Awareness & Development	33	To continue to deliver bespoke fraud awareness training sessions / workshops, to ensure that fraud awareness remains high amongst staff and that there is a clearly demonstrable embedded anti-fraud culture in place at the Trust.
Managing Organisational Fraud Risk	35	To continue to undertake detection work in key risk areas using local, regional and national intelligence sources. In addition, the time spent will be utilised in order to follow up previous detection work to ensure that deterrence outcomes are clearly demonstrable.
Compliance, Governance & Reporting	12	It should be noted that the NHS Protect Qualitative Assessment process, which is currently under review, is due to be re-introduced to assess the work completed in 2012/13. Dependent upon the requirements of the new process, the resource for this area may need to be revisited during the year in order to ensure the LCFS is provided with adequate time to complete the assessment process.
Investigations , Sanctions & Redress	0	Any referrals received by the LCFS will be dealt with by way of a request for reactive days and submitted for authority to the Director of Finance. No investigations will be carried out unless authority has been granted.
TOTAL RECOMMENDED DAYS	**80**	

The following tables detail the utilisation of the above days in more detail.

ANTI- FRAUD CULTURE 1a) Ensure that The Dudley Group NHS Foundation Trust has a clear programme of work attempting to create a real anti-fraud and corruption and zero tolerance culture. 2a) Ensure there are clear goals for this work (to maximise the percentage of staff and public who recognise their responsibilities to protect the organisation and its resources). 3a) Ensure this programme of work is being effectively implemented. 4a) Ensure there are arrangements in place to evaluate the extent to which a real anti-fraud and corruption culture exists or is developing throughout the Trust. 5a) Ensure there are agreements in place with stakeholder representatives to work together to counter fraud and corruption. 6a) Ensure arrangements been made to ensure that stakeholder representatives benefit from successful counter fraud and corruption work.	**AREAS OF WORK:** ▪ Induction Sessions, inclusive of design & dissemination of new starter fraud pack. (12 sessions) ▪ Follow up contact with new starters, inclusive of letter, information and liaison (12 occurrences) ▪ Bespoke Fraud Awareness Training Sessions / Workshops, inclusive of all fraud awareness material, design & dissemination. Evaluation of sessions and follow up work. (8 sessions) ▪ Implementation and delivery of Fraud E-Learning toolkit ▪ Arrangement & delivery of annual fraud awareness event, including promotion. ▪ Design and maintenance of organisation Intranet site fraud section. (2 occurrences) ▪ Key personnel meetings, enabling Trust to drive work-plan according to risks and requirements. (Minimum of 10 meetings) ▪ Utilise “fraud toolkit” to promote role of counter fraud, such as electronic communication means.ie. email/ payslip/text messages. ▪ Undertake an organisation survey to measure culture and identify areas of development.

NUMBER OF DAYS TO BE DELIVERED	**33**

DETERRENCE/ PREVENTION/DETECTION 1b) Ensure The Dudley Group NHS Foundation Trust has a clear programme of work attempting to create a strong deterrent effect which publicises the: ▪ hostility of the honest majority to fraud and corruption; ▪ effectiveness of preventative arrangements; ▪ sophistication of arrangements to detect fraud and corruption; ▪ professionalism of those investigating fraud and corruption and their ability to uncover evidence; ▪ likelihood of proportionate sanctions being applied; and ▪ likelihood of losses being recovered. 3b) Ensure The Dudley Group NHS Foundation Trust successfully publicises work in this area. 4b) Ensure publicity been targeted at the areas of greatest fraud losses. 1c) Ensure The Dudley Group NHS Foundation Trust seeks to design fraud and corruption out of new policies and systems and to revise existing ones to remove apparent weaknesses. 2c) Ensure concluding reports on investigations include a specific section on identified policy and systems weaknesses that allowed the fraud and corruption to take	**AREAS OF WORK TO INCLUDE**: ▪ Regular Liaison with Communications Lead / Team to promote and facilitate areas of awareness, prevention & investigations work.(4 occurrences) ▪ Design, and disseminate regular newsletters, fraud articles and relevant deterrence material. (6 occurrences) ▪ Design / Implement / Review Protocols & Strategies, consisting of: Comms Strategy, Redress Strategy, HR Protocol, IA Protocol, Contractor Services protocol, Investigations Protocol, LSMS protocol. (3 occurrences) ▪ Develop and implement counter fraud in policy / system review, design & implementation cycle. ▪ Review key high risk policies, such as Financial, HR and Corporate policies & procedures. (Minimum 5 policies) ▪ Design / Implement and Review Counter Fraud Policy & Whistle Blowing Policies. Test and measure awareness and effectiveness. ▪ Test awareness and compliance of selected policies across organisation (Minimum 3 policies) ▪ Assist in fraud review of contracts, SLA's with key staff / contractors ▪ Attendance and liaison with Risk Management Group / Manager. Provide guidance on risk register.(1 occurrence)

place. 3c) Ensure there is a system for considering and prioritising action to remove these identified weaknesses. 1d) Ensure there are effective 'whistleblowing' arrangements in place. 2d) Ensure analytical intelligence techniques are used to identify potential fraud and corruption. 3d) Ensure there are effective arrangements for collating, sharing and analysing intelligence. 4d) Ensure there are arrangements in place to ensure that suspected cases of fraud or corruption are reported promptly to the LCFS for further investigation. 5d) Ensure that identified potential cases are promptly and appropriately investigated. 6d) Ensure proactive exercises undertaken in key areas of fraud risk or known systems weaknesses.	▪ Submit and follow up intelligence bulletins, fraud alerts / notices received by organisation. (As required) ▪ Process Fraud Prevention Instructions, advise and assist organisation in compliance with set timescales. Test at periodic intervals for continued compliance and robust arrangements. ▪ Process / Direct National Fraud Initiative actions, inclusive of reporting outcomes to organisation ▪ Undertake any mandatory National Proactive Exercise as determined by NHS Protect ▪ Undertaken Local Proactive Exercise, as determined by risk across organisation. Inclusive of development work, testing, reporting and follow ups. 3 exercises as follows: ▪ *Declaration of Interests* ▪ *TBC with Director of Finance based on emerging risks.* ▪ *3rd exercise to be agreed during the year depending on risks identified* ▪ Testing and follow up of counter fraud recommendations made, inclusive of maintenance and reporting of tracker tool. ▪ Ensure that organisation is compliant with Data Protection Act for LCFS duties. ▪ Completion of Strategic and local Fraud Risk Assessment, using RSM Tenon "Fraud Mapping Tool."
NUMBER OF DAYS TO BE DELIVERED	**35**

STRATEGIC APPROACH 1h) Ensure The Dudley Group NHS Foundation Trust has a counter fraud and corruption strategy which is clearly linked to the organisation's overall strategic objectives. 2h) Ensure that the LCFS has a clear remit covering all areas of fraud and corruption affecting the organisation. 3h) & 4h) Ensure there are effective links between 'policy' work and 'operational' work; ensuring that the full range of integrated action is being taken forward. 5h) Ensure The Dudley Group NHS Foundation Trust focuses on outcomes and not just activity. 6h) Ensure the strategy been directly agreed by those with political and executive authority for The Dudley Group NHS Foundation Trust. 7h) Ensure the LCFS has the appropriate authority needed to pursue their remit effectively, linked to the fraud and corruption strategy. 8h) Ensure there is strong political and executive support for work to counter fraud and corruption. 9h) Ensure the level of financial investment in work to counter fraud and corruption is proportionate to the risk that has been identified. 10h) & 11h) Ensure the LCFS is professionally trained and accredited for their role. The LCFS through regularly training will ensure they are abreast of new developments	**AREAS OF WORK:** Full compliance with Secretary of State's Directions for Countering Fraud and NHS Protect reporting requirements: ▪ Undertake any training as required by NHS Protect. ▪ Collating and reporting of required statistical information each quarter. (4 occurrences) ▪ Management of NHS Protect First Case Management System & Intranet (excluding investigations) ▪ Collation of required information and submission of annual Qualitative Assessment Declaration. ▪ Responding to additional requests for assistance / information from NHS Protect, LCFS' or external agencies. Completion and submission of reports for organisation, inclusive of: ▪ Annual Report. ▪ Audit Committee papers (inclusive of attendance). (4 per year) ▪ Provision of Benchmarking data and best practice guidance documents relating to sector ▪ Drafting LCFS Work-plan 2014/15. ▪ Participation in meetings, fraud forums and intelligence groups, including preparation,

and legislation. 12h) The LCFS will undertake this work in accordance with a clear ethical framework and standards of personal conduct. 13h) & 14h) & 15h) Ensure there are framework agreements in place to work with other organisations and agencies and the framework agreements are focused on the practicalities of common work. Ensure regular meetings are held to implement and update these arrangements. 16h) Ensure the organisation is undertaking the full range of necessary action.	attendance and reporting. ▪ Contract Management, inclusive of quality assurance of work, additional client liaison (brief, non-specific) and compliance with Secretary of State Directions and NHS Protect's regulatory requirements. ▪ Providing advice and guidance to staff / managers on non-specific counter fraud matters, when required. *It should be noted that the NHS Protect Qualitative Assessment process, which is currently under review, is due to be re-introduced to assess the work completed in 2012/13. Dependent upon the requirements of the new process, the resource for this area may need to be revisited during the year in order to ensure the LCFS is provided with adequate time to complete the process.*
NUMBER OF DAYS TO BE DELIVERED	**12**

INVESTIGATIONS/ SANCTIONS/REDRESS 1d) Ensure 'whistleblowing' arrangements are in place. 2d) & 3d) Ensure analytical intelligence techniques are used and there are effective arrangements for collating, sharing and analysing intelligence. 4d) & 5d) Ensure all suspected cases are reported promptly to the appropriate person and all cases are promptly and appropriately investigated. 6d) Ensure proactive exercises undertaken in key areas of fraud risk or known systems weaknesses. 1f) & 2f) & 3f) Ensure there is a clear and consistent policy on the application of sanctions where fraud or corruption is proven to be present. All possible sanctions – disciplinary / regulatory, civil and criminal are considered. Consideration of appropriate sanctions takes place. 1g) & 2g) & 4g) A clear policy on the recovery of losses: Ensure The Dudley Group NHS Foundation Trust is effective in recovering any losses utilising where appropriate criminal and civil law; ensure the proceedings for the recovery of losses are monitored and identify The Dudley Group NHS Foundation Trust's recovery rate.	**AREAS OF WORK:** ▪ Ensure full compliance with legislative requirements and conduct investigations as required in line with Appendix 5 of the NHS Counter Fraud and Corruption Manual. ▪ Entry and updating investigations data onto NHS Protect's First Case Management System, inclusive of case closures. ▪ Action findings from outstanding recommendations from the National Fraud Initiative (NFI). ▪ Liaison with other LCFS' and external bodies relating to investigations work. ▪ Respond to requests for assistance on referrals and report to Director of Finance & Audit Committee as required ▪ Consider all available sanctions with all investigations conducted. ▪ Consider and pursue where appropriate redress of monies lost to fraud.
NUMBER OF DAYS TO BE DELIVERED	**As Required**

May 2013

Trust Annual Clinical Audit Plan 2013/14

KEY: Audit Rationale					
A	NICE Guidance	G	NCEPOD	M	Compliance with National Guideline/Royal College/Professional Bodies
B	National Audits for Quality Account	H	Adverse Incidents	N	Service Evaluation
C	NHSLA Documentation	I	Complaint	O	Suggestion from the patient or public
D	NHSLA Written Consent	J	Clinical Risk 'held on Risk Register'	P	Clinical Effectiveness Work Programme
E	CNST	K	NPSA		
F	Patient Satisfaction	L	Compliance with Local Guideline/Policy /Standard		

Audit ID	Date added to plan	Audit Title	Objectives	Lead Contact	Speciality / Team	Directorate	Expected Start Date	Expected End Date	Rationale	Re-audit
1	Apr-13	ICNARC Case Mix Programme (CMP)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Julian Sonksen	Anaesthetics / Critical Care	Surgery and Anaesthetics	Continual		B	No
2	Apr-13	BTS Emergency Use of Oxygen	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Sr Nicola Millward / Dr M Chaudri	Respiratory Medicine	Emergency, Specialty Medicine and Elderly Care			B	
3	Apr-13	Medical & Surgical Programme - NCEPOD	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Angela Duffill, Trust Info Dept	Trustwide				B	
4	Apr-13	National Audit of Seizure Management (NASH)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Nicholas Stockdale	Emergency Medicine	Emergency, Specialty Medicine and Elderly Care			B	
5	Apr-13	National Emergency Laparotomy Audit (NELA)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Jenny Wright	Anaesthetics / Critical Care	Surgery and Anaesthetics			B	
6	Apr-13	National Joint registry (NJR)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Rita Rai, Asst General Manager	Trauma & Orthopaedics	Trauma and Orthopaedics	Continual		B	
7	Apr-13	CEM Paracetamol Overdose	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Nicholas Stockdale	Emergency Medicine	Emergency, Specialty Medicine and Elderly Care			B	

8	Apr-13	CEM Severe Sepsis & Septic Shock	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Nicholas Stockdale	Emergency Medicine	Emergency, Specialty Medicine and Elderly Care			B	
9	Apr-13	Trauma Audit & Research Network (TARN)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Joanne Taylor	Emergency Medicine	Emergency, Specialty Medicine and Elderly Care	Continual		B	
10	Apr-13	National Comparative Audit of Blood Transfusion	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Craig Taylor	Haematology	Diagnostics			B	
11	Apr-13	Bowel Cancer (NBOCAP)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Jane Gritton	Cancer Services	Emergency, Specialty Medicine and Elderly Care	Continual		B	
12	Apr-13	Head & Neck Oncology (DAHNO)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Jane Gritton	Cancer Services	Emergency, Specialty Medicine and Elderly Care	Continual		B	
13	Apr-13	Lung Cancer (NLCA)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Jane Gritton	Cancer Services	Emergency, Specialty Medicine and Elderly Care	Continual		B	
14	Apr-13	Oesophago-gastric Cancer (NAOGC)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Jane Gritton	Cancer Services	Emergency, Specialty Medicine and Elderly Care	Continual		B	
15	Apr-13	Acute Coronary Syndrome or Acute MI (MINAP)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Andrew Hunter / Dr Joe Martins	Cardiology	Emergency, Specialty Medicine and Elderly Care	Continual		B	
16	Apr-13	Cardiac Arrhythmia (HRM)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Nicola Gordon / Dr Joe Martins	Cardiology	Emergency, Specialty Medicine and Elderly Care	Continual		B	
17	Apr-13	Heart Failure Audit	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Gill Jones / Dr Joe Martins	Cardiology	Emergency, Specialty Medicine and Elderly Care	Continual		B	
18	Apr-13	National Cardiac Arrest Audit (NCAA)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	William Dainty / Dr P Innes	Anaesthetics / Critical Care	Surgery and Anaesthetics	Continual		B	
19	Apr-13	National Vascular Registry (inc. CIA, NVD, AAA Peripheral Vascular Surgery/VSGBI Vascular database)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts		Vascular Surgery	Surgery and Anaesthetics	Continual		B	
20	Apr-13	BTS Paediatric Bronchiectasis	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts		Paediatrics / Neonates	Women and Children			B	
21	Apr-13	Chronic Obstructive Pulmonary Disease (COPD)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Mazhar Chaudri	Respiratory Medicine	Emergency, Specialty Medicine and Elderly Care			B	
22	Apr-13	Diabetes Audit (Adult) (inc. National Diabetes Inpatient Audit (NaDIA), Pregnancy in Diabetes (NPID)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts		Diabetes & Endocrinology	Ambulatory Medicine			B	
23	Apr-13	Diabetes (Paediatric) (NPDA)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Anand Mohite	Paediatrics / Neonates	Women and Children			B	

24	Apr-13	Inflammatory Bowel Disease Audit (inc. Paediatric IBD Services (previously listed separately on 2010/11 QA)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Shanika De Silva	GI Medicine	Emergency, Specialty Medicine and Elderly Care			B	
25	Apr-13	National Review of Asthma Deaths (NRAD)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Mazhar Chaudri	Respiratory Medicine	Emergency, Specialty Medicine and Elderly Care			B	
26	Apr-13	Renal Replacement Therapy (Renal registry)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Beverley Capewell	Renal Medicine	Ambulatory Medicine	Continual		B	
27	Apr-13	Fall and Fragility Fractures Audit Programme (FFFAP) (inc. National Hip Fracture Database (NHFD)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts		Trauma & Orthopaedics	Trauma and Orthopaedics	Continual		B	
28	Apr-13	Sentinal Stroke National Audit Programme (SSNAP) (previously Sentinal Stroke and Stroke Improvement National Audit Programme)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Anne Gregory / Dr A Salam	Stroke Medicine	Emergency, Specialty Medicine and Elderly Care	Continual		B	
29	Apr-13	Elective Surgery National PROMS Programme	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts			Surgery and Anaesthetics	Continual		B	
30	Apr-13	Child Heath Programme (CHR-UK)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Zala Ibrahim	Paediatrics / Neonates	Women and Children			B	
31	Apr-13	Epilepsy 12 Audit (Childhood Epilepsy)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Anil More	Paediatrics / Neonates	Women and Children	Mar-13		B	No
32	Apr-13	Maternal, Infant and Newborn Programme (MBRRACE-UK) (previously as Perinatal Mortality in QA)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Justine Edwards / Dr H Morsi	Obstetrics & Gynaecology	Women and Children	Continual		B	No
33	Apr-13	CEM Paediatric Asthma	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Mr Nicholas Stockdale	Emergency Medicine	Emergency, Specialty Medicine and Elderly Care			B	
34	Apr-13	Neonatal Intensive and Special Care (NNAP)	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Claire Cockburn / Dr R Mudgal	Paediatrics / Neonates	Women and Children	Continual		B	No
35	Apr-13	BTS Paediatric Asthma	Department of Health national clinical audits and enquiries for inclusion in Quality Accounts	Dr Rakesh Mudgal	Paediatrics / Neonates	Women and Children			B	No
36	Apr-13	NHSLA Trust Documentation Audit 2013	Monitor compliance with record keeping standards against NHSLA criteria and National and Royal College standards	Clinical Audit & Effectiveness	Trustwide				C	
37	Apr-13	NHSLA Trust Written Consent Audit 2013	Monitor compliance with record keeping standards against NHSLA criteria and National and Royal College standards	Clinical Audit & Effectiveness	Trustwide				D	
38	Apr-13	Global Trigger Tool Audit (GTT)	Patient Safety Campaign. Evaluation of care to identify harm, triggers and events.	Karen Broadhouse	Trustwide		Continual		P	No

39	Apr-13	Nursing Care Indicator (NCI) Audits	Reduce harm, improve patient safety	Karen Broadhouse	Trustwide		Continual		P	No
40	Apr-13	Safety Thermometer Audit	Reduce harm, improve patient safety	Karen Broadhouse	Trustwide		Continual		P	No
41	Apr-13	WHO Surgical Checklist	Assess compliance with the Safe Surgery Saves Lives Initiative	Martin Potts	Trustwide		Continual		K	No
42	Apr-13	Protected Mealtime Policy Audit	Monitoring compliance with CQC4: Meeting nutritional needs	Karen Broadhouse	Trustwide		Continual		P	No
43	Apr-13	Privacy and Dignity Policy Audit	Improve patient satisfaction and promote best practice	Karen Broadhouse	Trustwide		Continual		P	No
44	Apr-13	Fluid Balance SOP Compliance Audit	Monitoring compliance with CQC4: Meeting nutritional needs	Karen Broadhouse	Trustwide		Continual		P	No
45	Apr-13	Audit of the use of subcostal TAP block on patients in Emergency Theatre	Assess the potential benefit of subcostal Tap block in patients undergoing emergency abdominal surgery	Dr Nicola Calthorpe, Consultant	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013	07/06/2013	F	No
46	Apr-13	Competency in airway management on ITU: re-audit	Monitor compliance with Difficult Airway Society (DAS) guidelines	Dr M Cheung, CT2 / Dr C Patel	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013	30/04/2013	M	Yes
47	Apr-13	Audit of volatile use and fresh gas flows in a DGH	Monitor compliance with Association of Anaesthetists of Great Britain and Ireland (AAGBI) guidelines for low flow anaesthesia	Dr B Smith, CT1 / Dr M Tindall	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013	30/04/2013	M	No
48	Apr-13	Patient satisfaction of information obtained during pre-assessment clinic	New service. Assessing patient satisfaction as part of quality improvement programme	Dr P Lo, CT2 / Dr T Warrener, CT1	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013	30/04/2013	F	No
49	Apr-13	Audit of independent elective caesarean section list	Monitor compliance with NICE CG132 Caesarean Sections	Dr A Barlow, CT2 / Dr C Brennan	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013	14/05/2013	A	No
50	Apr-13	Audit of venous thromboprophylaxis in overweight orthopaedic patients	Monitor compliance with UK Medicines Information (UKMI) guidance on Thromboprophylaxis in obese patients	Mr E Dickenson, CT2 / Mr T Clare	Trauma & Orthopaedics	Trauma and Orthopaedics	01/04/2013		M	No
51	Apr-13	Review of preferred place of death of patients known to the Dudley Palliative Care Community Team	Monitor compliance with the patient choice key topic of The Gold Standard Framework for Palliative Care	Dr H Greenstone, FY1 / Dr J Bowen	Palliative Care	Emergency, Specialty Medicine and Elderly Care	01/04/2013	01/06/2013	N	
52	Apr-13	Audit of Paediatric clinic non-attender follow up	Monitor compliance with local and national guidance for the follow up of paediatric patients who fail to attend hospital appointments	Dr D Sinton, ST4 / Dr Z Ibrahim	Paediatrics / Neonates	Women and Children	01/04/2013	01/08/2013	L	No
53	Apr-13	Audit of medical prescription charts	To ensure adherence to the 'Principles of Good Prescribing' from The British Pharmacological Society	Dr A Symonds, FY1 / Dr H Smith, FY2	Paediatrics / Neonates	Women and Children	01/04/2013	30/07/2013	M	No
54	Apr-13	Evaluation of TPN use in the neonatal unit	Regional audit reviewing TPN practice and prescribing in accordance with BSPGHAN and ESPGHAN guidelines and NCEPOD	Dr S Mahadevan-Bava,	Paediatrics / Neonates	Women and Children	01/04/2013	30/04/2013	M	No

			recommendations	Consultant						
55	Apr-13	Evaluation of outpatient prescribing at RHH	Evaluation of the effects of the introduction of the GP referral letter regarding the dispensing of non-urgent medication	Leanne Nation, Hospital Pharmacy Lecturer Practitioner	Pharmacy	CSIC	01/04/2013	30/06/2013	N	
56	Apr-13	Administration of oral medicines to adult inpatients	Monitor compliance against National and DGOH Medicine Management Policy 2012	Daniel Hearsey, Pre-registration Pharmacist	Pharmacy	CSIC	01/04/2013	30/04/2013	M	
57	Apr-13	Assess compliance with DGOH IV Immunoglobulin Management Plan February 2013	Monitor compliance against DoH clinical guidelines for Immunoglobulin use and DGOH IV Immunoglobulin Management Plan	Cherrelle Dayus, Pre-registration Pharmacist	Pharmacy	CSIC	01/04/2013	30/04/2013	M	
58	Apr-13	Compliance with National Patient Safety Rapid Response Report 014: Reducing treatment dose errors with LMWH	Rapid Response Report NPSA/2010/RRR014: reducing treatment dose errors with low molecular weight heparin	Christine Rose, Pre-registration Pharmacist	Pharmacy	CSIC	01/04/2013	30/04/2013	K	
59	Apr-13	National British Society for Rheumatology Audit on the Management of Gout	Monitor compliance with NICE TA164 Hyperuricaemia and the use of Feboxustat, EULAR guidelines and BSR guidelines on the management of Gout	Dr N Erb, Consultant	Rheumatology	Ambulatory Medicine	01/05/2013	30/05/2014	A	
60	Apr-13	Audit of on call service provided by Podiatric Surgery 2012	Monitor compliance with NICE IPG140 (2005) Metatarsul joint replacement of the hallux	Suzannah Morley, Podiatric Surgery	Podiatric Surgery	CSIC	01/04/2013	31/01/2014	A	
61	Apr-13	Inpatient Mortality Audit	Peer review of all inpatient deaths using the mortality tracking audit tool	Mr N Molony, Trust Audit Lead	Trustwide		Continual		M	
62	Apr-13	Audit of patient satisfaction with paediatric ophthalmology clinic and orthoptic combined clinics	Are patients seen in line with Outpatient review of national findings published by the Audit Commission	Mr John Barry, Consultant	Ophthalmology	Surgery and Anaesthetics	01/04/2013		F	
63	Apr-13	Review of readmissions in plastic surgery	Identify cause of readmissions - due to complications or unrelated medical conditions	Dr Dagdelenis Ioannis, Trust Grade	Plastic Surgery	Surgery and Anaesthetics	01/05/2013	30/07/2013	N	
64	Apr-13	Audit of basal cell carcinoma recurrence following surgery and relation to excision margins	Review practice and evaluate excision margins, rate of recurrence and plan follow up pathway for patient with bcc	Dr B Ouali, Trust Grade	Plastic Surgery	Surgery and Anaesthetics	01/06/2013	31/012/2013	N	
65	Apr-13	Audit of compliance to rapid access referrals in skin oncology	Monitor compliance with two week wait for first appointments and 31 and 62 days for treatment	Lindsay Hughes, MDT co-ord	Plastic Surgery	Surgery and Anaesthetics	01/04/2013	31/08/2013	M	
66	Apr-13	Review of emergency referrals to plastic surgery	Assess referral pattern of emergency workload in plastic surgery	Mr AKM Fazul Haque, Specialty Doctor	Plastic Surgery	Surgery and Anaesthetics	01/05/2013	31/07/2013	N	
67	Apr-13	Audit of MET call and cardiac arrest procedures	Further to Trust action plan based on NCEPOD publication 2012: Cardiac Arrest procedures: Time to Intervene	Dr Gautam Bagchi, ST5 / Dr H Paraiso	Acute Medicine	Emergency, Specialty Medicine and Elderly Care	01/04/2013	30/05/2013	M	
68	Apr-13	Audit of the management of hepatorenal syndrome and cost per year	Compliance to National EASL guidelines	M Weeresinghe / M Rudolfo / A Suleman (Med Students)	GI Medicine	Emergency, Specialty Medicine and Elderly Care	01/04/2013	31/08/2013	M	

69	Apr-13	Audit of anaesthetic staffing on the obstetric unit	Compliance with CNST standards	Dr Catherine Brennan	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013	30/06/2013	E	No
70	Apr-13	IV Diuretics Clinical Effectiveness Audit	Evaluate service to ensure it is a viable alternative to hospital admission in terms of effectiveness of treatment, safety and cost efficiency.	Tammy Davies	Community Heart Failure	CSIC	01/04/2013		N	
71	Apr-13	Audit of the Effectiveness of Treating Headaches and Migraine with Manual Physiotherapy Techniques	To audit the efficacy and benefits of the new headache service	Art Shah/David Griffiths	Community Physiotherapy	CSIC	01/04/2013		N	
72	Apr-13	Community Physiotherapy Back Exercise Classes Audit	To identify patient satisfaction and outcome from attending community run back exercise class	Nicky Edwards	Community Physiotherapy	CSIC	01/04/2013		N	
73	Apr-13	Care of Women in Labour, including progress of labour	NICE (2007) Intrapartum care: care of healthy women and their babies during childbirth.	Justine Edwards / Dr H Morsi	Obstetrics & Gynaecology	Women and Children	01/04/2013		A	No
74	Apr-13	Substance abuse in pregnancy audit	Monitor compliance with NICE guidelines CG110 Guidance on vunerable women	Dr Ritu Mishra	Obstetrics & Gynaecology	Women and Children	01/04/2013		A	No
75	Apr-13	Patient Questionnaire to Investigate Reasons for Poor Compliance with Clinic Attendance Post Bariatric Surgery	Identify reasons why patients are not attending clinic review after bariatric surgery. To improve the service and increase attendance in fu clinics.	Liz Higginson, CNS Research & Metabolism	Chemical Pathology	Diagnostics	01/04/2013		F	
76	Apr-13	Patient Experience	To measure patient experience of care and satisfaction across the Trust	Trust Communications Dept	Trustwide		01/04/2013		F	
77	May-13	Postpartum Haemorrhage (PPH) Audit	Monitor the compliance with Trust guideline. Identify any deficiencies in the implementation, and create action plan to ensure level 3 CNST standard compliance.	Dr H Hoyte FY1 / Mr H Morsi	Obstetrics & Gynaecology	Women and Children	29/04/2013	15/06/2013	E	No
78	May-13	Anti-D Administration Audit	To ascertain numbers of take up & identify reasons for declining treatment. To improve the service and increase the take up.	Jane Wardlaw / Justine Edwards	Obstetrics & Gynaecology	Women and Children	01/07/2013	01/12/2013	E	Yes
79	May-13	Obstetric Medical Staffing Audit	Annual audit to review obstetric medical staffing, for compliance at level 1 CNST criterion	Justine Edwards	Obstetrics & Gynaecology	Women and Children	01/06/2013	01/09/2013	E	No
80	May-13	Staffing Levels within Community Midwifery	Annual audit to review midwifery staffing within the community , for compliance at level 1 CNST criterion	Justine Edwards	Obstetrics & Gynaecology	Women and Children	01/06/2013	01/09/2013	E	No
81	May-13	Midwifery Staffing Audit	Annual audit to review midwifery staffing within the Trust , for compliance at level 1 CNST criterion	Justine Edwards	Obstetrics & Gynaecology	Women and Children	01/06/2013	01/09/2013	E	No
82	May-13	Obstetric OPD Staffing Audit	Annual audit to review obstetric staffing in the outpatients department, for compliance at level 1 CNST criterion	Justine Edwards	Obstetrics & Gynaecology	Women and Children	01/06/2013	01/09/2013	E	No
83	May-13	Stillbirth Audit	Audit of all stillbirths from April 2012 to March 2013, to identify any trends and produce report for the DCDRP as per recommendations from safeguarding review.	Justine Edwards	Obstetrics & Gynaecology	Women and Children	01/04/2013	30/05/2013	N	No

84	May-13	Community Dental List; Paediatric Fasting Guidelines	Determine whether we are adhering to local & national guidance. Review information/instructions given to patients and the levels of attendees fit for surgery and the effect of those who aren't. Have we improved from the previous audit.	Dr T Warrener SHO / Dr P Innes	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/12/2012	01/06/2013	M	Yes
85	May-13	Temperature Reusable Probe Audit	Establish if the reusable temperature probes are being used in line with surgical site saving lives programme (NICE Guidance CG65)	S/N Jane Trow / Dr L Plant	Anaesthetics / Critical Care	Surgery and Anaesthetics	05/02/2013	18/02/2013	A	No
86	May-13	Outcome of Abdominal Sacrocolpopexy	Ascertain success & complication rates from procedure, compliance with NICE guidance IP 283	Dr P Murthy / Mr H Morsi	Obstetrics & Gynaecology	Women and Children	30/05/2013	01/11/2013	A	No
87	May-13	Lower Limb Patient Experience	Establish patient satisfaction with the Podiatry Biomechanics clinic and Orthotics Department	Mrs Kelly James	Podiatry	CSIC	01/05/2013	31/07/2013	F	No
88	May-13	Annual Cataract Surgery - Complications and Outcomes Audit	Compare outcomes and complications of Cataract Surgery with Royal College of Ophthalmologists national cataract data	Mr R Bhardwaj	Ophthalmology	Surgery and Anaesthetics	01/12/2013	30/04/2014	M	Yes
89	May-13	Evaluation of Ophthalmology Referrals and Outcomes from Radiological Investigations	Identify the reasons for referral and appropriateness of referrals. Develop local guideline for referrals.	Mr M Quinlan	Ophthalmology	Surgery and Anaesthetics	01/07/2013	31/12/2013	N	No
90	May-13	Dietetic Input for Children with Enteral Tubes	Identify the frequency of dietetic input that children with enteral tube feeds receive	Miss Cheryl Southall	Dietetics	CSIC	06/05/2013	31/05/2013	L	No
91	May-13	Tube Feeding for Stroke Patients	Compliance with NICE Guidance CG38. Determine whether people with an acute stroke who are unable to take adequate nutrition and fluids orally receive tube feeding within 24 hours of admission	Miss Sarah Hughes	Dietetics	CSIC	01/06/2013	30/06/2013	A	No
92	May-13	Compliance with NICE Glaucoma Guidelines for COAG	Assess compliance with NICE Guidance for Glaucoma Criterion 4 for monitoring intervals for COAG	Mr A Raj	Ophthalmology	Surgery and Anaesthetics	01/07/2013	28/02/2014	A	No
93	May-13	Compliance with NICE Glaucoma for OHT or Suspected Glaucoma	Assess compliance with NICE Guidance for Glaucoma Criterion 3 for monitoring intervals for OHT or suspected glaucoma	Mr A Raj	Ophthalmology	Surgery and Anaesthetics	01/07/2013	31/03/2014	A	No
94	May-13	Phasing Requests and Outcomes	Assess compliance with NICE Guidance CG85 on Glaucoma for phasing requests and outcomes	Dr L Okafor	Ophthalmology	Surgery and Anaesthetics	02/05/2013	30/06/2013	A	No
95	May-13	National Bowel Cancer Mortality Outlier Review	Review mortalities identified by the NCBA.	Mr R McEwan	General Surgery	Surgery and Anaesthetics	06/05/2013	30/06/2013	M	No
96	May-13	Chaplaincy Documentation Audit	Assess compliance with UKBHC documentation guidelines	Rev. Mark Stobert	Chaplaincy	CSIC	01/07/2013	01/11/2013	M	No
97	May-13	Chaplaincy Patient Experience Audit	Assess compliance with UKBHC guidance on assessing patient's spiritual needs	Rev. Mark Stobert	Chaplaincy	CSIC	01/07/2013	01/11/2013	F	No

98	Apr-13	National Audit Project (NAP5) Accidental Awareness during General Anaesthesia (AAGA)	To identify all reports of AAGA over one year and to learn as much as possible from those reports, both quantitatively and qualitatively	Dr C Moody	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013	31/05/2013	M	No
99	Apr-13	National Obstetric Anaesthetic Database (NOAD)	Collection of national obstetric anaesthetic data Reference: Obstetric Anaesthetists Association OAA www.oaa-anaes.ac.uk/content.asp? Content ID=241	Dr Catherine Brennan	Anaesthetics / Critical Care	Surgery and Anaesthetics	Continual		M	No
100	Apr-13	Risk assessment of the Higher Risk General Surgical Patient	To assess the risk of current emergency surgery patients to reach the standards set in 'Emergency Surgery Standards' and by NCEPOD.	Dr Nicola Calthorpe	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013		M	No
101	Apr-13	Audit of Emergency Usage of Second Theatre Team in Obstetrics	To prospectively look at second theatre opening in Obstetrics, identify reasons and how staff were recruited for cover. This is necessary due to increased frequency of use and increased workload in Theatre 4 due to the vascular hub.	Dr Jennifer Wright	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013		L	No
102	Apr-13	Re-audit Post operative nausea and vomiting audit	To assess the implementation and effectiveness of local guidelines	Stephanie Brooks Kate Ainsley, Medical Students	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013		L	Yes
103	Apr-13	Audit of aseptic iv drug administration	Assess compliance to guidelines in the administration of iv drugs	Dr Zsolt Faluvegi, Locum Consultant	Anaesthetics / Critical Care	Surgery and Anaesthetics	01/04/2013		M	No
104	Apr-13	Antenatal Clinic Waiting Times	To indicate waiting times in clinic.	Justine Edwards	Obstetrics & Gynaecology	Women and Children	01/04/2013		L	No
105	Apr-13	Reaudit on Pregnancy of Unknown Location(PUL)	To analyse the management and outcome of pregnancy of unknown location(PUL) cases at Russell's Hall Hospital and compare with previous audit results. To revise the protocol in unit based on audit results.	Dr Aruna Sarva	Obstetrics & Gynaecology	Women and Children	01/04/2013		L	Yes
106	Apr-13	Induction of Labour Audit	CNST requirement	Dr Ihab Abbasi, ST4	Obstetrics & Gynaecology	Women and Children	01/04/2013		E	No
107	Apr-13	Fetal Blood Sampling Audit	CNST requirement	Dr Ritu Mishra, ST5	Obstetrics & Gynaecology	Women and Children	01/04/2013		E	No
108	Apr-13	Audit of the management of obesity in pregnancy and childbirth	Assess compliance with CMACE / RCOG guidelines	Dr Mohamed Salama, Clinical Fellow	Obstetrics & Gynaecology	Women and Children	01/04/2013		M	No
109	Apr-13	NHS Fetal Anomaly Scan Audit	Assess compliance with NHS Fetal Anomaly Screening Programme and local guidelines	Dr Poornima Henchinamane Murthy, ST4	Obstetrics & Gynaecology	Women and Children	01/04/2013		E	No
110	Apr-13	Children on Artificial Enteral Feeding	To address a lack of clarity regarding follow up and what is happening to these children in community. Review practice to draw conclusions and make recommendations based on that.	Dr Subra Iyer	Paediatrics / Neonates	Women and Children	01/04/2013		L	No

111	Apr-13	Neonatal Abstinence Syndrome (NAS) Audit	Review of our practice and make conclusions and recommendations based on that and the Scottish Interagency Child Protection guideline 2004: Working with Children and Families affected by Substance Misuse in the Borders.	Dr David Sinton	Paediatrics / Neonates	Women and Children	01/04/2013		M	No
112	Apr-13	Patient experience of the new centralised upper GI cancer pathway	To audit the patients experience of the new service and look into any complications that may have arisen. These results will be used as a base line for the new service.	Mr A Bohra	General Surgery	Surgery and Anaesthetics	01/04/2013		I	No
113	Apr-13	Posting appointments- a waste of time, paper and money.	To show that the current system of posting appointments to patients instead of giving them prior to leaving the department is unnecessary and expensive and not what patients would want.	Mr Alastair Marsh	Trauma & Orthopaedics	Trauma and Orthopaedics	01/04/2013		N	No
114	Apr-13	Reason for delay in admission to an orthopaedic ward in patients with fractured neck of femur	Identify percentage of the national target the trust is meeting for specified time period for patient transfer to orthopaedic ward	Dr Chloe Skinner, FY2 / Alistair Marsh	Trauma & Orthopaedics	Trauma and Orthopaedics	01/04/2013		M	No
115	Apr-13	THULIUM Laser Enucleation of Prostate (THULEP)	To analyse the outcome of THULEP with regard to improvement in patient flow rate, symptoms and satisfaction	Dr Nuwan Premachandra / Mr Asad Abedin	Urology	Surgery and Anaesthetics	01/04/2013	End of 2013	L	No
116	Apr-13	Feasibility of daycase THULEP / TURB / TURP	To compare current practice in the management of patients admitted for THULEP / TURP / TURBY with standards outlined in the Enhanced Recovery Guidelines (DoH).	Mr Asad Abedin	Urology	Surgery and Anaesthetics	01/04/2013	End of 2013	L	No
117	Apr-13	Audit of newly introduced Urology HOT clinic - baseline of usage and outcome	Evaluation of new service	Dr David Galloway, FY1	Urology	Surgery and Anaesthetics	01/04/2013		N	No
118	Apr-13	Intra-Vitreal Triamcinolone Injection Audit	To establish clinical benefit/efficacy and look at re-injection rates/duration of benefit.	Mr S Shafquat	Ophthalmology	Surgery and Anaesthetics	01/04/2013		N	No
119	Apr-13	Audit of Ophthalmic Prescription Writing	To audit compliance against local pharmacy guidelines of the writing of prescriptions in the Eye Department.	Julia Phillips / Mr Mike Quinlan	Ophthalmology	Surgery and Anaesthetics	01/04/2013		L	No
120	Apr-13	Readmissions Audit	Assess readmission rate and reason for admission	Jasdeep Bhogal, CT1 Dr S Mandal	Acute Medicine	Emergency, Specialty Medicine and Elderly Care	01/04/2013		N	No
121	Apr-13	GLP-1 Mimetics Audit	Audit the long-term outcome of GLP1 mimetics, exanatide, liraglutide and bydureon in the treatment of diabetes	Margaret Jackson / Dr K Ashawesh	Diabetes & Endocrinology	Ambulatory Medicine	01/04/2013		L	No
122	Apr-13	Rapid Acting Insulin Audit	Audit the long-term outcome of rapid acting insulin in the treatment of diabetes	Margaret Jackson / Dr K Ashawesh	Diabetes & Endocrinology	Ambulatory Medicine	01/04/2013		L	No
123	Apr-13	Parkinson's Disease "Get it on time" Audit	To ascertain what proportion of medications are missed and why?	Bethany Edge, ST5	Elderly Medicine	Emergency, Specialty Medicine and Elderly Care	01/04/2013		L	No
124	Apr-13	End of Life Care: Applications of the Medical Principles of the Liverpool Care Pathway in an Acute Hospital	To establish whether appropriate anticipatory medications are prescribed for end of life care. To determine compliance	Dr Joanne Bowen	Palliative Care	Emergency, Specialty Medicine and Elderly Care	01/04/2013		M	No

		Setting	with the completion of the LCP.							
125	Apr-13	To Assess Compliance Following the Implementation of the McKinley T34 Syringe Pump across Acute and Community Settings Audit	Response to the NPSA /2010/RRr019 - Safer ambulatory syringe driver. Replacement of Graseby ms26 syringe driver with the McKinley T34 syringe pump across hospital and community settings.	Sue Edwards	Palliative Care	Emergency, Specialty Medicine and Elderly Care	01/04/2013		K	No
126	Apr-13	Audit of Biologic Switching in Rheumatoid Arthritis Patients in the Midlands 2011	WMRSTC Audit - to determine if NICE guidance is being followed when biological agents are changed in Rheumatoid Arthritis.	Dr Nicola Erb	Rheumatology	Ambulatory Medicine	01/04/2013		A	No
127	Apr-13	Rheumatology Polyclinic: an audit of Outcome	Monitor referral rates & diagnostic category of pts seen in Polyclinic. Assess the use of AHP in clinics and monitor discharge rates.	Dr Nicola Erb	Rheumatology	Ambulatory Medicine	01/04/2013		N	No
128	Apr-13	Rheumatology ultrasound service outpatient audit	Service evaluation	Dr Theodoros Dimitroulas, Locum Consultant	Rheumatology	Ambulatory Medicine	01/04/2013		N	No
129	Apr-13	Neutopenic Sepsis Audit - 'door to needle time'	Monitor compliance with NICE guidelines CG151	Dr Lisa Milverton / Dr Helen Hoyte	Haematology	Diagnostics	01/04/2013		A	No
130	Apr-13	Audit on management of Clostridium difficile GDH Positive Toxin Negative Patients	Monitor and ensure compliance with Trust guidelines	Dr L Mohankumar, Consultant	Microbiology	Diagnostics	01/04/2013		L	No
131	Apr-13	Nail Surgery AQP pre and post surgery satisfaction	To measure AQP defined quality standards and evaluate clinical effectiveness of podiatric nail surgery	Stephen Miller, Podiatry Team Leader	Podiatry	CSIC	01/04/2013		M	No
132	Apr-13	Audit of the Impact of new SLT Dementia Service on General Dementia Population	To demonstrate the clinical effectiveness and efficacy of SLT Dementia service	Sarah Little / Beccy Clarke	Speech & Language Therapy	CSIC	01/04/2013		N	No
133	Apr-13	Videofluroscopy Referrer Satisfaction Audit	To ensure that the current videofluoroscopy service is working successfully.	Linzie Priestnall	Speech & Language Therapy	CSIC	01/04/2013		N	No
134	May-13	Audit of EVAR	Compare outcomes of our EVR and EVAR1 National trial. Establish whether outcomes have improved prior to vascular hub status NICE IPG163	Dr Sachin Modi / Dr S Latif	Radiology	Diagnostics	May-13	01/09/2013	A	No
135	May-13	Acute medicine Mortality Review Tool	In complaince with local hospital guidelines and assess medical management of patients prior to death	Dr Randa Abasaeed Elhag	Acute Medicine	Emergency, Specialty Medicine and Elderly Care	01/04/2013	31/03/2014	L	Yes
136	May-13	Discharge Letter Audit	Identify factors associated with delayed discharge summaries and assess if junior doctor shift patterns have impacted	Dr Randa Abasaeed Elhag	Acute Medicine	Emergency, Specialty Medicine and Elderly Care	01/05/2013	30/06/2013	M	Yes
137	May-13	Transient Loss of Consciousness Audit (TLoC)	Monitor compliance with NICE guideline CG109	Dr Hassan Paraiso	Acute Medicine	Emergency, Specialty Medicine and Elderly Care	01/08/2013	31/12/2013	A	Yes

138	May-13	AMU Outpatient Clinic Non-attenders	To profile clinic non-attenders with a view of improving DNA rates	Dr Hassan Paraiso	Acute Medicine	Emergency, Specialty Medicine and Elderly Care	01/08/2013	31/12/2013	L	Yes
139	May-13	Acutely ill patients in hospital Audit	Monitor compliance with NICE guideline CG50	Dr Hassan Paraiso	Acute Medicine	Emergency, Specialty Medicine and Elderly Care	01/08/2013	31/12/2013	A	Yes
140	May-13	Compliance with antibiotic guidelines for H. Pylori	Monitor compliance with NICE guideline CG17 Managing Dyspepsia in Adults	Dr Giovanna Sheibani	GI Medicine	Emergency, Specialty Medicine and Elderly Care	01/05/2013	31/12/2013	A	No
141	May-13	Evaluation of Front Load Senior Led Triage Service	Service improvement for patients presenting to EAU, in order to reduce waiting times, length of stay and improve flow of patient through department	Dr Gautam Bagchi, ST5 / Dr H Paraiso	Acute Medicine	Emergency, Specialty Medicine and Elderly Care	01/05/2013		N	No
142	May-13	Colposcopy Audit: outcome after LLETZ in incompletely excised CIN in patients aged more than 50 years	Compare our practice with national guidelines with regards to LLETZ procedures	Dr Sabita Nair, ST5	Obstetrics & Gynaecology	Women and Children	01/05/2013		M	No

Enclosure 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 6th June 2013

TITLE:	**Summary of Key issues from the Risk & Assurance Committee held on 23rd April 2013**		
AUTHOR:	**Julie Cotterill** **Governance Manager**	**PRESENTER**	**Ann Becke (NED)** **CQSPE Committee Chair**

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

SUMMARY OF KEY ISSUES:

Emergency and Specialist Medicine Risk Register - The Clinical Director, General Manager and Matron attended the Committee to discuss the Directorate top risks and share their concerns about the management of these. The Committee reviewed the following risks:

- EM003 – Patient trolley waits
- OP015 – Failure to undertake observations and monitoring patients
- OP119 – Non attendance of Medical Registrar out of hours
- OP122 –Hyper acute stroke status
- OP123 – Failure to control Directorate Overspend

The Committee discussed the risk management arrangements within the directorate, the process for escalating risks to the corporate risk register and the levels and robustness of assurance provided.

Operations Directorate Risk Register (Top 5) – The Committee received a report from the Director of Operations focussing on the top 5 risks in each of the clinical directorates , the controls and assurance in place and actions to mitigate any gaps in control or assurance.

Nursing Directorate Risk Register - this had recently been reviewed, updated and cross referenced to both directorate and corporate registers. Eight risks were being actively managed. A number of risks had been removed following the review and some had been re-assessed.

Finance, Information and IT Directorate Risk Report – the directorate was managing 10 risks, 1 of which scored 20. The Committee discussed the actions planned to mitigate / manage this.

Human Resources Risk Register – the directorate was managing 5 risks. One new risk relating to measles vaccination had been added to the register. The remainder were actively managed.

Community Services and Integrated Care (CSIC) Risk Register - the CSIC Board had reviewed the risk register on 26th March 2013. 9 risks were reviewed, 4 risks reduced following mitigation and 2 closed. One new risk was received and accepted. As at 10th April 2013 the Directorate had a total of 55 risks on the register of which 14 scored 15 and above.

Compliance with NPSA Safety Alerts - The Committee received the report confirming the Trust progress against the remaining outstanding alert. The Committee was advised that the key functions of the NPSA had transferred to the NHS Commissioning Board Special Health Authority in June 2012.

National Cardiac Arrest Audit (NCAA) Report for the period April 2012 to December 2012 - the Committee received the results of the NCAA and discussed the Trust position when benchmarked against other participating organisations. The report confirmed that the Trusts Cardiac Arrests rates per 1000 admissions were within the lower half of reporting Trusts at an average of 12 per month .Almost three quarters of events were within the medical care speciality. The Committee discussed the variance in figures for shock able and unshockable events and noted the impact on survival rates. Training of staff was also considered together with current initiatives to improve attendance rates.

Diversity Management Group held on 23rd January 2013 - The Equality Impact Assessment sub group had held its first meeting and was producing a guide to completing EIA's. The group would also develop awareness training for diversity .The Single Equality Action Plan was approved and provided a calendar of reporting activity on diversity issues. The Friends and Family Survey was discussed in relation to the nine protected characteristics and it was agreed that age and gender would be added to the information collected to ensure that the Trust was capturing a cross section of people in the survey.

Health & Safety Group – The Committee discussed the Summary of issues focussing on Slips, Trips and Falls and the current arrangements for provision of training.

Policy Group Recommendations - The Committee received a recommendation to formally ratify 42 policies/guidelines which had been reviewed by the Policy Group. The full documents were available for review on the Directors shared drive prior to the meeting. The report had been updated to confirm the status of the policies/guidelines and if they were required for the NHSLA or CNST. The Committee **reviewed** the schedule of Policies and Guidelines and **ratified** all 42 documents listed.

Diversity Annual Plan – The Director of HR presented the Diversity Annual Report confirming compliance with the statutory duties and the progress achieved in implementing the arrangements specified in the Single Equality Scheme and action plan. Good progress had been made against the 2 Trust objectives which had been set for a 3 year period ending 2015. All Trust statistics had been reviewed against the local census data and no issues had been identified. The Single Equality Plan was adopted by the Diversity Management Group and would be implemented. The Trust had also received a positive opinion from the Internal auditors. The Committee **received** the Diversity Annual Report

Research and Development Directorate Report - this report outlined the new studies taking place within the Dudley Group and the risk levels of these, the serious adverse events reported during the period as defined by individual study protocols and ICH Good Clinical Practice guidelines for clinical research

Board Assurance Framework - The Committee considered the updated Board Assurance Framework which highlighted those risks scoring 20 or above (7 in total) that had the potential to impact on the achievement of the Trust objectives. The Committee considered the robustness of assurance received since the last report and the action plans to mitigate and /or manage the risks.

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE BOARD:

To note the key issues arising from the Risk & Assurance Committee held on 23rd April 2013 and refer to the full minutes for further details.

The Risk and Assurance Committee has overarching responsibility for risk and ensures that the Trust has appropriate and effective systems and processes in place to identify, record, manage and mitigate all risks (clinical and non clinical) to the provision of high quality, safe, patient centred care. The duties of the Committee include the assessment of the Trust risk portfolio and the provision of assurance to the Board of Directors on the adequacy and effectiveness of the risk management arrangements across the Trust and in the Community.

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on June 6th 2013

TITLE:	**Annual Report of the Risk and Assurance Committee**		
AUTHOR:	**Julie Cotterill** **Governance Manager**	**PRESENTER**	**Ann Becke (NED)** **Risk & Assurance Committee Chair**

CORPORATE OBJECTIVE: To deliver an infrastructure that supports delivery

SUMMARY OF KEY ISSUES:

Following the review of the Board Committee structure the Risk and Assurance Committee replaced the Risk Committee holding its inaugural meeting on 15th May 2012. This report outlines the work undertaken by the Risk and Assurance Committee on behalf of the Board and the key issues arising from this, for the financial year ending March 2013.

The Committee has focussed on current risk issues arising from reports of working groups or from incident reports, the risk register or external reviews and has sought and obtained assurance on key risk areas and monitored progress on high risk and emerging issues. Assurance has also been sought from lead officers and when appropriate, matters have been escalated to the Board or another Board Committee.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Committee considered and discussed a number of risks on the directorate registers.
	Risk Register: Y		**Risk Score:** Various
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 1 - Respecting & Involving people Outcome 4 – Care & welfare of people Outcome 7 - Safeguarding Outcome 12 – Requirements relating to workers Outcome 16 – Assessing & monitoring quality of service provision
	NHSLA	**Y**	**Details:** Risk management arrangements and policy ratification.
	Monitor	**Y**	**Details:** Ability to maintain at least level 1 NHSLA
	Equality Assured	**Y**	**Details:** Better health outcomes for all Improved patient access and experience
	Other	**Y**	**Details:** Information requirements for the AGS – Risk Register gaps in assurance and control

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD

The Board is requested to receive this report and to note the scope of the work undertaken by the Risk and Assurance Committee during 2012/13.

ANNUAL REPORT OF THE RISK AND ASSURANCE COMMITTEE

FOR THE YEAR ENDING 31st MARCH 2013

1. Introduction

The Board is responsible for ensuring that the organisation has appropriate risk management arrangements and processes in place to deliver the Annual Plan and to comply with the registration and monitoring requirements of the various regulatory bodies. Within the Board itself an informed consideration of risk should underpin organisational strategy, decision making and the allocation of resources.

Following the review of the Board Committee structure the Risk and Assurance Committee replaced the Risk Committee holding its inaugural meeting on 15th May 2012. This report outlines the work undertaken by the Risk and Assurance Committee on behalf of the Board and the key issues arising from this, for the financial year ending March 2013.

2. Terms of Reference and Membership

2.1 The Risk and Assurance Committee has delegated Board responsibility for ensuring that the Trust has appropriate and effective systems and processes in place to identify, record, manage and mitigate all risks (clinical and non clinical) to the provision of high quality, safe, patient centred care.

The duties of the Committee include assessing the Trust risk portfolio quarterly, providing assurance to the Board on the adequacy and effectiveness of the risk management arrangements across the Trust and in meeting the Standards of Quality and Safety set out in the registration requirements of the Care Quality Commission and NHSLA. They ensure that systems are aligned to maximise the benefit and organisational learning from the risk management arrangements.

A summary of key issues arising from the Committee is received at the Board following each meeting.

The duties of the Committee can be summarised as follows:

- To assess the Trust risk portfolio quarterly and recommend risk control priorities to the Board of Directors and Management following each meeting.
- To provide assurance to the Board of Directors on the adequacy and effectiveness of the risk management arrangements across the Trust and in the Community.
- To ensure that the Trust meets the Standards of Quality and Safety set out in the registration requirements of the Care Quality Commission and NHSLA requirements.
- To provide assurance to the Board of Directors that the strategic risks are adequately managed and/or mitigated as appropriate and identify and advise on improvement priorities,
- To ensure systems are aligned to maximise the benefit and organisational learning from the risk management arrangements.
- To monitor performance of all reporting groups, approving Terms of Reference and receiving minutes, action plans, exception reports and progress recommendations made to the Committee.

Membership of the Committee comprises Non Executive and Executive Directors of the Board. The required quorum for meetings in this reporting period, is three members including one Non-Executive Director. In addition to the core members, the Committee is routinely supported by key officers/ specialists with specific responsibility for risk management at operational / directorate level. Other specialists attend at the invitation of the Chair.

2.2 Committee membership and attendance for the financial year end March 2013 :

		15/05/12	17/07/12	05/09/12	04/10/12	16/10/12	22/01/13
A Becke (Chair)	Non Executive Director (NED)	√	√	√	√	√	√
D Badger	NED						√
D Bland	NED	√	**A**	**A**	**-**	√	√
P Clark	Chief Executive	**A**	√	**A**	√	**A**	√
P Assinder	Dir of Finance	√	√	√	**A**	√	√
R Beeken	Dir of Ops	√	√	√	**A**	√	√
P Harrison	Medical Director *	**A**	**A**	**A**	**A**	**A**	**A**
D Mcmahon	Dir of Nursing	√	√	√	√	√	√

**Note: the Deputy Medical Director would usually be in attendance in the absence of the Medical Director.*

2.3 Reporting Groups

The following groups report to the Risk and Assurance Committee:

- H&S Group
- Policy Group
- Diversity Management Group
- Directorate Risk Management Teams.

The terms of reference for these groups (with the exception of the Directorate Risk Management Teams) and the reporting mechanism and frequency is agreed by the Risk and Assurance Committee.

2.4 Agenda Management

The terms of reference define the key duties and responsibilities of the Risk and Assurance Committee. During the financial year the Committee has focussed the agendas to meet these and to provide an appropriate reporting framework for ad hoc assurance reports received in the Trust. Standing agenda items include the receipt and discussion of the Corporate and Directorate Risk Registers, compliance with Safety Alerts, reports from reporting groups and the ratification of policies.

The Committee continued to formalise the reporting arrangements at directorate level encouraging directorates to standardise the reporting of their risk register and inviting Clinical Directors and General Managers to personally present their top 5 risks to the Committee.

Two extra ordinary meetings were held in September and October 2012 to specifically consider the recommendations of the Policy Group and ratify policies in readiness for the CNST and NHSLA assessments.

The schedule below confirms the Committee activity for the year:

Agenda management

	15/05/12	17/07/12	Ext Ord 05/09/12	Ext Ord 04/10/12	16/10/12	22/01/13
Risk Management						
• Corporate Risk Register	√	√			√	√
• Directorate Risk Registers	√	√			√	√
• Compliance with NHSLA Standards	√					
• Compliance with Safety Alerts	√	√			√	√
• Risk Management Strategy				√		
• Maternity and Children's Risk Management Strategy				√		
Board Assurance Framework						
• External Reviews						
o Quality Risk Profile	√					√
o West Mids Local Supervising Authority Audit 2011/12 and Action Plan		√				√
o Survey of Women's Experiences of Maternity Services					√	
o NHSLA Risk management Standards						√
o CNST Maternity Standards						√
o NHSLA Risk Management Survey 2012						√
• Assurance Reports						
o Internal Audit Report – Risk Management	√					
o Internal Audit Report CQC	√					
o Movement and trends of medicine incidents		√				
o Single Equality Scheme						√
Other						
• Risk & Assurance Committee Terms of Reference	√	√				
• Annual Plan Schedule	√					
• Prevent in Healthcare: Expectations from the Prevent Strategy 2011						√

	15/05/12	17/07/12	Ext Ord 05/09/12	Ext Ord 04/10/12	16/10/12	22/01/13
Reporting Groups						
• Health & Safety Group	√	√			√	√
• Diversity Management Group	√	√			√	
• Directorate Risk Management Teams					√	√
• Ambulatory Directorate Risk Register (Top 5 Risks)						√
Policies for ratification	√	√	√	√	√	√
AOB						
• Major Internal Incident Update				√		
• IRMER No: 000907						√

3. Key issues arising

3.1 Risk Management

3.1.1 The Committee received regular reports from lead Directors, focussing on key risks at both corporate and directorate level and the robustness of assurance received. This was supported by reports from directorate teams and external assurance received. Directors were challenged to update risk descriptions and mitigating actions and to ensure that risks were reflective of the key business issues and commercial risks. They were also requested to consider the sources of assurance and any additional requirements at Board level. During the year the Committee escalated the following:

- COR016 – Impact of Any Qualified Provider – the Board received a briefing paper on this.
- MAT003 - Maternity Unit risks - A full business case was presented to the Board of Directors in September.

. The Committee continued to formalise the reporting arrangements at directorate level encouraging directorates to standardise the reporting of their risk register and latterly inviting Clinical Directors and General Managers to present their top 5 risks to the Committee. This process will be developed further during 2013/14.

Ambulatory Risk Register – Top 5 Risks - Dr Stewart (Clinical Director) and Ms Benson (General Manager) attended the Committee to discuss their highest risks and the actions in progress to manage or mitigate these. The Committee considered the operational arrangements and changes required to clinical practices in the Renal Replacement Therapy Unit together with the current lack of capacity and the associated financial risks.

The Committee discussed the directorate proposals to operate the unit in three shifts as opposed to two at present and the repatriation of patients from satellite units. The remaining risk related to the maladministration of insulin and the advice available to staff.

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3.1.2 **NHSLA Risk Management Standards**

The Trust was assessed against the NHSLA Risk Management Standards (level 1) in November 2012 and achieved full compliance. The Committee received the supporting report which provided an overview of the risk areas covered by the assessment, confirming the key findings and recommendations for consideration.

NHSLA CNST Maternity Compliance Level 1 Action Plan

Maternity services achieved CNST level 1 compliance in October 2012 with 100%. The Committee received the supporting report and action plan. The assessor commented on the high standard of submitted evidence and examples of good practice.

3.1.3 **NHSLA Risk Management Survey 2012**

The Committee received this report which summarised the views of Risk Managers and Chief Executives in relation to their overall satisfaction with the current system, standards and assessment and the future design of these.

3.1.4 **National Patient Safety Alerts (NPSA)**

Through analysis of reports of patient safety incidents, and safety information from other sources, the NPSA develop advice for the NHS that can help ensure the safety of patients. Advice is issued as and when issues arise, via the Central Alerting System. The alerts cover a wide range of topics, from vaccines to patient identification. Types of alerts include Rapid Response Reports, Patient Safety Alerts, and Safer Practice Notices.

The Committee monitored compliance with the following 3 NPSA alerts issued during the year focussing on actions taken and achievement of closure deadlines.

- NPSA/2011/PSA003: The adult patient's passport to safer use of insulin – closed 30th September 2012
- NPSA/2011/PSA001: Safer Spinal (intrathecal), Epidural and Regional Devices. Part B remains active with a closure date of April 2013.
- Rapid Response Report RRR001 regarding 'Harm from flushing of nasogastric tubes before confirmation of placement'. Breached its closure date of 21/09/2012. Urgent action was taken with a predicted closure date of 12/10/2012. Assurance was received that no risks had been identified and all staff had been alerted. This was closed on 12th December 2012.

3.2 Board Assurance

3.2.1 The Board must be confident that the systems and processes, policies and people they have put in place are operating effectively, focussed on key risks and driving the delivery of objectives. The Risk and Assurance Committee has a fundamental role in ensuring that robust and appropriate risk management arrangements are operating and that the supporting Assurance Framework is both scrutinised and challenged.

3.2.2 During the year the Committee has considered the adequacy of the assurance identified at both Corporate and Directorate level in the risk registers and has sought independent assurance where this has failed to satisfy the Committee that risks were being robustly managed or mitigated or where further explanation was required to understand the effectiveness of controls or assurance in place.

Additionally the Committee received a number of independent reports from external review bodies, identifying associated risks and actions for follow up (see below).

3.2.3 **Internal Assurance**

Medicine Incidents – (*update to paper presented to the Risk Committee in January 2012)*. This paper outlined the progress made against each of seven actions arising from the report and provided information for the first quarter on incidents from high reporting areas and the causes of these. Assurance was received that the Safe Medicines Practice Committee monitored the serious incidents and areas of both high and low reported incidents.

Prevent in Healthcare: Expectations from the Prevent Strategy 2011 - The Trust Prevent Lead outlined the expectations for the delivery of this Strategy and actions taken and planned for the future. He provided some background on CONTEST, the Governments national counter terrorism strategy, which aimed to reduce the risk to the UK and its interests overseas from international terrorism. This is an ongoing initiative designed to become part of everyday safeguarding routine for staff.

CQC Quality Risk Profile Exceptions Report - This report summarised information received from the CQC comparing the previous risk estimate and latest risk estimate and the Trust position. The majority of the dials were showing low yellow.

Research and Development - The Committee opened the meeting with a presentation on the role and function of Research and Development in the Trust and the appropriate reporting and monitoring arrangements for this.

Single Equality Scheme - the Committee formally accepted the Single Equality Scheme and approved the Terms of Reference for the Diversity Management Group.

3.2.4 **External Assurance**

Supervisors of Midwives - The Committee received two reports from the Local Supervising Authority (LSA). The Dudley specific report was very positive and no recommendations were identified. The Trust received many acknowledgments of good practise and positive comments on the Supervisors of Midwives (SOM) processes for conducting investigations and provision of assurance on the completion of audits.

The second report reviewed key themes from the audit of all LSA Supervisory teams at each Trust. The generic themes had been reviewed and an action plan developed to ensure these were monitored

Response to the Local Supervising Authority Midwifery Officer (LSAMO) Annual Report 2011/2012 - this report was a statutory requirement of the SHA Cluster in its role as the monitor of the Local Supervising Authority performance and activity. Dudley Supervisors of Midwives had reviewed the report and developed an action plan against the identified areas to be addressed. The Committee accepted and approved the response report and action plan.

Survey of Women's experiences of maternity services – the Committee reviewed two surveys, one from the CQC and one from NHS Maternity Services. The Trust achieved good ratings in both.

3.3 Reporting Groups

The Committee received the minutes and updates from the following reporting groups focussing on key issues and risk related concerns. The terms of reference were also reviewed and updated as appropriate.

Key issues highlighted during the year included:

3.3.1 **Health & Safety Group**

- HSE Improvement Notice - issued on 7th August following inspection of the containment level 3 (CL3) laboratory. The notice identified inadequacies in the physical and procedural controls necessary to minimise the risk of exposure to

biological agents. A response was sent to the HSE by the deadline of 12th October 2012. The Committee discussed the process for managing these notices and the supporting guidelines.

3.3.2 **Diversity Management Group**

- Changes to the EIA process were agreed
- A comprehensive set of base line information had been implemented which covered 9 protected characteristics, by applicants to vacancies at the Trust, Trust employers and leavers. No significant issues were identified.

3.3.3 **Policy Group**

- The Committee considered and supported a proposal for the establishment of a Policy Group with responsibility for reviewing all procedural documents prior to ratification.
- During the year the Committee supported the ratification of circa 140 policies / guidelines.

3.3.4 **Directorate Risk Management Teams**

The Committee discussed and agreed the future reporting arrangements for the receipt and discussions of the Directorate Risk Management Team minutes and areas for review including standardised agendas and action monitoring. It was agreed that General Managers and Clinical Directors would be invited to attend the meeting to outline their top 5 risks and any significant issues.

4. Conclusion

The Risk Management arrangements have been formalised and strengthened over the year which has impacted on the management of the Risk and Assurance Committee and the quality of the reports and information received and considered.

The Committee has focussed on current risk issues arising from reports, the risk register or external reviews and has sought and obtained assurance on key risk areas and monitored progress on high risk and emerging issues. Assurance has also been sought from lead officers.

The Terms of Reference and Committee membership has been reviewed and updated.

The Board is requested to receive this report and to note the scope of the work undertaken during 2012/13.

Ann Becke
Chair of Risk and Assurance Committee
April 2013

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On the activities of the Finance & Performance Committee

TITLE	**Finance & Performance Committee meeting held on 23rd May 2013**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**
CORPORATE OBJECTIVE: SO 10 Enabling Objective			
SUMMARY OF KEY ISSUES: • **During April, in common with much of the NHS acute sector, the Trust has experienced significant increases in emergency admissions and A&E attendances. This has placed both operational and business strain on performance.** • **Not withstanding this the Trust continues to perform well against the long list of access and waiting target set by the NHS nationally and locally.** • **Financial performance in April was marginally worse than plan due to reduced income from CCG's and some slippage against savings plans.**			
IMPLICATIONS OF PAPER:			

RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Risk to achievement of the overall financial target for the year** **Risk to achievement of A&E target in Q1**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **Monitor has rated Trust at Amber/Red for Governance & '3' (good) for Finance at Q3. The Trust remains on quarterly monitoring by Monitor.**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

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

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to:

1. **Note the report.**

The Dudley Group NHS
NHS Foundation Trust

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

Finance and Performance Committee Meeting held on 23rd May 2013

1. Background

The Finance & Performance Committee of the Board met on 23rd May 2013. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered forecast year end performance reports. The Committee noted in particular the following matters:

2. Workforce

a. Absence
The Trust absence rate for the month of March is 4.32% and was 4.15% for the year. The 2012-13 target was 3.50% and 2011-12 was 3.65%.

b. Turnover
Turnover continues to remain consistent and within target at 7.94%.

c. Pre-employment Checks
Pre-employment checks managed through the Centralised Recruitment Department perform at 100%, together with 100% for Medical Workforce recruitment. Staff bank performed at 75%.

d. Mandatory Training and Appraisals
The compliance rates for Mandatory Training has shown a small increase overall for April increasing from 71.6% to 72.5%.
Appraisals have increased this month to 81.8% with four Directorates on Amber.
In view of its relatively poor performance, the Committee requested the Emergency and Speciality Medicine Directorate to attend the meeting to present their action plans.

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

f. Vacancies
The current live vacancy rate has decreased slightly to 187.55 FTE.

3. Financial Performance for Month 1 - April 2013 (Appendix 1)

The Trust made a small trading deficit of £297,000 in April. Although planned, this deficit was £142,000 higher than Plan, due to receiving slightly lower levels of income from CCGs for elective activity in April. In common with most areas of the local NHS, pressures on emergency and unplanned care in April caused some cancellation and rescheduling of planned activity, resulting in lower income. The Trust is seeking to confirm the allocation of £3m transitional support from NHS Dudley to offset this impact.

The second contributory factor to poor trading in April was slippage on some CIP schemes, with £3.5m achieved to date against a 2013-14 savings plan of £12.5m. This is £453k behind the phased plan for April and will thus require closer scrutiny by the Committee over the next couple of months.

At this stage of the year, the Trust forecast outturn remains at a £500k surplus in line with the approved plan.

The Trust's balance sheet and liquidity position remains strong.

4. Performance Targets and Standards (Appendices 2 & 3)

Directors reported strong performance against all measures for the month of April other than A&E. During the first weeks of 2013-14, the Trust has experienced unprecedented levels of demand for emergency admissions to Russells Hall. However, the vast majority of national and local access and waiting targets are being met or exceeded in Dudley.

Notwithstanding this commendable overall performance, the Committee noted the following matters:

a) A&E 4 Hour Waits

The percentage of patients who waited under 4 hours within A&E for April was 90.1%, which is well below the target of 95% and is consistent with Acute trusts' performance nationally and is reflective of the significant pressures being placed upon the emergency care streams in Dudley.

The Committee noted that the high number of patient wait breaches during April represents a risk that the Monitor Quarter 1 target will not be achieved. The position after 3 weeks of May was 95.6%.

b) Cancer 62 days target for treatment following GP referral

Following an isolated drop in performance in February 2013, this target has been consistently exceeded since, with April recording 88.1% (target 85%).

c) Never Events

The Trust had no 'never events' in April.

d) Mortality Indices

The Committee noted that the Standardised Hospital Mortality Indicator (SHMI) for Quarter 2 July to September 2012 (DoH issue indices in arrears) of 1.04 for the Trust falls well within the expected range as measured by both extant national methodologies. The Trust's crude mortality rate continues to fall.

5. Procurement Report

The Committee considered a detailed report on the activities of the Procurement and Supplies Department in Quarter 4.

6. Annual Plan 2013 to 2016

The Committee approved the Trust's Annual Plan for submission to Monitor.

7. Approvals under delegated authority

In accordance with authority delegated to it by the Board, the Committee approved the following:

- Trust Audited Financial Accounts for 2012-13
- Trust Audited Quality Accounts for 2012-13
- Annual Report and Accounts 2012-13
- A Letter of Representation signed on behalf of the Board to Deloittes, external auditors, in support of the above sets of accounts and reports.

8. Committee Terms of Reference

Following an internal audit review, the Committee resolved to recommend to the Board of Directors one minor change to its terms of reference, which will enable the Committee to approve quarterly returns to Monitor on the Board's behalf due to timing of meetings.

9. **Matters for the attention of the Board of Directors**

- The Board is asked to note actions taken under delegated authority in Paragraph 7, above
- The Board is asked to approve changes to the Committee's terms of reference in Appendix 4.

PA Assinder
Director of Finance & Information
Secretary to the Board

THE DUDLEY GROUP NHS FOUNDATION TRUST

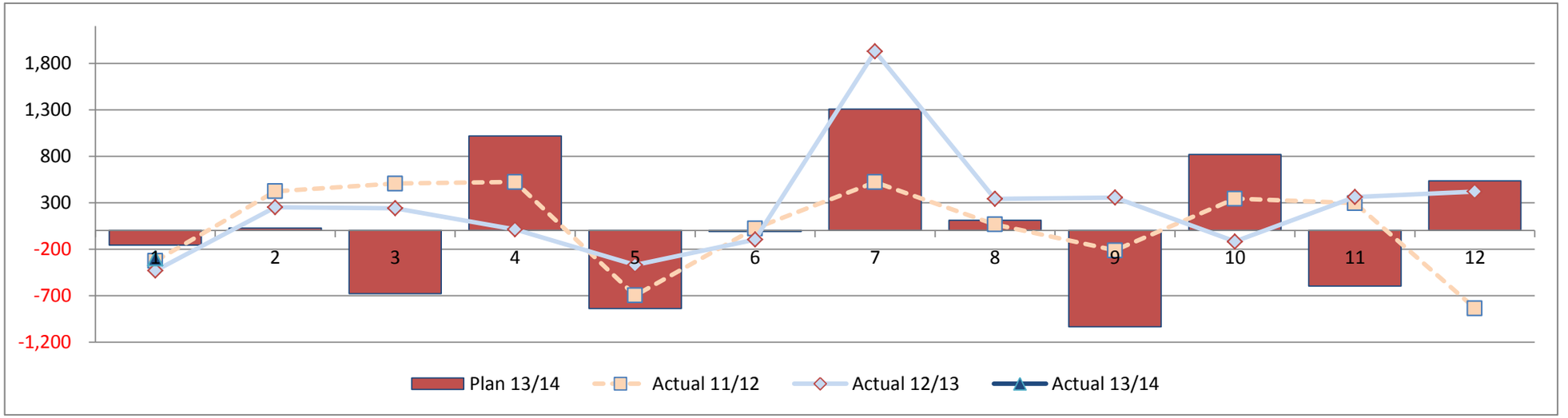
FINANCIAL SUMMARY **APRIL 2013**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£25,277	£24,451	-£827
PAY	-£15,279	-£14,691	£588
CIP	£453	£0	-£453
NON PAY	-£8,712	-£8,159	£553
EBITDA	**£1,740**	**£1,601**	**-£139**
OTHER	-£1,895	-£1,898	-£3
NET	**-£156**	**-£297**	**-£142**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£25,277	£24,451	-£827
PAY	-£15,279	-£14,691	£588
CIP	£453	£0	-£453
NON PAY	-£8,712	-£8,159	£553
EBITDA	**£1,740**	**£1,601**	**-£139**
OTHER	-£1,895	-£1,898	-£3
NET	**-£156**	**-£297**	**-£142**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£301,707	£303,542	£1,835
PAY	-£184,116	-£177,869	£6,248
CIP	£8,909	£0	-£8,909
NON PAY	-£103,152	-£102,325	£827
EBITDA	**£23,348**	**£23,348**	**£0**
OTHER	-£22,848	-£22,848	£0
NET	**£500**	**£500**	**£0**

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



Key Comments

£297k deficit in April (£142k behind planned deficit of £156k). The position is almost identical to that achieved in 12/13 and 11/12.

The April income position is £827k behind plan although it should be noted that this does not yet factor in any transitional support from the CCG.

Both pay and non-pay costs remain under the current budget for April by £588k and £553k respectively.

CIP achievement below in-month plan by £453k.

Other "below the line" items are consistent with plan.

At this stage of the year, the forecast position remains at a £500k surplus. This assumes full achievement of CIP and 100% outturn for CQUIN.

2013/14 EXPECTED RIGHTS AND PLEDGES FROM THE NHS CONSITUTION 2013/14

The Dudley Group NHS
NHS Foundation Trust

Appendix 2

Page	Area	Breach Consequence	Measure	Month Actual	Month Target	Monthly Trend	Year End Forecast
4	A&E	2% of the Actual Outturn value of the service line revenue	A&E 4 hour wait	90.1%	95%	↑	●
5	Cancer		14 Day – Urgent GP Referral to Date First Seen	97.6%	93%	↑	●
5	Cancer		14 Day – Urgent GP Breast Symptom Referral	98.0%	93%	↓	●
5	Cancer		31 Day – Diagnosis to Treatment for All Cancers	100%	96%	→	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Anti Cancer Drugs	100%	98%	→	●
5	Cancer		31 Day – 2nd/Subsequent Treatment – Radiotherapy	-	-	-	-
6	Cancer		31 Day – 2nd/Subsequent Treatment – Surgery	100%	94%	→	●
6	Cancer		62 Day – Referral to Treatment after a Consultant upgrade	100%	85%	→	●
6	Cancer		62 Day – Referral to Treatment following National Screening	100%	90%	→	●
6	Cancer		62 Day – Urgent GP Referral to Treatment for All Cancers	88.1%	85%	↑	●
8-9	Diagnostics		Percentage of diagnostic waits less than 6 weeks	99.9%	99%	→	●
-	MSA	Retention of £250 per day the patient affected	Mixed Sex Sleeping Accommodation Breaches	0	0	→	●
7	RTT	Deduction of 0.5% for each 1% under-achievement, to a max of 5%*	Admitted % Treated within 18 Weeks	94.5%	90%	↑	●
7	RTT		Non-Admitted % Treated within 18 Weeks	99.5%	95%	↓	●
7	RTT		Incomplete % waiting less than 18 Weeks	98.0%	92%	↑	●
-	Compliance	Retention of up to 1% of all monthly sums payable under clause 7 (*Prices and Payments*)	Failure to publish a Declaration of Compliance of Non-Compliance pursuant to clause 4.24. *Retention of monthly sums will continue for each month or part month until either a Declaration of Compliance or Declaration of Non-Compliance is published.*	Annual – Trust Compliant			●
-	Compliance		Publishing a Declaration of Non-Compliance pursuant to clause 4.26.				●
4	HCAI	Deduction of 0.1% for each 1% under-achievement, to a max of 2%*	C Diff – Post 72 hours *(77 breaches allowed)*	1	3	↑	●

One month behind

** See Standard Contract for Acute Services Schedule 3 Part 1 for more details*
*** Set out in clause 43. of Core Legal Clauses and Section B Part 8.4 of the Standard Contract for Community Services*

10	Never Events	0	
11-12	Monitor Summary Report – Governance Risk Rating	1	
13	Mortality Reports – 2012/13 Qtr 2 SHMI	1.04	

↓ Position Deteriorating ↑ Position Improving → Position Unchanged

↑ Within Target ↑ Outside Target → Position Unconfirmed

Dudley Group FT MORTALITY - SHMI
Quarterly KPI Report

SUMMARY HOSPITAL-LEVEL MORTALITY INDICATOR

Source: NHS Choices

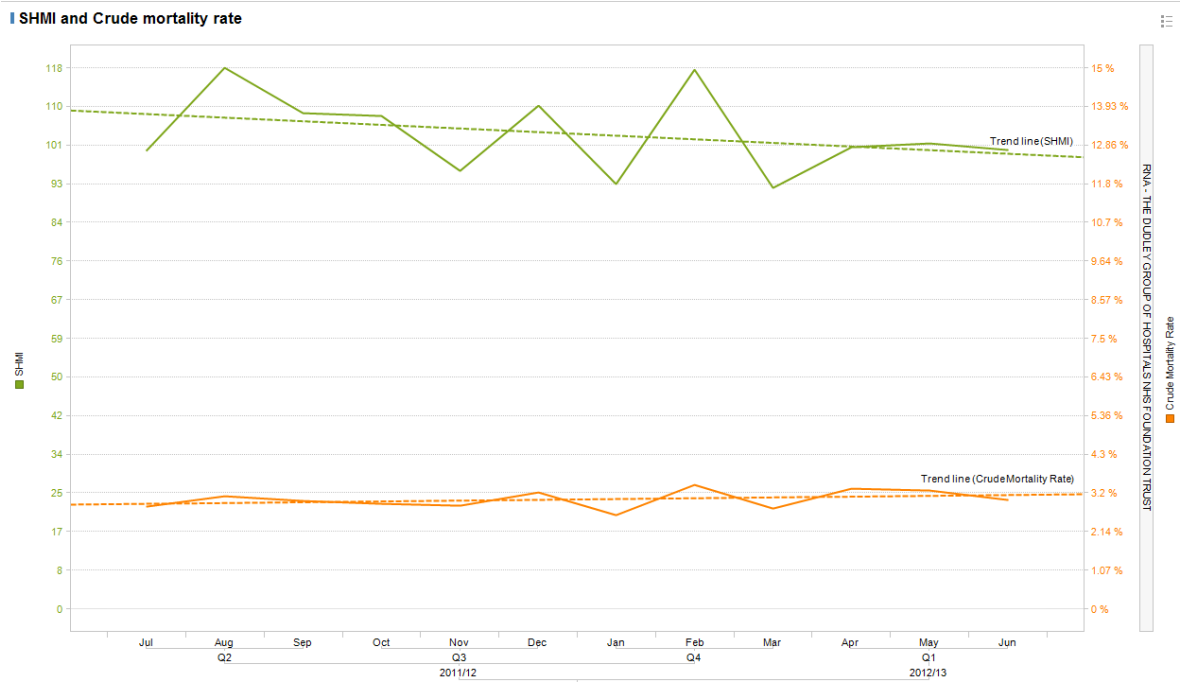
The Full SHMI is only issued by the NHS Information Centre on a quarterly basis. The SHMI intends to compare the number of deaths that actually occur against a statistical estimate of the number of deaths that might have been expected, based on the national average death rate and the particular characteristics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

SHMI	Source	2011/12 Q4		2012/13 Q1		2012/13 Q2	
Full SHMI	**NHS Choices**	1.07		1.04		1.04	

Within over dispersion range

Within both Poisson and over dispersion range

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



Source: HED

The Dudley Group NHS
NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution

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

2. Membership

Deputy Chairman (Committee Chair) **plus** 2 further Non-Executive Directors
Chief Executive
Director of Finance & Information
Director of Operations

In the absence of the Deputy Chairman the Committee will be chaired by a Non Executive Director.

The Head of Human Resources, Director of Community Services and integrated Care, Deputy Director of Finance – Performance, Deputy Director of Finance – Financial Reporting and Head of Information shall attend each meeting.

3. Attendance

3.1 All other members of the Board shall be entitled to attend and receive papers to be considered by the Committee.

3.2 Other managers/staff may be required to attend meetings depending upon issues under discussion. The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as necessary and to commission input from external advisors as agreed by the Chair

3.3 The Trust Secretary will ensure that an efficient secretariat service is provided to the Committee.

4. Quorum

4.1 A quorum shall be 4 members comprising at least two Non Executive Directors.

5. Frequency of meetings

5.1 The Committee will meet monthly within 20 working days of the month end. The Agenda will be circulated with papers 3 days before the meeting.

5.2 Ad hoc meetings may be called by the Trust Chair or as a result of a request from at least three members of the Committee, including at least one Non Executive Director and one Executive Director. The request will be made to the Trust Chair.

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

6. Authority

6.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference and is expected to make recommendations to the full Board. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances and prior approval of the Board is required.

6.3 The Committee is authorised by the Board of Directors to approve the quarterly and annual return to Monitor.

6.4 The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

7. Duties

The duties of the Committee can be categorised as follows:

7.1 Strategic and Business Planning

7.1.1 Consider processes for the preparation and the content of Strategic and Business Plans and Annual Revenue and Capital Budgets and test the key assumptions and risks underpinning such plans.

7.1.2 Review the Trust Annual Plan and Annual Budgets before submission to the Board of Directors.

7.1.3 Monitor performance compared with the Annual Plan and Budgets and to investigate variances from these.

7.1.4 Consider financial aspects of Business Cases for significant revenue or capital expenditure, as defined in the Trust's Standing Financial Instructions and Scheme of Delegation, prior to submission to the Board of Directors.

7.1.5 Review such Business Cases retrospectively for return on investment/benefits realisation.

7.1.6 Review opportunities for increasing activity/income from market intelligence analyses.

7.2 Performance Management

7.2.1 Monitor the financial performance of individual Clinical Units and Directorates.

7.2.2 Consider regular performance management reports from individual Clinical Units and Directorates.

7.2.3 Consider explanations of significant variances/deviations from Budget or Performance Plan by Clinical Units and Directorates on a regular basis and to consider proposals for remedial action.

7.2.4 Develop a strategic approach to managing cost improvement programmes.

7.2.5 Agree the annual cost improvement programme, monitor performance against it and take appropriate action.

7.2.6 Consider performance against external performance targets set by the Care Quality Commission, Monitor and as agreed in legally binding contracts.

7.2.7 Develop, implement and maintain an effective service line accountability framework.

7.2.8 Compliance with cancer performance targets.

7.2.9 Compliance with the HR and Organisation development targets.

7.3 Legally Binding Contracts with Third Parties

7.3.1 Consider regular reports of Trust and Directorate performance in respect of contracts agreed with third party organisations and to take appropriate action.

7.3.2 Ensure that Local Delivery Plans and contracts with Primary Care Trusts and other bodies are determined, managed and delivered.

7.4 Financial Accounting

7.4.1 Consider the likely impact of technical changes to accounting policy or practices and agree significant changes to accounting practice in advance.

7.4.2 Consider detailed expenditure, cash flow and working capital plans and forecasts.

7.4.3 Consider regular financial performance reports and forecasts, focusing particularly on risks and assumptions.

7.4.4 Commission and consider various financial reports and analyses, as appropriate.

7.4.5 Consider other topics or matters, as directed by the Board of Directors.

7.5 Business Risks

7.5.1 Consider the short to medium term impact on current performance of internal and external business risks.

7.5.2 Review Monitor's risk rating and instigate appropriate action.

7.5.3 Undertake detailed financial assessment of the Trust's strategic risks in conjunction with the Board of Directors and monitor trends and progress in reducing financial exposure.

8. Reporting

8.1 The Finance and Performance Committee reports to the Board of Directors. There are no groups/committees which report directly into this Committee.

The committee will receive the following reports:

- Income/expenditure performance of the Trust
- Balance sheet performance
- Performance against activity plans
- Performance against waiting list targets
- Performance against Care Quality Commission Outcome Standards
- Performance against contracts with local PCTs
- Business risks.
- Workforce KPIs.

9. Review

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

The Dudley Group
NHS Foundation Trust

Enclosure 13

Paper for submission to the Board of Directors
on 6 June 2013

TITLE:	Charitable Funds Committee		
AUTHOR:	Chris Walker Deputy Director of Finance – Financial Reporting	**PRESENTER**	Richard Miner Non Executive Director

CORPORATE OBJECTIVE: SG02/SG05/SG06

SUMMARY OF KEY ISSUES:

The report provides a summary of the work of the Charitable Funds Committee over the last 6 months.

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	**Y**	**Details:** Charity Commission

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

To note the contents of the report.

Charitable Funds Committee

Report to Board of Directors – 6th June 2013

The Charitable Funds Committee has met three times since the last report to the Board of Directors. A review of the Terms of Reference of the Committee has taken place to ensure that the Committee now operates as a sub-committee of the Board rather than its previous terms of reference as a 'working group'. The revised Terms of Reference have been approved by the Board of Directors.

The main activities of the Committee over the reporting period are summarised below.

Charity Fundraising

The Fundraising Co-ordinator has made good progress over the past twelve months. The Committee have set a clear fundraising strategy which places a lot more emphasis on corporate fundraising going forward. This should not only increase the amount of funds raised but also raise the awareness of the Charity to local businesses. The results of this change in direction are already being seen with the Charity being chosen as one of the recipient charities for the 'Free Radio' Walk for Kids Appeal. The Charity is expected to receive £30k as a result of this. A number of local businesses have also been contacted including the Tesco Store which is due to open opposite the hospital very shortly.

The planned level of funds being raised by the Fundraiser for the 2013-14 financial year has also been set higher than any other year to date. A target of £155k (£97k contribution once expenditure has been accounted for) has been set backed up by a clear plan of various fundraising initiatives of differing scales. This would deliver a return on salary of 3.71 which is the level expected of a dedicated fundraiser.

The Committee continues to monitor the work of the fundraiser at each meeting.

Charity Finances and Investments

For the financial year ending 31st March 2013 the Charity had fund balances totalling £2.79m. This was an increase of £315k from the previous year. The headlines for the year were total income of £792k, made up of £658k in donations, £63k in investment income and £71k in other income. There was £577k of expenditure. This was made up of £510k on charitable activities, £53k costs of generating funds and £14k on governance costs. There was a gain of £100k on the value of investments contributing to the overall movement. The Charity had £1.15m held in investments and £1.7m in short term deposits and cash. Small levels of debtors and creditors made up the remaining balances.

The Committee also receives reports showing the performance of Charity investments and an update on the position of legacies. The Committee is kept informed where the Charity has been made aware of a legacy due up until the actual payment is received.

Although the finances of the Charity are healthy the Committee members are keen to ensure that the funds are actively being spent. The majority of the fund balances are

held in specific ward and department funds which can only be spent on those particular areas. Through the Finance Department the Committee has met with each of the fund managers and requested spending plans. Any fund manager for a fund that has not had any expenditure over the previous six months will be invited to attend a future Committee meeting and asked to present a spending plan. If the Committee are not assured by the plan then they reserve the right to take over control of the fund and ensure that it is spent in line with the donor's wishes. The Committee is clear that funds are not there to simply earn interest and must be spent in line with the original donor's intentions.

Bids against the General Fund

In the past the Committee have received bids from all wards and departments. While the Committee is happy to receive bids from anyone in the Trust we have made it clear that going forward the ward or departments own fund should be fully utilised before any bid is made to the general fund. During the reporting period the Committee have approved a number of bids from the general fund. The highlights are as detailed below.

1. Portable monitoring System – Maternity HDU (£2,600)
2. Waiting room chairs and Neurology treatment plinths – Guest (£6,000)
3. Accutor monitors – Ward C3 (£6,000)
4. Out Door Gym – Contribution to grant received by Action Heart (£5,000)
5. Organ donation memorial (£15,000)
6. Surewash hand hygiene training system (£22,200)

The Committee have established a clear bid process going forward with staff now presenting the bids to the Committee members.

Other items to note

Cochrane Memorial Fund – the Committee reviewed the activity in the Cochrane Memorial Fund during the reporting period. This fund has remained inactive for a number of years due to the restrictions on its use and the fact that only the income earned from the fund can be used. The capital has to remain untouched. Given that there is only a balance of £45k on the fund the income being earned is minimal. The Committee agreed to seek to remove the restriction on the fund so that the funds can be utilised for general charitable purposes. The Charity is currently seeking approval of the lifting of the restrictions with the Charity Commission.

Richard Miner
May 2013

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors
On Thursday 6th June 2013

TITLE:	Security Annual Report		
AUTHOR:	Local Security Management Specialist (LSMS)	**PRESENTER**	Director of Strategy, Performance & Transformation
CORPORATE OBJECTIVE: SGO1			

SUMMARY OF KEY ISSUES:

Attached is the annual security report provided by the Local Security Management Specialist for the Board of Directors.

The report summarises the Security Management work undertaken at the Trust, under the generic headings specified by NHS Protect.

- **Violence and Aggression**
- **Asset Protection**
- **Drugs, Pharmacy, Hazardous Materials**
- **Maternity/Paediatrics**
- **Pro Security Culture**
- **Deterrence/Prevention**
- **Detection**
- **Investigation/Sanctions/Redress**

The LSMS continues to develop links with the Local Police Team, including attending a Joint Helpdesk. This will support any future developments, such as in the progression of sanctions which are supported by the Trust.

Communication Bulletins are planned through the coming year, bringing "Security Awareness" to the attention of staff.

The resurrection of the Security Liaison Group and the expansion of Datix reporting system will further support security management.

NHS Protect have developed the Organisational Crime Profile (OCP) return, replacing the Crime Risk Assessment tool kit. This return is now due and will be requested on an annual basis.

The Security Management Standards Checklist, developed by NHS Protect, will need to be reviewed and the assessments completed by 30 June 2013. It is expected that the assessment made can be evidenced and if the standard is not currently met, then procedures need to be in place which will lead to a 'green' assessment at a subsequent review.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** MAT021 – Baby tagging system failure
	Risk Register: Y		**Risk Score:** 4x3 12
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:**
	NHSLA	**Y/N**	**Details:**
	Monitor	**Y/N**	**Details:**
	Equality Assured	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

The Board of Directors is asked to note and discuss the content of the attached report.

The Dudley Group NHS
NHS Foundation Trust

OPERATIONS DIRECTORATE

LOCAL SECURITY MANAGEMENT SPECIALIST (LSMS) ANNUAL REPORT 2012/2013

1. Introduction

The report summarises the Security Management work undertaken at the Trust, under the generic headings specified by NHS Protect. 2012/2013 is the final year that Secretary of State Directions will apply. Security Management Standards, as part of the NHS Contract, will specify the Security Management work which will need to be undertaken by the Local Security management Specialist (LSMS) and the Trust.

2. Violence and Aggression

The number of assaults complying with the NHS Protect definition, that there was physical contact and intent, was 91 during 2011/2012.

The number of assaults recorded during 2012/2013 again complying with the NHS Protect definition is summarised as 92, although a further review is to be undertaken prior to completion of the violence against staff (VAS) return to NHS Protect.

Interserve commenced reporting all security related incidents through the Datix Incident Reporting System from February 2013. This is an important development and will enable the Trust to report all security related incidents via the Security Incident Reporting System (SIRS) direct to the NHS Protect.

The Restraint Policy, recently ratified, was developed over 2012/2013, involving clinicians, Summit Healthcare and the LSMS. The Policy makes reference to the responsibility of Security staff to ensure that a patient's human rights are not violated*. 'Clinically Related Challenging Behaviour Guidance' has been circulated for comments and will be issued by NHS Protect during 2013/2014. *(Human Rights Act 1998).

3. Asset Protection

LSMS attendance at the Police Helpdesk sessions will recommence on a monthly basis during 2013/2014. The LSMS will attend the Helpdesk on a quarterly basis to talk to staff about on site security concerns and provide information and support.

Hospital Watch:

New signage has been displayed to advise visitors that smoking is only allowed in the smoking shelters.

Interserve have commenced reporting all security related incidents through Datix. These incidents are therefore notified direct to the LSMS for investigation.

4. Drugs, Pharmacy, Hazardous Materials

Following a meeting with the Counter Terrorism Security Advisor, it is proposed that 'Project Revise' will be delivered at the Trust during 2013/2014. Project Revise is supported by the Medical Research Council and aims to raise awareness of security issues relating to safeguarding access to laboratories and hazardous materials and chemicals.

5. Maternity/Paediatrics

The ongoing action plan, following the risk assessment to address access to
the Maternity Unit out of hours highlighted problems with unauthorised entry through the external ground floor doors. The security concerns experienced at the Maternity Unit will be revisited by the LSMS during 2013/2014.

The Lone Worker Identicom Scheme, with funding through NHS Protect, 55 devices were allocated to staff, the majority being issued to Community Midwives and Paediatric nurses. The usage of these devices will be reviewed and alternative devices and lone working procedures considered as part of a planned LSMS review.

6. Pro Security Culture

The Trust employs a total of 5436 staff, including bank workers. Security awareness posters, including anti violence posters, have been displayed across the Trust. The LSMS contact details are also displayed, due to be updated during 2013/2014 so that staff can easily raise any security concerns.

The Security Liaison Group involving officers from Summit and Interserve, as well as Trust representatives, has been meeting to manage security management issues. The LSMS has arranged a meeting in July 2013 and it is proposed that the Group continue to meet on a quarterly basis. This group will report to the Health & safety group and then in turn to the Risk & Assurance Committee.

The Communications Team have been notified of the dates of the Police Helpdesk, to be held monthly at the Health Hub. The LSMS has requested that these dates, as well as those of the LSMS attendance, be advertised on the Trust's Intranet.

Conflict Resolution training (CRT) has been delivered to staff, as well as the e-learning module. The LSMS will continually review the content of this module and the training package to ensure NHS Protect objectives for CRT training are being met.

7. Deterrence/Prevention

Ongoing development of links with the Interserve Security Supervisor, Summit and the local Police will support the management of onsite security to protect staff and Trust's assets. The recommencement of regular Security Liaison Group Meetings and regular liaison with the Police will support the delivery of effective Security Management at the Trust.

8. Detection

The implementation of Datix reporting by Interserve will enable the LSMS to be aware of all security issues which required further action.

The Violence Against Staff (VAS) return forwarded to NHS Protect listed 91 physical assaults for 2011/2012. The initial summary of physical assaults against staff for 2012/2013 totals 92. These incidents will be reviewed by the LSMS to ensure that the incidents reflect NHS Protect's definition:

"The intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort" before completion of the annual VAS return due by 21 June 2013.

9. Investigation/Sanctions/Redress

Following an assault against a staff member in the Emergency Department, an investigation into the patient included meeting with Emergency Department Senior Staff, liaison with the Police, Security and the West Midlands Ambulance Trust (WMAS). The staff member did not wish to progress sanctions which was supported by the Emergency Department, due to the age and erratic behaviour of the patient, who is a known self-harmer. The patient had no forensic history, although the Police did issue a resolution letter to her explaining the seriousness of her behaviour. A warning indicator has been put on her patient record at WMAS to alert ambulance crews and a warning indictor is due to be placed on the Oasis system.

There have been a series of thefts in EAU and improvements to security procedures followed have been supported by the LSMS. There have been no recent incidents.

The national Joint Working Agreement between ACPO, the CPS and NHS Protect has been further developed to instigate regional agreements. It is proposed that the West Midlands Agreement will form the basis of how the Trust will work with the Police to manage violence against staff and patients.

10. Summary

The LSMS continues to develop links with the Local Police Team, including attending a Joint Helpdesk. This will support any future developments, such as in the progression of sanctions which are supported by the Trust.

Communication Bulletins are planned through the coming year, bringing “Security Awareness” to the attention of staff.

The resurrection of the Security Liaison Group and the expansion of Datix reporting system will further support security management.

11. Conclusion

The above initiatives will strengthen effective security management at the Trust.

NHS Protect have developed the Organisational Crime Profile (OCP) return, replacing the Crime Risk Assessment tool kit. This return is now due and will be requested on an annual basis.

The Security Management Standards Checklist, developed by NHS Protect, will need to be reviewed and the assessments completed by 30 June 2013. It is expected that the assessment made can be evidenced and if the standard is not currently met, then procedures need to be in place which will lead to a ‘green’ assessment at a subsequent review.

Carol Stockdale
Interim Local Security Management Specialist (0322)

CS/SMC/28/5/2013

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors
On Thursday 6th June 2013

TITLE:	Work programme for Director of Strategy, Performance & Transformation		
AUTHOR:	**Director of Strategy, Performance & Transformation**	**PRESENTER**	**Director of Strategy, Performance & Transformation**

CORPORATE OBJECTIVE: SGO1, SGO3, SGO4 and SGO6

SUMMARY OF KEY ISSUES:

The enclosed brief paper was presented to the Executive Directors during May 2013, to demonstrate the specific roles and responsibilities of the new Director role, together with a high level timetable of the outputs expected from it.

It is equally important that the Board of Directors understand and agree to these responsibilities and outputs, so that an improvement in the organisation's planning and performance management functions can be evaluated at the end of the proposed secondment period.

There are also included, some initial, high level observations of our previous Integrated Business Plan of 2008 and its ongoing relevance to today's NHS and our current strategic direction as a Trust.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Lack of executive director capacity to manage the strategic development, service reconfiguration and planning agenda
	Risk Register: Y		**Risk Score:** 4 x 4 = 16
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	X	

The Dudley Group NHS
NHS Foundation Trust

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

The Board of Directors are requested to note the specific responsibilities and outputs proposed for the newly created executive director role.

Board Strategic Themes: Quality , Safety & Service Transformation, Reputation	**SG01: To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation**
Board Strategic Theme: Patient experience	**SG02: To provide the best possible patient experience**
Board Strategic Theme: Diversification	**SG03: To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio**
Board Strategic Theme: Clinical Partnerships	**SG04: To develop and strengthen strategic clinical partnerships to maintain and protect our key services**
Board Strategic Theme: Staff Commitment	**SG05: To create a high commitment culture from our staff with positive morale and a "can do" attitude**
Enabling objectives	**SG06: To deliver an infrastructure that supports delivery**

Report to: **Executive Team**

Report of: **Director of Strategy, Performance & Transformation**

Title: **Proposed work programme and responsibilities 2013/14**

Length of secondment

It is intended that the new role be established for a period of 12 months, ending on 11th April 2014.

General responsibilities of the role

1. Leading the strategy development and planning process for the Trust, including, not exclusively; the business planning process, refresh of IBP, development of service strategy and estates strategy
2. Lead executive for service response to external reconfiguration agenda (i.e. Pathology, Stroke, vascular etc.)
3. Lead executive for delivery of the objectives of the Transformation Programme
4. Lead executive for the management of Facilities & Estates, via the PFI contract (including emergency and contingency planning)
5. Lead the performance management framework and iterations to its process
6. Lead the commercial development activities of the Trust, including CIP schemes relating to commercial development and diversification of portfolio

What the role does NOT have responsibility for

1. Leading and being accountable for the Trust CIP programme as a whole
2. Leading and being accountable for all the Trust-wide CIP schemes
3. Operational delivery against standards or targets

Resources

A small team of direct reports will assist in the responsibilities of the role:

- Deputy Director of Operations (F&E) – Robert Graves
- Head of Transformation – Lucy Chatwin
- Service Development Manager – Karen Morrey (temporary contract)
- Head of Planning and Performance – Stuart Nugent (secondment until 11/4/14)
- 0.5 WTE PA – Linda Smith
- 0.4 WTE Emergency Planning Officer – Paul Oxley

Specific tasks and indicative timelines associated with each

1. Estates Strategy - Board agreement, dissemination to directorates and initial implications discussions with directorates **by 31 MAY 2013**
2. Estates Strategy – Site Development Control Plans agreed **by 28 NOVEMBER 2013**
3. Monitor Annual Plan - To Finance & Performance Committee **by 16 MAY 2013**
4. Agree project plan and delivery milestones for commercial CIP/commercial development projects – **by 12 JULY 2013**
5. Agree formal changes to Performance Management Framework and consult with directorates around changes – **by 31 JULY 2013**
6. Make any necessary performance management reporting changes to F&P and Board – **by 29 AUGUST 2013**
7. Initiate IBP refresh working group (membership to be agreed) – **by 13 JUNE 2013**
8. Initiate service strategy discussions with CDs, GMs and Matrons – **by 16 MAY 2013**
9. Initiate full service strategy speciality analysis programme (to be designed) – **by 4 JULY 2013**
10. Agree final production date for any as yet unwritten, supporting strategies (i.e. Finance, HR) – **by 27 SEPTEMBER 2013**
11. IBP refresh (including Trust Service Strategy) to Exec Team for debate and agreement – **by 20 DECEMBER 2013**
12. IBP refresh agreed by Board of Directors in time to drive content of 2014/15 Annual Plan and directorate business plans – **by 27 JANUARY 2013**

Integrated Business Plan 2008

Some reflections on our previous IBP and thoughts on our proposed 2013/14 refresh of this plan:

- The vision of the old IBP focused on community care models and consensus with PCT. This didn't happen, however, this intention is still very relevant today
- Financial strategy in 2008 appeared to be the outputs of the Enterprise programme. Ditto the HR/Workforce plan based on Enterprise also.
- No discernible analysis of specialities and subsequently, no services strategy appear in the 2008 plan. This must be rectified for the new version.
- Market analysis capacity/ability strong in 2008. We probably don't have this now. How do we want to tackle this weakness? Do we want to?
- LTFM work very strong. We must refresh our LTFM, based on best and worst case scenarios associated with commissioning intentions and the economic conditions worsening
- PBR appears as major lever in old IBP. Should we abandon it as a primary financial lever, going forward?
- PESTLE analysis in 2008 good. Propose do this again as part of speciality analysis process in 2013/14
- Overall, 2008 plan not overly clinical in focus, yet that is our business.....

Richard Beeken, 26 April 2013