The Dudley Group
NHS Foundation Trust

Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ

Ref: FOI-052023-00091

Date: 30/6/23

Address / Email:

Dear

Request Under Freedom of Information Act 2000

Thank you for requesting information under the Freedom of Information Act

2000. **Request**

I'm submitting an FOI request for electronic copies of all:

1. Minutes of Board of Director Meetings
2. Declarations of Interests (DoI) statements for members of the Board of Directors

for Dudley Group NHS Foundation Trust - and all predecessor NHS Trusts that have merged into Dudley Group NHS Foundation Trust – going back to January 2008, or the earliest date for which electronic copies of this information are available if this date is later than January 2008. There is no need to provide copies of Minutes or Declarations of Interests that are provided on the website of Dudley Group NHS Foundation Trust.

If these minutes and/or DoI statements are contained within larger Board paper packs then of course the entire packs can be provided if this is easier than separating out the Minutes/DoI statements.

Response

Sincere apologies for the delay in responding.

The Trust website has Board Reports going back to 2013 and can be found at Board meetings - The Dudley Group NHS Foundation Trust (dgft.nhs.uk)

Once information on the other 5 years has been sorted this will be forwarded on to you.

If you are dissatisfied with our response, you have the right to appeal in line with guidance from the Information Commissioner. In the first instance you may contact the Information Governance Manager of the Trust.

Information Governance Manager
Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ

Email: dgft.dpo@nhs.net

Should you disagree with the contents of our response to your appeal, you have the right to appeal to the Information Commissioners Office at.

Information Commissioners Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 0303 123 1113
www.ico.org.uk

If you require further clarification, please do not hesitate to contact us.

Yours sincerely

Freedom of Information Team
The Dudley Group NHS Foundation Trust

The Dudley Group
NHS Foundation Trust

Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ

Ref: FOI-00091

Date: 6/7/23

Address / Email: toby.kenward.13@ucl.ac.uk

Dear Toby Kenward

Request Under Freedom of Information Act 2000

Thank you for requesting information under the Freedom of Information Act 2000.

Request

I'm submitting an FOI request for electronic copies of all:

1. Minutes of Board of Director Meetings
2. Declarations of Interests (DoI) statements for members of the Board of Directors

Response

Please see attached reports that are not on the website and please note there were no public Board meetings from October 2008 to December 2012

If you are dissatisfied with our response, you have the right to appeal in line with guidance from the Information Commissioner. In the first instance you may contact the Information Governance Manager of the Trust.

Information Governance Manager
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Dudley
West Midlands
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Yours sincerely

Freedom of Information Team
The Dudley Group NHS Foundation Trust

The Dudley Group of Hospitals NHS
NHS Trust

Public Trust Board Agenda
Thursday 31st January 2008

	Item	Time	By
1. 2. 3.	**Chairman's welcome and note of apologies** **Declarations of Interest** **Announcements**	2 mins	A Edwards
4.	**Minutes of previous meetings** • Thursday 20th December 2007, Board Meeting **Enclosure 1**	2 mins	A Edwards
5.	**Action Sheet – Progress Report by Exception** **Enclosure 2**	5 mins	A Edwards
6.	**Matters Arising**	10 mins	A Edwards
7.	**Chief Executive's Report**	10 mins	P Farenden
8. 8.1	**Strategic Issues** **Foundation Trust Update** **Verbal**	5 mins	P Assinder
9.	**Operational Performance** • Report from Finance and Performance Committee on 31st January 2008 **Verbal**	5 mins	P Assinder
10.	**Reports for Approval** • Private Patients Policy **Enclosure 3** • Overseas Visitors Policy and Procedure and Overseas Visitor Team – Finance Procedure **Enclosure 4** • Amendment to Standing Financial Instructions (SFI's), Authorised Limits – Theatre Specialty Managers and Pharmacy **Enclosure 5** • Quality of Care – Food and Nutrition Report **Enclosure 6** • Healthcare Commission Maternity Survey **Enclosure 7** • Standard Template for Board and Committee Reports **Enclosure 8**	5 mins	P Assinder P Assinder P Assinder A Close A Close
11.	**Information Items to be noted**	5 mins	
12.	**Any Other Business** • Limited to urgent business notified to the Chair/Trust Secretary in advance of the meeting	1 min	A Edwards
13.	**Date of Next Trust Board Meeting** • 28th February 2008 at 11.00am in the Clinical Education Centre		

Enclosure 1

The Dudley Group of Hospitals NHS
NHS Trust

Minutes of the Trust Board meeting held at 11am on Thursday, 20th December, 2007, in the Clinical Education Centre, Russells Hall Hospital

Present:

Alfred Edwards, Chairman
Ann Becke, Non Executive Director
David Badger, Non Executive Director
Jonathan Fellows, Associate Non Executive Director
David Wilton, Associate Non Executive Director
Paul Farenden, Chief Executive
Paul Brennan, Director of Operations
Ann Close, Nursing Director
Paul Assinder, Director of Finance and Information
Les Williams, Director of Corporate Development

In Attendance:

Helen Forrester, PA/Admin. Manager
Ann Middleton, PPI Forum Chair
Clare Craddock, Communications Manager

07/51 Chairman's Welcome and Note of Apologies

The Chairman welcomed the attending member of staff and member of public to the meeting. It was noted that apologies has been received from Paul Harrison, Janine Clarke and Kathryn Williets.

07/52 Declarations of Interest

There were no Declarations of Interest.

07/53 Announcements

There were no announcements to report.

07/54 Minutes of Previous Meetings - 29th November 2007 – Trust Board Meeting

The minutes of the 29th November Trust Board meeting, given as Enclosure 1, were approved as a correct record and signed by the Chairman.

07/55 Action Sheet – 29th November 2007 - Progress Report by Exception

The Board reviewed the Action Sheet, given as Enclosure 2, as follows:

07/55.1 Item 07/28 and 07/42.2 Update on Cash Balance

Paul Assinder, Director of Finance and Information reported that he had looked at the guidance from Monitor and this recommended a balance equivalent to 30 days' trading. It was noted that the Trust had excess cash above these guidelines and the Director of Finance and Information would discuss cash flow risk with Monitor .

The Quarter 2 position for Foundation Trusts had recently been released and the balance sheets would be examined to identify what level of cash balance these carried.

Director of Finance and Information to discuss cash flow risk with Monitor and examine Quarter 2 balance sheets and report back to Board with a recommendation

07/55.2 Item 07/40.1 Committee Representation

Alfred Edwards, Chairman reported that he had met with Non Executive Directors earlier in the week and it had been agreed all Non Executive Directors would be invited to sit on all Board Committees and there would be nominated representatives to be sitting members. The Chairman would produce notes from his meeting and finalise arrangements at the next Board meeting. Ann Close, Nursing Director raised concern over Governance arrangements when meetings were attended in this way and this was noted.

The Chairman to produce notes from the meeting with Non Executive Directors and finalise arrangements at the next Board meeting

07/55.3 Item 07/45.3 Draft IT Disaster Recovery Plan

The Director of Finance and Information reported that the Plan had been taken to the previous meeting of the Board. It was noted that there was to be further discussion with Siemens regarding the desk top simulation exercises and results of these would be made available to the Board. There was also more work to be completed on the link up plan. Siemens were happy to help with this process and had agreed that our Auditors were able to work with the appropriate Siemens staff.

Director of Finance and Information to feedback to the Board on the results of the desk top simulation exercises

07/55.4 Item 07/47.2 Timings of Meetings and Management of Information

The Chairman reported that it had been agreed at the previous meeting of the Board to rearrange the Integrated Governance Committee to a different Thursday in the month, and after further discussion it was agreed to continue with the current arrangements for the Finance and Performance Committee and Trust Board meetings to be held together on the last Thursday of the month.

07/56 Matters Arising

None to report.

07/57 Chief Executive's Report

Paul Farenden, Chief Executive presented his report to the Board, which included a summary of the Operating Framework, which had previously been covered the Director of Finance and Information in the Finance and Performance Committee. The document emphasizes making the Health Service more responsible at a local level. The Chief Executive reminded Board members at there were still at least 170 centrally imposed targets. It was noted that there is a shift in emphasis on to the role of PCTs in the new NHS, with expectations of PCTs increasing dramatically to provide "World Class Commissioning".

The Chief Executive also asked the Board to note that, given the healthy financial position of the NHS, it was an expectation that all targets will be met.

There was increasing sensitivity around the NHS about the current difficulties on access given the time of year. The Chief Executive has reported to the Finance and Performance Committee that the Strategic HA Chief Executive had asked for personal assurances around this issue. It was noted that the Chief Executive had been able to give this for the operations of the Trust, but was not in a position to give assurance on behalf of the wider health economy due to problems surrounding delayed discharges. A response was required from the whole health economy to manage this issue.

The Chief Executive also informed the Board that the Trust had been chosen by the Healthcare Commission for a visit to review hospital acquired infections and this could take place at any time from 1st January 2008 to 31st March 2008. The Trust was one of forty Trusts chosen, and it was noted that the visit would specifically be looking at the hygiene code.

07/58 Strategic Issues

07/58.1 Foundation Trust Update

Les Williams, the Director of Corporate Development reported that, as discussed in Finance and Performance Committee, good progress had been made on the workstreams except for the strategic objectives and risks. An outline timetable based on the Trust's previous experience had been identified for the Monitor Assessment and due diligence process, leading up to authorisation on 1st July 2008. It was noted that Monitor would confirm their final timetable in February. A review of the Compliance Framework had been undertaken and it had been agreed to reformat the Performance Report to the Finance and Performance Committee from January onwards.

07/59 Operational Performance

Report from the Finance and Performance Committee on 20th December 2007 - The Director of Finance and Information reported that the Finance and Performance Committee had, at its meeting on 20th December, discussed and noted the following position up to the end of November:

- Elective activity was above target
- Non-elective activity was 2,300 spells above plan
- Outpatients were 8,000 attendances above plan
- Additional patient income in-month was £975,000

- Performance against HCC targets demonstrated the current difficulties in achieving the 4 hour A&E maximum wait target in November. The year to date figure had dipped below 98% and was now recorded as 97.94%. Additional measures had been put in place and there was confidence that we would be able to recoup the position by the end of the year
- There had been no additional MRSA Bacteraemias. The year to date total was 18 (against the year end target of 12)
- Up to the end of November the surplus year to date was £8.9m. This had improved in November by £680,000
- The normalised position was now £7.5m. It was noted that the Strategic HA had set a control target of £7.5m for year end and the Director of Finance and Information would be speaking with them regarding surplus. It was expected that compensating reductions were being experienced by PCT organisations.

The Board noted this position.

07/60 Reports for Approval

07/60.1 Human Resources Report including Sickness Absence Policy, Capability Policy and Disciplinary Policy

As Janine Clarke, Director of Human Resources was unavailable to speak to this report, given as Enclosure 3, it was requested that Non Executive Directors contact the Director of Human Resources directly with any questions. David Badger, Non Executive Director, commented that a list of designated staff to take actions would be helpful, although it was noted that this is provided in the Scheme of Delegation agreed by the Board earlier in the year. Jonathan Fellows, Associate Non Executive Director raised an issue regarding the definition of gross misconduct and suggested the addition of failure to follow cleanliness procedures. It was felt that this was covered by the general requirement to adhere to all Trust policies.

The Board approved these reports.

The Board approved the Sickness Absence Policy, Capability Policy and Disciplinary Policy

07/61 Information Items to be Noted

07/61.1 Quality of Care

Ann Close, Nursing Director spoke to this paper, given as Enclosure 4. It was noted that the Nursing Director would be submitting further reports to the Board as more emphasis from the Department of Health and Monitor were put on quality of care. David Badger, Non Executive Director questioned the way in which the information that was reported would be dealt with and it was discussed how the detail could be connected to patient survey outcomes.

The Board received the paper.

07/61.2 Guest Hospital Land Sale

Paul Brennan, Operations Director spoke to this paper, given as Enclosure 4. It was noted that the Board needed to record that, following its agreement to proceed with the sale, the land had been sold to English Partnerships for a net fee of £6m. Contracts had been exchanged and completion required 4 weeks notice on either side, and this would take place early in the New Year and no later than the end of March

07/62 Any Other Business

There being no other business, the Chairman closed the meeting.

07/63 Date of Next Meeting

The next Board meeting will be held at 11am on Thursday, 31st January, 2008 in the Clinical Education Centre.

Signed as a correct record: . . . . . **Chairman**

Date: . . . . . .

Enclosure 2

The Dudley Group of Hospitals NHS
NHS Trust

Action Sheet
Minutes of the Public Trust Board meeting held at 11.00 am on Thursday 20th December 2007 in the Clinical Education Centre

Item No.	*Subject:*	*Action:*	*Responsible*	*Due Date*	*Actioned*
07/42.2	Action Sheet Update External Audit Letter 2006/07	ALE Working Group to feedback on action required to achieve ratings of '4' to the next Audit Committee meeting on 15/4/08	DFI	24/4/08	
07/55.1	Update on Cash Balance	Discuss cash flow risk with Monitor and examine Quarter 2 balance sheets and report back to Board with a recommendation	DFI	31/1/08	
07/55.2	Committee Representation	Notes to be produced from the meeting with Non Executive Directors and finalise arrangements at the next Board meeting	C	31/1/08	
07/55.3	Draft IT Disaster Recovery Plan	Feedback to the Board on the results of the desk top simulation exercises which will be run by Siemens in the next financial year	DFI	When available from Siemens (08/09 financial year)	

Enclosure 3

The Dudley Group of Hospitals NHS
NHS Trust

Policy and Procedure for the Management of Private Patients

Date: **December 2007**

Ref: **PPP01**

Version: **2**

Contents Page No.

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1. INTRODUCTION

POLICY STATEMENT

The Trust welcomes private patients and uses the income generated from private patients for the benefit of all patients within the Trust. This policy document sets out recommended standards for best practice for Trust Consultants and staff about their conduct in relation to private practice. The standards are designed to apply equally to honorary contract holders in respect of their work for the Trust.

POLICY

This private patient policy will ensure that the Trust:

- Provides clear guidelines to staff for the management of private practice within the Trust.
- Does not contravene Government Legislation concerning private patient practice.
- Provides the same standards of clinical care and services for all patients whether NHS or private.
- Maximises income generated from private patient work carried out within the Trust. All income received will be treated as revenue income.
- Make all staff aware of their responsibility with regard to identifying private patients and ensuring that their Trust colleagues are made aware of their private status so that the patient status is correctly recorded in the Trust's systems.
- Has a complete audit trail of all consultations, admissions, diagnosis and treatment of all private patients carried out within the Trust in order to protect the Trust from claims of clinical negligence and to comply with the requirement of the insurance companies.
- Has a completely open and auditable process, where the same standards are applied uniformly across the Trust.

CONSULTANTS GUIDANCE

- If any private practice or Cat II work is undertaken during PAs or SPAs the Consultant cannot charge the patient for his time. Although a charge will still be made by the Trust, for the use of Hospital facilities.

- To ensure capacity and resources are effectively utilised, Consultants should consider the following options:-

  (a) Private patients are seen separately from scheduled NHS patients – treated in designated private theatre sessions and private out-patient sessions, as agreed with his or her Medical Service Head.

  (b) Hire fixed sessions or hire space on a need to use basis, but on the understanding that payment for the capacity is made in advance.

  (c) To avoid incurring additional NHS staff costs, private patient activity must be undertaken in a timely manner, i.e. no clinics or theatre sessions to over run as a result of the inclusion of private patients.

  (d) If private patients are seen at the beginning or end of normal clinic times and NHS staff are supporting the Consultant outside their contracted hours, the Matron responsible for the specialty will need to be advised to ensure the Staff receive remuneration in their salary.

  (e) If an NHS secretary works additional private patient hours to his/her contracted hours, on Trust premises for the Consultant, the Consultant should declare this to his/her Medical Service Head as part of the job planning process, so that a suitable fee can be levied for the use of Trust equipment, stationery, postage and IT support. The Medical Service Head would then notify the budget holder for Medical Secretarial Services for action.

  Generally, early private consultations should not lead to earlier NHS admission.

  Normally, access to diagnostic and treatment facilities should be governed by clinical considerations and standards of clinical care should be the same for all patients.

  It is the responsibility of Consultants to ensure that their private patients are identified as such.

  Additional guidance on the management of private practice in NHS hospitals is set out in the BMA's "A Code of Conduct for Private Practice – Guidance for NHS Medical Staff" and this guidance forms part of this policy. Key points of this guidance can be found at Appendix 1.

2. CODE OF CONDUCT FOR PRIVATE PRACTICE

Key Principles

Consultants and the Trust are required to work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is important that Consultants and the Trust minimise the risk of any perceived conflicts of interest.

- The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services.

- With the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work.

- **The Trust's facilities, staff and services may only be used for private practice with the prior agreement of his/her Medical Service Head. This will be reviewed annually as part of the Consultants Job Planning process, in line with their contract of employment.**

Disclosure of Information about Private Practice

Consultants must declare any private practice work to his/her Medical Service Head, detailing their current and future intended private practice work commitments. This disclosure information must detail regular private practice commitments, including the timing, location and broad type of activity. Any subsequent changes to that already disclosed must be notified to the Medical Service Head in writing as soon as it is known in order to facilitate increased efficiency through more effective planning of NHS work and out of hours cover.

Scheduling of Work and On-Call Duties

In circumstances where there is or could be a conflict of interest, programmed NHS commitments must take precedence over private work. Consultants must ensure that, except in emergencies, private commitments do not conflict with NHS activities included in their NHS job plan.

Consultants must ensure in particular that:

- Private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS.
- There are clear arrangements to prevent any significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled.

- Private commitments do not prevent them from being able to attend a NHS emergency while they are on-call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response must not be undertaken at these items.

Where the Trust requires changes to the scheduling of NHS work, the Consultants will be given a reasonable period of time to arrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

3. PROVISION OF PRIVATE SERVICES ALONGSIDE NHS DUTIES

Authorisation

The Chief Executive (or delegated authority) may at their discretion and only under the following circumstances allow private patient services, using NHS resources, to be undertaken alongside a Consultant's scheduled NHS duties. This applies whether private patient services are carried out in the Consultant's own time, in annual or unpaid leave.

Clinic/Session Rules for Treatment of Private Patients on NHS Premises

Private patient services must take place at times that do no impact on normal services for NHS patients.

Private patient clinics/sessions must take place either before a NHS clinic/session (in which case it must not in anyway delay the start of the NHS clinic/session) or after the NHS clinic/session has finished. **NHS clinic/session times must not be reduced to accommodate private patient clinic/session times**.

New private patient clinic/sessions may only be set up with the prior written consent of the Operations Director, via the Consultants Medical Service Head. The Consultant must notify the Chief Executive (or delegated authority) in writing of the type of private work to be carried out, documenting timings, location, staffing and other resources required.

Only once written consent has been provided by the Chief Executive (or delegated authority) may a new private patient clinic/session be set up. The Consultant must set up the new clinic/session in conjunction with the relevant Associate Medical Director - Operations.

Private patients attending a consultation on Trust premises before or after a NHS clinic or treated on Trust premises before or after a NHS session will be deemed to have attended a private patient clinic or session, in which case the above will apply.

It is the responsibility of the Consultant to ensure the necessary arrangements are made for the attendance of a private patient (use of room, any special equipment, etc). Usually this will be done by the private secretary communicating with the NHS secretary.

Private patients can only ever attend NHS clinics/session in clinically justified circumstances. In these cases the Associate Medical Director- Operations must be notified in writing (by letter or e-mail) of the circumstances in advance of the patient's attendance. Any issues concerning this must be discussed with the Consultant in advance of the patient's attendance. Such cases will be deemed to be urgent or emergency cases and will be recorded on clinic and session lists as such.

If a NHS patient cancels an appointment at short notice then all means necessary should be taken to fill the appointment with the longest waiting patients on the 'Primary Target List'. **The cancelled appointment must not be filled with a private patient**.

Admission Rules

Private patients may attend the Trust as an in-patient or day-case if the patient is deemed unfit for treatment in a private hospital, requires emergency surgery, if the nearest private hospital does not have a license for the specific condition or if the insurer will only cover the treatment in a NHS hospital.

The admission of such patients must adhere to "The Six Principles of Good Practice",

1. The provision of accommodation and services for private patients should not significantly prejudice non-paying patients.

2. Subject to clinical consideration, earlier private consultation should not lead to earlier NHS admission or to earlier access to NHS diagnostic facilities.

3. Common waiting lists should be used for urgent and seriously ill patients as at present and for highly specialised diagnosis and treatment. The same criteria should be used for categorising paying and non-paying patients.

4. After admission, access by all patients to diagnostic and treatment facilities should be governed by clinical considerations. This principle does not exclude earlier access by private patients to facilities especially arranged for them, if these are provided without prejudice to NHS patients and without extra expense to the NHS.

5. The standards of clinical care and the services provided by the hospital should be the same for all patients. This principle does not affect the provision, on separate payment, of extra amenities, nor the practice of day-to-day care of private patients usually being undertaken by the Consultant engaged by them.

6. Single rooms should not be held vacant for potential private use longer than the usual time between NHS patient admissions.

Where a staff member does not believe these principles are being adhered to they should report their concerns to their Medical Service Head or Matron, who will raise them with the Associate Medical Director - operations.

Notification of Private Patient Status

The Consultant responsible for providing/arranging private services for a patient in the Trust must ensure, in accordance with this policy, that all staff assisting in providing services are aware of the patient's private status, and that all documentation clearly identifies the patient as being private. This ensures that the coding of patients is correct for contracting purposes and that a clear audit trail is maintained at all times.

Request forms for Physiotherapy, Dietetics, Orthotics, Occupational Therapy, Chaplaincy, X-Ray, Pharmacy, Pathology or any other diagnostic procedure, must be clearly marked by the Consultant as "private" and signed for.

The Consultant is responsible for notifying the General Office as soon as they become aware of a private patient's requirements to receive Trust services by completing a "Notification of Fee paying Patient Form' (Appendix 2) and forwarding to the General Office.

Agreement to Pay

This form relates only to the contract established between the Trust and the Patient and deals only with the Trust's charges; except for all diagnostic radiology, pathology and imaging bills, which should include the Consultants' fees.

Except in emergencies, Consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained in advance of admission/treatment/tests from (or on behalf of) the patient, in accordance with the Trust's procedures.

It is the Consultants responsibility to ensure the 'Agreement to Pay' form (Appendix 5) is completed, signed and witnessed by the patient before any services are provided.

The patient will be notified in advance of all Trust services they are likely to receive along with an estimate of the cost of such services (a deposit will be required to cover the estimate). The patient should be made aware by the Consultant that the anticipated services may change as a result of test or diagnostics findings.

The Trust will determine and make such charges for the use of its services, accommodation or facilities, as it considers reasonable. Any charge will be collected by the Trust, either from a patient or a relevant third party.

A charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.

All patients will be expected to pay a deposit and provide details of their medical cover if insured. The deposit will be 100% of the estimated total cost. Where the actual cost of services received is less/more than the deposit paid the patient will receive a refund/charge for the difference.
The Trust will invoice the patients for in-patient, day case and out-patient final service cost (offsetting the deposit paid) which will enable them to recover the charge from their insurance company, if applicable.

Fees of Consultants

The Consultant is responsible for advising the patient of all professional fees to be levied including the hospital fees for the use of NHS facilities. Consultants should note that they **cannot receive payment** from a patient for a consultation/treatment carried out on Trust premises unless the patient has signed an 'Agreement to Pay' form (Appendix 5).

The Consultant must also sign the form and have the form witnessed by a staff member.

The Consultant must send all 'Agreement to Pay' forms back to the General Office.

The Consultant will be responsible for collecting his/her own professional fees unless covered by prior arrangement with the Trust and Insurance Companies i.e. Radiology charges to BUPA and diagnostic tests include Consultant fees.

4. TRUST'S RESPONSIBILITY FOR THE TREATMENT OF PRIVATE PATIENTS

Overview

The Trust will ensure that Consultants only offer and provide to patients those services which the Trust has the capability and capacity to safely provide.

The Trust and the Consultant will provide services to patients in an economical and efficient manner consistent with professional standards of medical care generally accepted in the medical community and in accordance with Standing Clinical Guidelines.

The Trust's agreement with the patient does not guarantee a single room, but a booking is always made with this request. However, the allocation of accommodation on the ward is in the hands of the booking team who will meet such a request when possible. No specific accommodation is allocated purely for private work. The Trust fees are the same for a private patient whether accommodated in a single room or in a bay on the Ward. The Trust does not have specific private wards or rooms.

5. INFORMATION FOR NHS PATIENTS ABOUT PRIVATE TREATMENT

Consultant's Responsibility

In the course of their NHS duties and responsibilities Consultants must not initiate discussions about providing private services for NHS patients, nor must they ask other NHS staff to initiate such discussions on their behalf, such actions will be deemed to be solicitation.

Where an NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, Consultants must ensure that any information provided by them, is accurate and up-to-date and conforms to any local guidelines.

If a patient decides to be treated as a Private rather than a NHS patient, the Consultant must not indicate or suggest that they are being treated as a NHS patient by the Trust.

Except where immediate care is justified on clinical grounds, Consultants must not, in the course of their NHS duties and responsibilities, make arrangements to provide private services. Nor must they ask any other NHS staff member to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

6. CHANGE OF STATUS

Regulations

All patients, whether NHS or Private, have the right to change their status from NHS to Private and vice versa

Rules Governing Change of Status

Before a patient can change their status they must first **complete a 'Change of Status' form** (Appendix 3 & 4) which must be signed by the Consultant, the patient and a Finance Officer. **Unless a change of status form has been correctly completed and signed the patients' change of status will not be recognised by the Trust.**

One copy of the change of status form should be filed with the patient's case notes: another copy should be kept by General Office for logging and cross-referencing with PCS and the patient's records. The patient's details can either be set up on PCS or updated on PCS, if the patient has already received services in the Trust.

The General Office will ensure that the Information Department are notified of the patient's change of status on PCS.

Where the patient has been referred by their GP and has received notification of an appointment but has **not yet seen a Consultant**, they may on notification of their appointment or any time up until they meet with their Consultant, change status. This change of status **does not count** (no change of status form is required) as they have not yet seen a Consultant. In this instance the patient will need to notify their GP to change their status, the GP will then notify the change of status to the Consultant or Medical Records Department. All patient records should be either set up on the PCS (if the patient is new to the Trust) or updated on PCS (if the patient has already received services in the Trust) to reflect this change of status.

A patient may only change status once per individual episode of care. Once a patient has changed status, they cannot change back again in the same episode of care. Consultants are responsible for ensuring that a second change does not happen.

An episode of care is defined as an initial out-patient appointment, any further required procedures and follow-up appointments. However, if the procedure is diagnostic then this in itself is one episode of care. For example, if a patient requires a laparoscopy after an initial NHS appointment and requests that it is done privately then they have made one change of status in this episode of care. The out-patient appointment for the results must then also be done privately as this is the same episode of care. If the patient then requires surgery following the results of the laparoscopy then this begins a new episode of care and so there may, once again, be one change of status.

A patient cannot change their status mid-way through a consultation, treatment or series of tests at any single visit to the Trust. The patient may only change their status after the consultation, treatment or tests have been completed for that visit. The change of status will be effective for subsequent consultations/treatments/admissions for the same episode of care.

A private out-patient, who elects to have NHS treatment after an initial private consultation, must join the appropriate waiting list as the same point as if their consultation has been under the NHS, and that place must be determined by clinical need.

A private in-patient has the right to change to NHS status if there is a significant change in their medical circumstance, prior to admittance.

If a patient has been admitted to a NHS hospital as a private in-patient, but subsequently decides to change to NHS status before having received treatment, there should be a Consultant's assessment to determine the patient's priority for NHS care.

Patients sent from a private hospital for x-ray, pathology or any other diagnostic procedure, or test in the Trust will be treated as a private patient unless they provide a change of status form. If a patient has changed status, the patient cannot return to the private hospital for further consultations or services in the same episode of care. It is the Consultant's responsibility to ensure that the private hospital is made aware of the patient's change of status.

Private patient's who have diagnostic procedures or provision of prosthesis as a result of private treatment at the Trust, or elsewhere, will be treated as private patients and charged accordingly.

All patients who change status are still liable for the charges they incur for treatment while they are still categorised as private. Consultants seeing NHS patients who then make the decision to transfer to 'private' MUST make the patient aware that until the episode of care is complete they will be unable to transfer back to being a NHS patient and therefore will be liable for all the charges incurred throughout that episode of care.

Any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status.

Verifying a Patient's Status

Prior to admission or out-patient treatment, the Medical Secretary undertakes to use all reasonable endeavours to:

- Identify the patient as a bona fide insurance company member or as a self-payer.

- Ensure that his/her General Practitioner (UK only) has referred the patient. An insurance company will not undertake to pay claims where the patient has not been referred by his/her GP. In this case GP covers opticians and dentists but not other health professionals such as physiotherapists.

- Obtain evidence of current cover and any restrictions, registration number (if the patient has private insurance), current address and, (if at this address less than 6 months), previous address.

- Contact the insurance company (if the patient has private insurance) for confirmation of any aspects of the patient's details and eligibility for full cover that is otherwise unclear.

- Notify the General Office that a private patient attendance is being arranged, by completion of Notification of Fee Paying Patient.

Prior to admission the General Office will endeavour to:

- Issue an agreement to pay form and an estimate of charges for the treatment to the patient. Hospital charges are updated annually from April each year. The estimates must be relevant to the financial year that the treatment is taking place.

- Notify the patient that a deposit is required, relevant to the estimate of treatment cost. (mainly Inpatient and Day Case)

- Ensure that the relevant price list is being used. (Price list available from Management Accounts, Finance)

7. OUT-PATIENTS

Notification of Private Patient Status

It is the individual Consultants responsibility to ensure that their private secretary notifies the Medical Records of the patient's private status and that all clinic lists and hospital notes clearly identifies the patient as being private.

It is also the responsibility of the individual Consultant to notify the General Office in advance of all private out-patient appointments by e-mailing a 'Notification of Private Patient' form as soon as the patient has been allocated an appointment. The form should be e-mailed to general.office@dgoh.nhs.uk.

Where the patient is an emergency case, a 'Notification of Private Patient' form should be e-mailed to the General Office before the commencement of the clinic so that an 'Agreement to Pay' form (Appendix 5) can be prepared and given to the patient to complete before any consultation or treatment is provided.

Private patients may be seen by appointment in an out-patient clinic, preferably in a dedicated clinic rented by the Consultant, or, where this is not possible, at the beginning or end of a clinic session in the Out-Patient Department. The General Office should be advised that the patient is attending the clinic and the patient must be identified as a private patient on PCS. A charge will be made for any procedure that takes place, consumables or diagnostic services used and for drugs prescribed and dispensed. All requests for diagnostic testing and for drugs to be prescribed must be clearly marked as "Private". The patient should be asked to sign an 'Agreement to Pay' form (Appendix 5). The General Office will arrange for an invoice to be raised, based upon the information in the patient's records/cmds. Only if the outpatient procedure is likely to be a significant value will the patient be requested to pay a deposit.

Consultants may order private tests or treatment in any department. All requests to these departments must state that the patient is a private patient. Private patients booked for a diagnostic procedure such as MRI, CT or ultrasound, should be notified to the General Office, who will ensure that the patient's insurance cover is appropriate, or that the patient is notified of the charge should they be self-funding and arrangements made for payment in advance of the procedure. Consultants will be asked to complete a record of treatment requested arising from a private out-patient attendance which should be forwarded to the General Office to enable the invoice to be raised.

NHS case notes will not be made available for private out-patient attendances. Consultants should make up and retain their own sets of private notes for these patients.

Private patients are entitled to take away their x-ray, CT or MRI films, on CD.

A patient referred for diagnostic testing from a private consultation either at this hospital or elsewhere (e.g. at a private hospital) will be considered to be a private patient, liable to pay the full cost of the diagnostic test.

An out-patient cannot be both a private and an NHS patient for the treatment of one condition during a single visit at an NHS hospital. Private patients are normally expected to remain private throughout their whole treatment episode and should not transfer to the NHS unless there is a significant and unforeseen change in circumstances. The patient is nonetheless legally entitled to change status at a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking made to pay charges.

Referrals and Clinic Bookings

The clinic list should show all private patient appointments as either before the clinic start time (in which case there should be sufficient time set aside so that the NHS clinic is not affected) or after the clinic end time. Any private patient seen within NHS clinic time will be deemed to be an emergency case and should be noted as such by Medical Records. The clinic administrator should report all such emergency cases, to the Out-Patient Manager and the General Office (general.office@dgoh.nhs.uk).

At the start of each clinic Medical Records should e-mail general.office@dgoh.nhs.uk with a list of all private patients attending the clinic, providing the patient's full name, date of birth, post code and patient number, they should also highlight any patients deemed to be an emergency case. The General Office will check that the patient has been set up on PCS with the correct patient status and obtain the rest of their details. They will also check that both a 'Notification of Private Patient' form has been received from the Consultant and that an 'Agreement to Pay' form (Appendix 5) has either been sent to the patient or has been provided for the patient to sign at the clinic. At the end of each clinic a list of patients who did not attend should be e-mailed by the Clinic Administrator to general.office@dgoh.nhs.uk detailing the reasons, where known, for the non-attendance and any follow up action to be taken.

Out-patient Appointment Scheduled for more than 7 days after Receipt of Private Patient Notification

On receipt of the 'Notification of Private Patient' form from the Consultant, the General Office should query with the Consultant any details that are unclear and then send out an 'Agreement to Pay' form (Appendix 5) to the patient. The patient must be advised of estimated total charges so that a deposit/financial guarantee may be obtained where appropriate.

The patient should be made aware that when they sign the 'Agreement to Pay' form (Appendix 5) they are entering into a contract with the Trust and it is their responsibility to settle all charges within 14 days of receipt of the invoice. They will be issued with a receipt to enable them to claim reimbursement from their insurance company. (Unless their cover is provided by BUPA for radiology services)

It should be made clear to the patient that the completed and signed 'Agreement to Pay' form (Appendix 5) should be brought along to their appointment along with their deposit, if not already provided. The Consultant should not provide any services to the patient until they are in receipt of the completed, signed and witnessed form.

Out-patient Appointment scheduled for less than 7 days after receipt of Private Patient Notification

The process followed should be the same as that for 'more than 7 days' except that the General Office will telephone or e-mail the patient notifying them of the procedure and informing them that an 'Agreement to Pay' form (Appendix 5) will be provided to them for signing at their appointment.

The Consultant should not provide any services to the patient until the 'Agreement to Pay' form (Appendix 5) has been completed, signed and witnessed.

The same process should be applied in emergency cases.

8. TO ARRANGE TESTS, INVESTIGATIONS OR PRESCRIPTIONS FOR PRIVATE PATIENT (TRUST PREMISES)

Requirements

The Consultant must ensure that the private box is ticked very clearly on all requests for Physiotherapy, Dietetics, Orthotics, Occupational Therapy, Clinical Imaging and Pathology of any type. Also any Pharmacy requests for private patients must be clearly marked "private". The Consultant must sign all request forms.

Consultants should not arrange services, tests, investigations or prescriptions for private patients until the patient has signed an 'Agreement to Pay' form (Appendix 5).

All services supplied should be updated against the patient's record in PCS.

The providing department must notify the General Office at the end of each week, all private patient services provided. The General Office will reconcile all charges relevant to each specific patient and raise the necessary invoice.

Specific to Pathology and Pharmacy

If a request is forwarded by a Consultant from his private rooms, then an agreement to pay form must also be completed by the patient and sent with the request. If there is no agreement to pay form then the requested tests will not be performed. The Consultant should advise his/her patient that there will be a separate charge from the hospital for these tests and that the hospital will be invoicing them direct.

Also, the General Office will advise the Consultant that if there is a problem with recovery of debt relating to a referral from private rooms, the Trust will seek recompense from him/her direct.

It is the Pathology department's responsibility to ensure that the necessary patient's details and costs are entered on an authorised invoice request form and that this is sent, with the agreement to pay form to the General Office, Russells Hall Hospital.

It is the Pharmacy department's responsibility to ensure that the necessary patient's details and costs are entered on an authorised invoice request form and that this is sent to the General Office, Russells Hall Hospital.

9. PRIVATE IN-PATIENTS/DAY CASES

Elective Admissions

It is the individual Consultants responsibility to ensure that his secretary notifies the Booking Team to the patient's private status and that all admission lists and hospital notes clearly identifies the patient as being private.

It is also the responsibility of the individual Consultant to notify the General Office in advance of all private patient admissions by e-mailing a 'Notification of Private Patient' form as soon as the patient has been allocated an admission date. The form should be e-mailed to general.office@dgoh.nhs.uk.

Where any staff member has any reason to believe a patient may be private, (for example in maternity where the patient's case notes show that the patient has been seen by a Consultant instead of a midwife for ante-natal care) and there is no 'change of status' form filed in the case notes the senior staff nurse must ask the patient if they are "private". If the patient notifies the staff member they are "private" the General Office must be e-mailed or telephoned to prepare an 'Agreement to Pay' form (Appendix 5). The General Office will then bring the forms to the Ward for the patient and the Consultant to sign.

Private patients are accommodated in any part of the hospital, in a single room or other accommodation most suited to their medical and nursing needs.

The General Office will contact the patient to advise of estimated cost of treatment, ensure they have signed a Agreement to Pay form, and arrange for the receipt of a suitable deposit.

A deposit based on the estimate calculated payment for the treatment must be prepared for the patient before their admission. The charge will be calculated by the General Office, based upon the advice of the Consultant regarding the procedure to be carried out and the likely length of stay. Should the actual charge be greater than the deposit an additional invoice will be issued. If the actual charge is less than the deposit paid, the balance will be refunded to the patient by cheque. The charge must be paid on or before admission.

If a patient is admitted privately, in an emergency, the Consultant must advise the General Office **immediately** in order that arrangements can be made to ensure payment processes are followed. When such an admission occurs out of office hours (9.00 am – 5.00 pm, Monday to Friday), the patient wishing to be admitted privately should be asked to sign an 'Agreement to Pay' form (Appendix 5), confirming that they will pay all charges.

On discharge, the General Office will collate all the treatment and services received. An invoice will be raised within 5 days and submitted to the patient.

Private In-Patients

It is the responsibility of the individual Consultant to notify the General Office as soon as possible for all private patients admitted out of hours by e-mailing a 'Notification of Private Patient' form to general.office@dgoh.nhs.uk.

The senior ward staff member should notify the General Office via e-mail that they are prepared and obtained a signature from the patient and the Consultant for the 'Agreement to Pay' form (Appendix 5) and advise the General Office of their status with regard to payment of a deposit.

The Ward Clerk or Duty Nurse at the time of admission should set the patient up on PCS with the patient status of PP and record any transfers or discharges.

The General Office (or delegated authority) must request that the private patient pays a deposit equivalent to the total value of treatment likely to be received. If the actual treatment received exceeds the amount paid, the patient will be invoiced for the difference. Similarly where the deposit paid is greater than the actual cost of the treatment received the patient will be refunded the balance.

10. CATEGORY II

Definition

Category II work includes investigations or tests for non-clinical reasons. Examples are X-Rays made on behalf of insurance companies or requested by individuals for employment or emigration, also cardiac tests for DVLA purposes.

Category II Fees

The Trust sets its own fees for use of facilities. These are the same as the private patient tariff unless otherwise indicated. Consultants set their own charges for Category II work and collect their own fee.

Procedure to be followed

The procedure to be adhered to is the same as for that for the Out-Patient Clinic except that it will be the company that will meet the cost of the services provided and not the patient or the patient's insurer. Consultants must identify all such patients as private and adhere to the same process as they would with any other private patient attending an Out-Patient Clinic.

The General Office will need to be notified to invoice the Company rather than the patient for the facilities used. Copies of correspondence from the Company requesting the service will need to be provided to General Office. This will ensure that the debt is recovered promptly.

11. SECTION 58

Definition

Section 58 charges relate to the NHS Act 1977, which allows the Trust to provide accommodation and services not covered under other sections of the Act. Section 58 would be used, for example, for:

- Pathology tests on specimens sent from private consulting rooms where the patient does not attend a Trust hospital.
- Treatment and diagnostic facilities provided on behalf of non-NHS bodies, e.g. patients in private hospitals.
- Administrative costs of making records, x-rays available (nb. – records must be requested through the Medical Records Section in writing).
- Physiotherapists to see their own private patients outside their contracted hours.

Provision of Service

All requests on behalf of Consultants for their Private activity to the Trust will be clearly marked as having been requested from the private hospital or private consulting rooms. All requests in the above instances should be marked and treated as **private**.

Where a contract has been set up with the Consultant (private hospital, private consultancy), staff members and Consultants should check that the particular service requested is documented on the respective contract. This should be validated by the Trust's Contract Manager (or delegated authority).

Where a contract does not exist between the Consultant and the Trust a purchase order must be requested from the Consultant, or an equivalent 'Agreement to Pay' document. This document must be signed by the Consultant.

Where a contract exists or an undertaking to pay has been provided, services should be supplied to the Consultant where the Trust has the capabilities and capacity to safely provide them.

All request forms on completion must be sent to the General Office for invoicing. Where the providing department requires keeping copies of originals, photocopies will suffice.

Where services are requested regularly from a customer a contract must be set up between both parties to cut down on paperwork.

If neither a purchase order or equivalent 'Agreement to Pay' form (Appendix 5) is provided by the customer nor no contract exists from the provision of the requested service then no services can be provided.

12. TRANSFER OF PRIVATE PATIENTS

If a private patient is transferred to another medical establishment, they will be expected to pay for any transport costs incurred by the Trust.

Except in emergency cases, staff must inform the General Office of the details concerning such a transfer, in advance of its occurrence.

13. INVOICING PROCEDURE

Database

In order to effectively and efficiently manage the treatment of private patients in the Trust, the General Office will maintain a log of all private patients receiving Trust services. A Private Patient schedule produced from Oasis (Patient Care System) on a daily basis will be reconciled to the General Office records.

The Income Officer will ensure an account is set up on SLS for each private patient, thus ensuring that any deposit paid can be lodged correctly.

Out-Patient Procedures

It is the responsibility of the ward/department that the private patient attended, e.g. x-ray, pathology, to advise the General Office of the attendance. Each visit or session of visits, should be accompanied by a private out-patient Agreement to Pay form (Appendix 5), usually completed prior to the patient's attendance or completed in the department. An invoice request form (Appendix 9) should be completed by the department and sent to the General Office with the Agreement to Pay form. The ward/department may also provide a schedule of services/treatment provided (Appendix 2).

On receipt of the 'Agreement to Pay' form (Appendix 5) from the Consultant, the General Office should cross reference the forms with the private patient report provided from Oasis. Any anomalies should be discussed with the Out-Patient Manager and, where applicable, forwarded onto the Finance Director.

All change of status forms (Appendix 3 & 4) must be reconciled with the patients 'Agreement to Pay' form (Appendix 5).

Once the forms have been cross-referenced and any anomalies dealt with, the invoice will be raised. A control sheet (Appendix 6) will be completed and an invoice issued.

If a patient has paid a deposit for treatment, any balance outstanding should be invoiced and any overpayment should be credited back to the patient by sending the patient a cheque.

In-Patient and Day Case Procedures

The same process must be followed as with out-patients, except forms must not be forwarded to the General Office until the patient is discharged.

Details of private in-patients or Day Cases are received from the Consultant (Appendix 2).

A Private In-Patient agreement to pay form is sent to the patient with an accompanying letter detailing the charges involved, requesting a suitable deposit and a memorandum about private patient facilities (Appendix 8), together with a prepaid envelope. The agreement form should be signed by the patient and returned to the General Office before the admission date.

The General office will establish the OPCS code for the operation by contacting the consultant's secretary. The OPCS code can then be converted to an HRG code by referring to the HRG Grouper software programme installed on the General Office PCs.

The HRG code is linked to the relevant charge in the current private patient charges and should be detailed in the letter sent to the patient.

A control sheet (Appendix 6) should be completed for each in-patient/Day Case advised to the General Office by the Consultant. This form is used to record all necessary information to be included on the invoice.

Once it has been confirmed that the patient has been discharged, the General Office should collect all the relevant information necessary to raise an invoice . All the information, including the Agreement to Pay form, should be attached to this sheet and forms the back up documentation to the invoice being raised.

The invoice will be raised within 5 working days of discharge.

If a patient has paid a deposit for treatment any balance outstanding should be invoiced and any overpayment should be credited back to the patient by sending the patient a cheque.

14. CHARGES

Hospital charges are updated annually and relate to the financial year April to March.

When staff provide an estimate of costs for a private patient they must ensure that they are using the correct charges for the financial year that the patient will be treated in.

The Trust currently has a specific contract with BUPA, in respect of Radiology facilities.

BUPA clients attending for these services should sign an agreement to pay form, but a deposit will not be requested. Initial contact for non payment will be made direct to BUPA and upon their instruction, the patient will be contacted.

Requests for deposits will be based upon estimated charges for the outpatient treatment or inpatient treatment. Deposits will be lodged against the Patients Account code on SLS as unallocated income. Invoices will be issued after treatment is completed, identifying the full charge and the deposits paid will then be allocated.

Appendix 1

BMA's "A Code of Conduct for Private Practice – Guidance for NHS Medical Staff"

Key points of this guidance include:

- There should be no real conflict of interest between independent work and NHS work.

- Work outside NHS employment should not adversely affect NHS employment, nor in any way hinder or conflict with the interests of the NHS employer, other NHS employers or NHS employees.

- NHS facilities, staff and services may only be used for private practice with the agreement of the Trust.

- Where the employer has agreed that a Consultant may use hospital facilities for the provision of fee paying or private services, the employer may determine and make such charge for the use of its services, accommodation or facilities as it considers reasonable. Any charge will be collected by the employer, either from the patient or third party commissioning the work, or from the Consultant. A charge will not be made if a Consultant is remitting a fee to the NHS organisation.

- Where arrangements are made to use NHS staff for private practice, it must be made clear that treatment of NHS patients and provision of NHS services is a priority. In most circumstances any work for the private sector should be done outside NHS time. However, with prior agreement of the employer, Consultants may undertake private work inside NHS time where there is minimal disruption to other NHS patients and the complexity of cases warrants specific use of NHS services.

- Consultants should not undertake elective private practice when on-call for the NHS, nor undertake on-call for the private sector when working for the NHS. However, there may be circumstances where, with the approval of the NHS employer, a Consultant with a low likelihood of recall may undertake some private practice when on-call for the NHS.

- There should be clear arrangements to ensure that there can be no significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late, or be cancelled.

- Consultants will not be put in a position where it could appear that they are asking patients to consider private treatment. However, when asked directly by patients, Consultants should be able to report the length of waiting lists and treatment available in the NHS and private sectors.

- Consultants should not spend time during NHS consultations discussing private treatment with patients, nor should they use their NHS patient lists to promote their private practice.

- Consultants may use NHS facilities for the provision of fee paying services either in their own time, in annual or unpaid leave, or in NHS time where work involves minimal disruption.

- If NHS sessions are disrupted regularly, the Consultant should rearrange the private sessions. Agreed fixed NHS commitments should take precedence over private work. NHS employers will reach agreement with Consultants to determine when fixed commitments (e.g. operating lists, out-patient clinics) are to be scheduled. Where there is a proposed change to the scheduling of NHS work, the employer will be required to allow a reasonable period for Consultants to rearrange any existing private sessions, taking into account any binding commitments entered into (e.g. leases).

- Subject to clinical considerations, Consultants should be expected to contribute fully to maintaining a high quality service to patients, e.g. reducing waiting lists. This could include patients having the opportunity to be treated by other NHS colleagues or NHS Trusts where this will maintain or improve the quality of care such as reducing their waiting time. When a patient is seen privately and it is agreed they will subsequently be transferred to an NHS waiting list, the patient should be entered on the list at the same point as if they had been seen under NHS arrangements, i.e. on the date of the private consultation.

Appendix 2

THE DUDLEY GROUP OF HOSPITALS NHS TRUST
Notification of Fee-paying Patient

SECTION A – (To be completed for all patients)

From…… (Consultant)

Patient's Name……

Hospital number …….. Date of Birth…….

Patient's address …….

…… Post Code……

1. Will attend for private consultation in the following Hospital Out-patient Dept:

   Russells Hall ☐ Corbett ☐ Guest ☐ on…….. 20……

   Was seen ☐ in my private rooms ☐ in the course of a domiciliary visit

SECTION B – PRIVATE OUTPATIENT

The above named patient requires treatment as a Private Non-Resident Patient as per Section 66 of the NHS Act 1977 and has agreed to sign a Private Patient Agreement Form. He/she is required to attend the following Hospital Department(s):

	OPCS code (if known)	✓Tick as required
OPD Consultation		
Day Case Ward (please specify)		
Radiology		
ECG/Cardiology		
Endoscopy		
Occupational Therapy		
Physiotherapy		
Pathology Laboratory (samples)		
Operating Theatre		
Other (please specify)		

Signed……
Date……..

SECTION C – PRIVATE IN-PATIENT/DAY CASE PATIENT

The above named patient requires treatment as a Private In-patient under Section 65(2) of the NHS Act 1977 and has agreed to sign a Private Patient Agreement Form. Please confirm that there is a bed available within the statutory complement for an estimated period of:

…….days at Russells Hall Hospital
Specialty …….
Ward……
OPCS code …….
Date of admission……..

Signed …….
Date…….

This form to be completed by the Consultant and sent to the General Office, Russells Hall Hospital prior to treatment.

Appendix 3

CHANGE OF STATUS FORM
FROM PRIVATE TO NHS

To be completed by patient

I hereby confirm that I have asked the Consultant named below to change my status from that of a Private Patient to an NHS patient as from this date.

Signed: …….. (Patient)……..Print Name
Date: ……..

INPATIENT

To be completed by Consultant (PLEASE PRINT)

This is to certify that by agreement, my patient ……..
…….. (Patient's name)
Hospital No: …… was transferred from Private to NHS on:
……..

Signed: …….. Consultant
Date: ……..

OUTPATIENT

To be completed by Consultant (PLEASE PRINT)

From: …… Consultant

To: General Office

Re: Patient …… Name
…… Address
……

The above-named has recently been seen by me as a Private patient. S/he has requested that further investigation and treatment are undertaken as a NHS patient.

I am therefore arranging (please tick)

a) To see this patient in my out-patient clinic/day case unit
b) For the patient to be admitted

The degree of urgency is:

a) Urgent
b) Routine

Signed: …….. Consultant
Date: ……..

CHANGE OF STATUS FORM
FROM NHS TO PRIVATE

To be completed by patient

I hereby confirm that I have asked the Consultant named below to change my status from that of a National Health Service patient to a private patient as from this date.

Signed: …….. (Patient) ……..Print Name
Date: ……..

INPATIENT

To be completed by Consultant (PLEASE PRINT)

This is to certify that by agreement, my patient ……..
…….. (Patient's Name)
Hospital No: …… was transferred from NHS accommodation to a private bed on:
……..

Signed: …….. Consultant
Date: ……..

OUTPATIENT

To be completed by Consultant (PLEASE PRINT)

From: …… Consultant

To: General Office

Re: Patient …… Name
…… Address
……

The above-named has recently been seen by me as a NHS patient. S/he has requested that further investigation and treatment are undertaken as a private patient.

I am therefore arranging (please tick)

c) To see this patient in my out-patient clinic/day case unit
d) For the patient to be admitted

The degree of urgency is:

c) Urgent
d) Routine

Signed: …….. Consultant
Date: ..……..

appendix 5 30

Russells Hall Hospital
Dudley, West Midlands, DY1 2HQ

The Dudley Group of Hospitals NHS
NHS Trust

You are advised to read and complete this form in full before signing. Please use black ink only

SECTION A - PERSONAL DETAILS

Surname ..... Mr/Mrs/Miss/Other .....

Forenames ..... Date of Birth .....

Maiden name ..... Passport number (if not British) .....

National Insurance or Social Security number ..... Nationality (if not British) .....

Preferred Language .....

Car Make/Model ..... Reg. No: ..... Are you registered owner of this vehicle **YES/NO**

HOME ADDRESS DETAILS

Owner / Rented / Tenant / Living with parents Please delete where applicable

House and/or street details .....

Town ..... Country/State .....

Country ..... Post or Zip code .....

Tel. no: Home ..... Tel. no: Work ..... Tel. no: Mobile .....

EMPLOYER'S DETAILS

Name and address .....

Town ..... Country/State .....

Country ..... Post or Zip code .....

Tel. no: of employer ..... Payroll Numbers ..... Current Position .....

SECTION B - NEXT OF KIN INFORMATION

Surname ..... Mr/Mrs/Miss/Other .....

Forename(s) ..... Relationship .....

House and/or street details .....

Town ..... Country/State .....

Country ..... Post or Zip code .....

Tel. no: Home ..... Tel. no: Work ..... Tel. no: Mobile .....

SECTION C - INSURANCE DETAILS

I hereby authorise the Trust, or its authorised agents, to make enquiries with my insurers to confirm the extent of, and the limits to, my health insurance policy. My insurance details are:

Insurers name and address .....

Town ..... Country/State .....

Country ..... Post or Zip code .....

Name of personal benefits administrator ..... Tel. no. .....

Insurance policy number ..... Insurance claim number .....

Notwithstanding the provisions of my personal undertaking, I agree to assign to the Trust any of my rights to be paid hospital or other related charges by my insurers in respect of the current episode of treatment provided. Should there be any shortfall in payment by the insurer I understand that and agree to accept full liability. I also unreservedly authorise disclosure of any medical notes including the provision of copies thereof to my insurer as part of their claim and payment processing requirements.

SECTION D - OVERSEAS ADDRESS DETAILS *(if not UK national and/or not ordinary resident in the UK)*

Owner / Rented / Tenant / Living with parents Please delete where applicable

House and/or street details .....

Town ..... Country/State .....

Country ..... Post or Zip code .....

Tel. no: Home ..... Tel. no: Work ..... Tel. no: Mobile .....

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SECTION E - FOREIGN GOVERNMENT, EMBASSY, OR HIGH COMMISSION AS GUARANTOR *(complete only if your Government is paying for your treatment)*

Full name and title of responsible Embassy or High Commission representative: .....

Name of mission .....

Address of mission e.g.: London ..... Tel. no: .....

Embassy or High Commission reference number ..... Letter of guarantee attached .....

SECTION F - NOTE: FOR OVERSEAS

For the purposes of security, the Trust reserves the right to instruct an appropriate agency to verify the patient's address. Such an enquiry will be recorded on the agency's file and may be shared with other users. I also understand that if I am not a British passport holder and/or am not ordinarily resident in the UK, the Trust and/or (the recovery agents) reserve the right to contact British Government missions abroad for the purposes of confirming and/or verifying the information provided by me regarding myself, next of kin, and/or sponsor for visa purposes.

SECTION G - PATIENT/GUARANTOR DECLARATION

I fully understand that being insured does not mitigate my legal responsibility to settle the account rendered in full and within the terms stipulated- i.e. within 14 days. I understand that the account will be referred to the Trust's recovery agents if unpaid immediately thereafter and that ALL the above details will be made available to the said (RECOVERY AGENTS). This authority is unconditional and irrevocable

I FURTHER UNDERSTAND THAT SUCH CHARGES DO NOT INCLUDE THE SERVICES OF A MEDICAL OR DENTAL PRACTITIONER UNDER WHOM I AM ADMITTED AND TO WHOM I HAVE ARRANGED TO PAY SEPARATE FEES.

I agree not to bring jewellery and other valuables into the hospital. I understand that the responsibility for losses rests solely with myself as the hospital does not provide internal security in respect of such items.

Signed ..... Date .....

Name in Full .....

Witness' signature ..... Date .....

Witnessed by (name) ..... Designation .....

SECTION H

1. This form should be completed by the patient or his or her representative who is willing to accept **FULL** responsibility on the patient's behalf.
2. Minors must NOT sign this agreement.
3. All charges are subject to the provisions of section 65 (3) of the National Health Service Act 1977 as or may be subsequently amended.
4. This undertaking must be signed only by an individual accepting personal liability. It must not be signed by a TRUST, CHARITY, LIMITED COMPANY, PARTNERSHIP, LIMITED LIABILITY PARTNERSHIP, or any other corporate body.
5. This document is an agreement to pay for any and all hospital charges and is legally binding
6. Should you be in any doubt concerning any of the above provisions, please contact the General Office Manager at the Dudley Group of Hospitals NHS Trust on telephone number 01384 456111 Ext 1231

I understand that Dudley Group of Hospitals NHS Trust may store the information I have given on this form, and that I have a right to see a copy of the information held about myself on application to the Trust's Information Governance Officer.

The data collected will be used for the purpose of payment for care.

The Trust's Data Protection Adviser can be contacted on (01384) 321014 via Email at information.governance@dgoh.nhs.uk. Further information relating to the Data Protection Act 1998 can be found on the Protection Commissioner's website at www.dataprotection.gov.uk.

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Fee Paying Patient Control Sheet

1 Patient's Name ..... Hospital Number .....

2 Patient's Address ..... Date of Birth .....

..... Ward .....

Consultant.....

3 Is Patient an Overseas Visitor ☐ Yes ☐ No

4 Insurance Company to pay ☐ Yes ☐ No

5 Agreement Form sent out on .....

6 Agreement Form received on .....

	£
7 *IN-PATIENT Resident Admission From ..... To	
*OUT-PATIENT Consultation on	
Day Case on	
8 OPCS Code	
9 HRG Code	
10 TOTAL AMOUNT DUE: £.....	

*Delete as necessary

INVOICE DETAILS:

NUMBER	DATE	AMOUNT

Comments:

Appendix 7

MEMORANDUM TO PRIVATE OUT PATIENTS

Following your request you are attending a National Health Service Hospital as a private out patient and this memorandum has been prepared to explain to you the charges, etc. made for the use of hospital facilities and services.

A fee is charged for specific diagnostic tests and treatment time where applicable, at a hospital department and for use of the hospital facilities. These fees are determined on an annual basis by the Trust. Invoices are issued in respect of the hospital services used and do not include the fees of the Consultant(s) treating you. An estimate of the charges will be made and if significant, a deposit will be required. The invoice issued will reflect the total charge in order to recover the amount from your insurance company.

Whilst attending the hospital as a private out patient you will be required to use the same National Health Service facilities as all other patients. We are unable to give priority to private patients over NHS patients in respect of waiting time within departments for treatment or diagnosis.

We trust your attendance at the hospital will be as pleasant as possible.

Appendix 8

MEMORANDUM TO PRIVATE IN PATIENTS and DAY CASES

Following your request you are being admitted to a National Health Service Hospital as a private patient and this memorandum has been prepared to briefly explain your entitlement to hospital services.

The fee that you will be charged is determined on an annual basis by the Trust and is based upon the average cost of maintaining a patient in a National Health Service Hospital. The standards of clinical care and services provided are therefore similar to those provided for all other patients in the Trust's hospital.

You will, if possible be provided with a single room. However this will be subject to the clinical needs of both yourself and other patients. The charge for the hospital's services is …… but this will increase if the period of your stay exceeds ……. days. This charge excludes the fees of the Consultant and/or Anaesthetist which is a matter of private agreement between yourself and the Consultant and/or Anaesthetist treating you.

An estimate of the charges will be made and a suitable deposit will be required. The final invoice issued will reflect the total charge in order to recover the amount from your insurance company, if applicable.

Please indicate the company name and policy details on the agreement to pay form.

Following your discharge from hospital your Consultant(s) may require you to attend the hospital for follow-up treatment/tests for which a separate invoice on behalf of the Trust will be issued.

We hope your stay in hospital will be as pleasant as possible.

Enclosure 4

Overseas Visitors Policy and Procedure

December 2007

Introduction

The National Health Service provides healthcare for people who are **"ordinarily resident"** in the United Kingdom. People who are not "ordinarily resident" in this country are not automatically entitled to use the NHS free of charge – regardless of their nationality or whether they hold a British passport, a NHS medical card or have lived and paid taxes in this country in the past.

The law places an obligation on NHS trusts to establish if people using their services are not normally resident in the UK. If they are not, then charges may be applicable for the NHS services provided. When that is the case, the trust has no alternative but to charge the person liable (usually the patient) for the costs of the NHS services.

The Trust will need to inform the Department of Health if they provide NHS services to a person from one of our European Economic Area partners (plus Switzerland) or one of the other countries with which the UK has a reciprocal healthcare agreement. This information is needed at a national level to maintain those agreements and ensure that they remain fair to both the UK and our partners.

The Trust and members of the public may seek help and advice from the Department of Health about any aspect of the regulations and guidance.

Overseas Visitors Policy Team
Department of Health
Room 4W04B
Quarry House Quarry Hill
LEEDS
LS2 7UE

Telephone: 0113 254 5819

Email: overseasvisitors@dh.gsi.gov.uk

The Department of Health cannot give specific advice in relation to individual cases. The decision as to whether a particular patient is liable for charges rests with the NHS trust providing treatment. In some cases, perhaps where a patient's circumstances is unclear or appears not to be provided for in the regulations or guidance, the trust may need to take legal advice.

Up to date advice and information is also available on the Department of Health website at www.doh.gov.uk/policy

The Department of Health guidance is advisory. It cannot be a substitute for the National Health Service (Charges to Overseas Visitors) Regulations 1989, as amended and cannot cover all possible situations.

Policy

The Trust policy is based upon the Department of Health Overseas Visitor Regulations and Guidance Notes.

The Trust policy will:

- provide clear guidelines to all staff for the correct management of Overseas Visitors and Asylum Seekers within the Trust.
- ensure that no person is discriminated against in the application of the regulations providing for charges for NHS treatment.
- ensure that the relevant recording and reporting mechanisms are in place in order to identify and charge Overseas Visitors and Asylum Seekers, accordingly.
- ensure that posters and leaflets, explaining the charging regulations, are available for patients to read throughout the Trust and for issue to local GP surgeries.
- establish formal contact with local GPs to ensure that they identify any temporary residents who may be Overseas Visitors, when or if they refer them to the Trust for treatment.
- ensure that appropriate back up services are provided, such as interpreters to assist in the interview process of potential Overseas Visitors and Asylum seekers.
- ensure that treatment charges for Overseas visitors and Asylum Seekers are reviewed and updated annually, at the beginning of each financial year.
- ensure that debt recovery procedures are in place for the recovery of overseas visitor debt.
- provide Overseas Visitor activity data to the Department of Health in respect of patients from EEA countries, Switzerland or a non EEA country with a reciprocal health care agreement.

Procedure

General Guidelines:

It is vitally important that no person is discriminated against in the application of the regulations providing for charges for NHS treatment. (Article 14 of the European Convention on Human Rights Act, which is now incorporated into UK law as part of the Human Rights Act, prohibits discrimination against a person in the exercise of their rights under the convention, on any ground such as: sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.)

The only thing that is relevant is residence and this cannot be judged from external appearance, name, language, nationality, past or present payment of taxes, or whether they are registered with a GP and have been given a NHS number.

It is, therefore, necessary to ensure that **all** patients – regardless of their address, appearance or accent – are asked where they have lived for the previous 12 months immediately preceding a **new** course of treatment. It is not necessary for the question to be asked if the patient is attending as part of their on going treatment.

In some departments, catering for the very elderly or mentally confused patients, the initial question may be inappropriate or unworkable. In these cases staff should still be aware of the possibility of patients being chargeable and should notify the overseas visitor team, General Office of any patient who, on the information they have, may be an overseas visitor.

Although there is no exemption from charges for life saving treatment (other than that given in Emergency Department) the Trust should always provide immediate necessary life saving treatment whether or not the patient has been informed of, or agreed to pay charges. Not to do so would be in breach of the Human Rights Act. While it is a matter of clinical interpretation whether treatment is immediately necessary to save life, this should not be construed simply as meaning that the treatment is clinically appropriate, as there may be some room for discretion about the extent of treatment and the time at which it is given, in some cases allowing the visitor time to return home for treatment rather than incurring NHS charges.

NHS TREATMENT IS GIVEN TO <u>ALL</u> PATIENTS WHEN THE FOLLOWING APPLY:

- Treatment given in the Emergency Department
- Treatment for certain diseases where treatment is necessary to protect the wider public health. – (Appendix 1**)**
- Sexually transmitted diseases. For HIV /AIDS this exemption only applies to initial diagnostic testing and associated counselling.
- Family planning services
- Treatment of mental health problems
- Patients who have lawfully lived in the UK for over one year

AN OVERSEAS VISITOR WILL BE EXEMPT IF THEY ARE:

- From a country with reciprocal healthcare agreement – (Appendix 2)
- Refugees and Asylum seekers who have made a formal application to the Home Office to stay in the country or those already granted asylum.
- Taking up Permanent Residence in the UK
- Registered on a Full Time Course of Study
- People who receive UK War pensions
- People working on ships registered in UK
- People working in the UK
- Prisoners
- Diplomats
- Members of UK forces
- Civil servants
- A missionary
- A person detained under the provision of the immigration Act 1971
- A volunteer with a voluntary organisation (there are various provisions of Acts which specify the services which the volunteer should be providing)
- An employee, recruited in the United Kingdom, of the British Council or the Commonwealth War Grave Commission
- A person who is working in employment that is financed in part by the Government of the UK in accordance with arrangements made by the Government of another country
- A person who has at any time had not less than ten years continuous lawful residence in the UK and is employed outside the United Kingdom for no more than five years.
- A person who is employed in another member state but is contributing under the Social Security Act 1971
- British Nationals who have been evacuated from Lebanon can be classed as exempt from healthcare charges and will not be asked to pay for any hospital treatment they may require

Note Spouses, civil partners or children of the patients will also not be charged for Services. In most cases this will be provided when the child lives on a permanent basis with the overseas visitor. However this does not apply to HM Forces, Civil Servants, Missionaries, British Council and Commonwealth Wargraves Commission employees and those whose employment is financed by the Government

All patients attending the Hospital for treatment will need to be asked the baseline question:

Where have you lived for the last 12 months? And can you show that you have the right to live here

This question should be asked, without exception, every time a patient is registered for a new course of treatment.

Frontline staff i.e. Emergency Department, OPD reception and ward staff will only need to ask the baseline question, all additional interview questions will be asked by the Overseas Visitor Team.

Where a patient indicates that he or she has not lived in the UK for the past 12 months action should be taken as follows:

- The person who identifies the patient as potentially liable should complete section A on the Overseas Visitor Interview Form (Appendix 4). The patient details on PCS will also need to be flagged that the patient is an overseas visitor. This will enable an overseas visitor report to be produced by the Information Department, Finance for the attention of Overseas Visitor Team, General Office as confirmation that all potential overseas visitors have been flagged for further action.

- On what date did you arrive in the UK?

- What is the basis for your staying in the UK?

- As Emergency Department treatment is free to all patients, the form should be included with the patient's records, as well as being **faxed** to the Overseas Visitor Team on **ext 3395**

- If the patient is referred to another ward or department, follow up procedures need to be implemented referred to outpatients care or admitted as an inpatient upon arrival the patient should be told immediately, where possible, that they will need to be interviewed by the Overseas Visitor Officer (Stage II interview) to establish eligibility for NHS treatment.

- A&E departments are exempt from charges so baseline questioning need not to be undertaken, until a patient is referred to outpatient care or admitted as an inpatient

- If an interpreter is required in order to explain the process to the patient, ward staff or the Overseas Visitor Team will need to provide the services of an interpreter, see http://carenet/reflibrary/policies/interpreters.htm to access details of the Trusts interpreter services.

INPATIENT SERVICES

- The receiving ward or department should complete section A on the Overseas Visitor Interview Form – Appendix 4 (unless it has already been completed in Emergency Department and is with the patients notes) and then contact the overseas visitors team, General Office ext 2881, immediately to arrange for an interview to take place before treatment is given (but if, in the opinion of medical staff, the treatment is needed urgently it should be allowed to go ahead without delay)

- In certain wards it would be inappropriate to ask the baseline question for example, direct admission to critical care or psychogeriatric wards. In these circumstances, the ward staff should alert the overseas patient team of any patient who, on the information before them, could potentially be liable for charges.

- If the overseas visitor team is unavailable due to treatment being required out of normal office hours i.e. 9am to 5pm, then the person who identifies the patient as potentially liable will complete section A on the Overseas Visitor Interview Form and either fax to the General Office, ext 3395 or email as an attachment to General.Office@dgoh.nhs.uk

- Where, following an interview by the Overseas Visitor Team, a patient is found liable for charges the patient should be asked to pay in advance of receiving the treatment or any further treatment (but if, in the opinion of medical staff, the treatment is needed urgently it should be allowed to go ahead without delay – appendix 3 to be completed).

- If the patient is unable to pay, but a friend or relative offers to settle the charges on the patient's behalf, then this is quite acceptable. The third party will need to complete an Agreement to Pay form (appendix 5)

ELECTIVE INPATIENT SERVICES

- When a consultant has agreed to treat an Overseas Patient prior to their arrival in the UK, then they should be charged as a Private Patient.

- It is the individual Consultants responsibility to ensure that his secretary notifies the Booking Team to the patient's private status and that all admission lists and hospital notes clearly identifies the patient as being private.

- It is also the responsibility of the individual Consultant to notify the General Office in advance of all private patient admissions by e-mailing a 'Notification of Private Patient' form as soon as the patient has been allocated an admission date. The form should be e-mailed to general.office@dgoh.nhs.uk.

- The General Office will forward an agreement to pay form to the patient and advise the patient that a deposit will be required prior to treatment.

- The deposit will be calculated by the Overseas Visitor team based upon an estimation of the cost of the procedure, the details of which would be provided by the medical secretary. If the deposit is not paid, then treatment will not be allowed to proceed.

- Once the patient has received treatment the actual costs will be offset against the deposit paid, either an additional invoice will be issued or a refund will be made to the patient.

OUTPATIENT REFERRALS

- A GP patient referral is sent to the Outpatient Booking Team. The Outpatient Booking Team will identify if the patient is potentially an overseas visitor (includes patients from a country with reciprocal healthcare agreements, appendix 2) The Overseas Visitor Team will need to be informed of all potential overseas visitors by completion the Overseas Visitor Interview form, (Appendix 4) section A. The form should be faxed to the General Office ext 3395, or emailed as an attachment to General.Office@dgoh.nhs.uk

- The patient details on PCS will also need to be flagged that the patient is an overseas visitor. This will enable an overseas visitor report to be produced by the Information Department, for the attention of Overseas Visitor Team, General Office as confirmation that all potential overseas visitors have been flagged for further action.

- If a patient is definitely confirmed as a chargeable Overseas Visitor by the Overseas Visitor Team, the consultant is issued with notification form (Appendix 3) which will need to be completed and returned to the Overseas Visitor Team, General Office.

MATERNITY SERVICES

- Maternity services must always be treated as immediately necessary care, and neither delayed nor withheld because the patient is a chargeable overseas visitor who may not be able to pay. This is because of the severe risks involved to both mother and child if the mother has not presented herself for medical care throughout her pregnancy.

- The Overseas Visitor Team should still identify chargeable overseas maternity patients and those patients should be informed that they are liable to charges and all reasonable attempts made, given the individual circumstances, to recover the debt. However, the Overseas Visitor Team should be particularly sensitive to the circumstances in these cases. Women who attend the hospital for maternity treatment must never be given the impression that if they cannot pay then treatment will be withheld, either there and then or at a later stage of their pregnancy.
- Any woman, who enters into maternity care free of charge, should continue to receive it on that basis, even if her residence status changes before the baby is born. Therefore, asylum seekers, whose applications, including any appeals, have failed but who began their maternity care before such a decision was reached, will continue to receive all their maternity services free of charge. Only maternity services begun after an application for asylum has been finally rejected are subject to charges.

- As regards pregnant women who are known, or found to be HIV positive, maternity services could be taken as including HIV treatment where it is considered clinically necessary to prevent mother-to-child transmission of the condition. Whether this is appropriate will always be a clinical decision by the consultant, not a decision for the Overseas Visitor Team.

OTHER HOSPITAL SERVICES

- The Overseas Visitor Team will identify if the patient has received or is likely to receive any further hospital services, such as Pathology, Radiology etc.

- If the patient is confirmed as a chargeable overseas visitor, the cost of these services will be included in the total charge payable by the patient.

OUTPATIENT CLINICS

- If a patient attends either an Outpatient clinic or a clinic that may be held in a ward area, the baseline question should be asked, without exception, every time a patient is registered for a **new** course of treatment.

- If it is suspected that the patient is a potential Overseas Visitor, based upon the patient's answer, the Overseas Visitor Team will need to be informed by completion of the Overseas Visitor Interview form, (Appendix 4) section A. The form should be faxed to the General Office ext 3395, or emailed as an attachment to General.Office@dgoh.nhs.uk

- The patient details on PCS will also need to be flagged that the patient is an overseas visitor.

- The patient should be told immediately, where possible, that they will need to be interviewed by the Overseas Visitor Officer (Stage II interview) to establish eligibility for NHS treatment.

- The Overseas Visitor Team will arrange for the 2nd stage interview to be conducted prior to the patient's treatment, where ever possible.

PAYMENT

- Payment for Hospital services will be accepted by cash, cheque (sterling), credit or debit card at the General Office, Russell's Hall Hospital.
  Should the cheque not be honoured, the debt will be pursued by the debt recovery procedures if necessary

EX PATRIOTS

- If they reside in the UK for at least 6 months and are not registered as a resident of another member state they are exempt from payment.

APPENDIX 1

The exempt diseases are:

Acute encephalitis
Acute poliomyelitis
Amoebic dysentery
Anthrax
Bacillary dysentery
Cholera
Diptheria
Food poisoning
Leprosy
Leptospirosis
Malaria
Measles
Meningitis
Meningococcal septicaemia (without meningitis)
Mumps
Ophthalmia neonatorum
Paratyphiod fever
Plague
Rabies
Relapsing fever
Rubella
Salmonella infection
Severe Acute Respiratory Syndrome (SARS)
Scarlet fever
Smallpox
Staphylococcal infections “likely to cause food poisoning”
Tetanus
Tuberculosis
Typhoid fever
Typhus
Viral haemorrhagic fever
Viral hepatitis
Whooping cough
Yellow fever

APPENDIX 2

EEA Countries:

Austria
Belgium
Bulgaria
Southern Cyprus and does not include the Turkish Republic of Northern Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Germany
Greece
Hungary
Iceland
Ireland
Italy
Latvia
Liechtenstein
Lithuania
Luxembourg
Malta
Netherlands
Norway.
Poland
Portugal
Romania
Slovakia
Slovenia
Spain
Sweden
Switzerland

Proof of entitlement – European Health Insurance card
Level of care – Treatment which a Medic decides is medically necessary
Exclusions – Elective treatment or the treatment of pre-existing conditions which in the medical opinion of the Medic can wait until they return to their home state.

British Nationals who have been evacuated from Lebanon can be classed as exempt from healthcare charges and will not be asked to pay for any hospital treatment they may require.

British Citizens without automatic right of abode in the UK who have been evacuated from Lebanon are to be granted discretionary leave to remain in the UK for a minimum of six months.

APPENDIX 2
(continued)

The UK has bilateral health care arrangements with these countries:

Anguilla $
Armenia **
Australia $
Azerbaijan **
Barbados $
Belarus
Bosnia-Herzegovina $
British Virgin Islands $
Channel Islands $
Croatia $
Falklands Islands $
Georgia **
Gibraltar $
Isle of Man $
Kazakhstan **
Kyrgyzstan **
Macedonia $
Moldova **
Montenegro $
Montserrat $
New Zealand **
Russia **
Serbia $
St. Helena $
Tajikistan **
Turkmenistan **
Turks and Caicos Island $
Ukraine **
Uzbekistan **

** Nationals from these countries

Proof of entitlement - Passport

$$ Residents of these countries

Proof of entitlement – A passport or proof of residence in the country concerned e.g. an identity or residence card

APPENDIX 3

The Dudley Group of Hospitals NHS
NHS Trust

OVERSEAS VISITORS

HOSPITAL CHARGING REGULATIONS

Dear Consultant……..

NAME OF PATIENT…….

Date of Birth: ……Hospital Number……..

This patient is an Overseas Visitor as defined in the National Health Services (Charges to Overseas Visitors) Regulations 1989 as amended. Having interviewed the patient we found him/her to be liable for charges as an Overseas Visitor.

Government advice to safeguard NHS resources is to obtain payment where possible before treatment is given. In this case the patient also declared that he/she will not be able to pay for the treatment to be provided prior to receipt of the treatment. Would you, therefore, please tick one of the declarations below:-

☐ I intend to give treatment which is immediately necessary to save the patient's life

☐ I intend to give urgent treatment, which is not immediately necessary to save the patient's life, but cannot wait until the patient returns home.

☐ No treatment will be given unless payment is made.

Where treatment is to be given (or has been given already), the Trust is obliged to raise an invoice for the cost of any such treatment, and to pursue debt recovery procedures if necessary.

Signed: ……..... **Date:** ……
(Consultant)
Print Name: ……
Signed: …….. **Date:** …….
Print Name: ……

Appendix 4

The Dudley Group of Hospitals NHS Trust

Overseas Visitor Interview

Section A

Interviewed by……Date:……..

Patient Surname: ……Consultant: ……

First name: …… Unit No: ……

Date of Birth: ……. Passport No: ……..

UK Address: …….. Overseas Address: …….
…….. ……..
……. ……
…….. ……

Tel No: …… Tel No: …….

Mobile No: ……..

Base Line Question:-
Where have you lived for the past 12 months? And can you show that you have the right to live here? ……...

General Office notified by (name)……on…….

Email		Fax		Verbal	

(Please tick relevant box)

Section B

Overseas Visitor officer:-

Q1. Are you seeking Asylum in the UK? ……

YES ☐ Home office ARC Card No: ……
NO ☐

Q2. Can you prove you have the right to live here?

Evidence Yes ☐
No ☐

Q3. What date did you arrive in the UK? ……

Q4. What country have you travelled from? ……...

Q5. What is the purpose of your visit to the UK? ……...

Additional Information: -
…….
……..
……..

NOTE:

If these documents are seen at the time of interview the patient **WILL BE EXEMPT** from Charges.

Documents seen by: …….
(Print Name)

Signed: …… Date: ……..

Acceptable evidence:

a copy of your passport (including your visa)

- Original Marriage Certificate
- Council Tax Documents
- Local Authority Rent Book
- Mortgage Repayment Documents
- Cheque Guarantee Cards and Associated Cheque Book
- Paid Fuel or Telephone Bill
- Flight Tickets to the UK showing single and not return journey
- Bill of Lading for shipping of personal belongings
- Credit / Loan Agreement with UK firms
- School Registration
- Payslips
- Letter referring to Transfer of Funds from previous country to the UK
- Copies of correspondence between patient and the establishment in the previous country of residence showing that the patient will be moving to the UK on a certain date
- Application to the Home Office for Permanent Residency

Asylum Seekers and Refugees

If you are an Asylum Seeker or Refugee, you should be able to produce ONE of the items listed below:-

- A Travel Document which shows that it was issued in the UK in accordance with the Convention of the Status of Refugees
- A Letter from the Home Office stating that the patient is a refugee or has been granted refugee status in the UK
- An Acknowledgement Letter from the Home Office confirming that the applicant has made an application for asylum.

Appendix 5

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

NHS CHARGES TO OVERSEAS VISITORS

AGREEMENT TO PAY

A. (To be completed in all cases where agreement is required)

Name of Patient……

Date of Birth……Hospital Number…….

UK Address……..

……..

Overseas Address…….

……..

B. (To be completed, in addition to A, if person giving the agreement to pay is not the patient)

Name of person giving the agreement……...

UK Address…….

……..

Overseas Address…….
(If applicable)
……..

Relationship to patient……..

C. Declaration
I agree to pay the Dudley Group of Hospitals NHS Trust such sums as may be due to it in accordance with the Regulations currently in force under Section 121 of the NHS Act 1977, in respect of NHS treatment provided as an overseas visitor.

Signed…….

Print Name…….….

Date……..

Witnessed by…… Print Name…….
(Member of Staff)

Appendix 6

Date:

Dear Dr (GP)

Re: Implementing the Overseas Visitor Hospital Charging Regulations

Since the NHS Act 1977, there has been a provision for charging Overseas Visitors as set out in Section 21 of the Act It is the responsibility of an NHS Trust providing secondary care to establish if a person is entitled to treatment without charge. We are improving our procedures and policies to ensure that all patients, regardless of their status or nationality, are subject to the same basic screening process as part of the hospital regulation procedure. This will involve asking them where they have lived for the last 12 months and whether they can show they have the right to live here. As a consequence of this exercise some overseas visitors will be exempt from charges and others will be asked to pay.

More recently the Overseas Hospital Charging Regulations have been amended in 2004, to assist hospital management in ensuring that application of the regulations is exhaustive.

It is often difficult at the point of attendance, (especially outpatient clinics) to conduct an interview; obtain appropriate evidence of residency; and where appropriate payment for the necessary treatment. Clearly, prior notification of patients referred to the hospital by General Practitioners and General Dental Practitioners for patients that have not been resident in this country for as long as the previous 12 months, would greatly assist hospital management in this process. Inclusion of this information in the hospital referral letter, simply using the words 'Overseas Visitor' would provide hospital staff with the opportunity of a dialog prior to the patient's attendance.

Your co-operation in this matter would be greatly appreciated.

Yours Sincerely,

Overseas Visitors Team
General Office

P.S Should you have any enquiries resulting from this letter, please do not hesitate to contact Overseas Visitor Team on 01384 456111 Ext 2881.

Overseas Visitor Team Procedure

19th December 2007

Overseas Visitor Team

The Interviews

It is important that all staff involved with the identification and interviewing of potentially liable patients should be properly advised of their role and provided with adequate training. Staff involved in interviewing patients should have an awareness of the regulations and guidance together with general training on interviewing techniques and handling difficult situations. Staff can sometimes be confronted with angry and abusive patients and/or relatives. They should be fully trained on the Trust's policy for dealing with violent or potentially violent situations.

Asking the baseline question:

All patients who have been resident in the UK for 12 months prior to receiving treatment are entitled to that treatment free of charge. Therefore the baseline question is:

Where have you lived for the last 12 months? And can you show that you have the right to live here.

This question should be asked, **without exception,** every time a patient is entered onto the Trust's records for in-patient or out-patient care, either on paper or computer and either by administration or ward staff. The Patient care system should allow the questioner to record either that the patient has lived in the UK for 12 months or that there is some doubt. In all cases of doubt the PCS flag for "Overseas Visitor" should be ticked. This will ensure that the daily report, produced from the Patient Care system for the Overseas Visitor team, will identify this potential Overseas Visitor. The questioner should inform the patient a copy of the leaflet *" Are you visiting the United Kingdom"* Copies of the leaflet are available from the Department of Health through the **Response line 08701 555 455.**

Patients who have spent up to three months out of the last twelve, immediately preceding treatment, abroad can still be regarded as UK residents. **(Calculating the period of residence** – the regulations provide that when calculating a period of residence a person can be out of the UK for up to 3 months before it is taken into consideration. For example, if someone has lived in the UK for the last 12 months but spent 3 months of that time on holiday abroad, they could still be considered to have spent the last 12 months in the UK. The period of absence can be calculated cumulatively, 3 separate periods of 1 month abroad during the last 12 months should be counted as a total of three months abroad.**)** It is important that the Overseas Visitor team are aware of this easement as it will apply to many older people who spend time abroad in the winter months. If they reside in the UK for at least 6 months and are <u>not registered</u> as a resident of another member state they are exempt from payment too!

Patients can qualify for NHS treatment without charge through the eligibility of their relatives. For example, civil partners, the husband of a female patient may be entitled or the wife of a male patient. Dependant children may qualify through one or both of their parents. This decision would need to be made at the 2nd stage interview.

Where it is not possible for a patient to be referred for immediate interview by the overseas patient team it may be helpful if the questioner places a note **inside** the medical records to alert other members of staff to the patient's potential liability for charges. A suggested form of wording is as follows:

Patient may not be normally resident in the United Kingdom

This patient may not normally be resident in the UK and has been referred for further interview by the Overseas Visitor Team. The patient may be liable to pay for any treatment received. The patient has been informed.

For further information contact Overseas Patients Team ext 2881

<u>ASYLUM SEEKER</u>

An Asylum seeker is a person who has made a formal application to the Home Office for recognition as a refugee under the 1951 UN Convention and its protocol Relating to the Status of Refugees.

A person who has made a formal application for asylum in the UK will be issued with an Immigration and Nationality Directorate (IND) Application Registration Card (ARC). This card contains a photograph of the asylum seeker, details such as their name and chip containing biometrics information. Where it is not possible to issue an ARC card, the asylum seeker will receive a form known as SAL (standard acknowledgement letter). There are two versions of SAL. **SAL1** is issued when the asylum application is made at the port of entry, **SAL2** is for asylum applications made

after entering the UK. In due course, all asylum seekers in possession of SALS will have them replaced by an ARC.

Where an asylum seeker has had an initial application for refuge refused he or she has rights of appeal. They will continue to be entitled to hospital treatment without charge until the system of appeal has been exhausted.

- IN UK FOR **LESS** THAN 12 MONTHS

If Patient has been in UK for less than 12 months and their Home Office application to remain in the country is finally rejected and all appeal rights exhausted, then they will become **chargeable for all hospital treatment they have received and continue to receive.**

- IN UK FOR **MORE** THAN 12 MONTHS

If the Patient has been in UK for more than 12 months when their application is finally rejected and all appeal rights have been exhausted, then **any course of treatment which began before their application was finally rejected** will continue to be free of charge. Any new course of treatment begun after that date will be chargeable.

Treatment given to an asylum seeker whilst appeal is being considered is free.

Generally, whilst active asylum seekers are fully entitled to free hospital treatment, failed asylum seekers are not (except for ongoing courses of treatment). However, a failed asylum seeker who has, exceptionally been granted leave to remain in the UK by the Home Office, even if only on a temporary basis (given reporting restrictions), could be considered to be ordinarily resident and therefore entitled to free treatment.

ILLEGAL IMMIGRANTS

The Trust may occasionally discover when establishing residence that a patient is in the UK without proper permission. This may be because they have entered the country on a visitor's visa, which has since expired, or they may have had an application for asylum refused and have not been removed from the country. These circumstances may arise within the first 12 months of their entering the country, if that date is clearly established, or it may be discovered that someone who has been in the UK for longer is not legally resident. If the former, charges may apply. However, immediately necessary life saving treatment should be given to such patients if required even if they are unable to pay. The charge will still stand, but if it proves to be irrecoverable then it should be written off. If the patient has been in the UK for more than 12 months then, at present, the 12 months residency exemption will come into effect.

PREGNANT OVERSEAS VISITORS

- Maternity services must always be treated as immediately necessary care, and neither delayed nor withheld because the patient is a chargeable overseas

visitor who may not be able to pay. This is because of the severe risks involved to both mother and child if the mother does not present herself for medical attention throughout her pregnancy.

- The Overseas Visitor Team should still identify chargeable overseas maternity patients and those patients should be informed that they are liable to charges and all reasonable attempts made, given the individual circumstances, to recover the debt. However, the Overseas Visitor Team should be particularly sensitive to the circumstances in these cases. Women who attend the hospital for maternity treatment must never be given the impression that if they cannot pay then treatment will be withheld, either there and then or at a later stage of their pregnancy.
- Any woman, who enters maternity care free of charge, should continue to receive it on that basis, even if her residence status changes before the baby is born. Therefore, asylum seekers, whose applications, including any appeals, have failed but who began their maternity care before such a decision was reached, will continue to receive all their maternity services free of charge. Only maternity services begun after an application for asylum has been finally rejected are subject to charges.

- As regards pregnant women who are known, or found to be HIV positive, maternity services could be taken as including HIV treatment where it is considered clinically necessary to prevent mother-to-child transmission of the condition. Whether this is appropriate will always be a clinical decision by the consultant, not a decision for the Overseas Visitor Team.

NEWBORNS

- Where a baby is born in hospital, mother and child count as a single patient so long as both are in hospital following the birth. If one is discharged and the other remains, charges will continue for the one remaining.

Exceptions to the charging regulations

- Treatment given in the Emergency Department is exempt from charges but the baseline question can be asked, so that the Patient Care System can be flagged as a potential Overseas visitor. In settings where the question would be inappropriate for example, direct admission to critical care or psychogeriatric wards, then ward staff should alert the overseas patient team of any patient who, on the information before them, could potentially be liable for charges.

- The vast majority of patients will not be liable for charges. The purpose of asking the baseline question at this stage is to avoid discrimination and to ensure that all patients who are liable for charges are identified. It is not intended that ward staff should do anything other than ask the baseline question and alert the overseas patient team if necessary. There is no need and

no question of staff at this stage asking supplementary questions or seeking documentary evidence.

The main interview

- This should take place in private, and for non urgent cases, before treatment has started.

- Before interview print patient details from PCS and use these to complete the 'overseas visitor interview form' (appendix 7) and also the 'Agreement to Pay Form' (Appendix 5).

- Always ask nursing staff if the patient is well enough to be interviewed and if an interpreter will be required.

- To obtain an interpreter refer to the Trusts Carenet for details.

- The Overseas visitor team interviewer should begin by explaining that people not ordinarily resident in the UK can, in some circumstances, be liable for the cost of their treatment. The interviewer should explain that the interview is taking place because the patient indicated during the process of administration (or because ward/clinic staff have indicated) that he or she may not normally live in the UK.

- Some patients will be clear that they are not normally resident here but others may dispute the assessment. It is therefore important to establish at the outset of the interview whether the patient considers him or herself to be an overseas visitor. When assessing the residence status of a person seeking free NHS services, trusts will need to consider whether they are :

- **Living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life for the time being. Whether they have an identifiable purpose for their residence here and whether that purpose has a sufficient degree of continuity to be properly described as "settled".**

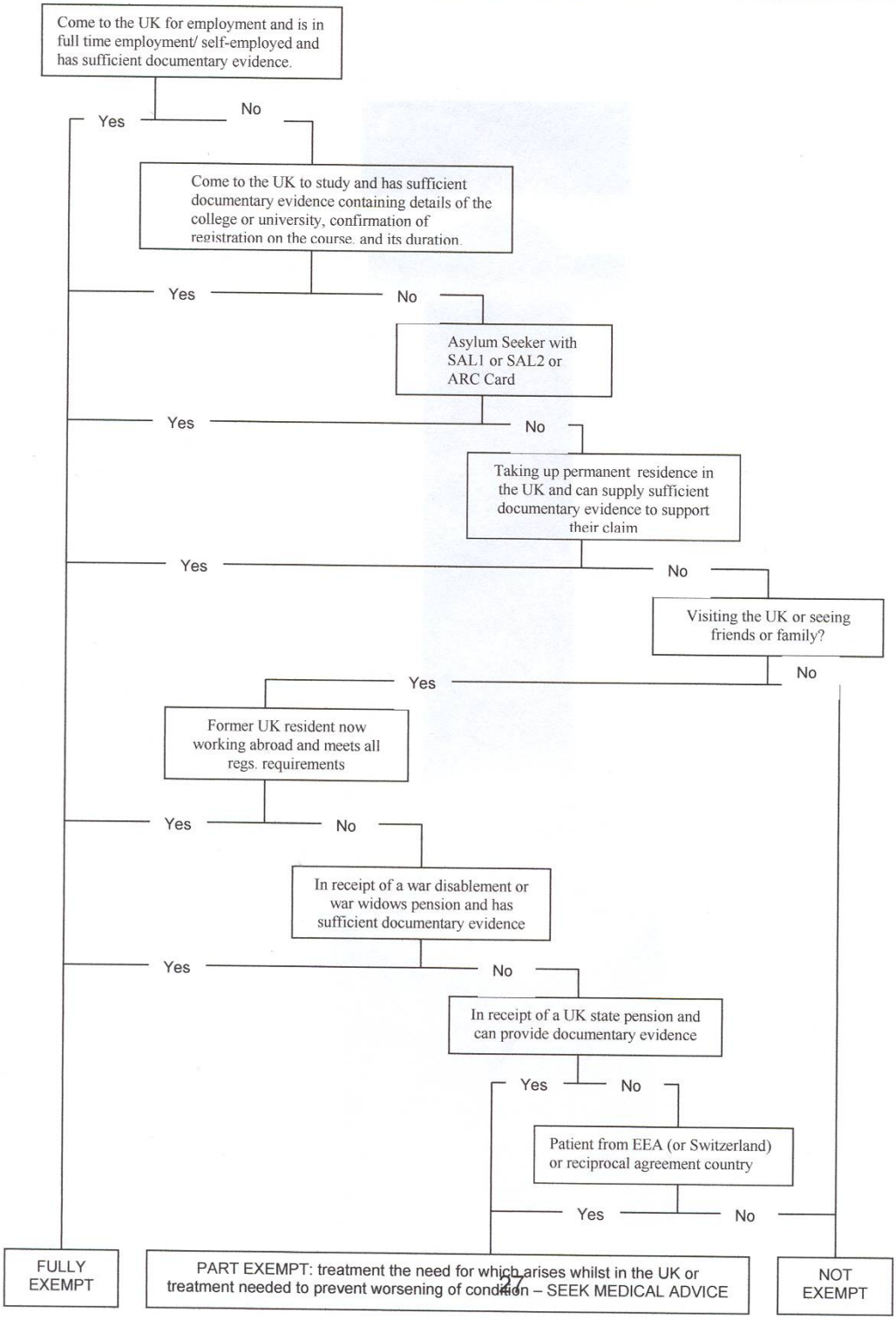
- Trusts need to make a judgement as to whether a patient is ordinarily resident in the light of the circumstances of that individual patient. For example a person coming to the UK to undertake a course of study at a recognised university will have an identifiable purpose for his/her visit. The trust then needs to decide if the course will last long enough to be properly described as settled. In the past the Department of Health has recommended that six months should be used as a yardstick in these cases but it is important to realise that this is only a guideline.

- The question of ordinarily resident status is the first and most fundamental issue to resolve, because if a patient is classed as ordinarily resident then the charging regulations do not come into play, even if the patient has only been in the UK for a few days or weeks. The Secretary of State has no powers, to charge for NHS treatment, someone who is ordinarily resident in the UK.

- Having established that the patient is not ordinarily a resident in the UK the interviewer then needs to establish if he or she can be exempted from charges because they fall into one of the categories for exemption listed in the regulations, for example a person claiming to be from a country of the EEA or Switzerland or any non-EEA country with which we have a reciprocal healthcare agreement.

When a patient claims to be covered by one of the exempt categories, or claims to be ordinarily resident, the trust is entitled, in the regulations to "make such enquiries as it is satisfied are reasonable in all the circumstances" in other words to seek some supporting evidence for the patients claimed status. It is for the patient to satisfy the trust of their claim to free treatment and, where the patient cannot do so, the trust may take the decision to charge for treatment. The patient can claim reimbursement at a later date providing that sufficient evidence can be produced to show that he or she was entitled to free treatment at the time it was given.

WHY HAS THE PATIENT COME TO THE UK?



Acceptable Evidence

It should, wherever possible, be left to the patient to provide whatever evidence he or she thinks is appropriate to support their claim. Interviewers should not generally suggest types of evidence unless specifically asked to do so. In particular, automatically asking to see passports as a matter of routine should be avoided. Access to NHS services is through residence not nationality and interviewers should avoid questions relating to immigration status unless it is strictly relevant e.g. asylum seekers or those claiming to be from a country with which we hold a reciprocal healthcare agreement. Having said that, there will be times when a passport can provide useful evidence, in which case asking to see one would not be unreasonable. If a passport is produced as proof of evidence then the following should be checked:

* Date of entry into UK
* Visa
* Right of abode

A multi visa does not constitute a right to NHS treatment

DOCUMENTRY EVIDENCE

We will require a copy of your passport (including your visa)

The following list which is not exhaustive, lists some documents, which may be useful, and at least THREE items should be provided:-

- Council Tax Documents
- Local Authority Rent Book
- Mortgage Repayment Documents
- Cheque Guarantee Cards and Associated Cheque Book
- Paid Fuel or Telephone Bills
- Flight Tickets to the UK showing single and not return journey
- Bill of Lading for shipping of personal belongings
- Credit/Loan Agreements with UK firms
- School Registration
- Payslips
- Letter referring to TRANSFER OF Funds from previous country to UK
- Copies of correspondence between patient and the establishment in the previous country of residence showing that the patient will be moving to the UK on a certain date
- Application to the Home Office for Permanent Residency

Asylum Seekers and Refugees

If you are an Asylum Seeker or Refugee, you should be able to produce ONE of the items listed below:-

- A Travel Document which shows that it was issued in the UK in accordance with the Convention of Status of Refugees

- A Letter from the Home Office stating that the patient is a refugee or has been granted refugee status in the UK
- An Acknowledgement Letter from the Home Office confirming that the applicant has made application for asylum

Documents must be taken to the Main Reception at Russells Hall Hospital

In general, patients will be able to provide satisfactory documentary evidence e.g. pension details, letters from employers or colleges etc to support their claim. Where however the patient does not have the evidence to hand, an interviewer may be asked to either accept confirmation from a reputable third party e.g. a letter from a solicitor or, in some cases, to accept the word of the patient without supporting evidence. The level of evidence which is acceptable is entirely a matter for the trust in the light of the individual patient's circumstances. Providing the trust can demonstrate, if need be, that it has acted reasonably in **all** cases it is unlikely to encounter criticism.

There may be occasions where patients produce entry clearance documents that are not familiar to the Overseas Visitor team. In these cases the immigration and Nationality Directorate (IND) have provided a helpline (0208 253 6712). This service will provide trusts with advice on interpreting different types of entry visas and visa stamps. This service will not provide trusts with details of a specific individual's immigration status. Under no circumstances should any medical information be divulged.

In exceptional circumstances, when all other avenues of establishing entitlement have been exhausted, it may be necessary to establish the immigration status of a person who has been living in the country for **less than** 12 months. This might include establishing whether a failed asylum seeker has exhausted all their appeal processes, or cases where a hospital comes across a person who appears to be in the country without the proper authority. In these exceptional circumstances, enquiries about immigration status can be sent to the IND via a separate, secure fax number. It is vital that patient confidentiality is not breached, therefore, this service can only be used in cases where the patients permission has been obtained. Under no circumstances should any medical information be divulged. IND will endeavour to respond within 3 working days and replies will only be sent to a NHS secure fax number. Trusts can obtain the IND secure fax number by contacting the DH Overseas Visitors policy team on 0113 254 6438.

In cases where a patient refuses to give the Trust permission to contact IND and has not provided valid evidence to support their claim to free treatment a charge can be levied. However once they have been living in the country 12 months they will become exempt and charges from that point must cease.

Timeliness of interview

It is important that patients are aware as soon as possible that there may be a charge for treatment. Whilst it may not be practicable for interviews to happen immediately, the trust should make every effort to see potentially liable patients as soon as they possibly can. Failure to do so, resulting in an invoice being presented to a person who was not aware that they were liable could result in accusations of maladministration.

IGA FORMS PROCEDURE

The Trust needs to inform the Department of Health if they provide NHS services to a person exempt from charges under a number of exemption categories.

- if the patient is from an EEA Member state and Switzerland and treatment the need for which arose during their visit.

- if the patient is from an EEA member state and Switzerland and has been referred for treatment via an E112/E123 form. A copy of the E112/E123 form must be attached to the IGA.

- if the patient is from a Non – EEA bilateral healthcare agreement country and received treatment the need for which arose during their visit.

- if the patient is from Non –EEA bilateral healthcare agreement country and has been referred (including emergency referrals) by an overseas authority for treatment under special arrangements.

Notification is currently via both an Income Generation Audit (IGA) form, which is sent to Leeds Primary Care Trust and via Secondary Uses Service (SUS). It is important that both the IGA forms and SUS record continue to be completed. This information ensures that UK claims on other EEA member states and reciprocal health countries are at the correct level. If an IGA form is not completed it could affect the Trust's allocation.

Where a patient from the EEA or Switzerland (except Malta where a quota system is in operation) has come specifically for treatment, the valid E112/E123 should be sent with the IGA form to Leeds PCT (the period of entitlement on the E112/E123 should cover the date of treatment specified on the IGA form). If no E112/E123 has been received, then only treatment that is immediately necessary should be provided. If an E112/E123 is not provided with the IGA form, the activity will not be included in any re adjustment of PCT allocations.

The British overseas territories of Anguilla, the British Virgin Islands, Montserrat, St Helena and Turks and Caicos Islands can refer four patients each, per year, specifically for treatment. Referral arrangements are made through Leeds PCT.

IGA forms can be accessed via the Internet at
http://www.ingo.doh.gov.uk/finman.nsf>NHS Trust Detailed Guidance>Chapter22>

COMPLETION OF IGA FORM

A separate form must be completed for every admitted patient care spell, outpatient attendance or other service.

Where the form concerns treatment given under National Specialist Commissioning arrangements please annotate the form 'NSCAG' The total cost in box 1 will not need to be completed as the cost will be applied centrally. The NSCAG service should be entered in Box 5.

Where the form concerns treatment given to a patient who has come specifically for treatment from Malta or a British overseas territory the quota number should be included on the IGA form.

The Trust should follow Non Contract Activity (NCA) guidance. The gateway reference for 2006/07 is 6832. Under this guidance the Trust should invoice the host PCT and include the same cost on the IGA form in line with 'Payment by results arrangements'

In the case of referrals from Gibraltar and the Channel Islands, these are commissioned through Lambeth PCT. Referrals from the Isle of Man are commissioned through West Cheshire PCT. These PCT's hold allocations from the Department of Health, for meeting the costs of treating these referrals. The Trust should invoice the respective PCT depending upon where the patient came from. The same cost should be included on the IGA.

Completed IGA forms should be sent quarterly in line with NCA guidance to Leeds PCT.

IGA forms that are incomplete or incorrect will be returned from Leeds PCT. They should be resubmitted with the correct data within 4 weeks, otherwise the activity will not be included in any re adjustment of PCT allocations.

Request the patients CMDS from Information via e-mail – ensure to quote unit number of patient only. This is required, as HRG is needed to enable cost to be quoted on IGA form.

The following details must all be recorded on the IGA form before submission to Leeds PCT.

Box 1

- **Organisation(provider)code** – RNA
- **Provider Name** – Dudley Group of Hospitals NHS Trust
- **Host Commissioner Code** - 5PE
- **Host Commissioner Name** – Dudley PCT
- **Total Cost** – Please refer to HRG on CMDS and refer to current Private Patient tariff – **non-elective tariff**

Box 2

- **Local Patient Identifier** – This is the Patients Unit number
- **Patients Name –** please give as detailed on CMDS
- **Date of Birth** – please give as detailed on CMDS
- **Adult/Child** - please identify
- **Patients usual Address** – This must be the patients overseas address **NOT** the UK address where the patient is residing whilst in the UK

Box 3

- **Postcode of usual address** – From CMDS
- **Patients Nationality Code** – information available from CMDS

Box 4

- **Date of arrival in UK** – if information is available but this is not necessary
- **Admission Method code**
- **Was the patient referred by an overseas authority**
- **Quota number**
- **Exemption category code under which treatment was given**: Choose from one of the following:

- **Enter code 3fi** – if the patient is from an EEA Member state and Switzerland and treatment the need for which arose during their visit.

- **Enter code 3fii** – if the patient is from an EEA member state and Switzerland and has been referred for treatment via an E112/E123 form. A copy of the E112/E123 form must be attached to the IGA.

- **Enter code 3gi** – if the patient is from a Non – EEA bilateral healthcare agreement country and received treatment the need for which arose during their visit.

- **Enter code 3gii** – if the patient is from Non –EEA bilateral healthcare agreement country and has been referred (including emergency referrals) by an overseas authority for treatment under special arrangements.

Box 5

- **Admitted patient care spell or other service**
- **Start date and end date of treatment** – this information is recorded on the CMDS

Box 6

- **Additional information costs ie** critical care

Box 7

- **Outpatient attendance**

Contact details (staff member who completed the form)

All patient details need to be logged on the Overseas Activity IGA spreadsheet. You will locate the spreadsheet on W//Income: Overseas Activity: Overseas Activity, IGA claims

Once all the details are recorded on the IGA form please submit to:

Leeds Primary Care Trust
Overseas Visitors Section (Finance)
Sycamore Lodge
7a Woodhouse Cliff
Leeds
LS6 2HF

For general enquiries or advice on completing the IGA form:

Telephone: 0113 305 9790 or 0113 305 9795
Fax: 0113 305 9870

Email: Rachel.Haywood@leedspct.nhs.uk
Brian.Kaye@leedspct.nhs.uk

For general enquiries on bilateral healthcare agreements or E112/E123 forms contact:

Overseas Health Care
Department of Health
3rd Floor
Wellington House
133-155 Waterloo Road
London
SE1 8UG

Telephone: 0207 210 4850

Email: Dhmail@dh.gsi.gov.uk

Financial Matters

Patients charged under the regulations are **NHS CHARGED PATIENTS.** They should not be confused with private patients. Unlike private patients NHS charged patients are liable to pay for their treatment even where an undertaking to pay has not been obtained.

The treatment of NHS charged patients is subject to the same clinical priority as that of other NHS patients. The beds they occupy are not pay beds and consultants cannot charge them for their services. They should be charged the full cost of any drugs prescribed in hospital including HIV/AIDS drugs.

An overseas visitor exempt from charges is normally liable for other statutory NHS charges, such as those for prescriptions, on the same basis as a UK resident. However some charge exempt patients will also be exempt from statutory prescription charges, for example asylum seekers, and will be issued with a HC2 (certificate for full help with health costs)

However it is important to note that being in possession of an HC2 certificate does not exempt a patient from charges for hospital treatment. A patient should be assessed in accordance with the regulations and if found to be liable, charges will apply; this will include the full costs of HIV/AIDS drugs.

Charges

The Trust should recover the full cost of the treatment given to an overseas visitor. The cost should be the relevant **reference cost** registered by the Trust in its annual return to the Department of Health with an on cost of 8%.

Where the trust has treated a patient from an EEA country (and Switzerland) and non EEA country with which the UK holds a reciprocal healthcare agreement, it should complete an IGA form, using reference costs when calculating the actual cost to the Trust of providing the treatment.

Where following interview, a patient is found liable for charges the patient should be asked to pay in advance of receiving treatment or any further treatment (but if, in the opinion of medical staff, treatment is needed urgently it should go ahead without delay).

It is important that charge liable overseas visitors are identified as early as possible, in order to reduce the incidence of failure to pay and to protect NHS resources. The Trust will seek to obtain deposits equivalent to the estimated full cost of treatment in advance of providing any treatment. Any surplus which is paid, can be returned to the patient on completion of treatment.

Obtaining payment before treatment is given will reduce the amount of money the trust has to seek to recover and will ultimately reduce the amounts which are written – off as irrecoverable.

If the patient is liable for charges, explain the procedure and the charges to the patient or the accompanying person.

The patient can be notified of the fee and pay before they leave the hospital, or prior to treatment.

If the Trust provides treatment prior to payment being made, although it is not mandatory, it may be helpful in recovery of the debt, to ask the patient to sign an agreement to pay form. It is essential that the patient's overseas address be obtained.

If the patient has medical insurance the Trust will invoice the patient and not the insurance company. Although, it is advisable to retain all the insurance detail for future reference.

If the patient is in possession of an HC2 certificate it does not exempt them from charges for hospital treatment. A patient should be assessed in accordance with the regulations and if found to be liable charges will apply.

An invoice should be raised and given to the patient on the day of discharge when it should be handed to the patient. Arrangements for payment should also be made at this time. Out patients will be invoiced on the day of treatment. Invoices are due for payment within 14 days.

If urgent coding is required to ensure an invoice is raised promptly – contact Sue Levitt ext 2277

HRG grouper software will be available in the General Office to assist in coding for an invoice being raised.

If the patient has no funds to pay either by credit card or cash, an instalment plan can be set up. A letter would be sent out to confirm amounts and due date . Should they default on this plan they will automatically be referred to CCI Legal recovery agents for full recovery of monies due.

CCI would need to be supplied with the following details:

- Patient U/R number
- Copy of interview sheet
- Copy of Agreement to pay
- Details of patients length of stay in UK

Invoice procedure - current year

The invoice is raised on SLS Company 4 and the charge to the patient is coded to

A X INCM 000 4035 00 Cr
A X 9987 002 9750 00 Dr

Due to the risk of non payment the outstanding debt is immediately journalled to the overseas bad debt provision:

A X DGOH 000 3328 00 Dr
A X 9987 000 9780 04 Cr (Overseas bad debt provision)

The value of the debt is entered onto the overseas bad debt provision spreadsheet, which will be reconciled to the balance on the ledger.

If the invoice is written off due to non payment at a later date, the detail is entered onto a write off memo and submitted to the Finance Director (if over £500) or the Financial Services Manager (if under £500)

Once the write off has been approved, a credit is raised against the invoice but it is coded to:

A X 9987 000 9780 04 Dr (Overseas bad debt provision)
A X 9987 002 9750 00 Cr

If further investigation confirms the patient is exempt from charges, the following codes are used:

A X 9987 002 9750 00 Cr
A R INCM 000 4035 00 Dr

A journal is also completed tp reverse out the bad debt provision

A X 9987 000 9780 04 Dr
A X DGOH 000 3328 00 Cr

The Overseas bad debt provision spreadsheet is updated to reflect the write off or credit of the debt.

Prior Year Invoices

If a prior year invoice is paid the following journal is required:

A X 9987 000 9780 04 Dr
A X DGOH 000 3328 00 Cr

An invoice written off is cleared by a credit note being coded to

A X 9987 000 9780 04 Dr
A X 9987 002 9750 00 Cr

assuming that it was coded to bad debt provision in the financial year it was raised.

If not coded to bad debt provision then the code to charge is

A X 9987 000 9777 03 Dr

If further investigation confirms the patient is exempt from charges, the following codes are used:

A X 9987 002 9750 00 Cr
A X 9987 000 9780 04 Dr

(see below)

Overseas Transactions – Current Year

	Invoices	Bad Debt	W/Offs	Paid	Credit Notes
Debtors Control AX 9987 002 9750 00 Inc prior year debt = Co. 4 Sales Ledger	DR Automatically Done		CR Automatically Done	CR Automatically Done	CR Automatically Done
Income AR INCM 000 4035 00 No prior year transactions	CR				DR
Bad Debt Prov'n AX 9987 000 9780 04 Inc prior year debt = Co. 4 Sales Ledger		CR (JV 27)	DR	DR (JV 27)	DR (JV 27)
DGOH Prov'n AX DGOH 000 3328 00 No prior year transactions		DR (JV 27)		CR (JV 27)	CR (JV 27)
Bank				DR Automatically Done	

Overseas Transactions – Prior year

	Invoices	Bad Debt	W/Offs	Paid	Credit Notes
Debtors Control AX 9987 002 9750 00 Inc prior year debt = Co. 4 Sales Ledger			**CR** Automatically Done	**CR** Automatically Done	**CR** Automatically Done
Income AR INCM 000 4035 00 No prior year transactions					
Bad Debt Prov'n AX 9987 000 9780 04 Inc prior year debt = Co. 4 Sales Ledger			**DR**	**DR** (JV 27)	**DR**
DGOH Prov'n AX DGOH 000 3328 00 No prior year transactions				**CR** (JV 27)	
Bank				**DR** Automatically Done	
Credits not taken AX 9987 000 9777 03 Only for prior year not on bad debt prov'n.			DR		

Methods of payment

The Trust can accept payment by cash, cheque (sterling), debit or credit card. Should the cheque not be honoured the debt will be pursued by the debt recovery procedures if necessary. There may be cases where patients cannot pay in advance of receiving treatment but offer some form of guarantee that their costs will be met by a third party. e.g. patients with travel healthcare insurance or patients being sponsored by an employer or government. The Trust would decide whether to accept the risk of providing treatment in advance of receiving payment.

In all cases, the patient remains liable for the cost of treatment. It is advisable for the patient to pay the Trust directly and recover the cost themselves from the third party. This will minimise the risk to the Trust in respect of fluctuating exchange rates.

Deceased Patients

The patient is solely liable for the debt. Therefore where a patient dies without making or completing payment to the Trust, no one else becomes liable for that debt. The Trust will attempt to seek repayment from the patient's estate, if possible but otherwise the debt will need to be written off. An offer from relatives or another person to meet the debt can be accepted but should not be actively sought.

Writing off Overseas debt

Reasonable measures must be taken to pursue overseas patient's debt. The Trust will employ the services of a Debt recovery agent that has expertise in collection of overseas debt.
In cases where the debt is considered to be irrecoverable then the Trust will write off the debt.

Appendix 7

The Dudley Group of Hospitals NHS Trust

Overseas Visitor Interview

Section A

Notified in General Office by……on……..
(Possible Overseas Visitor)

Interviewed by……Date:……..

Surname: ……. Consultant: ……

Name: ……. Unit No: ……

Date of Birth: ……. Passport No: ……..

UK Address: …….. Overseas Address: …….
…….. ……..
……. ……
…….. ……

Tel No: …… Tel No: …….

Mobile No: ……..

Base Line Question:-

Where have you lived for the past 12 months? And can you show that you have the right to live here?

……...

Section B

Base line Questions continued:-

Q1. Are you seeking Asylum in the UK? ……

YES ☐ Home office ARC Card No: ……
NO ☐

Q2. Can you prove you have the right to live here? ***Please refer to details overleaf***

Evidence Yes ☐
No ☐

Q3. What date did you arrive in the UK? ……

Q4. What country have you travelled from? ……...

Q5. What is the purpose of your visit to the UK? ……...

Additional Information:- …….

……..
……..

Examples of Evidence of Residence

- Housing Contract
- Utility Bills
- Bank Statement
- Wage slip

Examples of Evidence of Rights of Residence

- Birth Certificate
- Passport
- Entry Clearance Documents
- Ancestral Visa

NOTE:

If these documents are seen at the time of interview the patient **WILL BE EXEMPT** from Charges.

Documents seen By: …….
(Print Name)

Signed: …… Date: ……..

Enclosure 5

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Trust Board of 31st January 2008**

Report of: **Director of Finance & Information**

Subject: **Amendment to Standing Financial Instructions, (SFI's), Authorised Limits**

Introduction

The Board approved existing authorised limits in October 2006.
Further to review, a change to the authorised limits is proposed.

Schedule of Authorised Limits

In order to make more effective use of management resource, and overcome ordering inefficiencies the following amendment to the Schedule of Authorised Limits is proposed:-

- **Revenue Expenditure (including revenue requisitions, travel, removals and study documentation)**

  Theatre Specialty Managers to be increased from the £1,000 limit to £2,500.

Recommendation

Members are asked to approve this change to the Schedule of Authorised Limits.

Members will be asked to approve and adopt new Standing Orders and SFI's prior to FT status.

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Audit Committee 15th January 2008**

Report of: **Director of Finance and Information**

Subject: **Amendment to Standing Financial Instructions (SFI's), Authorised limits.**

1.0 Pharmacy Procurement Services

1.1 Introduction

In order for the pharmacy department to obtain value for money through the procurement process, commitments are made on future 12 months drugs usage. These agreements are through nationally and regionally PASA agreed contracts and give 'discount for bulk' savings.

It is necessary to ensure that savings are still maximised but that authorised limits are adhered to and sufficient checks and balances are built into the system.

1.2 Proposal

The contract negotiations and purchasing commitments are made by Principal Pharmacist (Procurement Lead). These commitments are based on usage for the previous 12 months plus any knowledge about likely changes in practice. The contracts are usually for a 12 month period and can be up to £200,000 in value. A revised system is required but it must ensure that there are no unnecessary delays, resulting in loss of best price and discounts. The proposal is: -

- That the Head of Pharmacy Services and Principal Pharmacist (Procurement Lead) have authorisation to enter into regionally and nationally agreed PASA contracts up to a value of £200,000 and for a one year period only.
- That for each contract the Head of Pharmacy Services will provide details to the Director of Finance & Information and Operations Director on the contract price, basis of the commitment (including previous use) and highlighting any risks.
- That the Head of Pharmacy will provide monitoring reports to the Drugs and Therapeutic Committee.
- That the Head of Pharmacy provides an quarterly report to the Finance and Performance committee, detailing contracts, usage, savings and risks.

1.3 **Recommendation**

Members are asked to approve the changes to the authorised limits and the proposed monitoring arrangements.

PAA/EW/AJF
9.1.08

APPENDIX

SCHEDULE OF AUTHORISED LIMITS

			£
Limit on single signatory payments	-	To third parties (inc. Charitable Funds)	10,000
	-	To obtain cash	1,500
Petty cash limit	-	Reimbursement of patients monies (inc. payments to relatives of deceased patients)	100
	-	All other payments	50
Level above which competitive quotations should be sought			5,000
Level above which competitive tendering should be undertaken			50,000
Level up to which competitive tendering process may be waived by approval of Chief Executive or Finance Director			100,000
Level above which a Non-Executive Director should be present at tender opening			150,000
Level above which tender evaluation should include:			
(i)		Executive Director (i.e. whether "voting" or not)	150,000
(ii)		Non-Executive Director	400,000
Level above which contract award must be approved by board			200,000
Level above which building/engineering contracts should be executed under seal			50,000
Limit of authority to approve write-offs:			
(i)		Financial Services Manager	500
(ii)		Director of Finance & Information	1,000

Revenue Budget Requisitions:

Lead Nurses/Midwives/Managers Deputy Medical Head of Service – Ambulatory Deputy Medical Head of Service – Anaesthetics/Critical Care/Theatres	up to	1,000
Theatre Specialty Managers	up to	2,000
Programme Director – Enterprise Business Support Managers Manager – Wheelchair Service Head of Technical Services – Cardiology Pharmacists – DRUGS ONLY	up to	5,000
Medical Head of Service Matrons Developments Manager Head of IT	up to	7,500
Associate Nursing Director – Operations Associate Medical Directors – Operations Associate Director – Performance Delivery Associate Director – Professional Clinical Services Head of Service – Professional Clinical Services (x2) Laboratory Managers (x5) Radiology Manager Principal Pharmacists (x4) – DRUGS ONLY	up to	15,000
Head of Pharmacy	up to	30,000
Director of Human Resources Nursing Director Director of Corporate Development Medical Director Operations Director	up to	50,000

SCHEDULE OF AUTHORISED LIMITS CONTINUED

Chief Executive Finance Director		over	50,000
Head of Pharmacy/Principal Pharmacists (Procurement Lead) authorisation to enter into regionally and nationally agreed PASA contracts of up to one year, with monitoring conditions		up to	200,000

NOTE: Immediate Line Manager required to sign in postholders absence

Variations to Project Agreement with Private Finance Partner:

Operations Director	Annual Recurrent	up to	50,000
	Non Recurrent	up to	250,000
Chief Executive Finance Director	Annual Recurrent	up to	150,000
	Non Recurrent	up to	500,000
Full Board	Annual Recurrent	over	150,000
	Non Recurrent	over	500,000

Capital Budget Requisitions:

Developments Manager	up to	25,000
Operations Director	up to	200,000
Chief Executive Finance Director	over	200,000

Business Case Approval:

Full Board	Annual Recurrent/Income Impact	over	150,000
	Non Recurrent	over	500,000

NOTE: In respect of capital schemes these will need to have been included in the Capital Programme approved by the Board and the revenue consequence having been agreed by the Directorate

Charitable Funds – approvals and requisitions:

All Funds

Medical Head of Service Matrons		up to	1,000
All Directors		up to	5,000
Chief Executive Finance Director	countersigned by Treasury Manager/Income Manager	up to	50,000
Full Board		over	50,000

Note: **Countersignature of Treasury Manager is required to confirm availability of funding. (Financial Controller or Income Manager to sign in postholder absence)**

Enclosure 6

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **Trust Board January 31st 2008**

Report of: **The nursing director**

Subject: **Quality of Care – Food and Nutrition**

Summary

The purpose of the paper is

- to inform the Trust Board of
  - The Trust's Nutrition Steering Group work and progress in implementing NICE guidelines on nutrition support (2006), the DOH action plan on 'Improving Nutritional care' and the NPSA 10 key characteristics of nutritional care.
  - The actions taken and further actions required regarding the above.
- To consider the following recommended actions
  - To receive the paper for information with regard to the actions taken
  - Consider formally signing up to the Council of Europe Alliance 10 key characteristics of good nutritional care in hospital
  - Consider nominating a Non Executive to lead in nutritional care
- To give their view on whether nutrition should be part of mandatory training.
- To provide the Board with information on the Protected mealtimes and Red tray initiatives see Appendix 1

Background

Nationally, the last two years has seen a growing focus on the nutritional care of patients in hospital with many reports and surveys indicating many shortfalls across the country. In February 2006, the NICE clinical guideline on nutrition support in adults was published, which covers the care of patients with malnutrition or at risk of malnutrition. This was followed by the Age Concern report 'Hungry in Hospital' in August 2006. More recently, the DoH has taken up the challenge of improving services as part of the dignity and respect agenda. The 'Council of Europe Alliance' was set up by the British Dietetic Association and the Hospital Caterers association, to implement the recommendations on food and nutritional care made by the council of Europe in its 2003 resolution.

At the beginning of October 2007, the NPSA published data on patient safety incidents relating to nutrition and hydration in hospital. During the same month, the Council of Europe Alliance launched its '10 key characteristics of good nutritional care'. Later in October, the DoH, in conjunction with the Nutrition Summit 25 stakeholders published an action plan 'Improving Nutritional Care'.

Following the publication of the NICE guideline in 2006, the Trust set up a Nutrition Steering Group, a multidisciplinary group of staff, which also includes staff from Interserve and chaired by Dr BJM Jones. This was an extension of the existing Trust Nutrition Team. Both the team and the Group have undertaken many actions to work towards compliance with the NICE Guideline and to improve nutritional care generally across the Trust.

The Group has now reviewed both the 10 key characteristics of nutritional care and the relevant actions for Acute Trusts from the DoH Action Plan. The purpose of this report is to summarise what actions have already been taken to comply with these and what further actions are needed to fully achieve the recommendations in both these reports. The required actions need to be undertaken by a wide variety of staff, co-ordinated by the Nutrition Steering Group. The support of the Integrated Governance Committee and Trust Board are requested with the Board being asked to especially consider and make a decision on the 'Actions to be Taken' in bold.

Issues for Consideration

A. '10 key characteristics of good nutritional care'

1a. All patients are screened on admission to identify the patients who are malnourished or at risk of becoming malnourished. All patients are re-screened weekly.

Actions Taken:
MUST tool piloted in a number of areas, training provided to staff in all areas and then officially launched in Feb 2007 with publicity and posters Audit in Oct 2007 in in-patient areas indicated 35.6% of patients being assessed Trust took part in National BAPEN screening audit in September 2007. This has shown that 28% of new admissions to 372 hospitals in England, Scotland, Wales and NI were undernourished. Local results are awaited. MUST included as part of the Trust admission documentation.
Further actions to be taken:
Dieticians to review practice on wards with poorest results Audit of outpatient areas planned Results of in-patient audit to be disseminated to all Matrons and lead nurses MUST to be included in all nutrition training sessions with nursing and medical staff

2a. All patients have a care plan which identifies their nutritional care needs and how they are to be met.

Actions Taken:
Care plans are produced but not in a systematic way based on MUST score – these also need to include to include reference to red tray guidelines and food charts

Further actions to be taken: Agree a standard nutrition care plan for the Trust based on MUST scoring

3a. The hospital includes specific guidance on food services and nutritional care in its Clinical Governance arrangements.

Actions Taken: Nutrition Steering Group established and reports to Patient Safety Group Trust policy on nutritional assessment agreed
Further actions to be taken: None

4a. Patients are involved in the planning and monitoring arrangements for food service provision.

Actions Taken: Focus group on Nutrition organized in Feb 2007 (with PALS) Dietician attended PPI Forum in 2007 Catering co-ordinator visits approx. 3 wards per day to talk to ward staff/patients and to generally monitor food service Catering Department undertake surveys Liaison with Age Concern, Coeliac Society Patient involvement in QPDTs e.g. Stroke Comment Cards and Complaints re. nutrition/food analysed. Comment cards responded to individually
Further actions to be taken: All complaints and comments re. food/nutrition to be reviewed by Nutrition Steering Group For new menus being reviewed (see 7a. below), focus groups will be established so there is patient input.

5a. The ward implements Protected Mealtimes to provide an environment conducive to patients enjoying and being able to eat their food.

Actions Taken: Implemented for lunchtime meals in all in-patient areas except maternity, paediatrics and critical care areas Audit undertaken in October 2007 – results being collated
Further actions to be taken: Awaiting outcome of audit Look to implementing in remaining areas, as appropriate. Principles have been adopted in these areas but not fully implemented. New posters to be distributed throughout hospital Re-training of Older Peoples and Essence of Care champions

6a. All staff have the appropriate skills and competencies needed to ensure that patient's nutritional needs are met. All staff receive regular training on nutritional care and management.

Actions Taken:
All areas have 'Champions' and nutrition and MUST included in training Two catering managers have achieved CIEH Nutritional Competency Level 2 and are CIEH professional trainers Nutrition included in a variety of training e.g. HCSWs, New Nurses Volunteers trained in feeding patients Catering managers and dieticians undertake joint training Protected mealtime training in all staff development programmes and student nurse inductions
Further actions to be taken:
Champions training on Nutrition to be repeated in 2008 Dieticians to review training with facilitators for SWs, new nurses, nurse development programmes and junior doctors All housekeepers are to be trained in basic nutrition during a 12 month programme in 2008

7a. Hospital facilities are designed to be flexible and patient centred with the aim of providing and delivering an excellent experience of food service and nutritional care 24 hours a day, every day.

Actions Taken:	
Kitchens at ward level – bespoke to each ward with 24/7 access	
Snack Boxes available in all areas	
24/7 restaurant	Restaurant has 'Healthy Eating Award'
Help Desk Facility	Review undertaken and purchase of weighing scales in all areas
Further actions to be taken:	
Full review of hospital menus commencing in Dec 07 – to be fully operational in April 08	

8a. The hospital has a policy for food service and nutritional care which is patient centred and performance managed in line with home country governance frameworks.

Actions Taken:
Trust reviewed by PEAT and HCC as per framework for England
Further actions to be taken:
None

9a. Food service and nutritional care is delivered to the patient safely.

Actions Taken:
Review of complaints and incidents undertaken Nutritional elements included in yearly QCR (Quality of Care Review) of all wards/departments Assessed by EHO regularly and last visit in Dec 07 received score of 4* (top score is 5) Interserve has its own Food Safety Advisor who audits the Dudley policies/procedures every 3

years
Further actions to be taken: None

10a. The hospital supports a multi-disciplinary approach to nutritional care and values the contribution of all staff groups working in partnership with patients and users.

Actions Taken: Nutritional Team and Steering Group in place Nutritional Steering Group has PCT representation
Further actions to be taken: None

B. NHS trust actions in DoH Action Plan – Improving Nutritional Care

1b. Make use of nutritional screening tools (eg BAPEN's 'MUST' tool) to assess service users' nutritional needs, their overall state of health and what they might require in terms of nutrition support, whether that is assistance with eating and drinking, modified diets, supplements or tube feeding. NICE guidelines should be followed (**Nutrition support for adults**, February 2006), which state that all people should be screened on admission to hospital as an inpatient and for all outpatients at their first appointment. There should be repeat screening where there is clinical concern.

Actions Taken: See 1a above
Further actions to be taken: See 1a above

2b. Consider signing up to the Council of Europe Alliance (UK)'s *10 key characteristics of good nutritional care in hospitals* (**www.bda.uk.com/www.bapen.org.uk**).

Actions Taken: Assessment of these undertaken by Nutrtional Steering Group – see above
Further actions to be taken: **Trust Board asked to sign the Trust up to these and to publicise this.**

3b. Ensure that appropriate structures are in place to deliver nutritional care. Trusts might wish to consider organising this via a nutrition steering group and/or a nutrition support team.

Actions Taken: Both team and steering Group in place
Further actions to be taken: None

4b. Champion nutritional care at board level. The board should ensure that it has access to regular up-to-date information on nutritional care within the trust, including the views of service users and complaints relating to that care.

Actions Taken: Nutritional Steering Group reports to Patient Safety Group twice a year and so reports on progress are taken to Board six monthly
Further actions to be taken: **Trust Board asked to nominate a non-executive director to lead on Nutrition** Service User comments, results of surveys and complaints included in six monthly reports

5b. Set aside training time for staff to complete the NHS core learning module on nutritional care and assistance with eating.

Actions Taken: *(Core learning module not available at present)*
Further actions to be taken: Trust Nutrition Steering Group will review Core learning module when it is available **Trust board asked to consider Nutrition as part of Mandatory training**

6b. Use the information, guidance, toolkits and best practice in the 'mealtimes' section of the **Dignity in Care online practice guide***.*

Actions Taken: Principles adopted into Older People champion training programme health promotion day in Nov 07
Further actions to be taken: Health promotion notice boards being developed by champions focusing on nutrition and 'Water for Health'

7b. Seek and act on feedback from service users on nutritional issues and their experiences of mealtimes while in hospital and use this to inform declarations of compliance with standards.

Actions Taken: See 4a above
Further actions to be taken: See 4a above

8b. Review discharge procedures to ensure that whatever accommodation an older person is returning to (e.g. own home or sheltered housing) appropriate arrangements are in place to ensure continuity of nutritional care.

Actions Taken: Individual discharge plans drawn up Dieticians involved as appropriate
Further actions to be taken: None required

9b.Work with voluntary sector organisations and community care services to consider how you can provide additional assistance with eating to those who need it, for instance by using trained volunteers to help at mealtimes.

Actions Taken: Focus Group organized in 2007 Liaison with Age Concern, Coeliac Society Community representation on Nutrition Steering Group
Further actions to be taken: Training input from Acute Trust agreed for Community staff – commencement in 2008

- **To Board is asked to**
  - **To receive the paper for information with regard to the actions taken and the position with regard to protected mealtimes and red tray initiatives**
  - **Consider formally signing up to the Council of Europe Alliance 10 key characteristics of good nutritional care in hospital**
  - **Consider nominating a Non Executive to lead in nutritional care**
- **To give their view on whether nutrition should be part of mandatory training.**
- **To determine when further reports are required on nutrition**

Ann Close
Nursing director
Wednesday 20th January 2008

Appendix 1

Dudley group of Hospitals NHS Trust
Protected Mealtimes and Red Tray Audit October 2007

Report completed by Karen Day, Nursing Practice Development Coordinator Jan 2008

In May 2007 the Trust introduced Protected Mealtimes (lunchtime) and the Red Tray system to all adult inpatient areas. The initiative was to form part of a plan by the Trust nutrition steering group to meet DOH recommendations around patient nutrition. The audit was carried out by the dietetic department during an unannounced lunchtime visit at the end of October 2007.

WARD	NUMBER OF PATIENTS AT TIME OF AUDIT	NUMBER OF RN ON DUTY	NUMBER OF CSW ON DUTY	IS THE WARD FULLY STAFFED	WHO COORDINATES THE MEAL SERVICE
A1	19	4	2	no	CSW
A2	42	4	6	yes	Not allocated
A2 (STROKE)	28	2	5	yes	SN & CSW
A4	11	2	1	no	House keeper & CSW
B2	48	4	6	yes	Not allocated
B3	44	4	3	no	House keeper & CSW
B4	44	5	4	yes	HCA
B5	34	5	1	no	House keeper & CSW
B6	15	3	2	yes	CSW
C1	47	4	4	yes	Not allocated
C3	52	4	6	yes	Not allocated
C4	21	3	2	no	CSW
C5	46	5	3	no	House keeper

C6	32	4	1	no	House keeper & CSW
C7	36	4	3	yes	House keeper
EAU	22	5	2	no	SN
MHDU	5	3	1	yes	CSW

The audit identified the following factors:

- *Of the 17 wards audited:*

- 47% offered hand wipes to patients to utilise prior to their lunchtime meal
- 70% of areas checked the amount of food eaten by patients at the end of the meal
- 53% of areas documented the patients food intake
- 88% of areas had implemented Protected mealtimes (1 of the areas audited utilizes the principles of PM but are unable to implement completely due to the nature of the patient care)
- 82% of areas had implemented the Red Tray system
- 58% of areas had inappropriate items on the patients meal table (e.g. urine bottles, clean vomit bowls, used tissues)
- 4 areas had additional activity during the mealtime (Doctors in 4 areas- noted as appropriate for patients needs; Cleaning in progress in 2 areas)

Areas of good practice identified:

- Continued implementation of Protected Mealtimes and Red Tray initiative
- Use of folder to monitor patients weight
- Good use of hand wipes
- Hostesses took and active part in the mealtime, assisting patients to make meal choices
- All patients received hot meal choice
- Meals placed appropriately within patients reach, appropriate assistance given (only 1 exception)
- Evidence of multi disciplinary working at lunchtime

- Staff noted to ask individuals politely to leave the ward in preparation for the protected mealtime
- Staff noted to ask hostesses for extra meals where choice not available
- Mealtime appeared organized and peaceful
- Patients were asked position they would like to be at to eat
- CSW's checked with Staff Nurses with regard to special dietary requirements
- Staff identified as 'red tray supervisors' , to fulfill this role

Challenges:

- Patients in barrier nurse side rooms- served separately by ward staff
- Re-educate staff with regard to appropriate use of Red Trays
- Drug round sometimes in progress at mealtime
- Cleaning staff reminded not to clean in the area whilst meal in progress
- Some Doctors chose not to leave during the protected mealtime despite requests from nursing staff

Recommendations:

- Further staff training around principles of Protected Mealtimes and Red Tray, including medical staff. (Already included in qualified nursing staff and CSW development programmes and pre-registration nursing induction)
- Ensure that food intake is documented in patients notes/charts where appropriate (in conjunction with MUST assessment)
- Matrons, Lead Nurses and Essence of Care/Older Peoples Champions to ensure that hand wipes are used at all mealtimes
- Matrons & Lead Nurses and Essence of Care/Older Peoples Champions to ensure that inappropriate items are removed from patient tables at mealtimes
- Liaise with Interserve regarding lunchtime cleaning

Enclosure 7

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board 31st January 2008**

Report by: **The Head of Midwifery**

Subject: **Health Care Commission Maternity Survey**

Summary

The purpose of this paper is to provide the Board with a more detailed action plan to make improvements to maternity service provision following the Healthcare commission survey of maternity patients during the summer of 2007.

The Board is asked to

- Approve the action plan
- Indicate when a progress report is required

Background

The Healthcare commission required all Trusts with maternity services to undertake a survey during the summer of 2007.
An initial report of the findings for this Trust was presented to the Board in August 2007 and a request made for a more detailed action plan to be brought to its attention when available.

- The initial report is attached at appendix 1
- The action plan is attached at Appendix 2
- The report Women's experiences of maternity care in the NHS in England is attached at Appendix 3

Issues for consideration

Overall women using our maternity services found it to be a positive experience. In particular the positive finding were:

Antenatal	Good continuity of care - seeing the same Midwife every time
	Being able to telephone the Midwife directly
	Antenatal clinics are accessible; there are enough clinics Available running at convenient times and partners are able to attend
Postnatal	Ward is clean
	Toilets and bathrooms are clean
	Women are treated with kindness and understanding

The action plan covers the following 5 areas to address the perceptions of mothers.

- Not given a choice of where to have the baby
- Not given a choice of home birth
- Not given choice about who carried the check up
- Not given a choice of where to have antenatal care
- Not given advice about contraception

Recommendation

The Board is asked to

- **Approve the action plan**
- **Indicate when a progress report is required to be submitted to the Trust Board**

APPENDIX 1

Health Care Commission Survey of Maternity Services 2007

As part of a national survey of maternity services by the Health Care Commission, an audit of women delivered with Maternity Units in the month of May 2007 was commissioned and undertaken by Picker. The initial findings of this audit have been reported to Trusts and the results of the survey are expected to be published in mid August 2007.

The results for Dudley maternity services are very favourable, with many scores being better than the average. The table below demonstrates both the excellent results and results were below average scores were achieved, with comments to explain the issues. A formal action plan will be developed on receipt of the final results from the auditors.

Question	Score	Average	Comment
B5+ Not given a choice of where to have baby	29%	18%	Choice is routinely offered to all women who live in Dudley during the early stages of pregnancy, usually at the first antenatal contact. This includes the option for home birth; however, historically most women residing in Dudley choose to deliver at the maternity unit within the Borough. Women who reside outside Dudley Borough who delivered at RHH and responded to this questionnaire may, however, have not been offered the choice option by their community midwife.
B6+ Not given a choice of home birth	54%	40%	It is standard practice for Dudley community midwives to provide information about having a home birth to all women who are risk assessed as suitable or who choose home birth. In Dudley the number of women having a home birth has increased in the last year by almost 25%. Women who live outside the Dudley area will receive their initial antenatal care from other Community midwifery teams, before they come to RHH to have their baby, and we are not sure whether offering a home birth is standard for other Community teams.
B10 Not given a choice of where to have antenatal	78%	72%	A choice of place for antenatal check ups is not routinely, offered.

Question	Score	Average	Comment
			Most women have their check ups with the Midwife at their GP Practice, however, at least 1 home visit is provided at home, usually this is the booking visit at around 12-14 weeks of pregnancy or a visit at 34 weeks of pregnancy. If a woman has chosen a home birth she is normally seen by the Midwife at home throughout her pregnancy. If women find difficulty accessing antenatal care, a service at home will be provided. For those GP practices that don't have a Midwife to provide antenatal care, women can either have checks ups at the home or in the hospital antenatal clinic area. We are currently developing services within Children's Centres where health care provision is available (centres run by the local authority in recognised areas of deprivation).
B12 Not given choice about who carries out the check up	85%	79%	In Dudley we aim to provide 75% of antenatal care by a named Midwife throughout a pregnancy. Most GPs in Dudley do not provide direct antenatal care. Women, who have no clinical indication for a consultant referral, but who request this, are normally provided with a single consultation appointment. Woman who request a change to their named midwife are given this option. This problem score can be seen as contradictory in the sense that the next question B13+ shows that DGoH is better than the average at providing consistent care for pregnant women.
H8 Not given advice about Contraception.	16%	8%	We are currently looking at developing our postnatal packs to include information about contraception, this is in consultation with the Dudley family planning service. Community Midwives are also encouraged to discuss family planning on their final postnatal visit.

The positives to come out of the survey are as follows:

Antenatal	-	Good continuity of care - seeing the same Midwife every time
	-	Being able to telephone the Midwife directly
	-	Antenatal clinics are accessible; there are enough clinics available running at convenient times and partners are able to attend.
Postnatal	-	Ward is clean
	-	Toilets and bathrooms are clean
	-	Women are treated with kindness and understanding

August 2007

APPENDIX 2

The Dudley Group of Hospitals NHS
NHS Trust

HCC National Maternity Survey 2007
Action plan response to women's experience of maternity care in the NHS - survey findings 2007

Identified Issue	Objective/Goal	Work Needed	Timescale	Responsibility	Monitoring	Link with other work
1. B5+ Not given a choice of where to have baby	Improve women's perception and understanding of the choices offered	Review 'Choices' leaflet given to all women at booking Ensure midwives discuss and record choice options	April 2008 March 2008	A Batty/G Cheadle Lead CMW/Lead MW Mat OPD	Lead CMW meeting/ Antenatal QPDT	Documentation Group
2. B6+ Not given a choice of home birth	Ensure women are provided with the information for choice of place of birth	As point 1 Ensure all midwives continue to provide written homebirth information Continue to ensure mw attend homebirth workshop updates Ensure non-Dudley resident women are appropriately referred to a CMW when they request home birth	March 2008 Ongoing March 2008	Lead CMW Lead CMW/A Hackett Lead MW Mat OPD	Lead CMW meeting Database Lead MW meeting	Mandatory training Cross-boarder meetings
4. B12 Not given choice about who carries out the check up	Ensure primary care provider is discussed with the woman	Continue to use clinical risk assessment to determine the most appropriate care Continue to discuss lead carer role with the woman and again consent for referral Continue to provide at least 75% of community care by the named midwife	Ongoing	Community MW/Lead CMW Community and hospital OPD MW Community MW/Lead CMW	Lead CMW meeting Audit	NICE AN care guidelines (2003) Maternity Matters (DOH 2007) SHA reducing perinatal mortality strategy (2005)
3. B10 Not given a choice of where to have antenatal	Ensure women are aware of any options of the place where care could be provided	Continue to develop services within Children's Centres Ensure women are provided care within the most appropriate setting for their needs Review midwifery caseloads and establishment to reflect additional services	Ongoing Ongoing April 2008	Lead CMW Lead CMW HOM/PCT	Lead CMW meeting Lead CMW meeting Clinical unit meeting/Lead CMW meeting	LIG meetings Children's Centre meetings SLA/Commissioning for community midwifery Maternity Matters (DOH 2007)

Identified Issue	Objective/Goal	Work Needed	Timescale	Responsibility	Monitoring	Link with other work
5. H8 Not given advice about Contraception.	Ensure women receive written information and have the opportunity to discuss contraceptive needs	Review documentation provided to women Ensure midwives have knowledge to provide appropriate information/sign-posting	Complete Ongoing	Lead MW/ Lead CMW/ A Hackett	Review /monitor postnatal information packs	Documentation Group Training needs Orientation for CMW
6. Disseminate action plan and the positive aspects of the survey	Ensure feedback on the action plan and the positive aspects of the survey is appropriately disseminated	Disseminate to staff through meetings and 'Chatter' newsletter Disseminate to users and the public	March 2008 March 2008	HOM/Matron/HOS HOM/Trust Communications	Clinical unit meeting	Staff meetings MSLC

NB: positive aspects reported as:

Antenatal
- Good continuity of care - seeing the same Midwife every time
- Being able to telephone the Midwife directly
- Antenatal clinics are accessible; there are enough clinics available running at convenient times and partners are able to attend

Postnatal
- Ward is clean
- Toilets and bathrooms are clean
- Women are treated with kindness and understanding

Steph Mansell
Head of Midwifery

January 2008

APPENDIX 3

Healthcare Commission

Women's experiences of maternity care in the NHS in England

Key findings from a survey of NHS trusts carried out in 2007

The Healthcare Commission

The Healthcare Commission exists to promote improvements in the quality of healthcare and public health in England. We are responsible for assessing and reporting on the performance of the NHS and independent healthcare organisations, to ensure that they are providing a high standard of care. We also encourage providers to continually improve their services and the way they work.

We aim to:

- safeguard patients and promote continuous improvement in healthcare services for patients, carers and the public
- promote the rights of everyone to have access to healthcare services and the opportunity to improve their health
- be independent, fair and open in our decision making and consultative about our processes

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Contents

Introduction

During the summer of 2007, the Healthcare Commission carried out the first survey of maternity services within the national programme of surveys about the experiences of NHS patients. It describes women's experiences of maternity care and provides a detailed picture of the current quality of maternity services as well as identifying areas for improvement. Overall, the vast majority of women reported a positive experience of the care received during pregnancy and during their labour and the birth with nine in ten rating the care they received as “excellent”, “very good” or “good”. More than three quarters of respondents reported that they had always been spoken to in a way they could understand, treated with respect and dignity, and treated with kindness and understanding at these stages of care. However, women were less positive about their experiences of care after the birth of their baby, with 12% rating their care overall as “fair” and 8% as “poor”. A high proportion of women reported a lack of information and explanations, not being treated with kindness and understanding, and poor standards of cleanliness in the hospital’s postnatal ward or room.

The findings of this survey suggest that to meet the Government's aspirations for maternity services, which are designed around women's individual needs, trusts should involve women more in decisions about their care. This needs to be not only during pregnancy, labour and birth but also immediately afterwards, and later at home with their baby.

How the survey was carried out

During the summer of 2007, almost 45,000 women were asked about their recent experiences of maternity care services provided by the NHS in England.

Women who had given birth in February 2007* were invited to take part in the survey, with the exception of:

- women who had a stillbirth or whose baby had died since delivery
- women aged 16 or under at the time of their baby's birth

Approximately three months after the birth, the women were sent a postal questionnaire to complete. Over 26,000 women took part. After taking account of undelivered questionnaires and those women ineligible for inclusion, this is a response rate of 59%. The average age of the survey's respondents was 31 years and 13% were from a black or minority ethnic group. Just over half (51%) of those who responded to the survey had previously had a pregnancy. This is significant because it strongly influences women's experiences. Where appropriate, the survey results are presented separately for these two groups of women.

Why the survey was carried out

To improve the quality of local maternity services provided by the NHS, it is essential that trusts understand what women think about their maternity care and treatment. The questionnaire used for this survey was based on that used in the National Maternity Survey 2006,[1] developed and carried out by the National Perinatal and Epidemiology Unit (NPEU) and co-funded by the Healthcare Commission. The NPEU survey sampled 4,800 women and provided a national picture. This new survey, carried out in 2007, was designed to complement the national survey by assessing individual trusts' performances and identifying areas where they can improve the quality of their maternity services.

This report focuses on the national findings: there are variations by trust but these will be explored, together with data from other sources, in a maternity services review to be published in January 2008. The Healthcare Commission will also examine variations in the survey findings by the ethnicity of the women responding.

Further detail, including the results of the survey for each trust, is available on the Healthcare Commission's website at **www.healthcarecommission.org.uk**

* If an NHS trust had fewer than 200 babies delivered in February 2007, then women who gave birth in January 2007 were also invited to take part in the survey.

Interpreting the results

The percentages presented in this report are the average for England. They were calculated so that the results for each trust had an equal influence. Please see Appendix 1 for more detailed information.

Where the results show a difference between two groups, for example between first-time mothers and other women who have previously had a baby, we used statistical tests to determine whether the difference was ‘real’ (statistically significant) or occurred by chance. All the differences presented in this report are statistically significant, meaning that it is highly unlikely that they could have occurred by chance.

How the report is structured

The key findings from the survey are presented on the following page. These highlight the areas of care where women reported the most positive experiences and those where maternity services require improvement. The report then considers the themes that run through the survey, such as choice, provision of information, and relationships with health professionals. Within these themes, women's experiences of care are examined at each of the three main stages in maternity care: during pregnancy (antenatal care), during labour and after the birth (postnatal care).

Key findings

Women reported positive experiences of care in the following areas:

- 91% said they first saw a health professional about their pregnancy as soon as they wanted
- 81% of women said they had a choice about where to have their baby, although only 57% said they were given the choice of having their baby at home. These figures exclude women who said that they were unable to have a choice due to medical reasons
- most respondents (94%) who wanted a screening test to check whether their baby was at increased risk of developing Down's syndrome, said they had the test
- 90% of respondents had the name and telephone number of a midwife who they could contact during pregnancy, and 95% when they were at home after the birth of their baby
- 89% of women rated the overall care received during labour and birth as “excellent”, “very good” or “good” and 82% said they were always spoken to in a way they could understand during this time
- 88% said they had received a postnatal check-up of their own health and most women (91%) had been given information or offered advice about contraception following the birth

However:

- of those respondents who had seen a midwife for their antenatal check-ups, 43% had not seen the same midwife “every time” or “most of the time”
- 36% of respondents said they were not offered any antenatal classes provided by the NHS, though the majority of these respondents (76%) were women who had previously given birth
- during labour and/or at the birth of their baby, a quarter of respondents (26%) reported that they had been left alone by midwives or doctors at a time when it worried them and 30% did not always feel involved in decisions about their care
- 20% of women rated the overall care received after the birth of their baby as either “fair” or “poor”
- of those respondents who stayed in hospital after the birth, 42% said they were not always given the information or explanations they needed and 37% felt they had not always been treated with kindness and understanding
- of the respondents who stayed in hospital after the birth, over half (56%) said the hospital food was “fair” or “poor” and 19% said the toilets and bathrooms were “not very clean” or “not at all clean”
- over a fifth of women (21%) said they would have liked to have seen a midwife more often after the birth of their baby
- similar proportions of women said that midwives or other carers had not given them consistent advice (23%), practical help (22%) or active support or encouragement (22%) with regards to feeding their baby (breast or bottle)

Care and treatment of women

The start of pregnancy

Standard 11 of *The National Service Framework for Children, Young People and Maternity Services*[2] acknowledges the importance of providing approachable and supportive antenatal services in convenient and accessible settings. This encourages women to access maternity services early in their pregnancy. Guidelines on antenatal care, published by the National Institute for Health and Clinical Excellence (NICE),[3] recommend that women access maternity services early so they can plan their pregnancy effectively and benefit from antenatal screening options. Around half of the women who responded to the survey (52%), said they had first seen a health professional about their pregnancy care during the first six weeks of their pregnancy. Almost all (94%) said they had accessed services by 12 weeks of pregnancy. The survey showed that most respondents (91%) were able to see a health professional about their pregnancy as soon as they wanted.

More than half of the women (58%) who responded to the survey had their booking appointment (the appointment when women are given their pregnancy notes) before 12 weeks of pregnancy. Of those who had not previously had a baby, 61% said they had their booking appointment by 12 weeks of pregnancy compared with 57% of the respondents who had previously had a baby.

Checks and screening during pregnancy

An antenatal check-up is any contact with a midwife or doctor to check the progress of a pregnancy. It usually includes checking the woman's blood pressure and urine. Almost all respondents (99%) had check-ups during pregnancy, with most women (71%) having between one and nine. NICE guidelines recommend that women are offered a minimum of 10 antenatal appointments if it is their first pregnancy and seven if it is a second or subsequent pregnancy.[3] The survey showed that 68% of first-time mothers had less than 10 antenatal check-ups and 45% of women who had previously had a baby had less than the recommended seven appointments. However, a woman who has her baby early, or has a late booking appointment will almost inevitably have fewer antenatal check-ups.

Most women (99%) saw a midwife for their antenatal check-ups, but a relatively high proportion said they also saw a hospital doctor (61%) and/or a GP (47%) for such checks.

The national service framework[2] states that all organisations providing maternity care should offer women the support of a named midwife throughout their pregnancy. However, 43% of respondents said they had not seen the same midwife “most of the time” or “every time” for their antenatal check-ups. The importance of continuity in midwifery care is reinforced in the Department of Health's recent publication, *Maternity Matters: Choice, access and continuity of care in a safe service*.[4] This outlines different aspects of continuity of care, such as ensuring that women and their families know what to do and who to contact if their named midwife is unavailable. Although a significant proportion of women had not seen the same midwife for most

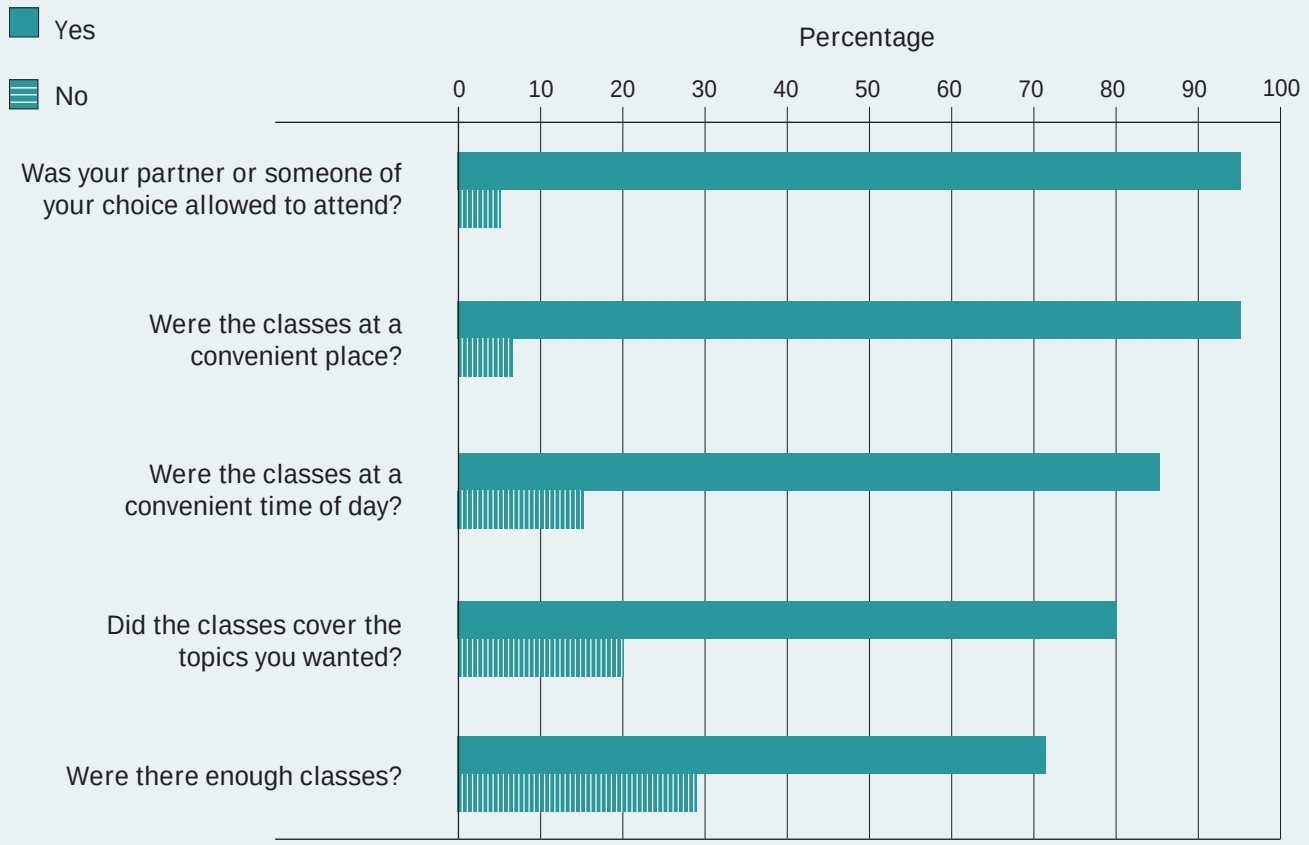
of their check-ups, 90% said they had been given the name and telephone number of a midwife they could contact if they were worried during their pregnancy.

All NHS maternity care providers should ensure that a comprehensive antenatal screening and diagnostic service is offered to all women to detect maternal or fetal problems at an early stage. Most respondents (94%) who wanted a screening test to check whether their baby was at increased risk of developing Down's syndrome, said they had the test. However such screening should be offered to all women.[3] The majority of respondents (89%) had also had a dating scan between 8 and 14 weeks of pregnancy and almost all (98%) had an ultrasound scan around 20 weeks of pregnancy. The lower proportion of women who had a dating scan, when compared with the 20-week scan, could partly be explained by some women accessing maternity services at a later stage in pregnancy - perhaps after the timing of when the scan is usually performed. The survey showed that of those women who first saw a health professional about their pregnancy within the first six weeks, 91% received a dating scan. This drops to 60% among those women who first saw a health professional when they were more than 12 weeks pregnant. Around a tenth of women who had seen a healthcare professional in the first six weeks of their pregnancy said that they did not receive a dating scan. This suggests that availability of dating scans appears to be a service provision issue, as well as being linked to late booking appointments.

Good antenatal care should include access to education about parenting and preparation for birth, whether through classes or other means.[2] However, over a third of women (36%) said they had not been offered antenatal classes provided by the NHS and 3% said they could not attend any classes because they were fully booked.* A lower proportion of first-time mothers said they had not been offered antenatal classes when compared with women who had previously given birth (14% compared with 76%). Sixty-one per cent of respondents said they attended classes provided by the NHS, and most responded positively about their experiences at the classes although 28% felt there were not enough classes provided (Figure 1).

* These figures exclude women who said they did not need to attend classes or who attended private classes.

Figure 1: Women's experiences of antenatal classes provided by the NHS



Care and treatment during labour and birth

National guidelines and standards recommend that a woman in 'established' labour should receive supportive one-to-one care from a midwife and should not be left alone except for short periods, or unless she requests it.[2,4,5] The survey asked women whether they were left alone by midwives or doctors at a time when it worried them, during labour and/or shortly after the birth. Overall, around a quarter (26%) said that they had been left alone at a time when it worried them: 15% during labour, 6% shortly after the birth and a further 5% both during and shortly after the birth. A higher proportion of first-time mothers said they had been left alone during labour and/or shortly after the birth at a time when it worried them when compared with women who had previously had a baby (28% compared with 25%).

Only 20% of women said they had one midwife who looked after them during labour and birth, with 43% reporting that three or more midwives looked after them at this time. Not surprisingly, women were more likely to have been looked after by one midwife during labour and birth if they had a shorter labour (less than eight hours) and/or had a normal (vaginal) birth.

Of those women who had a vaginal delivery:

- a quarter (25%) gave birth sitting, or sitting supported by pillows
- 5% on their side
- 12% standing, squatting or kneeling
- 30% lying down
- 27% lying with their legs supported in stirrups
- 1% in 'another' way

Overall the survey findings show that 57% of women gave birth lying down or lying with their legs supported in stirrups. This position is actively discouraged (for normal births) in recently published NICE guidelines on care during childbirth.[5]

Of those women who had a vaginal delivery, a quarter (24%) were given an episiotomy (cut) and 53% said they had a tear while their baby was being born. Of those women who required stitches following an episiotomy or tear, over a quarter (29%) had to wait more than 20 minutes for the stitches to be done. Twelve per cent of women waited more than one hour. Women should be encouraged to have uninterrupted time with their baby before stitches are done, but NICE recommends that stitching should be done as soon as possible, so delays should not be more than an hour.[5]

Care and treatment after the birth

All newborn babies should be physically examined to check for any problems within the first week of their life, or before they are discharged from hospital.[2,6] The majority of women (96%) reported that their baby had an examination or baby check before leaving hospital.* The national framework[2] suggests that a range of health professionals can undertake the examination to avoid delays in mothers and babies being discharged from hospital. Of those women whose baby had this check, 79% said it was carried out by a doctor, 16% by a midwife and 5% by another health professional.

Almost all respondents (95%) said they had been given the name and telephone number of a midwife or health visitor they could contact if they were worried after they went home.

Women were asked about the advice and support they had received from midwives and other carers in relation to feeding their baby (breast or bottle). Almost a quarter of women felt that they did not receive consistent advice (23%), practical help (22%) or active support and encouragement (22%). The findings are shown in Table 1. The national framework[2] highlights that previous surveys have shown that women are more negative about hospital postnatal services when compared with any other aspect of maternity care. Some of these complaints relate to conflicting advice on feeding their baby. A similar proportion of respondents to the National Maternity Survey 2006[1] said they had not received consistent advice (21%), practical help (19%) or support (18%) with feeding their baby.

* The survey asked specifically about a baby check before being discharged. However, some trusts carry out baby checks after discharge to enable women to go home earlier.

Table 1: Women's experiences of the advice and support provided from midwives and other carers in relation to feeding their baby (breast or bottle)				
	Yes, always	Yes, generally	No	Total
Thinking about feeding your baby (breast or bottle) did you feel that midwives and other carers gave you **consistent advice**?	38%	38%	23%	24,131
Thinking about feeding your baby (breast or bottle) did you feel that midwives and other carers gave you **practical help**?	39%	39%	22%	23,505
Thinking about feeding your baby (breast or bottle) did you feel that midwives and other carers gave you active **support and encouragement**?	41%	37%	22%	23,841

Early identification and management of a new mother's health problems is important, as many of these health problems may lead to ongoing pain, disability and depression.[2,6] Most women (88%) said they had received a postnatal check-up of their own health around four to six weeks after the birth and 91% said they had been given information or offered advice from a health professional about contraception.

Giving women choice and involving them in their care

The national service framework[2] acknowledges that most users of maternity services want to be actively involved in planning their care and choosing the type of care they receive. Building on the standards set out in this framework, *Maternity Matters*[4] defines the Government's commitment to four guarantees for all women and their partners. One of these guarantees is that by the end of 2009, when women first learn they are pregnant, they will have a choice between going directly to a midwife or to their GP. Choosing to see a midwife first should give women earlier access to maternity services.[4] The survey appears to support this. Most women (78%) went to their GP first about their pregnancy care, with only 19% reporting that their first contact was with a midwife. Of those respondents who had previously had a baby, 22% said they had seen a midwife first about their pregnancy care, compared with 16% of first-time mothers.

The survey showed that 65% of those women who had seen a midwife first about their pregnancy had their booking appointment by 12 weeks of pregnancy, compared with 57% of women who had gone to their GP first. This implies that some women may have earlier access to maternity services if they go directly to a midwife, rather than accessing services via their GP (Table 2).

Table 2: Proportions of women who had their booking appointment at different times during pregnancy by the type of health professional first seen about pregnancy care

		Roughly how many weeks pregnant were you when you had your booking appointment?					
		Less than 8 weeks	8-9 weeks	10-11 weeks	12-18 weeks	19 weeks	Total
Which health professional did you go to first about your pregnancy care?	GP	11%	24%	22%	38%	4%	18,929
	Midwife	15%	29%	21%	31%	4%	4,741
	Other	9%	22%	20%	43%	6%	703
Total		2,942	6,115	5,299	9,000	1,017	24,373

Respondents were asked if they had a choice about where they could have their baby. Eighty-one per cent said they did have a choice, although only 57% overall said one of these choices was to have their baby at home.* The option for women to have a home birth has recently been strengthened with the publication of *Maternity Matters* and the *NICE guidelines for the care of women during childbirth*.[4,5] The Government has pledged that by the end of 2009, depending on their circumstances, women and their partners will be able to choose between having their baby:

- at home
- in a local facility, including a hospital, under the care of a midwife
- in a hospital supported by a maternity care team including midwives, anaesthetists and obstetricians (doctors specialising in childbirth)

To help them choose, women and their partners should be given information and support.[2,4] However, only half of women (51%) said they had definitely been given enough information to help them decide where to have their baby. Of those women who said they had been given a choice about where to have their baby, 11% said they had not received any information to help them decide and 34% had only received enough information "to some extent".

While almost all women (99%) had antenatal check-ups during pregnancy, around a quarter (24%) said they were given a choice about where their check-ups would take place and only 14% said they were given a choice about who would carry out the checks. The National Maternity Survey carried out in 2006 also showed that options as to where antenatal checks could be carried out, and which health professional would undertake these, were limited.[1]

The national service framework[2] recommends that antenatal tests and screening should be offered to women as options, rather than as a routine part of their pregnancy. However, the survey showed that around a quarter of women did not feel they had a choice about having a dating scan (29%) or a 20-week scan (27%). In contrast, a relatively high proportion of women said they did have a choice about whether or not to have a screening test for Down's syndrome (88%).

It is recommended that women should be able to do what feels right for them during labour and delivery, with health professionals supporting their wishes wherever possible.[2,5] Most women (61%) said they were able to move around and choose the position that made them feel most comfortable "most of the time" during labour. Twenty-four per cent said this was possible "some of the time". The Government has also pledged that by the end of 2009 all women should have a choice of methods of pain relief that are appropriate to the type and place of birth chosen.[4] Of those women that had a labour, 64% said they "definitely" got the pain relief they wanted and 28% felt they had "to some extent".

* These figures exclude those women that said it was not possible to have a choice about where to have their baby due to medical reasons.

There is increasing evidence that involving people in decisions about their care and treatment not only leads to more knowledgeable and satisfied patients, but may also result in better recovery and health as well as a more appropriate and cost-effective use of health services.[7] Women were asked if they had been involved enough in decisions about their care. Around two thirds of respondents (67%) said they were always involved in decisions about their antenatal care and a similar proportion (70%) felt they had always been involved in decisions about their care during labour and birth. This means however that a third of women did not always feel they had been involved in their care. This suggests that if maternity services are to be truly designed around women's individual needs - as advocated in national guidelines[2,4] – there is still room for improvement.

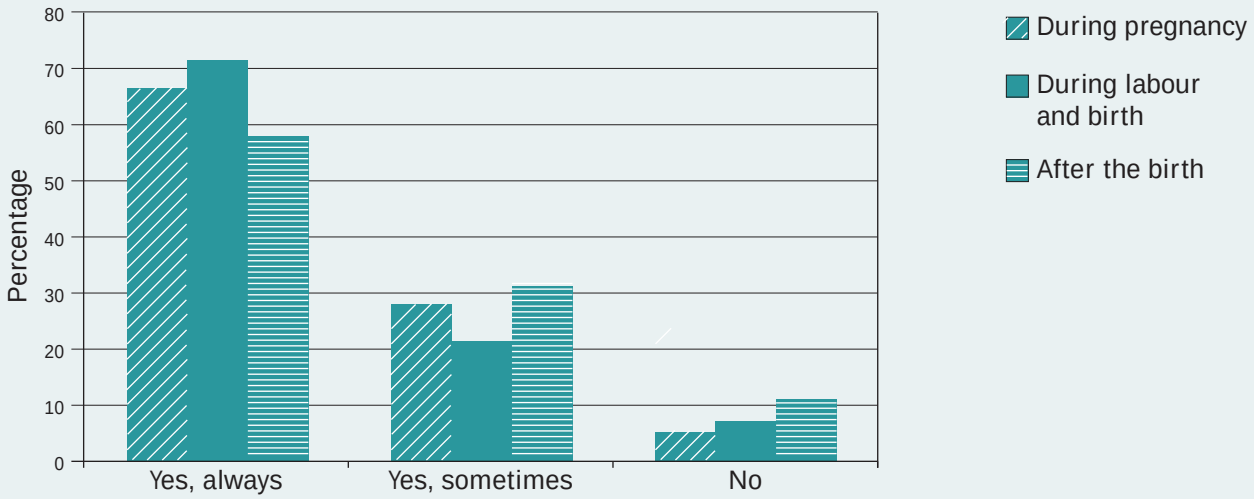
Analysis of the survey results showed that women who had previously had a baby were more likely to say they had been involved in decisions about their care compared with first-time mothers. Of those women who had previously had a baby, 68% said they were always involved in decisions about their antenatal care compared with 66% of first-time mothers. Similarly, a significantly higher proportion of women who had previously had a baby always felt involved in decisions during labour and birth (72%), compared with 67% of first-time mothers. For all respondents – regardless of whether they had previously had a baby – a significantly higher proportion rated their overall care positively if they had been involved in decisions about their antenatal care and/or care during labour and birth. For instance, of those respondents who said they had always been involved in decisions about their antenatal care, 82% rated their overall care during pregnancy as “excellent” or “very good”. In contrast, of those respondents who reported that they had not been involved enough in decisions about their antenatal care, only 25% rated their overall care at this time as “excellent” or “very good”.

Information provided to women

Overall

Women were asked if they had been given enough information during pregnancy, during labour and birth and after the birth of their baby. Figure 2 shows that at each stage the amount of information and explanations given to women could be improved as a relatively high proportion of women said that their needs were not always met. This is particularly evident after the birth where only 58% of women said they were always given the information and explanations they needed.

Figure 2: Women's views on the provision of information and explanations at different stages of maternity care



Providing women with enough information is important to encourage their involvement in decisions about their care and treatment. Of those women who said they had always been given the information or explanations they needed during labour and birth, 90% said they had always been involved in decisions about their care. This compares with only 5% of women who said they had not had the information or explanations they needed at this time.

Throughout this section, responses to the survey questions relating to information are compared between women who were having their first baby and other women. The information needs of the two groups of women are likely to be different as women who have previously had a baby will probably have a greater level of experience and knowledge compared with first-time mothers.[1]

Information provision during pregnancy

The Pregnancy book[8], published by the Department of Health, contains information for expectant parents to help them make choices and get the most from both the pregnancy and their new baby. The majority of women said they had been given a copy of *The Pregnancy book* (75%), although a quarter of women (25%) said they had not.* The proportion of respondents who said they had not been given a copy was significantly lower among first-time mothers when compared with other respondents who had previously had a baby (18% compared with 32%).

It is important that health professionals clearly explain to women the reasons for carrying out screening tests and scans during pregnancy. Most respondents (90%) that had received screening for Down's syndrome said that the reason for the test had been clearly explained to them. The majority of women also said that the reasons for the dating scan and 20-week or 'anomaly' scan had been explained (89% and 92% respectively). This supports the finding that most women had been spoken to in a way that they could understand by health professionals (outlined in the following section). An equal percentage of first-time mothers and other women, said that they were given an explanation of the reasons behind the screening test for Down's syndrome. However, for the dating scan and 20-week scan, a higher proportion of women who had previously given birth, than first-time mothers, said that the reasons for the scans had been explained to them (90% compared with 88% for the dating scan and 93% compared with 91% for the 20-week scan).

There is strong evidence that breastfeeding is beneficial for the mother's and baby's health in both the short and longer term. *The Infant Feeding Survey*[9] identified that one of the reasons why women stopped breastfeeding within six weeks of birth was because of a lack of information given to them during pregnancy. This highlights the importance of providing information on feeding babies to women in the antenatal period. Although 78% of the women who responded to this survey said that, during their pregnancy, their midwife had discussed feeding their baby with them, a fairly large proportion (22%) had not had such a discussion. The National Maternity Survey 2006[1] had a similar finding, with three quarters of women (76%) reporting that their midwife had discussed feeding with them, during their pregnancy.

Information about home births

For those women who had a home birth, most responded that they had “definitely” been given enough information about:

- the sorts of pain relief that would be available at home (80%)
- the monitoring of the baby that would be available at home (71%)
- the distance and location of the nearest hospital (82%)
- the sorts of emergency back-up that would be available, such as ambulance facilities if needed (75%)

* These figures exclude women who said they already had a copy of *The Pregnancy book*. Practice varies as to whether women who have already had a pregnancy are given a copy.

Information about neonatal care (special baby care)

A small proportion of respondents to the survey (10%) said that their baby was cared for in a neonatal unit (special baby care unit). The women were asked if they had been given enough information about the reasons for their baby's stay in the unit. Sixty-nine per cent said they had “definitely” received enough information and 24% said they had been given enough information “to some extent”. However, the responses were different depending on how long the baby stayed in the unit. Where the baby received neonatal care for one day or less, 67% of women said they had definitely been given enough information about why their baby was admitted for such care. This compares with 86% among those respondents whose baby was in the unit for 31 days or more.

Information provision after the birth

Postnatal care in the community should provide mothers and their partners or companions with information about how to nurture babies and what to expect at different ages, including growth and child development.[2,6] Women were asked about the advice and help they had received from health professionals about their baby's care in the six weeks after the birth. A fairly large proportion of respondents said they had not received any help and advice, or had only received help and advice to “some extent”, about their baby's crying (64%), sleeping position (44%), skin care (56%), health and progress (42%) or about feeding their baby (44%). Those respondents who had previously had a baby were more likely to report that they had “definitely” received help and advice from health professionals about each of the aspects of caring for a baby. The exception is feeding the baby, where a higher proportion of first-time mothers had “definitely” received enough help and advice (Table 3).

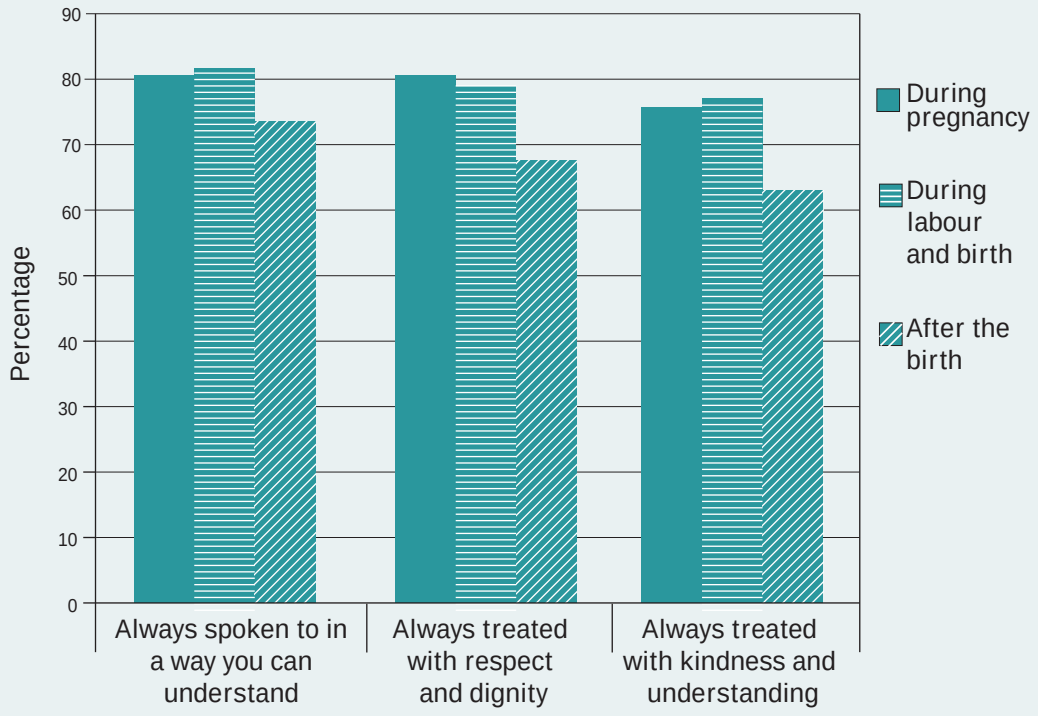
Table 3: The proportions of women who definitely received help and advice about their baby's care by parity			
	Parity		
	No previous births	One or more previous births	Total
Definitely received help and advice from health professionals about the **baby's crying**	35%	37%	6,465
Definitely received help and advice from health professionals about the **baby's sleeping position**	56%	57%	10,763
Definitely received help and advice from health professionals about **feeding the baby**	58%	54%	12,319
Definitely received help and advice from health professionals about the **baby's skin care**	42%	44%	8,568
Definitely received help and advice from health professionals about the **baby's health and progress**	57%	59%	13,471

Although 88% of women had been given a postnatal check-up of their own health, less than half (45%) responded that they had “definitely” been given enough information about their own recovery after the birth of their baby. However, of those women who had previously had a baby, a much higher proportion said they were “definitely” given enough information about their own recovery when compared with first-time mothers (52% compared with 39%). This reflects differences in the information needs of the two groups of women.

Relationships with health professionals

Respondents were asked how they had been cared for and treated by health professionals at different stages of their maternity care. In general, most women responded positively about the way staff had treated them, particularly during pregnancy and/or during labour and birth (Figure 3). More than three quarters of women reported that they had “always” been spoken to in a way they could understand, were treated with respect and dignity, and treated with kindness and understanding. However, respondents were less positive about their care while they were in hospital after the birth. One third of women said they had “not always” been treated with respect and dignity (34%) and a similar proportion (37%) said they had “not always” been treated with kindness and understanding at this time.

Figure 3: Women's views on the interpersonal aspects of care at different stages in maternity care



It is recognised that women and their partners will want to know and trust the midwife who is responsible for providing information, support and ongoing care.[2,4] Those women who said that they had seen the same midwife “every time” for their antenatal check-ups were more likely to report that they had “always” been:

- treated with respect and dignity
- treated with kindness and understanding
- spoken to in a way they could understand
- given the information and explanations they needed
- involved in decisions about their care

Table 4: Continuity of midwifery care by women's overall views on the antenatal care provided						
		Always treated with respect and dignity	Always treated with kindness and understanding	Always spoken to in a way you could understand	Always given the information or explanations you needed	Always involved enough in decisions
If you saw a midwife for your antenatal check-ups, did you see the same one every time?	Yes, every time	88%	85%	86%	76%	77%
	Yes, most of the time	86%	82%	85%	73%	73%
	No	74%	68%	76%	58%	59%
Total		19,278	18,266	19,432	15,871	15,948

It is recognised that during labour and birth, women prefer to be cared for by a midwife whom they have got to know and trust throughout pregnancy.[2] However, the survey showed that only 22% of women had previously met any of the staff that looked after them during labour and birth. To have confidence in staff is one of the main things that women want when giving birth.[2] Most women (68%) said they "definitely" had confidence and trust in the staff caring for them during labour and birth, and 27% said they had "to some extent". Perhaps unsurprisingly, a significantly higher proportion of women reported that they definitely had confidence and trust in staff during labour and birth if they had previously met any of them (Table 5).

Table 5: Familiarisation with staff by the level of confidence and trust in staff during labour and birth					
		Did you have confidence and trust in the staff caring for you during your labour and birth?			
		Yes, definitely	Yes, to some extent	No	Total
Had you met any of the staff who looked after you during your labour and the birth before you went into labour?	Yes	81%	18%	2%	5,398
	No	65%	30%	5%	19,547

The hospital environment

Women were asked about their views on the cleanliness of the wards and toilets/bathrooms, both in the labour and delivery rooms and in the ward after the birth. Although 63% of women said that the labour and delivery rooms were “very clean”, less than half (49%) reported this about the toilets and bathrooms they used. However, only 46% of women said that the hospital room or ward they were in after the birth was “very clean” and just 36% said the toilets and bathrooms were “very clean”. The National Maternity Survey 2006[1] also showed that women were more critical about the cleanliness of the postnatal ward environment than of the labour and delivery wards.

The national service framework[2] highlights that studies show women to have a more negative view of postnatal care than of any other stages of care. These views often focus on the availability and quality of hospital food and poor standards of hygiene. This survey also reveals there is room for improvement in the quantity and quality of hospital food provided to women. While a relatively high proportion of women (70%) said they had “always” been offered a choice of food, and 19% said they were “sometimes” given a choice, almost a quarter (23%) said they were not given enough food and 19% rated the food overall as “poor”.

Next steps

Key findings from this survey of women's experiences will be combined with data from other sources to inform a review of maternity services in England. This will be published in January 2008. The review will look at any local variations and assess each NHS trust. Our findings will help health professionals to plan and provide services that are tailored to individual women's expectations and needs. This information will also be available to women and their families, on our website, to help them to make choices in their maternity care.

A national report on the overall findings of the service review will be published in 2008.

Later we will examine responses to the survey of women's experiences in relation to the ethnicity of women and factors that may influence responses, such as the type of care provided.

References

1 National Perinatal Epidemiology Unit (2007) *Recorded delivery: a national survey of women's experience of maternity care 2006* Further information is available at www.npeu.ox.ac.uk

2 Department of Health (2004) *National Service Framework for Children, Young People and Maternity Services.*

3 National Institute for Health and Clinical Excellence (2003) *Antenatal care: routine care for the healthy pregnant woman.*

4 Department of Health/Partnerships for Children, Families and Maternity (2007) *Maternity Matters: Choice, access and continuity of care in a safe service.*

5 National Institute for Health and Clinical Excellence (2007) *Intrapartum care: care of healthy women and their babies during childbirth.*

6 National Institute for Health and Clinical Excellence (2006) *Clinical Guideline. Routine postnatal care of women and their babies*.

7 Coulter A and Ellins J (2006) *The quality enhancing interventions project: patient focused interventions. The Health Foundation.*

8 Department of Health (2007) *The Pregnancy book* 2007.

9 Bolling K (2005) *Infant Feeding Survey 2005: Early Results* Office for National Statistics.

Appendix 1: Further information on interpreting the results

Maternal age and parity (number of previous births) are two factors that could influence women's experiences of maternity services and consequently how they assess their care. The results have therefore been standardised so that each trust's age-parity profile reflects the national age-parity distribution. This allows trusts with different profiles to be more fairly compared and ensures that no trust will appear better or worse simply because of a different mix of patients.

Some trusts had higher response rates and/or larger sample sizes than others, and therefore would have a greater influence on the national average for England. To address this, we applied a 'weight' to the data so that responses from each trust have an equal influence over the average, regardless of differences in response rates and sample sizes between trusts. The percentages shown in this report represent the average for all NHS trusts in England that participated in the survey, with the exception of the following:

- two trusts were excluded due to them having considerably smaller maternity units and only a very small number of women in their sample
- the results from a third trust were excluded from the national figures due to a sampling error that resulted in their data not being comparable to other trusts
- the results from a fourth trust were excluded for some of the questions in the survey due to a data quality issue

The findings presented in this report therefore reflect the average trust standardised for the age and parity status of women who responded to the survey. However, the exception to this is where the results have been compared by two groups (e.g. by parity) or by two different questions. These figures are standardised by maternal age and parity but are not weighted to represent the 'average' for all NHS trusts in England.

This publication is available in other formats and languages on request. Please telephone 0845 601 3012.

આ માહિતી વિનંતી કરવાથી અન્ય રૂપે અને ભાષાઓમાં મળી શકે છે. મહેરબાની કરી ટેલિફોન નંબર 0845 601 3012 પર ફોન કરો.

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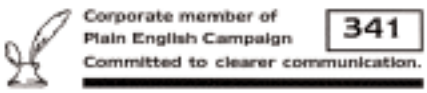


Enclosure 8

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Trust Board, Thursday, 31st January, 2008**

Report of: **Director of Corporate Development**

Subject: **Standard Template for Board and Committee Reports**

1. Summary

As part of the Trust's review of how the Trust Board and its Committees work, it was agreed to develop a standard template for Board and Committee reports. This has been developed by me and and agreed by Executive Directors. This is attached for Board discussion and approval.

Please note that this approach is to be adopted for all reports, with the exception of business cases, where a report format has already been agreed and is in use. However these should be prefaced by a one page summary in the format identified in the attached paper.

2. Recommendation

The Trust Board is recommended to:

- Discuss and amend the content of the attached paper
- Adopt this format and style for all Board and Committee meeting reports with immediate effect

Les Williams
Director of Corporate Development

21st January 2008

Enclosure [number as listed on agenda]

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Trust Board, Thursday, [date], 2008**

Report of: **Director of [title]/Author (if not Director)**

Subject: **[title – to match agenda item]**

1. Summary

This section to cover in **no more than one page**:

- The purpose of the paper
- Justification for taking paper in private section (if appropriate)
- Reference to any previous Board or Board Committee consideration, decision and minute
- Reference to any view taken by Executive Directors
- The recommended action for the Board to take:
  - Receipt of paper for information
  - Approval of policy or proposed course of action
  - Development of Board position on an issue
  - Agreement to further action required to implement Board decision

2. Background

This section to include**:**

- Brief description of relevant background information, required to assist Board members' understanding
- Reference to relevant national policy, SHA and commissioners' strategies or Monitor requirements
- Previous Board consideration and view taken
- Reason for presenting the paper, including reasons why a decision has to be taken at this meeting (where relevant)

3. Issue for consideration

It is not possible to be prescriptive about content of this section, as this will be determined by the nature of the issue. The following general guidance may be helpful:

- The level of detail provided should be proportionate to the materiality of the issue under consideration
- The style of writing and amount of detail should be based on an assumption that all Board or Committee members have read the supporting papers provided and understand the content of papers previously provided to them

- It is sufficient to refer to papers previously received by Board members and it is not necessary to include them again as appendices
- Detailed information should be included in numbered appendices
- This section should include a 'Conclusions' paragraph that summarises the issue and sets up the recommendation for the Board or Committee

4. Recommendation

This section must provide Board or Committee members with a clear decision or set of decisions to make.

- The Recommendation should identify the proposed action or set of actions the Board or Committee is being asked to take
- It should draw attention to, and acknowledge, any further action that may be necessary as an immediate consequence of the decision
- Each recommended action should include the title of the Board or Committee member responsible for carrying out the action
- Actions should specify a date by which they will be completed (this will be included in the Action Sheet for review at the appropriate time)
- This section should also include a recommendation for the timing of Board or Committee re-consideration of the issue.

Name: **[insert]**
Title: **[insert]**
Date: **[insert]**

Notes

Style:

Font: Arial 12
Headings: in bold, not underlined
Appendices: sequentially numbered
File reference: should appear at the end of the covering paper to ensure easy identification, search and retrieval from electronic files. This should include title, initials of originator and date the paper was produced

Collation:

When complete, the report originator should collate the papers in the correct order and pdf the full report and appendices, before sending to the Trust Secretary or relevant administrative support to the Committee. This will both reduce confusion and remove the potential for errors in collation. It also prevents any possibility of changes being made to the report after it has been sent by the originator.

Submission:

The Board of Directors Standing Orders and terms of reference of Board Committees require papers to be sent out 7 calendar days before the meeting. Therefore they should be submitted to the Trust Secretary or relevant administrative support 9 calendar days before the meeting.

Papers received between this time and 7 calendar days before the meeting will only be added to the agenda at the discretion of the meeting Chair.

Papers received after 7 calendar days before the meeting will not appear on the agenda. If urgent, the Chair may raise these under 'Any Other Urgent Business' but this will be at the Chair's discretion and should be exceptional.

Les Williams
Director of Corporate Development

4th January 2008

2008-01-04 – board report template - lnw

The Dudley Group of Hospitals NHS
NHS Trust

Public Trust Board Agenda
Thursday 24th April 2008
11.00am
Clinical Education Centre

	Item	Time	By
1. 2. 3.	**Chairman's welcome and note of apologies – P. Harrison** **Declarations of Interest** **Announcements**	2 mins	A Edwards
4.	**Minutes of previous meetings** • Thursday 27th March 2008, Board Meeting **Enclosure 1**	2 mins	A Edwards
5.	**Action Sheet – Progress Report by Exception** **Enclosure 2**	2 mins	A Edwards
6.	**Matters Arising**	2 mins	A Edwards
7.	**Chief Executive's Report**	5 mins	P Farenden
8. 8.1	**Strategic Issues** **Foundation Trust Update** **Verbal**	5 mins	P Assinder
9.	**Operational Performance** • Report to Finance and Performance Committee on 24th April 2008 **Verbal**	15 mins	P Assinder
10.	**Reports for Approval**	15 mins	
11.	**Information Items to be noted**	10 mins	
12.	**Any Other Business** • Limited to urgent business notified to the Chair/Trust Secretary in advance of the meeting	1 min	A Edwards
13.	**Date of Next Trust Board Meeting** • 29th May 2008 at 11.00am in the Clinical Education Centre		
14.	**Meeting Closes**	12.30pm	

The Dudley Group of Hospitals NHS
NHS Trust

Minutes of the Trust Board meeting held at 11.00 a.m. on Thursday, 27th March, 2008, in the Clinical Education Centre

Present:

Alfred Edwards, Chairman
Paul Harrison, Medical Director
Ann Close, Nursing Director
Kathryn Williets, Non Executive Director
Ann Becke, Non Executive Director
Paul Farenden, Chief Executive
David Badger, Non Executive Director
Jonathan Fellows, Associate Non Executive Director
Paul Assinder, Director of Finance and Information

In Attendance:

Helen Forrester, PA
Ian Mayers, Mills & Reeve

08/27 Chairman's Welcome and Note of Apologies

Apologies were received from Paul Brennan, David Wilton and Janine Clarke.

08/28 Declarations of Interest

There were no Declarations of Interest.

08/29 Announcements

There were no announcements.

08/30 Minutes of the Previous Meeting – 28th February 2008 – Trust Board Meeting

The minutes of the 28th February Trust Board meeting, given as Enclosure 1, were amended at item 08/17 Presentation to the Board on Fraud Prevention, third bullet point, to read "It was noted that there had been 5 enquiries within the last 4 weeks". With this amendment the minutes were approved as a correct record and signed by the Chairman.

A reporter from the Express and Star joined the meeting further down the agenda and the Chairman briefed him on the above amendment to the minutes, this was following an enquiry received earlier in the day by the Communications Department.

08/31 Presentation to the Board on Corporate Manslaughter by Ian Mayers, Mills & Reeve

Ian Mayers, Partner from Mills & Reeve Solicitors presented to the Board on The Corporate Manslaughter Act and Corporate Homicide Act 2007 which comes into law on 6th April 2008. Following the presentation a number of issues were raised, including:

- Kathryn Williets, Non Executive Director asked about the investigation of incidents and the decision as to whether it relates to corporate or individual failings. It was noted that protocols are in place between the police and the HSE. Kathryn also pointed out that the Act would be retrospective in terms of a breach in April being investigated by looking at performance prior to the Act coming into law. With reference to the public policy exemption, and in particular waiting list policy, Kathryn enquired if there was any particular guidance that should be followed. There was no guidance available but it was noted that providing the policy was followed, the Trust could not be held accountable.

- Paul Farenden, Chief Executive asked what timeframes were associated with the Act, what would happen if a death occurred at a much later date (i.e. 15 years) that could be related to failure in duty of care. It was noted that in theory the Trust could be found guilty but this is unlikely to happen.

- Ann Becke, Non Executive Director queried the boundaries of corporate responsibility, in particular if a clinician employed by the Trust was involved in an incident that didn't occur on Trust premises. It was noted that it would be highly unlikely that this incident would be regarded as corporate negligence.

Finally, Ian stressed that overall, risk assessments are still very important and encouraged the Trust to ensure that risk management processes were up to date and ongoing.

The Chairman thanked Ian for his informative presentation and asked him to provide an electronic copy for circulation to Board members.

Electronic copy of presentation to be circulated to Board members

08/32 Action Sheet – 28th February 2008 – Progress Report by Exception

The Board reviewed the Action Sheet, given as Enclosure 2, as follows:

08/32.1 Hygiene Code

Ann Close, Nursing Director, tabled a synopsis of the Hygiene Code as requested by the Board at its previous meeting.

08/32.2 Operational Performance – Delayed Discharges

Paul Brennan, Operations Director had tendered apologies. Item to be brought forward to the next meeting.

08/32.3 Operational Performance – Draft Annual Agenda

It was noted that this was in the process of being prepared and will be circulated for comments shortly. It was agreed that item 08/22 of the action sheet "key indicators trended for performance debate" due by 29th May 2008, would be built into the draft agenda.

Draft agenda to be circulated to Board members week commencing 31st March 2008

08/32.4 Whistleblowing Policy

This had been amended and agreed with the staff side and had now been published on the Intranet.

08/32.5 Quality of Care

Report on agenda at item 12 (Enclosure 4).

08/33 Matters Arising

None to report.

08/34 Chief Executive's Report

Paul Farenden, Chief Executive presented his report to the Board, this included:

- The Trust had been notified the previous day of a change in the FT approval process, by the Strategic HA, who would be playing a key role in the process, as a stronger filter before applicants progress to the Department of Health and Monitor and will focus on key targets. It was noted that the rigid approach to the authorization process will become more flexible and there will be a clearer cycle to the amount of authorizations taking place, and steps were being taken to improve the process. It was agreed that these changes would have no effect on us at this stage in the authorization process.

- A draft report had been received following the unannounced visit by the HCC to look at cleanliness and compliance to the Hygiene Code. The report gave the Trust a clean bill of health and states explicitly that the HCC were able to examine sufficient evidence within the Trust to confirm its compliance to the Code. It was noted that infection control remained a big challenge and this report will not change the emphasis on this.

08/35 Strategic Issues

08/35.1 Foundation Trust Update

Paul Assinder, Director of Finance and Information reported that there were 3 Foundation Trust items to note as follows:

- Work was underway to finalise the IBP, LTFM and Performance and Risk Management evidence. The Trust was on schedule to submit these documents to Monitor on Monday, 31st March 2008.

- Dates had been agreed for further Board workshops in April and May as follows:

  15th April 2008: 1.00pm – 5.00pm (lunch available from 12.00noon) Board Workshop for key IBP questions, Oak Room, Village Hotel, Dudley. (It was also noted that the Audit Committee would be held at 10.00am in the Oak Room).

  21st April 2008: 10.30am – 5.00pm Board Workshop on Self Certification, Oak Room, Village Hotel, Dudley (NEDs meeting to be held 8.30am – 10.30am in the Oak Room).

29th April 2008: 8.00am to 12.00noon 1st Board to Board meeting with KPMG, Oak Room, Village Hotel.

27th May 2008: 8.00am to 12.00noon 2nd Board to Board meeting with KPMG, Oak Room, Village Hotel.

- It was noted that there had been a successful conclusion to the elections for the 3 vacant seats on the Council of Governors. David Deeley, Principal Orthotist had been elected to the Scientists/AHPs staff constituency, David Ore, Security Manager had been elected to the Non Clinical Staff Constituency (replacing Clare Craddock) and Mrs Pat Siviter had been elected to the vacant public Wyre Forest seat. All three nominations had been uncontested and while the Council of Governors was still in shadow form the Trust Board was asked to ratify the three appointments.

- The Board also noted that Claire Molloy, appointed Governor from Sandwell PCT had that week informed the Trust that she was resigning as Governor due to a recent appointment outside of the PCT. The PCT Chief Executive was currently undertaking discussions within Sandwell to identify a replacement.

08/36 Operational Performance

Report to the Finance and Performance Committee on 27th March 2008

The Director of Finance and Information briefed the Board on his report to the Finance and Performance Committee. The Board discussed and noted the following position up to the end of Month 11 (February):

- At the end of February the total surplus was £10.5 million. This is equivalent to an EBITDA margin of 8.2% against an annual plan of 5.7%

- The forecast outturn remains at £10.5 million surplus for the year

- The normalized position is a surplus of £6.9 million for the year

- CIP efficiency savings had previously been set at £3.4 million but the Trust was on track to achieve £4.6 million savings for the year.

- Cash Balance at the end of February is £23.7 million and the Trust continues to maintain a strong balance sheet

- The Board noted that performance against the A&E 4hr wait target had continued to improve with strong performance in February at 99.1%, with a year to date position of 98.03% which is above target.

- GU Medicine 48 hours appointment target Performance had improved significantly and now stood at 97% in February against a target of 100% by March 2008.

- Outpatients/Inpatients/Cancer Referrals were showing no breaches in February and were all reporting 100% compliance

- MRSA – No breaches in February, performance remains on trajectory.

The Board noted this position.

08/37 Reports for Approval

08/37.1 Research and Development

Paul Harrison, Medical Director spoke to this paper, given as Enclosure 3. It was agreed that the Trust was a good recruiter into clinical trials and the Board was asked to note that Good Clinical Practice Courses are available to staff from March and the Medical Director had undertaken, and passed the training. There continued to be ongoing issues with funding for Research and Development but it was anticipated that more funding would be coming into the organization in the future.

The Chairman asked if it was possible to see outcomes from the clinical trials and it was agreed to invite Prof. George Kitas to report to the Board in six months time.

The Board approved the report.

Prof. George Kitas to be invited to September Board meeting to report on clinical trials

08/38 Information Items to be Noted

08/38.1 Quality of Care

Ann Close, Nursing Director spoke to this paper, given as Enclosure 4, which included the following:

- Initiatives to improve the quality of mental health care for older people across the Trust and in the Older Peoples Unit
- The Quality of Care review system and results following the assessment period
- Clinical support systems in place to support nurses in delivering quality of care
- End of year report for Essence of Care

The reporter representing the Express and Star queried the statement in the Essence of Care Report regarding the ordering of larger size nightwear and it was noted that more had been ordered due to increasing need.

The Chairman raised the management of equipment and ward stocks and asked if more could be done. It was noted that de-cluttering exercises were being regularly undertaken to ensure that excessive stocks of items are not being held.

The Chairman also asked a question raised by a member of public during a Trust Tour earlier in the week, about the guidance for wearing uniforms in the dining area.

It was noted that this was acceptable as appropriate protective equipment/clothing was worn over uniforms during clinical procedures.

The Chief Executive reported to the Board how enthusiastic and full of praise members of the public were for our clinical staff during the Trust Tour.

The Chairman thanked the Nursing Director for an interesting and informative report.

It was noted that a further Quality of Care Report will be presented to the Board in 3 months time. The Board received the report and noted the work being undertaken to improve the mental health of older people, the report on the Quality of Care reviews, the audits and actions being taken to improve clinical support for nurses and the Essence of Care end of year report and its benchmark areas.

Further Quality of Care Report to be provided to the Board at its June meeting

08/38.2 Human Resources Report

Janine Clarke, Director of Human Resources was not available to speak to this paper, given as Enclosure 5. The Board noted the contents of the report.

08/38.3 PALS Report

The Nursing Director spoke to this paper, given as Enclosure 6. The report provided an update on the PALS services and activities and included:

- Details of contacts made by patients accessing the PALS service
- PALS awareness week
- Patient feedback and comment cards
- Staff training
- Volunteer activities

The Nursing Director confirmed to the Board the appointment of the new Head of Customer Relations and the Communications Manager. David Badger, Non Executive Director asked that the annual cycle of reports on customer relations be discussed and agreed with the Board.

The Board received the report and noted the activities undertaken.

08/39 Any Other Business

There being no other business, the Chairman closed the meeting.

08/40 Date of Next Meeting

The next Board meeting will be held at 11.00am on Thursday, 24th April, 2008 in the Clinical Education Centre.

Signed as a correct record: …… Chairman

Date: ……

The Dudley Group of Hospitals NHS
NHS Trust

Action Sheet
Minutes of the Public Trust Board meeting held at 11.00am on Thursday, 27th March, 2008, in the Clinical Education Centre

Item No.	*Subject:*	*Action:*	*Responsible*	*Due Date*	*Actioned*
07/42.2	Action Sheet Update External Audit Letter 2006/07	ALE Working Group to feedback on action required to achieve ratings of '4' to the next Audit Committee meeting on 15/4/08	DFI	24/4/08	
08/22	Operational Performance	Further discussion on delayed discharges to be undertaken and reported back to Board.	PB/NEDs	24/4/08	
08/22	Operational Performance	Draft Annual Agenda to be provided to Board Members	C	24/4/08	
08/23.2	NHS Inpatient Survey	Actions Plans to be provided to the Board	ND	24/4/08	
08/31	Presentation on Corporate Manslaughter	Electronic copy of presentation to be circulated to Board members	HF	24/4/08	
08/22	Operational Performance	Key Indicators trended for performance debate	PA	29/5/08	
08/10.5	Healthcare Commission Maternity Survey	Progress Report to be submitted to Board in May	ND	29/5/08	
08/38.1	Quality of Care	Further Quality of Care Report to be provided to the Board in June	ND	26/6/08	
07/55.3	Draft IT Disaster Recovery Plan	Feedback to the Board on the results of the desk top simulation exercises which will be run by Siemens in the next financial year	DFI	When available from Siemens (08/09 financial year)	
08/37.1	Research and Development	Prof. George Kitas to be invited to September Board meeting to report on clinical trials	PH	25/9/08	

The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 10th January 2013 at 8.30am
Clinical Education Centre

(Note: This meeting will be held in Private Session but the Agenda is structured in Part One (Public) and Part Two (Private) formats in preparation for meeting in Public in 2013/2014.

Part One: Meeting in Public Session

All matters are for discussion/decision except where noted

	Item		By	Time
1.	**Chairmans Welcome and Note of Apologies**		J Edwards	8.30
2.	**Declarations of Interest**		J Edwards	8.30
3.	**Announcements**		J Edwards	8.30
4.	**Junior Middle Grade Trust Doctors Business Case**	Enclosure 1	A. Whallett	8.30
5.	**Minutes of Previous meetings:**			
	5.1 Thursday 6th December 2012	Enclosure 2	J Edwards	9.00
	5.2 Action Sheet Progress by Exception – 6th December 2012	Enclosure 3	J Edwards	9.00
6.	**Chief Executives Overview Report** including TME Minutes	Enclosure 4	P Clark	9.10
7.	**Quality**			
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 5	D Bland	9.20
8.	**Productivity**			
	8.1 Matters Arising from Finance and Performance Committee by Exception Report	Enclosure 6	D Badger	9.30
9.	**Prevention**			
	9.1 Infection Prevention and Control Exception Report	Enclosure 7	D Mcmahon	9.40
10.	**Date of Next Board of Directors Meeting**		J Edwards	9.50
	8.30am 7th February, 2013, Clinical Education Centre			
11.	**To exclude members of the public and press.**		J Edwards	10.00

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board Thursday, 10th January 2013 at 8.30 am

TITLE:	**To Develop a Trust Programme for Junior and Middle Grade Trust Doctors as part of a Workforce Plan**		
AUTHOR:	**Karen Morrey on behalf of the Hospital 24/7 Steering Group** **Dr Andrew Whallett, Head of Medical Education**	**PRESENTER**	**Andy Whallett**

CORPORATE OBJECTIVE:
SG04: Clinical Partnerships To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SG06: Enabling Objectives To deliver an infrastructure that supports delivery

SUMMARY OF KEY ISSUES: ***(please identify key issues arising from report or minutes)***

Further changes in the way in which we are allocated and organise our junior doctors that are proposed nationally and regionally will mean it is important that we consider that there may be different ways to provide clinical service in the future.

We propose that we act together in a strategic way as a Trust, rather than struggle as individual departments to address these issues.

This case outlines a proposal to develop two year programmes to secure high quality and consistent junior and middle tier cover, rather than providing ad-hoc cover using locums, which can be unpredictable resource, of variable quality and difficult to induce/train and regulate

We propose the best way to reduce risk of not having the right level and quality of junior doctors and the subsequent inconsistencies that we currently have in service provision is to recruit high quality, consistent junior and middle tier In-house training schemes, that supplements the deanery trainees.

We have looked at how we can use existing funded posts, and also to offset the money currently spent on locum posts. The rotations could be viewed in isolation.

This investment will also future proof the organisation against some high risk cost pressures which are likely to be incurred due to increasing demands on junior and middle grade doctors, for example both in ED and Surgery.

We also want to develop a further rotation to offset pressures in the Anaesthetic service. This will work to the same principles, and we believe this will be cost neutral, the detailed workings have not yet been completed.

The total recurrent cost of the rotations plus support is £1,551,696, the paper shows where existing budgets can be used to off-set the costs.

The total additional budget required for the rotation is £384,184

This can be analysed as follows:
£233k Medicine overspend (i.e. the overspend would be reduced by this amount but there is no budget to fund);
£50k Medicine – remaining gap
£56k Surgery gap – to be addressed in future BC for Urology
£45k – funding required for admin/non-pay

The total budget to be funded for 2013/14 is £279,746
There is already spend which is not funded. The total spending gap for 2013/14 is £151,622.
This could be reduced to £95,604 if the Urology business case is approved.

The F&P committee approved the case on 20/12/12, and the case was recommended to go to Board for final ratification, so we can commence the recruitment of the year 1 posts, admin & tutor. We will be returning to F&P committee to update on progress & benefits realisation.

We seek to proceed to recruitment to start the programme in April 2013.

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

RISK	**Y**		**Risk Description:** Without investing in the programmes the provision of the junior and middle tier service commitment will remain a challenge, and substantive posts will continue to be supplemented by the use of locum staff, these can be unreliable and deliver inconsistent levels of quality and productivity.
	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 BOARD: *(Please tick or enter Y/N below)*

Decision	Approval	Discussion	Other
Y	Y		

RECOMMENDATIONS FOR THE COMMITTEE:

To support the development of the Trust programme and to authorise the commencement of the recruitment to the rotations.

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 Dudley Group NHS
NHS Foundation Trust

Outline Business Case

TITLE OF PROPOSAL
To Develop a Trust Programme for Junior and Middle Grade Trust Doctors

PURPOSE *(Brief description of the service improvement setting out the objectives for the case and how these fit with the Trust Strategic Objectives)*

The discussion paper on the Development of a Medical Workforce Plan, which went to TME in August, changes in clinical practice and in the training and recruitment of junior medical staff have had an impact on how we provide our clinical service.

Further changes in the way in which we are allocated and organise our junior doctors that are proposed nationally and regionally will mean it is important that we consider that there may be different ways to provide clinical service in the future. We propose that we act together in a strategic way as a Trust, rather than struggle as individual departments to address these issues.

This case outlines a proposal to develop two year programmes to secure high quality and consistent junior and middle tier cover, rather than providing ad-hoc cover using locums, which can be unpredictable resource, of variable quality and difficult to induce/train and regulate

This would provide a sound basis improved planning for specialties around junior and middle doctor cover, and support the increasing demands the Trust faces.

BACKGROUND INFORMATION

- The balance of service provision locally (Black Country), regionally (West Midlands) and nationally is not uniform.
- Services that have moved to Dudley may not have been matched with increased resources to provide those services
- With formation of Health Education England, (HEE); Local Education Training Board, (LETBs), which has replace the Deanery; and Local Education Training Councils, LETCs, we will have a greater say in how we provide education at Local Education Provider, (LEP), level. However, with greater autonomy comes greater responsibility for quality assurance.
- We await the publication of *The Shape of Training* a report commissioned by the GMC. This is a 10-15 year workforce strategy chaired David Greenaway from Nottingham due to report June 2013. This will highlight the challenges of matching the numbers of trainees to the numbers of consultants and GPs needed, the balance between specialism/generalist and hospital/community.
- The distribution of the workforce training posts allocated by the Deanery, (medical and non-medical) is often based upon historical, rather than current needs. This does not necessarily meet the demand of what are needs are now, and what they will be in the future.
- Initial planning guidance from the Joint Working Group gives an indication of the expected

moves in training numbers that regions can expect over the next couple of years. This indicates a reduction in surgical and medical specialties. The Trust will need to plan to overcome the difficulties these changes will bring.

- This is a potential safety issue (if there are inadequate staff), and wasteful (if there is an excess).
- Regional and National reconfiguration of Educational structures will present potential opportunities and threats to our current 'deanery funded' medical workforce
- As a Trust we need a strong regional and national presence to make an argument for retaining as many 'deanery' posts as we can – these come with a percentage of their funding in the MADEL budget (currently £4.9 million pa).
- There is a limited scope for redistribution of this workforce. Often national imperatives (e.g. FY1 expansion in psychiatry/ more community experience at FY2) do not match with needs of the Trust.
- The Clinical Director in Medicine has consulted with the MSHs in Medicines regarding the benefit of "twilight" rota that was introduced to support the numbers of junior doctors available in the early evening and weekend. They are considered valuable, but the service could be provided in a more effective way. We are currently looking at what different options could be applied to improve the clinical contribution of the members of the twilight rota.
- Within the Trust we are seeing increasing demands on workload on the wards and clinical areas, this results in the need to authorise additional locum cover to support the existing rotas.
- When the deanery is unable to fill a post on the rota, we still have the requirement for the post, and so again often turn to short term bank or locum solutions.
- The Trust currently spends on locums is detailed in appendix 1
  It is proposed that a proportion of this spend should be reallocated to fund the programmes. As a consequence we would expect a reduction in the locum spend. The Directorates have reviewed the spend, and indicated where current spend is likely to continue, and where it could be reallocated to the rotations. The detail is highlighted below in the resource impact section
- Analysis on specific cost pressure to ED in 2011/12 from the deanery not filling junior doctor posts was £357,656.
- We are in the early stages of developing a similar rotation for anaesthetics. We have 5 new starters every year and they need minimum of 3 months locum cover before they can do on-call. Often the locum spend goes on beyond this if they are not ready for on-call, or if we are rotated gaps. In addition we are paying some staff grades £80 000 plus to cover on-calls as part of their normal working week (expensive resource and they provide less day-time theatre work); we also use locum staff grades from Hungary to cover. So in addition to large locum spend we have a large staff grade spend which is considerably bigger than it would be for the proposed new non-deanery trainees. If it was possible to recruit these non-deanery posts from overseas we could potentially get rid of the locum spend. This work needs to be further developed.

We therefore need to develop our own solution that enables us to meet the service requirement

CASE FOR IMPROVEMENT

We propose the best way to reduce risk of not having the right level and quality of junior doctors and the subsequent inconsistencies that we currently have in service provision is to recruit high quality, consistent junior and middle tier In-house training schemes, that supplements the deanery trainees:

- Two -year rotations within the Trust to help meet service demands. We would target the specialties that incur the highest locum spend and are deemed to benefit the most from the additional doctors.
- Doctors recruited from UK and overseas.
- This will require different departments to work together to create rotations
- We need to have support for these trainees – a designated tutor, careers advice, exam preparation and protected teaching.
- Good quality 'themed' schemes attract quality doctors, retain them, and generate a steady flow of successors.
- By staggering the starting time of the rotation with existing training posts ameliorates the current risk when an entirely new intake of junior doctors joins the firm together at three points in the year.
- Planned recruitment makes efficient use of HR and interviewer's time by avoiding duplication of effort.
- Future opportunity of linking with international schemes to broaden the recruitment pool.
- Additional middle grade support enables existing post holders to reduce their frequency of out of hours and weekend working, which enables them to be present for a greater degree for routine weekday clinics and ward work. This is seen as a huge benefit by the consultants.
- We also see the investment as a degree of future proofing against some of the service pressures the Directorate anticipate as inevitable due to increasing demand and expectations, but that are not yet fully explored.

The rotations would be attractive because:

- It offers a rotation of jobs for those who haven't finalised their career decision
- The range of specialties on the rotation would attract a wider range of candidates
- This may in future be convertible to LETB posts and into a training rotation, in line with the plans to move to broad base training
- Building in tutor and career advice to support the juniors
- The rotation will enable the juniors to develop a portfolio
- The rotation will ensure the juniors are affiliated to the trust, they will feel part of a team

The proposed rotations are described below:

ST1/ST2 Level for Medicine

	Rotation/Specialty		Total number of doctors
Start month	April	October	
Year 1	EAU/AMU X 2 doctors	Elderly Care/Rehab x 2 doctors	4
Start month	April	October	
Year 2	ED x 2 doctors	Medical Specialty of choice/Float x 2 doctors	4

This is based on 2x six month placements; this enables the juniors to be more productive, as it gives them time to understand the specialty that they're working in.

ST3/ST4 Level for Medicine

	Rotation/Specialty		Total number of doctors
Start month	April	October	
Year 1	Acute Medicine X 2 doctors	ED X 2 doctors	4
Start month	April	October	
Year 2	Specialty of choice X 2 doctors	Acute Medicine X 2 doctors	4

ST1/ST2 Level for Surgery

	Rotation/Specialty			Total number of doctors
Start month	February	June	October	
Year 1	General Surgery X 1doctor	Vascular Surgery X 1 doctor	ED X 1 doctor	3
Start month	February	June	October	
Year 2	SHDU X 1 doctor	Urology X 1 doctor	General Surgery X 1 doctor	3

ST3/ST4 Level for Surgery

	Rotation/Specialty		Total number of doctors
Start month	April - March	April - March	
Year 1	General Surgery X 1 doctor	Vascular Surgery X 1 doctor	2
Start month	April - March	April - March	
Year 2	Vascular Surgery X 1 doctor	General Surgery X 1 doctor	2

OPTIONS CONSIDERED (Brief description of alternative ways to achieve the improvement)

1. **Do nothing:**

The concerns outlined in the background information will remain, and the risks identified will continue to need to be managed.
The situation is likely to deteriorate if we lose deanery funded training posts. It could also impact on future "deanery" visits of existing trainees, who may well give poor feedback on their training experience if they feel unsupported and working in an uncoordinated environment.

2. Apply for additional "Deanery Funded" Training Posts

The likelihood of this being successful is extremely limited, and would only be for ad-hoc posts, which wouldn't allow the Trust to take a systematic approach to the problem

3. **Look at non-medical workforce**
    - Physician's & surgeon's assistants
    - Extended role nurse and AHPs
    - Nurse consultants

These options will be considered in parallel for specific areas, and will work to enhance the skill mix of the clinical workforce.

4. Development of a Trust Programme for Junior and Middle Grade Trust Doctors

The benefits would be as described above. The Trust would be able to plan for a more effective use of the resources that are currently being spent in an ad-hoc manner on locums, but also provide a much more robust level of service.

The posts should have the support of the relevant royal colleges, even though they may not be deanery (LETB) recruited. The aim is for the posts to be 'recognised for experience' for those doctors wishing to take professional examinations. This will make recruitment to the posts more attractive. We are actively pursuing this with other bodies.

It is recommended that we pursue options 3 & 4 as appropriate.

The resource requirements outlined here are to support option 4.

In summary we would be future proofing the junior doctor workforce.

MEASURES Many of the transformation projects require the input of the junior and middle grade doctors to enable them to deliver the required benefits. Anecdotally we are often told that we are unable to deliver changes at the required pace because of lack or resources/engagement of the junior and middle grade staff. If we developed these rotations we would have additional workforce and could put more emphasis on the transformational requirements. Involvement with the transformation programme could be factored into their programme.

The juniors would be more engaged with the Trust objective, as they would be part of a team, and so take greater ownership to deliver solutions.

We would expect the rotation to reduce the current locum spends, and to increase the value of their contribution on the basis that members of the rotation would be more productive & reduce both financial and clinical concerns about the use of locums.

Although we anticipate a contribution to well organised ward rounds, and a reduction in delays of patients being assessed, we have not included a financial value to this.
This proposal will mean that here will be a reconfiguration of the on-call rota for existing trainee doctors. Currently, there has to be a period of rest after on call, which means with the increased working at weekends that has be introduced over recent years for middle grades, missed days of work on Mondays and Tuesdays especially. This proposal will mean that the current middle grade workforce will be released to spend more time on daytime routine clinics and ward work within their specialty during the normal working week. This results in fewer 'reduced clinics' increasing throughput in clinics, more continuity of care and supervision of more junior trainees on the wards in the early part of the week so that decisions on treatment are made which improves patient safety and reduces length of stay.

We would expect positive feedback from trainees, which is crucial when deanery visits take place.

RESOURCE IMPACT *(Staffing, time, costs -capital and revenue, source of funding, income streams)*

The average annual cost of each of the doctors is £58,000.
This includes salary of £32,000, banding of £16,000 and £10,000 on-costs

	Number of Doctors/ WTE	£
ST1/ST2 level for Medicine	8	£434,712
ST3/ST4 level for Medicine	8	£496,984
ST1/ST2 level for Surgery	6	£326,034
ST3/ST4 level for Surgery	4	£248,492
Tutor support	0.1	£15,392
Admin Support	0.3	£10,082
Non pay costs		£10,000
TOTAL recurrent costs		**£1,541,696**

The current spend on junior agency and locums across the trust is as follows:

	Agency	Locum
2012/13 Spend to Month 5	£809,773	£778,794
Pro-rata forecast	£1,943,455	£1,869,105

The above spend does include departments that will not be affected by the rotation, further analysis can be found in APPENDIX 1.

Analysis of the spend has determined what could be diverted to support the introduction of the rotations:

Budgeted Posts to Use to Fund New Rotation	Budget Available	Proposed Junior Rotation Spend	Remaining to be funded	Expected saving in Locum/Agency usage (above budgeted)
ED				
1 WTE Associate Specialist	£97,954			
1 WTE Clinical Fellow	£45,043			
1 WTE Specialty Doctor	£69,061			
0.49 WTE Senior House Officer	£21,684			
	£233,742	£286,108	£52,366	£229,998
AMU				
1 WTE registrar	£62,644			
3 WTE SHO	£151,122			
	£213,766	£353,812	£140,046	£2,564
Elderly Care/Rehab				
No Budgeted Post to use for these New Rotation Posts				
	£84,736	£105,320	£20,584	£0
Float / Other Medical Specialties				
Assumed 4wte will be funded from vacant posts across the directorate	£201,496			
	£201,496	£239,116	£37,620	£0

General Surgery

Currently the demand for Ward cover, Theatres cover and Emergency patient increase is driving the Non consultant medical staffing away from regular consistent assistance in General Surgery Outpatient Clinics. These posts will enable additional activity throughput of 7 patients, in 2 clinics per week for each ST3/4 post . This will provide additional capacity in outpatient clinics of 1664 patients per year. Increasing our 2013/14 activity plan by £176K.

There is a current on call banding risk amongst General Surgery Non Consultant Staffing. This could drive the banding from 40% to 100%. If this were to occur it would cause a cost pressure of £200k. This new staff rotation will prevent this issue.

The remaining funding will be provided from Vacancies within General Surgery.

1. Budget from Increased Income via increased throughput of Outpatient Clinics	£176,400			
2 Vacancies in General Surgery	£56,524			
	£232,924	£232,924	£0	£0

Vascular Surgery

This needs to be funded via Phase 1 & 2 of Vascular Hub. In 2013/14 our contracted Activity amounted to £2m for vascular HUB PYE Phase one. In 2013/14 this Activity plan will grow by £1.5m or £2m for the FYE of phase one and the introduction of phase two Vascular HUB. This increased income shall be used to fund this element of the case.

Budget from Increased Income from Vascular HUB phase 1&2	£176,906			
	£176,906	£176,906	£0	£0

SHDU

This needs to be funded via Phase 1 & 2 of Vascular Hub. In 2013/14 our contracted Activity amounted to £2m for vascular HUB PYE Phase one. In 2013/14 this Activity plan will grow by £1.5m to £2m for the FYE of phase one and the introduction of phase two Vascular HUB. This increased income shall be used to fund this element of the case.

Budget from Increased Income from Vascular HUB phase 1&2	£56,018			
	£56,018	£56,018	£0	£0

Urology

The ST1/2 shall form part of the year 2 rotation. In early 2013 a Urology Business Case will be submitted which will outline a New Activity Plan for 2013/14 and resources required to enable us to deliver the suggested activity plan. The funding for this post will be picked up in the Urology Business Case.

	£0	£56,018	£56,018	£0
New Post - Admin Support		£10,082	£10,082	
New Post - Tutor 1pa		£15,392	£15,392	
New - Non Pay		£10,000	£10,000	
Totals	**£1,199,588**	**£1,541,696**	**£342,108**	**£232,562**
Medicine Rotation shortfall			**£250,616**	**£232,562**
Surgery Rotation shortfall - *However this is solely the Urology Post for which another Business case that will include funding request for this post will be submitted early 2013.*			**£56,018**	

Financial summary;

There is a Total Medicine shortfall in budget of £250,616. However, this shortfall is partly offset by the reduction in locum/agency spend that is currently taking place above budget, leaving an overall gap of **£18,054**. In addition, there may be a possibility of converting one of the ST3/ST4 specialty of choice doctors within Medicine to an Orthogeriatrician. This will make a further £66,906 budget available to offset the proposed costs.

There is a Surgery shortfall of **£56,018** which will be addressed in the Urology business case.

The admin support, additional tutor pa and non pay will all be additional spend equating to **£35,474**.

The total additional budget required for the rotation is <u>£342,108</u>
This can be analysed as follows:

£232,562 Medicine overspend (i.e. the overspend would be reduced by this amount but there is no budget to fund – mainly ED medics);

£18,054 Medicine – remaining gap but may be able to offset a further £66,906 for an Orthogeriatrician post;

£56,018 Surgery gap – to be addressed in future business case for Urology

£35,474 – funding required for admin/non-pay

RISKS AND DEPENDENCIES
Without investing in the programmes the provision of the junior and middle tier service commitment will remain a challenge, and substantive posts will continue to be supplemented by the use of locum staff, these can be unreliable and deliver inconsistent levels of quality and productivity.

If we proceed with the programme the risks will be:

- Failure to recruit to the programme: we would be left with gaps in the rotation that we'd have to fill using locums, so being no better off than currently position.
- Lack of support from the royal colleges would mean that we may not attract the highest calibre of candidates, we would still work to a minimum standard specification to ensure we were delivering the appropriate quality of care
- Failure to get support from the specialties to support the programme means that we would not have a balanced attractive programme, and we would not give the service contribution to the pressured specialties
- Failure to plan the programme rotas to support service delivery to enable the reduction in the use of locums means that we would not release the predicted costs

If we don't proceed with the programme:

- Delay in implementing the programme means that the issues that are identified within the background section as risks with the current system would still continue

HIGH LEVEL IMPLEMENTATION PLAN *(Key actions ,delivery timescale, who lead/ involved, tools to be used, follow up, post-project review & learning)*

The tutor would be in overall charge of the programme and would act as the clinical lead to the implementation programme. The post holder would monitor the progress of the programme. The progress will be reported to the Head of Medical Education, and on to the Medical Director.

Anticipate Start Date:
We have designed the start date of the programme to complement the August changeover of the

junior trainees
We would roll out by recruiting to year 1 of the medical and surgical ST1/ST2 rotation. If we had timely approval we would aim to begin the first rotation in April 2013.

Curriculum:

- The curricula would follow the CMT teaching, and the Surgical Core trainee teaching programmes. They would align with the relevant royal college requirements.
- Teaching would be alongside the junior doctor trainees
- They would produce a portfolio equivalent to that of the trainees, but it may need to be paper based initially
- Teaching would be based on educational supervision and assessments

Recruitment:

- There would be a rigorous panel assessment. Senior clinical trust representatives would form the panels
- It would be OSCE style, (Objective Structured Clinical Examinations), with 3 stations
- Normal Trust recruitment standards would be applied

Induction programme:

- The programme would be based on a similar structure to that of the trainee juniors

IDEA ORIGINATOR *(Name & Signature)*

IDEA SPONSOR/ LINE MANAGER *(Name & Signature*)

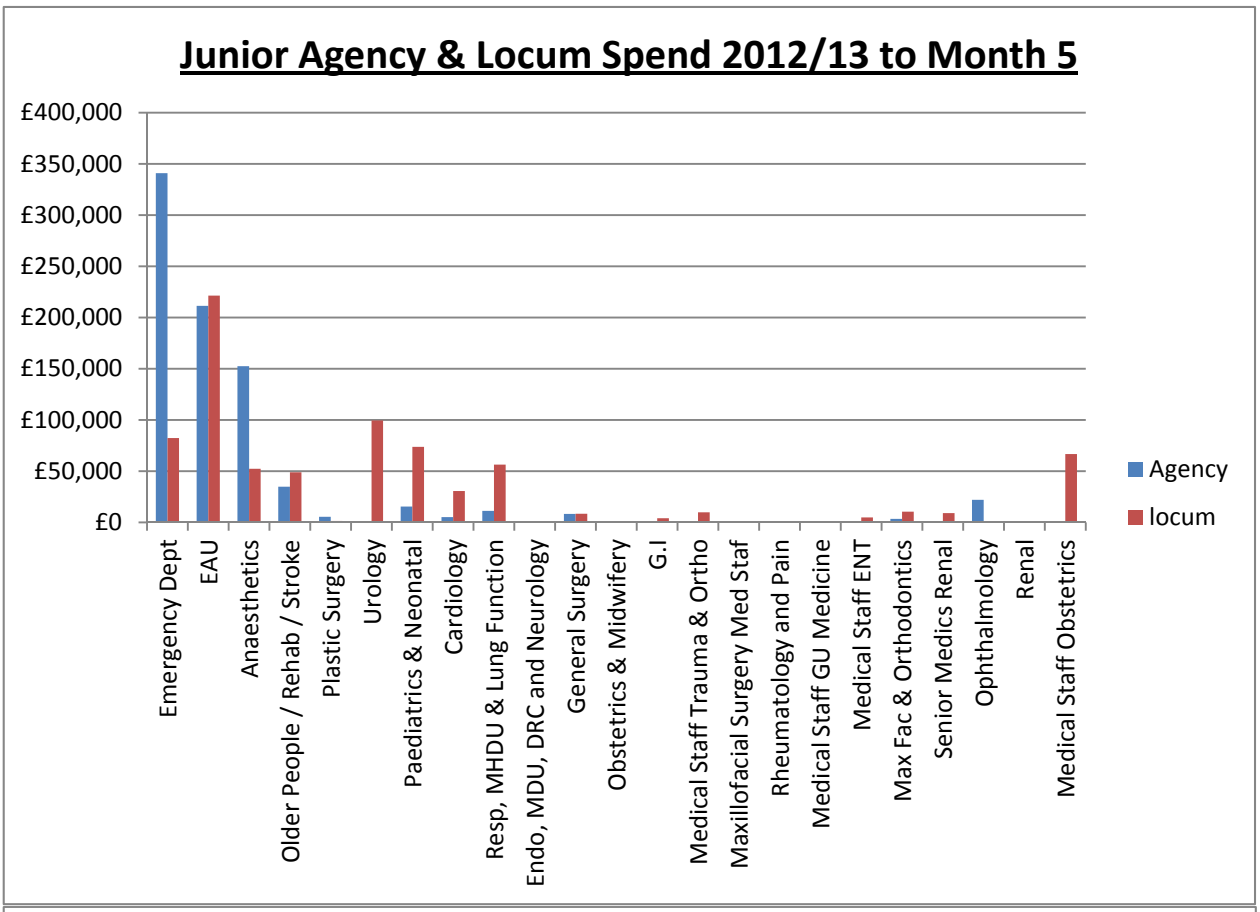
APPROVED BY:

Medical HOS……..
Matron……..
General Manager ……..
Director (Corporate Directorates)……..
Senior Asst Director of Finance……..

APPENDIX 1:

JUNIOR MEDICAL STAFF AGENCY EXPENDITURE 11/12

	2011/12		2012/13 (to Month 5)		Comments
	Agency	**Locum**	**Agency**	**locum**	
Emergency Dept	£903,462	£124,993	£340,852	£82,238	11/12 spend high due to unfilled deanery posts
EAU	£268,581	£361,596	£211,326	£221,384	Case will address part of this spend
Anaesthetics	£419,873	£134,244	£152,365	£52,299	Case will not affect this spend
Older People / Rehab / Stroke	£349,194	£67,584	£34,779	£48,848	Reduced significantly from 11/12.
Plastic Surgery	£137,910	£76,732	£5,371	£1,323	Case will not affect this spend
Urology	£129,248			£99,489	Case will not affect this spend
Paediatrics & Neonatal	£36,068	£88,303	£15,446	£73,691	Case will not affect this spend
Cardiology	£16,565	£101,836	£5,047	£30,519	Floating Medicine juniors may impact on this spend
Resp, MHDU & Lung Function	£60,829	£52,735	£11,116	£56,308	Floating Medicine juniors may impact on this spend
Endo, MDU, DRC &Neurology	£53,021	£27,887			Case will not affect this spend
General Surgery	£21,454	£29,559	£8,151	£8,300	
Obstetrics & Midwifery	£240	£43,883			Case will not affect this spend
G.I	£19,914	£22,134		£3,991	
Medical Staff Trauma & Ortho		£23,856		£9,714	Case will not affect this spend
Maxillofacial Surgery Med Staf		£22,035			Case will not affect this spend
Rheumatology and Pain	£4,961	£14,108			
Medical Staff GU Medicine		£17,082			
Medical Staff ENT		£12,594		£4,723	Case will not affect this spend
Max Fac & Orthodontics	£8,294	£2,107	£3,395	£10,344	Case will not affect this spend
Senior Medics Renal		£5,111		£9,000	Case will not affect this spend
Ophthalmology	£3,493		£21,927		Case will not affect this spend
Renal	£1,456				
Medical Staff Obstetrics				£66,623	Case will not affect this spend
TOTAL	**£2,434,563**	**£1,228,379**	**£809,773**	**£778,794**	


Junior Agency & Locum Spend 2012/13 to Month 5
£400,000
£350,000
£300,000
£250,000
£200,000
£150,000
£100,000
£50,000
£0
Emergency Dept
EAU
Anaesthetics
Older People / Rehab / Stroke
Plastic Surgery
Urology
Paediatrics & Neonatal
Cardiology
Resp, MHDU & Lung Function
Endo, MDU, DRC and Neurology
General Surgery
Obstetrics & Midwifery
G.I
Medical Staff Trauma & Ortho
Maxillofacial Surgery Med Staf
Rheumatology and Pain
Medical Staff GU Medicine
Medical Staff ENT
Max Fac & Orthodontics
Senior Medics Renal
Ophthalmology
Renal
Medical Staff Obstetrics
Agency
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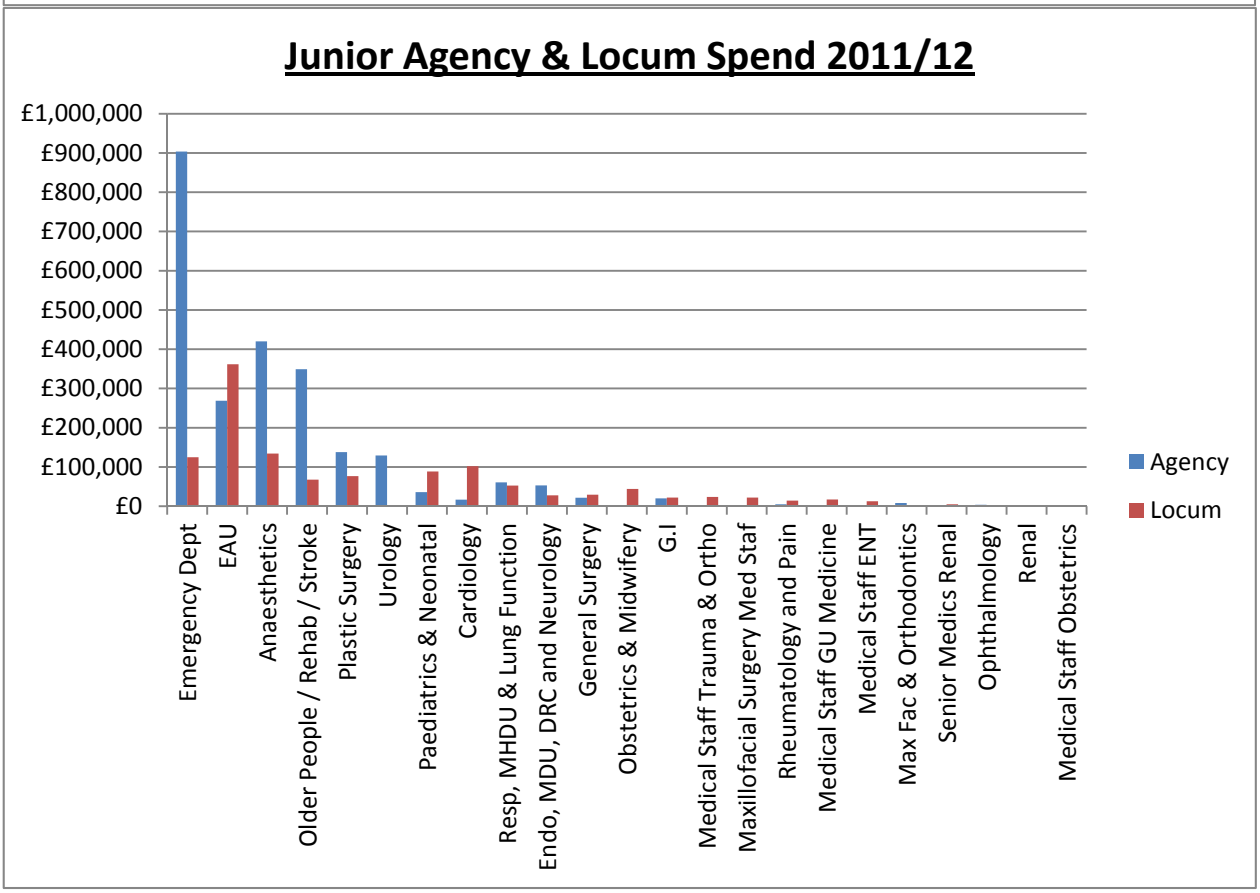

Junior Agency & Locum Spend 2011/12
£1,000,000
£900,000
£800,000
£700,000
£600,000
£500,000
£400,000
£300,000
£200,000
£100,000
£0
Emergency Dept
EAU
Anaesthetics
Older People / Rehab / Stroke
Plastic Surgery
Urology
Paediatrics & Neonatal
Cardiology
Resp, MHDU & Lung Function
Endo, MDU, DRC and Neurology
General Surgery
Obstetrics & Midwifery
G.I
Medical Staff Trauma & Ortho
Maxillofacial Surgery Med Staf
Rheumatology and Pain
Medical Staff GU Medicine
Medical Staff ENT
Max Fac & Orthodontics
Senior Medics Renal
Ophthalmology
Renal
Medical Staff Obstetrics
Agency
Locum

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

In Confidence

Minutes of the Board of Directors Meeting held on Thursday, 6th December, 2012, in the Clinical Education Centre

Present:

John Edwards, Chairman
David Bland, Non Executive Director
Richard Miner, Non Executive Director
Richard Beeken, Director of Ops, & Transformation
Paula Clark, Chief Executive
David Badger, Non Executive Director
Ann Becke, Non Executive Director
Paul Harrison, Medical Director
Denise Mcmahon, Nursing Director
Jonathan Fellows, Non Executive Director

In Attendance:

Helen Forrester, PA
Annette Reeves, Assoc. Director for HR
Kaye Sheppard, Matron (item 1.)
Jackie Dietrich, Communications Manager (item 10.2)
John Thornbury, Assoc. Director of IT (items 10.4 & 10.7)
Elena Peris-Cross, Apprentice
Tessa Norris, Director CSIC
Michael Sullivan (Item 8.1)

P12/147 Matron's Presentation (Enclosure 1)

Kaye Sheppard, Matron for Critical Care, MHDU and AMU, presented her report, given as Enclosure 1, including:

- Nursing Care Indicators, Monthly Ward Progress Reports: B5 results are a temporary irregularity and do not reflect the care in that area. C7 scores are a result of the acuity of patients needing 1:1 nursing care, staffing levels have now been increased in this area. C2 Paediatrics scores are as a result of problems with documentation and not nursing care.

- Infection Control: Issue with terminal cleans. The Chief Executive suggested that the Trust extends fogging into the evening. The Nursing Director confirmed that a Fogging Business Case is currently being prepared for the next TME meeting.

- NHS Safety Express

- Matrons' Key Issues

Board members noted that the Trust is continuing with its leadership work to look at who its Consultant leaders are. It was also noted that Allocate are being used to help with consultant job planning to facilitate early discharge.

Jonathan Fellows, Non Executive Director, asked about progress with the new electronic whiteboard trials. Kaye confirmed that there had been some technical difficulties.

The Chairman thanked Kaye for her informative presentation.

P12/148 Welcome and Apologies

Apologies were received from Paul Assinder.

P12/149 Declarations of Interest

There were no declarations of interest.

P12/150 Announcements

The Chairman confirmed that a brief Nominations Committee meeting was being held directly after the Board.

P12/151 Minutes of the meeting held on 1st November, 2012 (Enclosure 2)

David Bland, Non Executive Director, queried the first paragraph on page 12 of the minutes under the Infection, Prevention and Control Report. The minutes were amended to clarify the point as follows:

"The Nursing Director confirmed that Kevin Shine had produced a good piece of work on taking out the Trust's who are not similar to our own so that benchmarking is more meaningful. Dudley Group has a 0.20 rate of C.Diff per 10,000 bed days and similar to other Acute Trusts."

With this amendment the minutes were agreed as a correct record and signed by the Chairman.

P12/152 Matters Arising on the Action Sheet of 1st November, 2012 (Enclosure 3)

P12/152.1 AMU Business Case

Item completed.

P12/152.2 Chief Executive's Report

Medical Revalidation covered on the agenda under item 10.1.

In relation to the car parking increase, the Director of Operations and Transformation confirmed that there had been little progress. With regard to the action point of payment machines being in place before the uplift takes place and improvements made to access points, the Summit Board had rejected the improvements to access and also had not agreed to 'chip and pin'. The Chairman reiterated that the cost increase should not be implemented until all issues are resolved.

P12/152.3 Board Secretary's Report

Item completed.

P12/153 Chief Executive's Report (Enclosure 4)

The Chief Executive presented her report given as Enclosure 4. Board members noted the following key areas:

- **Monitor Visit:** Meeting went well and was very low key.

- **Friends and Family:** Figures remain static with NPS of 76 for November overall. The Chairman asked if there were any implications of changing the questions. Board members noted that all Trusts were in the same position. David Bland confirmed that we were moving to a 6 point scale. The Chief Executive commented that this is something the Trust continues to work on and the feedback from the MBA students will be interesting to discuss.

- **Benchmarking for Friends and Family:** Tenth place regionally (joint with a number of other Trusts)**.**

- **Issues:** Noted that wards B2 and C8 are struggling and have asked for help.

- **Emergency Pressures and BBC Midlands Today:** The Trust played host to BBC Midlands Today following an enquiry about ambulance turnaround times. Pressures on the hospital remain and Q3 95% ED performance is at risk. The Chief Executive confirmed that numerically the Trust can still limp over the 95% line in Q3 but this is something that needs constant attention to maintain focus on the target. The Director of Operations and Transformation confirmed that the Trust should be receiving recommendations from the Intensive Support Team visit later that day.

- **NHS Mandate:** The NHS Mandate has been launched which sets out the Government's and NHS Commissioning Board's objectives for the next two years.

- **NHS Confederation Regional Event:** Gloom noted around how the system is moving forward.

- **Summit Board:** The Chief Executive presented to their Board the previous Friday. She met with Alison Phillipson and Jackie Cardiff, the Projects Team representing Summit Healthcare. Alison and Jackie have requested a meeting with the Trust's Executive Team and the Chief Executive confirmed that she thought the Trust should take advantage of the new start with Alison and Jackie. The Director of Operations and Transformation pointed out that neither Alison nor Jackie had yet approached himself or Robert Graves. The Chairman commented that Summit need to change their approach and the way they steer the SPV and it was unacceptable that they had not yet spoken with the Trust Representative. The Chief Executive responded that we first to need confirm if they have officially commenced and whether they have attempted to make contact and would speak to Bob Marsden to check. The Chairman also stated that he would raise with David Poynton. Jonathan Fellows, Non Executive Director, suggested that the issue could be an agenda item at the next CEG meeting.

- **Nurse of the Year Awards:** Board members noted that we have a nurse, Sara Davies, in the national final of only 2 nurses and this was excellent news.

P12/154 Quality

P12/154.1 Clinical Quality, Safety and Patient Experience Committee (Enclosure 5)

David Bland, Committee Chair, presented the exception report from the meeting held on 11th October, 2012, given as Enclosure 5. The Board received the report for information and noted the following points:

- **Three Areas Lacking Compliance:** Committee to continue to monitor.
- **Friends and Family:** Discussed under the Chief Executives Report.
- **Patient Experience Strategy:** There was a general view that it is a more operational list and we need to move up a level.

The Chairman asked about the latest position of food provision. The Director of Operations and Transformation confirmed that there is a proposal to move to the 'Steamplicity' System which had the full backing of Dr Cooper, Nutritional Lead. It was hoped to implement the system early in the New Year and should deliver around a £400k saving. Richard Miner, Non Executive Director, asked how 'Steamplicity' worked. The Director of Operations and Transformation confirmed that it was basically a microwaveable plated meal with the aim of retention of moisture and nutritional value. David Badger, Non Executive Director, acknowledged that the system has worked in other Trusts and had been well received. The Chairman asked if this would mean a change of supplier. The Director of Operations and Transformation confirmed that we need to check as this was a sub contractual decision for Interserve. The Chairman asked for a one page update to the February 2013 Board. David Badger reminded Board members that we gave a commitment to let Governors try the food. The Director of Operations and Transformation confirmed that Robert Graves is aware of this.

Board members noted the report.

Update on food provision to the February, 2013, Board.

P12/155 Productivity

P12/155.1 Matters arising from the Finance and Performance Committee by Exception (Enclosure 6)

David Badger, Committee Chair, presented matters arising from Finance and Performance Committee, given as Enclosure 6.

David Badger explained that Transformation efficiency savings were being identified, the Transformation Programme Board has a big challenge on its hands and he believed the whole health economy needs to be involved.

The Board noted that the Workforce KPI's had seen an increase in sickness absence making the Trust's end of year target now a challenge.

David Badger informed the Board that the amount of appraisals being undertaken had decreased again which is a cause for concern; however we have received a detailed action plan which should improve the situation. The Chairman expressed his disappointment with the appraisal figures. Board members noted that the 14 month rolling programme provides assurance that this is being addressed. The Chairman asked if the figures for appraisals included PFI staff. The Associate Director for Human Recourses confirmed they were not included in the numbers.

The Chief Executive commented that the staff survey response was worse this year despite changes being made. Staff morale is low at present and this is a big challenge, however it depends on staff wanting to engage we must turn these bad feelings around in the next 12 months.

Ann Becke, Non Executive Director, said that she was confident we will see changes, the appraisals are important as they are a tool to make staff feel valued.

David Badger announced to the Board that the Trust had received a good response from the CCG which puts us back into a possible projection for end of year balance.

The Board noted the Trust is still operating with a significant trading deficit.

The Chairman queried where the non-pay overspend is coming from. Michael Sullivan clarified that there was no consistent pattern as it comes from a number of areas, recently the amount of drugs used in October was high and we have also had PFI uplift.

Regarding the performance targets, the Board noted the A&E breaches in October and that the diagnostics waits had improved dramatically ahead of the Trust's improvements plans.

The Nursing Director confirmed that there was an error in the figures for c-diff which should read 34 cases and not 92 as shown in the report. The Chief Executive also suggested that the wording should be changed to ''ceiling'' and not referred to a trajectory as this figure is not a target.

P12/156 Prevention

P12/156.1 Infection Prevention and Control Exception Report (Enclosure 7)

The Nursing Director presented the Infection Control Report, given as Enclosure 7.

C.diff: The Board noted that there had been 6 cases of C.diff for October and November, this is below the ceiling.

MRSA: 1 case – details in report stated the patient was negative on admission, during their stay they moved wards and tested positive, the patient has since died so it will be classed as an MRSA death. This is one case against our target of 2.

Norovirus: Confirmed on 2 wards; C8 and C5, the cases are enclosed in 2 stations.

The Nursing Director clarified that the Trust was now in outbreak mode because of 2 consecutive months with 6 cases. There is Chlor cleaning taking place across the Trust.

Enterobactor: No cases.

Whooping Cough: One member of staff diagnosed and one oncology patient confirmed.

The Nursing Director reminded the Board if a member of staff is suspected of having whooping cough they must be sent home.

The Chief Executive asked how we clinically judge norovirus cases.

The Nursing Director informed that if a sample is positive, all patients in that bay are considered as infected and are dealt with accordingly.

P12/156.2 Risk and Assurance Committee Exception Report (Enclosure 8)

Ann Becke, Committee Chair, presented the Risk and Assurance Committee Exception Report, given as Enclosure 8.

Ann clarified that the Committee meet quarterly and have recently had two extraordinary meetings to get policies updated, this was successful and they are now on the Trust's Hub, alerts are now in place to keep all policies up to date.

The Board noted that before the structure of the Committees had been altered, Clinical Directors were attending the Committee; however it was felt not to be a good use of their time. It has since been agreed Clinical Directors and General Managers to attend on a rota basis.

Ann Becke confirmed that the Trust had achieved very good ratings on the survey for maternity services.

The Chairman pointed out the key risk for Human Resources is around mandatory training.

Richard Miner, Non Executive Director, asked if Monitor raised any issues. The Chairman confirmed that Monitor had only asked for assurance that the Board were dealing with mortality issues.

P12/156.3 Safeguarding Report (Savile Allegations) (Enclosure 9)

The Nursing Director presented the Safeguarding Report, given as Enclosure 9.

Board Members noted that this is a quarterly report. The Nursing Director emphasised the good news on item 4 on the report regarding the CCG securing the funding for the learning disability liaison role.

The Nursing Director confirmed that the safeguarding audit was now complete but there were still a few issues. There is a focus at ward and department level.

The Nursing Director confirmed that some of the PFI partner staff had now undertaken safeguarding training and she was hopeful to continue to see movement.

David Badger, Non Executive Director, indicated the need to stress the importance of this and raise the 17% of PFI partner staff to have completed the training as the Board held responsibility for PFI staff. He also questioned if there are other areas that we train our staff on that their staff should be doing. The Associate Director for Human Resources explained the mandatory training list will have to be examined.

The Director of Operations and Transformation confirmed that PFI staff were not hitting targets and Robert Graves, Deputy Operations Director (Estates and Facilities) had been applying NCI's.

The Chairman assured the Board he would raise this matter with David Poynton.

The Nursing Director confirmed that the Trust had received a letter from David Nicholson stating that the Board needs to examine their position on safeguarding following the Savile Allegations. The Trust takes assurance on the process being undertaken although there were still some minor issues to resolve.

The Nursing Director confirmed that the following policies were being reviewed:

- Safeguarding
- CRB policy
- Volunteers policy
- Wishing Well

In relation to celebrity visitors, the Nursing Director reminded the Board that appropriate supervision was necessary at all times. She added that the Trust already does this but needs to get its procedures regarding celebrity visitors included as a policy.

Tessa Norris, Director of Community Services and Integrated Care, stated that only performing one CRB is not really adequate and we need to follow up with regular checks if an employee changes jobs or roles within the organisation.

David Badger, Non Executive Director, asked if there was a consistency of judgement with the application of CRB checks.

The Chief Executive said we had to ensure all organisations align risk rating on past spent convictions. She confirmed that she would raise this with Wolverhampton University at a meeting early in the New Year.

The Associate Director for HR confirmed that the policy was ratified for NHSLA and CRBs would be followed up every 3 years.

David Bland, Non Executive Director, asked if Trust volunteers are CRB checked. The Nursing Director assured that they were.

The Board noted the report and an update of progress will be given in the next quarterly report to the Board.

The Chairman reminded the Director of Operations and Transformation that we need absolute assurance from PFI partners that they follow our policy and undertake the e-learning we provide for mandatory and safeguarding training.

The Chairman will raise this with David Poynton.

Trust to receive assurance from PFI partners around their policy on CRB checks.

Update on progress in next safeguarding quarterly report to the Board.

Chairman to raise PFI staff training with David Poynton.

P12/157 Corporate and Strategic Matters

P12/157.1 Medical Revalidation Report (Enclosure 10)

The Medical Director presented the Medical Revalidation Report, given as Enclosure 10.

The Medical Director confirmed that medical revalidation had gone live on the 1st December, 2012. The process is complicated and there is still work in progress. Appraisals are an important part of the revalidation process and these are now done electronically. The Assistant Medical Director, David Perks, is leading the work on this process.

The Medical Director reported to the Board the impact of revalidation was:

- Two day formal training programme will have to undertaken
- A new team of separate appraisers will be needed which creates a lot of work.
- There are potential costs for remediation.

Ann Becke, Non Executive Director, asked for clarification of the term strengthened. The Medical Director clarified it fits in with the GMC's description of an appraisal.

Jonathon Fellows, Non Executive Director, asked how many doctors are included in this. The Medical Director confirmed that it includes all staff grade associates of which there were approximately 200-250.

The Medical Director confirmed that the biggest issue are the costs, especially for the remediation and also the time impact.

David Badger, Non Executive Director, pointed out that this creates additional pressure for the Medical Director and the workforce.

The Medical Director assured the Board that the process gives a better understanding and assurance of the workforce. He pointed out we were monitored on this by the GMC and SHA.

David Badger asked if any resources had been allocated to Trusts. The Medical Director confirmed that there was no funding available.

Jonathan Fellows questioned who undertakes the GP appraisals. The Medical Director confirmed there was a team of responsible officers for the West Midlands.

The Medical Director confirmed that as he was the responsible officer for the Trust he was unable to undertake appraisals.

The Chairman noted the issues including direct and indirect costs as well as the time impact. The Board noted contents of the report and requested the Medical Director to provide further feedback at the March Board meeting.

The Medical Director to feedback to the March, 2013, Board meeting.

P12/157.2 LiA Report (Enclosure 11)

Jackie Dietrich, Communications Manager, presented the LiA Report, given as Enclosure 11.

Jackie confirmed that 16 teams were still undertaking LiA's, 2 teams to have completed these are Oncology and main Outpatients. Four teams have yet to commence due to other pressures were Chaplaincy, Health Records, Maternity and Anaesthetics.

Jackie Dietrich gave some highlights from the report as follows:

- Co-ordinator – cancer services.

- Wrong patients were turning up in Cardiology as it is not clear what Department they are, the lack of identity and recognition of this department effects staff morale. Ideas to resolve this included putting up posters clearly stating 'Cardiology' and giving them unique uniforms. Morale was boosted by creating an appraisal system specially personalised for this department.

- Raising profile of clinical audit.

- Improving the quality of service in Community Podiatry.

- Improve the quality of referrals and reduce inappropriate referrals in Dietetics.

- Improve communication of the financial position – Finance customers and staff view.

- Improve the flow from unit to ward in surgical HDU.

The Chief Executive thanked Jackie Dietrich for 'keeping the plates spinning' with the LiA's, considering that Communications were presently low on staff. She suggested that the LiA system can be pushed forward once the new communications staff member starts in the New Year to give the programme some real emphasis again.

The Chairman noted that the success of this was down to the leaders who have to be motivational. The Chief Executive agreed and stated that these staff should be encouraged to go further and lead change.

The Chairman asked if the Associate Director for Human Recourses could look at the appraisal system used in Cardiology to see if it can be used elsewhere. He also thanked Jackie Dietrich for keeping on top of the LiA's.

Jackie confirmed that there were plans to have an LiA page on the Hub as well as undertaking another mood meter after Christmas.

P12/157.3 Medical staff update (Verbal)

The Medical Director presented the Medical staff update as a verbal report.

The Medical Director informed the Board there were a number of cases outstanding with the GMC, however only one new case has been opened since the last update. Most of these cases involve junior doctors, many of which no longer work with the Trust. The Medical Director had previously met with the GMC and was told compared to other trusts we have a low number of cases.

The Medical Director confirmed that the Trust has 2 ongoing cases and 1 case due to commence, these were regarding inappropriate behaviour issues. Three cases reported in the last report have since been closed. Importantly no one had been suspended.

The Board was happy to note we were in a better position than other Trusts.

P12/157.4 Real Time Bed Management Business Case (Enclosure 12)

John Thornbury, Associate Director for IT, presented the Business Case, given as Enclosure 12, and apologised for not presenting the Business Case to the Finance and Performance Committee beforehand.

John confirmed to the Board that the biggest problem currently in the Trust is being unable to produce a real time bed state, leading to not being able to provide a good admissions service. This has an impact on many processes and it is very important we have a system in place.
The Paper proposes putting electronic whiteboards on all wards which use a drag and drop service which can admit, discharge and transfer patients quickly, furthermore handover notes and MRSA alerts can be flagged up.

John explained how the software costs are fairly small, however the PFI partners charges in installing the whiteboards is considerably large. Despite this, there are potential savings, although managing bed states will mainly be a driver to enable other projects.

The Medical and Nursing Directors and the Director of Operations and Transformations all expressed their enthusiasm for the business case.

Richard Miner, Non Executive Director, confirmed that he was enthused when reading the report, however was let down by the finance team and the lack of benefits they had worked up for this.

David Badger, Chairman of the Finance and Performance Committee, explained that the business case had not been to Finance and Performance Committee and the report did not go far enough to be a business case, however he welcomed it as a proposal.

The Chief Executive said the pace has to be picked up with this, however all business cases should follow a process.

David Badger suggested that the Board should agree a trigger for bypassing the Finance and Performance Committee.

John Thornbury informed the Board that not many sites have this system, Worcester use this but have not demonstrated the benefit. The Trust should drive this and show the benefits.

Jonathon Fellows, Non Executive Director, asked how quickly this product could be rolled out into the Trust and what backup there was if IT systems fail. John confirmed that the timeframe depends on the PFI partners and the installation, subject to that it should only take 6-8 weeks. With regard to back-up he pointed out that the product included desk top touch screens as well as a portable touch screen which can be used all over the Trust.

The Director of Operations and Transformation confirmed that the Trust must consistently challenge the PFI partners costs as these are too high and we should do this at an early point so that the 6-8 week process can begin.

David Bland queried how many whiteboards will be installed. John confirmed that there will be around 70 of varying sizes. David asked if we had looked at other products. John assured the Board that he had undertaken market analysis and this product was 50% cheaper than competitors, it also has the exact integration the Trust requires.

The Board approved the investment as this enabled work of huge value to the Trust. The Chairman included the following caveats:

- Cost benefit analysis to be produced
- Board to be clear about options and evaluation
- IT business cases need to revisited at the Finance and Performance Committee on a quarterly basis and then presented to the Board in the Finance and Performance Report.

The Chairman confirmed that he would raise the installation cost issue with David Poynton.

Chairman to raise issue regarding installation costs with David Poynton.

IT business cases to be revisited at the Finance and Performance Committee on a quarterly basis.

P12/157.5 Charitable Funds Committee Terms of Reference (Enclosure 13)

Richard Miner, Committee Chair, presented the Charitable Funds Committee Terms of Reference, given as Enclosure 13.

Richard made the point that he wanted to make the group more focused and efficient for releasing funds.

The Board endorsed the Terms of Reference.

P12/157.6 Pathology Report (Enclosure 14)

The Director of Operations and Transformations presented the update on Pathology, given as Enclosure 17. He explained the progress report was brief update following the report to the previous Board. Board members noted the revised timetable commencing with the PQC process in January 2013. The MoU between Sandwell and West Birmingham and Synlab will be signed next week.

The Director of Operations and Transformations confirmed that the joint Project Board had agreed not to inform front line staff that the relationship with Synlab was being formalised. He also confirmed the engagement with LTS industrial engineers to look at scenarios.

An Options Appraisal will be presented to the Board in the New Year.

Options Appraisal to be presented to the Board in the New Year.

P12/157.7 Integrated Rostering and Bank Solutions Business Case (Enclosure 15)

John Thornbury, Associate Director for IT, presented the Business Case, given as Enclosure 15.

The Business Case was approved last week under Chairman's Authority due to savings.

Board members noted that the Trust currently has various software from several different companies. The Business Case shows that a company who has all of the software and performance dashboards in one product can provide a potential saving of £60k per annum.

The Nursing Director agreed that this was a good system and it had much more functionality however gave a health warning around the WTE savings in the report. It gives us a really good product to manage rosters and weekend shifts. With regard to management of the product the Nursing Director confirmed that she would need to understand further the requirements.

The Chairman confirmed that the Director of Finance's opinion of this product was that it was more efficient and better. It will allow the Trust to have a safe rostering template which other staff cannot over-ride.

The Nursing Director added it would give us a cost per bed and nurse ratio per bed which would also help us evaluate the skill mix work.

The Chairman agreed it gave us better assurance around patient safety and better staffing.

Ann Becke, Non Executive Director, pointed out non tangible benefits, giving us evidence for Commissioners around bed blocking and management.

Jonathon Fellows, Non Executive Director, asked how quickly the system could be up and running and what impact Siemens will have. John confirmed that the product will take 5-6 months to set up and that he was currently doing a detailed plan. He confirmed that Siemens will have no impact.

The Board endorsed the proposal.

The Chairman asked for an update to the Finance and Performance Committee and noted the Nursing Directors comments about the management of the system.

P12/ 157.8 Any Other Business

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

P12/158 Date of Next Meeting

The next Board meeting will be held on Thursday, 10th January, 2013, at 8.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 3

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors
Held on 6 December 2012
PRIVATE

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
P12/157.4	Real Time Bed Management Business Case	Chairman to raise issue regarding installation costs with David Poynton. IT Business Cases to be revisited at the Finance and Performance Committee on a Quarterly basis.	C DFI	Dec 12 March 13	Done
P12/133	Clinical Directorate Presentation	Once discussions around Upper GI have progressed further, the Chief Executive to provide an update in her Chief Executives Report.	CE	10/1/13	In CEs Report
P12/157.6	Pathology Report	Options Appraisal to be presented to the Board in the New Year.	DOT	10/1/13	To Feb Board
P12/117.3	Audit Committee Exception Report	Audit Committee Terms of Reference to be amended after NHSLA to include the requirement of the Nursing Director or Medical Director or a nominee to attend the Committee.	JF	15/1/13	
P12/142	Transformation Report	Transformation to be reported to the Board on a Quarterly basis. Executive Directors to debate the membership of the Transformation Programme Board.	C	7/2/13	
P12/154.1	Clinical Quality, Safety and Patient Experience Committee	Update on food provision to the February, 2013, Board.	DOT	7/2/13	
P12/101	Any Qualified Provider Report	AQP outcome report to be presented to the Board when the process is complete.	DCSIC	Feb/March 2013	

P12/156.3	Safeguarding Report	Trust to receive assurance from PFI partners on their policy for CRB checks. Update on progress in next Safeguarding Quarterly Report to Board. Chairman to raise PFI staff training with David Poynton.	ADHR ND C	7/3/13	
P12/157.1	Medical Revalidation Report	The Medical Director to feedback to the March, 2013, Board meeting.	MD	7/3/13	
P12/144	Vascular Hub	Progress report to be presented to the Board in May, 2013.	DOT	2/5/13	
P12/134	Intelligent Kindness	Update report in Intelligent Kindness to be presented to the Board in July, 2013.	MD	4/7/13	

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 10th January 2013

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Report
- Stroke Services Review update
- Upper GI update
- GEH
- Alcohol consultation

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
NHS Foundation Trust

Chief Executive Update – January 2013

Friends and Family Report:

	Apr-12	May 12 overall	June 12 overall	July 12 overall	Aug 12 overall	Sept 12 overall	Oct 12 overall	Nov 12 overall	Dec 12 overall
Date range	Baseline Month	29/04/2012 26/05/2012	27/05/2012 30/06/2012	01/07/2012 28/07/2012	29/07/2012 25/08/2012	26/08/2012 29/09/2012	30/09/2012 27/10/2012	25/10/2012 24/11/2012	25/11/2012 29/12/2012
Organisation NPS - weekly	52	77*	76*	73*	77*	77*	76*	76*	75*
% of footfall (inpatient discharges - Min'm 10%)	12%	15%	12%	19%	18%	18%	22%	29%	21%
* CQUIN upper quartile achieved									

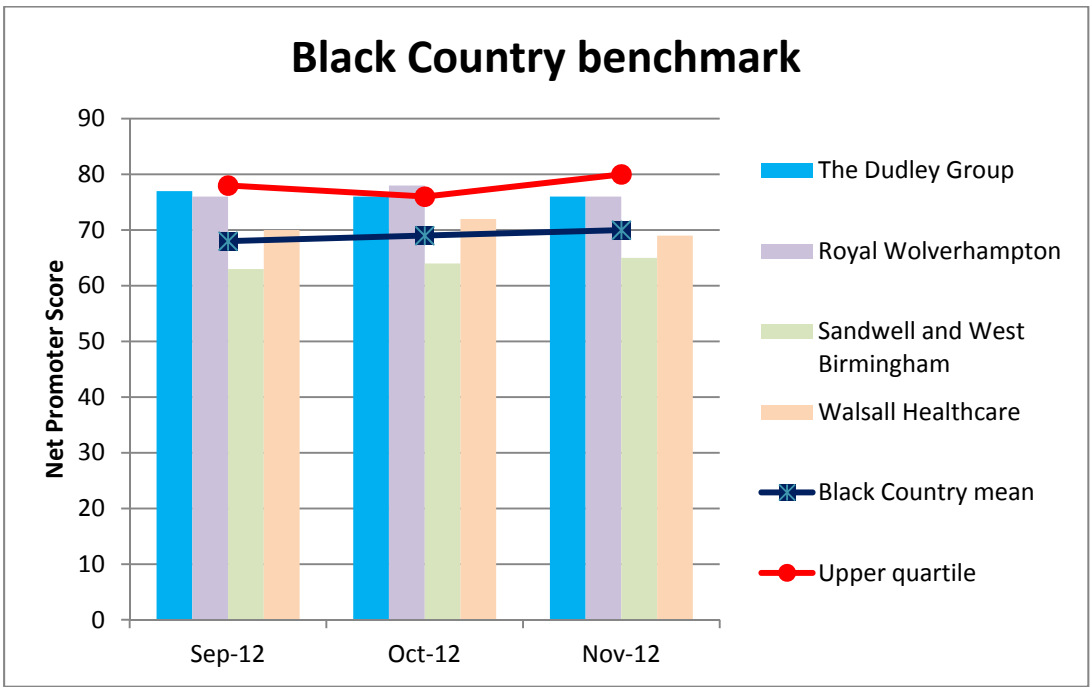
NPS Score	>= 71
	52** to 70
	< 52
% of footfall	>= 10%
	< 10%
** 52 is DGH baseline set in April	

Figures remain static

Benchmarking

Regional average for November was a score of 69
Black Country average for November was 70

The chart below shows the Black Country trend for the past three months. Consistency of scores can be seen across all Trusts with The Dudley Group/Royal Wolverhampton gaining higher scores, followed by Walsall and then Sandwell and West Birmingham.



November upper quartile was 80 (our score was 76) – this will not affect the CQUIN payment as the CQUIN upper quartile was fixed at 71 in April.

Feedback
Seventy one per cent of comments were positive, with food remaining the most requested item for improvement at 18 per cent. A factory visit to view the proposed Steamplicity food system has been arranged for the end of January. A hospital visit to see the system in action and observe the patient experience is also being arranged. It is envisaged that the system will tackle the most frequently raised issues relating to food: choice, temperature and quality.

Issues
Six wards failed to reach minimum of 10 per cent data collection in December: B5, C4, C7, C8, CCU, MHDU.

The importance of FFT will be reinforced via Matron and Lead Nurse meetings during January/February along with information about the new FFT requirements from April – particularly in view of the requirement to break down to individual areas results.

Stroke Service Review:
The deadline has slipped again for the final submission, now due mid February. The finance template that was sent out earlier in December proved impossible for any provider to complete, the finance template is therefore being reviewed by finance leads in the Birmingham and Black Country region on the 3rd January with the aim of producing an amended finance template for completion and submission in February. There is a further meeting in Birmingham on the 10th January to review where we all are with the process. Our project team continue to meet weekly to update and review our detailed 3rd submission (next meeting 9th January) feedback from the 2nd wave asked for us to demonstrate we have a robust ESD service in place.

It has also been discussed that as 3 stoke units have been 'removed' from the Birmingham & Black Country region due to recent reconfigurations, that commissioning HASU's may not now be on a competitive/successful bidder basis but on an 'accreditation basis' which in effect would mean all existing Acute providers would become HASU's.

Update on upper GI:
At the last Board there was discussion on whether the Trust could partner with UHNS in terms of delivering upper GI cancer surgery on their site for our patients following changes at UHB which has meant Mr Bohra will no longer be able to operate there. This was explored but has not proved possible.

GEH:
The George Eliot NHS Trust is proposing to move forward their partnering plans by an open tender process. The Board are asked to discuss whether we wish to proceed.

The Dudley Group NHS
NHS Foundation Trust

Alcohol Consultation:

The Government is consulting on five issues arising from the National Alcohol Strategy published on 23rd March 2012. This is a considered response to the consultation questions. In addition to the responses of key Boards, individuals are invited to submit their responses via the website.
P:\Alcohol\Alcohol consultation responses\alcohol-consultation-document.pdf

A MINIMUM UNIT PRICE FOR ALCOHOL

This Government is consulting on the introduction of a recommended minimum unit price of 45p. In June 2012, following consultation the Scottish Government passed legislation which would allow it to introduce a minimum unit price for alcohol. It is intended that this will be set at 50p per unit.
The Government wants to ensure that the chosen minimum unit price (mup) level is targeted and proportionate.

Consultation Question 1:
Do you agree that this mup level (45p) would achieve these aims?
If you think another level would be preferable, please set out your views on why this might be.
The intention to introduce a minimum unit price level for alcohol is welcomed. A 50p mup for alcohol should be introduced. If the intention is to achieve a significant reduction in harm then a higher level than 45p will be needed. The modelling of a 50p mup shows an overall reduction in harm of -5.7% compared with -3.5% for a 45p mup. There is an estimated health gain of 13.3% at 50p mup as measured by a reduction in alcohol related admissions to hospital. This would be very welcome in Dudley where we have experienced an average rise in the rate of admissions of 13% over the last ten years - much higher than the national average of 7% over the last decade. Crime is also expected to decrease by 2.9% at a 50p mup against 1.7% if a 45p mup were introduced. There is consistently strong evidence to suggest that increasing alcohol price is associated with a reduction in consumption with harmful drinkers affected the most. Meng et al (2012)[1] have shown that there are significantly greater gains for health improvement, crime reduction and absenteeism from work by introducing higher level minimum unit pricing.

(197 words)

[1] Meng, Y. et al. (2012) **'Model-based appraisal of alcohol minimum pricing and off-licensed trade discount bans in Scotland using the Sheffield Alcohol Policy Model (v.2): Second update based on newly available data'** ScHARR, University of Sheffield

Consultation Question 2:
Should other factors or evidence be considered when setting a minimum unit price for alcohol?
The introduction of a minimum unit price on its own will bring some noted benefits but other actions being taken in conjunction with it is likely to bring even greater benefits. Affordability and increased availability of alcohol are two of the main reasons why alcohol consumption has increased so dramatically over the last decade. Whilst alcohol prices have increased slowly, household disposable income has increased more steeply. The affordability of alcohol has increased sharply since 1996. The relaxation of the licensing laws has meant alcohol is readily available for longer periods of time both as a result of on-trade licensing hours and off-trade 24 hour supermarket trading. Tackling affordability through minimum unit pricing is welcome but there also needs to be measures in relation to the wide availability of alcohol.

(words 130)

Consultation Question 3:
How do you think the level of minimum unit price should be adjusted over time?
The minimum unit price should be automatically updated in line with inflation each year.
Consultation Question 4:

The aim of minimum unit pricing is to reduce the consumption of harmful and hazardous drinkers, while minimising the impact on responsible drinkers. Do you think there are any other people, organisations or groups that could be particularly affected by a minimum unit price for alcohol?
There is some concern that low income moderate drinkers may be affected by the introduction of a mup and whilst it may be the case that they tend to buy cheaper alcohol, if they are drinking at low levels the financial impact is likely to be small.
Conversely, high earners who are drinking at harmful levels are less likely to be impacted on by a mup since they are more likely to consume more expensive wines or spirits which are already above the 45p or 50p mup levels. Alternative interventions need to be considered to tackle this group of harmful drinkers.

(words 101)

A BAN ON MULTI-BUY PROMOTIONS IN THE OFF-TRADE

The Government wishes to consult on introducing a ban on multi-buy promotions in the off-trade as part of its wider strategy to reduce excessive alcohol consumption alongside the minimum unit price proposal.
The following promotions would not be allowed:

- *2 for the price of 1 (or 3 for 2, buy one get one free, or buy 6 get 20% off etc.)*
- *3 for £10 where each bottle costs more that £3.33*
- *24 cans of beer being sold for less than 24 times the price of one can in the same retailer, or a case of wine priced more cheaply than 12 times the individual price of the same bottles.*
- *Different multi-pack prices ore multi-buy multi-pack offers e.g 10 bottles of alcopops being sold for less per bottle than a package of four bottles, or 3 packages being sold for less than three times the price of one 10 bottle pack.*

It would not affect:

- *Half price offers*
- *A third off offers*
- *£x off any individual item.*

(as long as the mup was still observed)

Consultation Question 5:
Would you support a ban on multi-buy promotions involving alcohol in the off trade?
We support a ban on multi-buy promotions involving alcohol in the off trade.

Consultation Question 6:
Are there any further offers which should be included in a ban on multi-buy promotions?
The proposals on multi-buys seem appropriate. There is a risk that the price of individual items would be reduced to match the price of items in a multi-pack as a loss leader as is currently the case with below cost sales and steps should be taken to reduce the risk of this.

Consultation Question 7:
Should other factors or evidence be considered when considering a ban on multi-buy promotions?
Scotland are trialling this at the moment, it would be helpful to know the outcome of this evaluation in order to make a reasoned response. It is anticipated that the outcome of the Scottish trials will be released shortly.

Consultation Question 8:
The aim of a ban on multi-buy promotions is to stop promotions that encourage people to buy more than they otherwise would, helping people to be aware of how much they drink, and to tackle irresponsible alcohol sales. Do you think that there are any other groups that could be particularly affected by a ban on multi-buy promotions?

REVIEWING THE MANDATORY LICENSING CONDITIONS

The Government is committed to reviewing the impact of the current mandatory licensing conditions to ensure they are sufficiently targeting problems such as irresponsible promotions in pubs and clubs. The Government has also committed to consult on whether these mandatory licensing conditions should, where relevant, apply to both the on- and off-trade.
There is an expert group considering the implications of this objective.

Consultation Question 9:
Do you think each of the mandatory licensing conditions is effective in promoting the licensing objectives (crime prevention / public safety / public nuisance / prevention of harm to children)
We would not wish to see licensing objectives relaxed in any way.

Consultation Question 10:
Do you think that the mandatory licensing conditions do enough to target irresponsible promotions in pubs and clubs?
No, they are not enough.
The mandatory licensing objectives do have some impact on irresponsible promotions, but they need to have continuous monitoring and enforcement to make them effective. This is a resource drain on the police, licensing authorities and trading standards, who have to remain vigilant.

Consultation Question 11:
Are there any other issues relating to the licensing objectives which could be tackled through a mandatory licensing condition?
Public health measures could be considered, either as an additional mandatory target, or as a consideration on the existing targets e.g. awareness of the different impacts of alcohol consumption on children and adolescents, plastic drinking containers etc

Consultation Question 12:
Do you think the current approach, with five mandatory licensing conditions applying to the on-trade and only one of those to the off-trade is appropriate?
The mandatory conditions should be applicable to both on and off-trade premises

HEALTH AS A LICENSING OBJECTIVE FOR CUMULATIVE IMPACT POLICIES

The Government is committed to enable local authorities to take wider alcohol-related health harm into account in licensing decisions; a current gap, which would need to be amended through legislation.
Recent evidence shows that levels of health harm can be linked to the density of licensed premises. It is proposed that health harms can be taken into account when deciding on cumulative impact policies. Currently these are decided on based on crime and disorder data. The consultation is to establish how population health data can be used in areas with high levels of alcohol mortality and morbidity to reduce the density of licensed premises in an area. The Government had considered a separate mandatory licensing objective for health but has decided that this would be disproportionate. The new power would be discretionary and would allow areas with high levels of alcohol related harm to maintain or reduce the density of licensed premises in an area.

Consultation Question 13:
What sources of evidence on alcohol related health harm could be used to support the introduction of a cumulative impact policy (CIP) if it were possible for a CIP to include consideration of health?
We consider that health should be a separate mandatory licensing objective and ask the Government to reconsider their decision on this.
For CIP the following evidence could be used:

- Mapping of licensed premises to show density in an area

- Mapping of alcohol mortality (HES)
- Alcohol related admissions to hospital (HES)
- Crime and alcohol data from A&E attendances (would need to be more robust – possibly make it a reporting requirement for the new drugs and alcohol reporting system to PHE)
- Findings from local lifestyle surveys on alcohol consumption
- Data from local service providers showing numbers in treatment and mapped by postcode

Consultation Question 14:
Do you think any of the current cumulative impact policy process would need to be amended to allow consideration of data on alcohol related health harms?
Yes.
CIP at the moment is only recommended by the police where crime and disorder is an issue. It relates to a comparatively small area and is usually related to the activity of the on-trade. In order to take account of wider health impacts it will be necessary to be able to look at the density of the off-trade premises as well. These premises are not usually associated with crime and disorder but do provide opportunities for large volumes of alcohol to be bought and consumed elsewhere in the neighbourhood e.g. parks, wasteland, woodland, on the streets.
When CIP is being considered by a Licensing Committee, there is an onus to prove that the crime and disorder is associated with a particular premises. This is not going to be possible when considering the impact of alcohol related harm which may take many years to manifest itself. Using A&E data is very limiting in this situation.

(words 172)

Consultation Question 15:
What impact do you think allowing consideration of data on alcohol related health harms when introducing it a cumulative impact policy would have if it were used in your local area?
Dudley has some areas where alcohol mortality and alcohol admissions to hospital are well in excess of regional and national averages which are, themselves, too high for the country's population health. Reducing affordability and availability of alcohol is known to impact on the amount and type of alcohol drunk, so making it more difficult to access and more expensive to buy will impact the most on hazardous and harmful drinkers and ultimately improve health and wellbeing. It will also contribute to reducing health inequalities since alcohol harm disproportionately affects those from the poorest backgrounds; so although they may drink less than other socio-economic groups, they bear the greatest burden of alcohol related ill health. This is particularly true for males aged 35-54 in Dudley who are contributing most to the high numbers of alcohol related hospital admissions in the Borough.

.(words 129)

FREEING UP RESPONSIBLE BUSINESSES
Following the Government's Red Tape challenge in 2011, three areas of reform were specified:

- *Alcohol licensing for certain types of premises providing minimal alcohol sales (ancillary sellers)*
- *Temporary events notices (TENs)*
- *The licensing of late night refreshment*

The Government believes there is scope for deregulation where the sale of alcohol can be considered to be ancillary to the main purpose of a business. The examples quoted are a guesthouse offering new arrivals a welcome drink, or a hairdresser offering a glass of wine as a choice along with tea, coffee or a soft drink. At the moment this would require a full licence and adherence to all of the mandatory licensing requirements.
The details of this will be explored through a technical group which will report back in due course.
The consultation questions for this objective are mainly in a tick-box format to be completed on-line, with limited scope for comment. However the following observations could be included in the submission.

- **Alcohol licensing for certain types of premises providing minimal alcohol sales (ancillary sellers)**

Whilst we understand the need to not be overly bureaucratic with small businesses, this relaxation of licensing law compliance could be seen to promote alcohol as an accompaniment to everyday activities such as buying flowers or going to the hairdressers, and whilst the intention is not to promote heavy drinking it provides additional opportunities and venues for the easy availability of alcohol with its known risks of additional health harm.

- **Temporary events notices (TENs)**

We agree that licensing authorities should have the power to allow organisers of community events involving licensable activities to notify them through a locally determined process. We do not agree that the current number of TENs should be increased in respect of individual premises as this could be construed as a way of circumventing the need to apply for licence variations and increase late night drinking and public nuisance.

- **The licensing of late night refreshment**

We agree that the local licensing authorities should have local discretion around late night refreshment by determining the types of premises that could be considered to be exempt from a local licence. We consider that the licensing of late night refreshment is a useful mechanism for the control of anti-social behaviour late at night.
We support the proposal that motorway services should be exempt from the licence condition for the provision of late night refreshment but would not support the sale of alcohol as part of this exemption.

The Dudley Group NHS
NHS Foundation Trust

TRUST MANAGEMENT EXECUTIVE

MINUTES OF THE MEETING HELD ON 29TH OCTOBER 2012

Present: Paula Clark, Mushtaq Ahmed, Rachael Benson, Richard Cattell (part), Lucy Chatwin, Rob Game, Robert Graves, Karen Hanson, Denise McMahon, Tessa Norris, Annette Reeves Julian Sonksen, John Thornbury

Apologies: Paul Assinder, Richard Beeken, Paul Harrison, Mourad Labib, Louise McMahon, Jennie Muraszewski, Karen Morrey, Jeff Neilson, Sally-Anne Osborne, Richard Price, Graeme Stewart, Paul Stonelake, Adrian Warwick, Jim Young

In attendance: Linda Smith, Jill Krynicki (CHKS), Kevin Shine

		Action
12/191	**Welcome and Note of Apologies**	
12/192	**CHKS Presentation** Paula Clark introduced Jill Krynicki from CHKS to the team. Jill has been asked to attend TME to show the group the basics of the Market Share system. A report was circulated with the TME papers. The Market Share system is designed to inform us where referrals are coming from (by PCT and GP practice) and highlight any changes that could impact on us financially. The system goes back as far as 2008 for comparisons and can show individual specialties. These are based on national tariffs and provide an indication on Trust income rather than actual income as this depends on local agreements with commissioners. Jill then went on to show the team the live system. Paula agreed this is quite a straight forward system. Jill said there is a demo to show teams how to use the system, but Directorates can nominate someone from their team, Jill is happy to train whoever needs to be trained. Paula said we need to coordinate our approach to practice visits and markets using the data. Paula thanked Jill for the presentation.	
12/193	**Minutes of Previous Meeting** The minutes of the 15th October 2012 were agreed as a correct record. **Action sheet**: **12/180** – Denise McMahon circulated Enc 2. App 1. The paper highlighted the wards with biggest concerns on stage 4 pressure ulcers. We are targeting areas with the highest incidents. The stage 2 pressure ulcers are not continuing which is good news and we have had a reduction in	

	pressure ulcers again this month. **12/189** – Denise McMahon confirmed she had sent out information on unqualified member of staff handover of patients, there is no reason that a Band 2 member of staff and porter cannot do this wrist band check. The porter would check in first instance and then the Band 2 and porter would check the wrist band at point of test.	
12/194	**Announcements** Paula announced that Wolverhampton Hospitals had been knocked back on their Foundation Trust bid. Their Chairman has resigned. The bid is still with Monitor but we are not sure at what stage. The bid is off the agenda until Monitor are satisfied with concerns over money and governance.	
12/195	**Business Case – Oncology Pharmacist** This business case has been postponed until the next TME meeting.	
12/196	**Business Case – ICT** John Thornbury presented the ICT Business Case. The paper had been approved at Directors this afternoon. John explained he is trying to make the organisation 'paper light'. John stated that Choose and Book is one area that is not integrated, if we can pull this together and link clinical letters where we can see them all in one place, this will make practices much more efficient. John has agreed he would like to work with individual clinicians on the way of working to support them. This system could also bring in District Nurses and all other referrals, taking us forward. No separate sign on will be required. Rob Game highlighted his concern that Partial Booking is due to start very soon, which will empty the system of bookings and need to rebook them all again and the timing of this new system is imperative. John confirmed he would check all of this before he implements the new system in these areas. Karen Hanson asked if the local authority could have access to this system. John confirmed we could allow them access under a data sharing protocol. Mushtaq Ahmed said at present some referral letters have a lot of unnecessary information. John explained with the new system we can refine the standard referral system with Docman and this would alleviate this problem. John will be having a meeting with the PCT: regarding Discharge Summaries to get a better process on referrals. The team are happy to support this business case.	
12/197	**Business Case – Call Centre** John Thornbury presented the Call Centre Business Case to the team. John explained that our current system is out of date and not efficient.	

	The new system would be an 'umbrella' contact centre, which is much more responsive and will allow better customer service. The patient could email in the evening when convenient for them and it would go into the system and a response generated as soon as someone is available. It also allows for interactive discussion as well as telephone calls. It will help to manage workload which the present system does not do. John will send out a communication to the organisation, explaining what we plan to do and asking for any suggestions. This system is still a relatively cheap option. Another initiative that is being looked into is rationalise printing. The Trust currently has 1200 printers, which is an expensive cost to the Trust to replace cartridges. We are looking at fewer faster printers that would be networked. This will be communicated through the Chief Exec's bulletin.	
12/198	**Workforce KPIs** Annette Reeves presented the Workforce KPIs that went to the Finance and Performance Committee. Annette commented that the absence rate for the month of August is 3.28% and 3.86% for the year to date. This is above target. Appraisals are down at 65%. An appraisals action plan is attached to TME papers. National Survey – the return rate for the National Survey is only 27%. No reminder letters will be sent out this year, as per feedback from the LiA sessions. Please remind staff these are completely confidential and ask them to complete and return. Messages have gone out on payslips and on screensavers. We would like to get as many back as possible.	
12/199	**Audit Committee Update (16th October 2012)** Attached to the TME papers is the report of the Chair of the Audit Committee. Please read for information.	
12/200	**F&P Performance Report** Paula presented the Performance Report. • Performance - we have a 'sea of green' which is fantastic • SHMI and Mortality – going in the right direction • Trust Benchmarking – we are 11 out of 46 Trusts again fantastic • ED are struggling and Karen Hanson requires all teams help to discharge early in the day. October has been a particularly bad month. Yesterday and today are very bad days • Finance – September is normally a good trading month, but it has not been this year. We are falling behind. We are trying to do a deal with the CCG on Winter Pressures. If we do 'break even' is the best we can expect at the end of year. Despite the financial side performance is holding on. Well done to teams.	

The Dudley Group NHS
NHS Foundation Trust

Action & Approval Sheet
TRUST MANAGEMENT EXECUTIVE

Subject	Action	Timescale	Responsible	Completed
12/184 Information Governance Training	Request for all Directorate management teams to increase the number of staff completing the course	On-going	**All**	
12/176 Postage	Need to introduce a standard template letter format to ensure that font size and address positioning is standard. John Thornbury's team to create a solution to send around to Directorates for feedback	12th November	**J Thornbury**	
12/187 Transformation Programme Board	Lucy to bring update after agreement by the Board	12th November	**LC**	
12/186 Readmissions re-audit	Request been made to CCG. Request for additional CDs to get involved in the audit	November	**CDs**	

December

Subject	Action	Timescale	Responsible	Completed
12/26 – Audit Committee Report	Annette Reeves to pick up with Tom Kippax re: Helpful, simple guidance for study leave/interviews for Junior Doctors and circulate to TME members. ***Policy needs to be ratified by policy group when next held and will then be circulated to TME.***	10th December	**A Reeves**	

January 2013

Subject	Action	Timescale	Responsible	Completed
12/84 Postage Update	Heather Taylor to update on postage position.	7th January	**H Taylor**	

The Dudley Group NHS
NHS Foundation Trust

TRUST MANAGEMENT EXECUTIVE

MINUTES OF THE MEETING HELD ON 12TH NOVEMBER 2012

Present: Denise McMahon (Chair),Richard Cattell , Lucy Chatwin, Rob Game, Robert Graves, Karen Hanson, Jennie Muraszewski, Karen Morrey, Jeff Neilson, Richard Price, Graeme Stewart, Paul Stonelake, John Thornbury

Apologies: Mushtaq Ahmed, Rachael Benson, Paula Clark, Paul Assinder, Richard Beeken, Paul Harrison, Mourad Labib, Louise McMahon, Tessa Norris, Sally-Anne Osborne, Annette Reeves, Julian Sonksen, Paul Stonelake, Adrian Warwick, Jim Young

In attendance: Linda Smith, Andy Whallett, Dawn Westmoreland

		Action
12/201	**Welcome and Note of Apologies**	
12/202	**Medical Workforce Plan** Andy Whallett attended TME to discuss the Medical Workforce Plan. The current agency expenditure is the biggest expense for the Trust. The plan shows changes in the clinical practices and in the training and recruitment of junior medical staff, this has had an impact on how we provide our clinical services. Changes in the way we are allocated junior doctors will mean it is important we consider that there may be different ways to provide clinical services in the future. The plan outlines a proposal to develop a two year programme to secure high quality junior and middle grade cover rather than using locums, which can be unpredictable. Service provision locally, regionally and nationally is not uniform. Services that have moved to Dudley may not have been matched with increased resources to provide those services. With formation of Health Education England (HEE) Local Education Training Board (LETBs) which has replaced the Deanery, and Local Education Training Councils (LETCs) will have a greater say in how we provide education at Local Education Provider (LEP) level. The distribution of the workforce training posts allocated by the Deanery, is often based upon historical, rather than current needs. This does not necessarily meet the demand of what our needs are now and will need in the future. This proposal is to use a proportion of the spend for locums to fund the programme so that we have two year rotations within the Trust to help meet service demands particularly in hard-pressed areas such as emergency medicine, elderly care and vascular surgery for example. To attract good quality doctors, the trainees would have a designated tutor, careers advice and protected teaching. By staging the starting time of the rotation with existing posts ameliorates the current risk when an entire new intake of junior doctors joins the Trust. There is flexibility in the plan	

	that juniors could have a floating element and cover gaps that may arise in rotations for example. As part of the wider Workforce Plan we are also looking at non medical ways to deliver services. Denise McMahon asked what the next steps were. Andy replied that the Business Case will be circulated to TME members then be presented at Finance and Performance Committee on 29th November and then hopefully to Board of Directors on 6th December for approval.	
12/202	**MRSA Update** Dawn Westmoreland attended TME to update the team on MRSA Emergency Screening. The results for October 2012 stand at 88.8% and we are required to be at 100%. Dawn reminded the group that lab forms need to be completed correctly. Your teams must put 'MRSA Screen' in the investigation required and not MC&S. If both are required 2 sets of swabs need to be taken. Denise emphasised we MUST get to 100% on this. Dawn also confirmed we have had our first MRSA post 48hours. This is the first positive post 48 hours in 16 months.	
12/203	**Announcements** None	
12/204	**Minutes of Previous Meeting** The minutes of the 29th October 2012 were agreed as a correct record. **Action sheet**: **12/184** Increase the number of staff completing the course for Information Governance Training – Majority of staff have now passed the training by just doing the test. The figures are showing lower on the performance tracker. Rachael Bailes to look into this. **12/176** – John Thornbury circulated a template letter to Directorate teams and has had feedback. John will bring back to TME for approval on 26th November. **12/186** – There was a question around exactly what was required of this audit. Karen Hanson thought we were doing a monthly report on readmissions. Richard Price thought we had agreed to do a full re-audit. **Take to Directors meeting to decide a way forward and report back to TME.**	
12/205	**Business Case – Oncology Pharmacist** This business case has been postponed until the next TME meeting. The Business Case will also need to be reissued with updated information.	
12/206	**Transformation Board Report** Lucy Chatwin presented the Transformation Board report to TME members. The report shows how the teams are managing the work streams. Board of Directors approved the report. The report shows where we are with Transformation. It includes a draft ToR and draft Stakeholder engagement plan. Lucy confirmed they had held the first peer group meeting today. This forum will be used to drive decisions forward.	

	TME are asked to have a look at the report and feedback any comments to the Weekly Operations Management Team meeting on Wednesday 21st November. Denise McMahon asked how this was working. Rob Game and Jennie Muraszewski were concerned that this was an extra meeting and could it be delivered through Weekly Operations Management Team meeting.	
12/207	**Any Other Business** **12/207/1** **National Survey – Response Rates** The closing date for the National Surveys is 30th November. TME members are requested to encourage their teams to return their questionnaires. The questionnaires are anonymous. It was suggested for next year that someone from Ventis could attend the Trust to talk to staff without management to explain even though forms have a reference number they are anonymous. **12/207/2** **Long Term Conditions** Denise reminded TME members that the WMQRS review us around several workstreams. On Long Term Conditions we had agreed with the CCG we would complete self assessments. So far Derek Eaves has only had one self assessment returned. Derek has sent chasing emails to each Directorate. These need to be done urgently for reporting to the Board of Directors and Quality meetings in December. If they are not completed next time you will be required to do peer reviews. If you have any queries please contact Derek Eaves directly.	
	Next meeting: Monday 26th November at 5pm Clinical Education Centre 1st Floor, C Block, Russells Hall Hospital	

DM/LS 15/11/12

The Dudley Group NHS
NHS Foundation Trust

Action & Approval Sheet
TRUST MANAGEMENT EXECUTIVE

Subject	Action	Timescale	Responsible	Completed
12/184 Information Governance Training	Request for all Directorate management teams to increase the number of staff completing the course. Rachael Bailes to update TME.	On-going 26th November	**All** **R Bailes**	
12/176 Postage	Need to introduce a standard template letter format to ensure that font size and address positioning is standard. John Thornbury's team to create a solution to send around to Directorates for feedback. Template to come back to TME for approval.	26th November	**J Thornbury**	
12/186 Readmissions re-audit	Request been made to CCG. Request for additional CDs to get involved in the audit. **12/204** take to Directors for a way forward on agenda Monday 19th November.	26th November	**Directors**	

December

Subject	Action	Timescale	Responsible	Completed
12/26 – Audit Committee Report	Annette Reeves to pick up with Tom Kippax re: Helpful, simple guidance for study leave/interviews for Junior Doctors and circulate to TME members. ***Policy needs to be ratified by policy group when next held and will then be circulated to TME.***	10th December	**A Reeves**	

January 2013

Subject	Action	Timescale	Responsible	Completed
12/84 Postage Update	Heather Taylor to update on postage position.	7th January	**H Taylor**	

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 10th January 2013

TITLE:	**Summary of Key issues from the Clinical Quality, Safety & Patient Experience Committee held on 8th November 2012.**		
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:

Mortality - The Committee received the mortality indices and actions taken to review mortality. The SHMI downward trend had continued since the last report and NHS Choices confirmed the Trust mortality ratio "as expected". Benchmarking placed the Trust 9th out of 15 Trusts showing a downward trend. The NHS Choices report stated that the Trust was "worse than expected" with a value of 114.9.

Medical Workforce Plan – The report highlighted proposed changes in the allocation and organisation of junior doctors and the different ways to provide clinical services in the future. The historic arrangements for the distribution of workforce training posts did not meet current demands and Regional and National reconfiguration of educational structures will present potential opportunities / threats to the current deanery funded medical workforce. The Committee received a business case outlining proposals to manage this. In view of the significant cost implications the Committee **agreed** that the business case including cost benefits should be discussed at the Finance and Performance Committee.

Workforce and Succession Data - The report showed the number of commissioned medical training places and supporting trend analysis and Monitor 3 year plan. There was a small increase in F/T equivalent staff for the first 2 years which levelled off for the remaining three and a reduction in the numbers of qualified nurses graduating over the next 3 years and an increase in the number of vacancies. The West Midlands was showing a decrease in the number of trainee midwives but the Trust was showing an increase. This could present a recruitment risk over the next three years. Potential changes to pathology may result in changes to the workforce and improvements in IT could mean a slight decrease in the number of admin staff needed.

CQC Exceptions Report - the report (Sept 2012) confirmed a generally positive and compliant position with the CQC Essential Standards of Quality and Safety. All the actions for Outcome 8: Cleanliness and Infection Control, had been completed and the Trust had been judged as compliant by the CQC. The Committee compared the Trust self assessment of compliance against the CQC Quality Risk Profile and on site compliance against the CQC prompt for each outcome. The report highlighted 3 areas requiring moderate actions, Cleanliness and Infection Control, Management of Medicines and Safety and Suitability of Premises.

Quality Governance Framework - the development plan is reviewed quarterly and shows progress made to achieving all the required actions by the set dates.

Patient Experience Report inc. PALS and Complaints - The report showed an increase in the number of surveys completed during the period and an increase in the number of complaints and PALS concerns received. The Complaints and Claims section of the report showed the lowest number of staff attitude complaints at 2% in quarter two.

NHS Choices - 24 comments had been posted on NHS Choices and/or Patient Opinion websites between July and September 2012, an increase of 8 comments on the previous quarter. 11 patients said they **would recommend** the hospital to a friend and 7 said **they would not.**

Patient Experience Strategy – The Strategy Update highlighted the Patient Experience Strategy

elements with delivery timelines which extended the outline previously presented to the Committee. Updates on the following were requested for the next two meetings:

1. How to identify core behaviours and shared values and then ensure that these are reflected in recruitment processes
2. How to ensure that behaviours and values are incorporated into training modules as well as a wider employee engagement programme

Incident Reporting and Investigation - Serious Incident (SI) Monitoring Report - 13 new incidents reported – 6 pressure ulcers and 7 general SI's. There were 22 open general SI's (9 undergoing investigation, 5 awaiting assurance that all actions identified from the RCA investigation had been completed and 8 recommended for closure). Concerns from the Pressure Ulcer SI's related to wards C3, B2 and C5. The Trust is currently looking at extra support for these wards. There were no breaches in the 2 day reporting from date of identification and completion of RCA's within the agreed time scales.

Incident Trends – 7 categories were highlighted in October 2012: Delay in Care/Treatment, Wrong Patient Treated, Breach of Infection Control Policy, Medication Errors, Stillbirth (pre-delivery), Physical Abuse or Assault x2.

Aggregated Incident Report – upward trends reported in the number of incidents reported in; Appointments, Discharge and Transfers, Clinical Care, Diagnosis and Tests, Facilities, Health and Safety and Infection Control. Upward trend (or consistently high) number of incidents also reported in some subcategories; Infection Control, patient accidents/injuries, records, communication and information and workload staffing and an upward trend (or consistently high) in the number of Serious Incidents reported; unexpected ill health/deterioration, patient falls resulting in a fracture, confidentiality information governance and pressure ulcers (inpatient)

Quarter on quarter increase in the number of reported incidents in the Infection control category. 16 of the 25 reported incidents related to Breach of Infection Control Policy.

Quality Dashboard Report for Month 6 - two of the quality indicators were red rated for the reporting period: Increase in breast feeding initiation rates and SUI: Root cause analysis completed within 45 operational days of the notification. The latter was outside the target due to one instance out of 17 cases that was not completed in the timescale.

Nursing Care Indicators - now include two new assessments: Fluid Balances and Bowel Assessments. The infection control questions have been amended to include urinary catheter care. Results have improved slightly following the change in the RAG rating. The Renal Unit and ED data was also included for the first time. Some areas were showing green but many were amber. The Think Glucose criterion showed continued improvement for the third quarter.

Safety Thermometer - 3 out of 4 criterion assessed showed improvements in the first six months. The Catheter Acquired Urinary Tract Infections (CAUTI) criterion shows an increase since collection of figures commenced. The Trusts results were good overall against National figures.

Quality Account Update inc. Priority Targets etc. - The Report confirmed the trusts position at the end of the 2nd quarter against the five Quality Priority targets and the National Clinical Audits:

- **Pressure Ulcers** - the decrease in avoidable ulcers reported in the community continued while the hospital numbers had halved from the last quarter
- **Infection Control** - the targets were being met to date.
- **Nutrition and Hydration** - the figures dipped in June but the trust was on course to achieve the targets.
- **National Audits &Confidential Enquiries** – the Trust would participate in all relevant audits

The Quality Account Priorities for 2013/2014 were approved by the Board of Directors who had agreed to roll this year's topics to next year.

Reporting Groups - The Committee received the minutes of the following and considered the key

issues: **Children's Services -** meeting held on 17th October 2012 and **Health Records -** an update was received from the General Manager.

Research & Development Group - 12 new studies taking place 8 low risk, 2 medium risks and 2 high risks.

Dr Harrison advised the Committee of serious adverse events reported during the period that had occurred to patients enrolled in research studies, as defined by individual study protocols and ICH Good Clinical Practice guidelines for clinical research.

Patient Safety Group (Verbal) - The Patient Safety Group scheduled for 10th October was cancelled as it was not quorate.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Committee reports were referenced to the risk register**.**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 1 - Respecting & Involving people , Outcome 4 – Care & welfare of people , Outcome 7 – Safeguarding, Outcome 16 – Assessing & monitoring quality of service
	NHSLA	**Y**	**Details:** Risk management arrangements eg 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 8th November 2012 and specifically
- The escalation of the Medical Workforce Business Plan to the Finance and Performance Committee

Enclosure 6

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 20th December 2012**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**

CORPORATE OBJECTIVE: SO 10 Enabling Objective

SUMMARY OF KEY ISSUES:

The Committee considered standing reports on performance for November 2012 and year end forecasts for 2012-13 financial year.

IMPLICATIONS OF PAPER:

RISKS	**Risk Register**	**Risk Score Y**	**Details: Risk to achievement of the overall financial target for the year**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details: Monitor has rated Trust at Green for Governance & 3 for Finance at Q2. The Trust remains on quarterly monitoring**
	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 20th December 2012

1. Background

The Finance & Performance Sub Committee of the Board met on 20th December 2012. 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 year end performance reports. The Committee noted in particular the following matters:

2. Junior middle Grade Trust Doctors Business Case

Dr Whallett presented a business case to develop a two year training programme for middle tier doctors to improve the quality and reduce costs of current ad hoc locum and agency sourced staff.

A phased recruitment of 26.4 wte doctors with full year costs of £1.5m was proposed . This would be funded from avoiding a current forecast £3.8m spend on agency and locum grades. Directorates had agreed to 'vire' current funded budgets of £1.2m, with the £342,000 balance to be met from reductions to current overspends.

The Committee approved the proposal for presentation to the Board and requested a detailed phased recruitment plan be submitted to the Committee with quarterly updates on its implementation.

3. Facilities and Estates Quarterly Assurance Report

Mr Graves presented his report for the preceding Quarter.
He commented that claims against the Trust for the Aseptic Dept penalties imposed earlier in the year, had been formally withdrawn by Summit. A claim in respect of waste treatment remains extant.
The Contract Efficiency Group process seems to be delivering improved benefits with identified savings/increased income of £1.1m now being processed.

The Committee were keen to see a proposed CIP benefit on Community premises rationalisation worked up in detail. Mr Graves agreed to report to the February meeting.
Contract deductions of £36,370 had been levied in the Quarter.
Cleanliness audit scores of 96.5% Russells Hall; 97.33% Corbett; and 98.92% Guest were noted.

The Committee noted the report.

4. Workforce KPIs

The Committee considered a progress report and noted:

- October absence is 4.12% an increase from 3.58% in September. and YTD is 3.94% (target 3.5%)
- Turnover is 7.33% a slight reduction on previously
- Mandatory Training - 4 subjects are fully compliant
- Appraisals 67% (down from 61% in September).
- Pre Employment Checks 99%
- Live vacancy rate is 178 posts (255 previously)

The Committee noted the report.

5. Income & Expenditure Position – October 2012

The Trust made a trading surplus of £342,000 in November due to an agreement with Dudley CCG to refund the contractual 2012-13 readmissions penalty of £2.3m (£1.5 in recognition of current cost pressures. However pay and non pay spending trends had once again increased significantly, so the underlying Trust I&E position remains poor and is deteriorating each month.

The Committee noted that in November EBITDA were 8.1% (Plan 8.2%) and now £49,000 behind the period Plan).

The annual I&E forecast had now moved £0.3m surplus.

CIP performance of £9.9m to date was marginally ahead of plan but included £3m non recurrent items.

Mr Assinder said that the Committee should receive these reports with some concern as the numbers were poor and were worsening each month. We were overspending our income budget regularly each month and the position was being covered from the use of 'one off' balance sheet reserves and the support of the local CCG. Neither of these could be relied upon beyond 31st March and unless significant improvements were made in the immediate future, the Trust would fall into significant deficit in 2013-14. Such improvements were outside the scope of traditional CIP and required transformational changes to clinical practice.

The Committee requested a monthly analysis of movements in headcount, by Dept, type etc and an analysis of all movement for year to date.

The Committee noted the report.

6. **Balance Sheet (Statement of Position)**

Mr Walker reported on the Trust's Balance Sheet (Statement of Position) at 31st November 2012, which remains strong;

- £30.2m cash balance
- 38.4 days liquidity margin.
- Debtor and Creditor days remain broadly on plan.

The Committee noted the report.

7. **Capital Programme**

Capital spending for April-November was £5.2m, £0.3m behind Plan. The Trust estimates a total annual capital spend of £9.2m against the approved programme of £9m. Key variances are medical equipment £0.2m below plan and IT Programme, £0.6m over plan.

The Committee noted the report.

8. **Performance Targets**

Mr Shine, Head of Information, reported strong performance for against all measures for the Month and Period to Date.

Key Performance headlines for the month are:

- No never events reported in month
- MRSA 1 and C-Diff cases, 6, are within monthly trajectory
- Other Monitor, CQC and contractual standards and targets have been met for the month
- Diagnostic waits – no breaches in November (6 breaches in October).
- A&E 4 Hours – 95.14% in November – concern about the quarter 3 performance, currently 94.78%

The Committee noted the report.

9. **Procurement Report Q2**

Mr Walker presented the report for Q2. The Committee noted procurement savings forecast of 3328,000 for the year (above plan) and a 97.7% E-procurement rate in September.
The Committee noted 2 recent national reports on procurement in the NHS and looked forward to receiving any relevant recommendations in due course.

The Committee noted the report.

10. Monitor Q2 Feedback report

The Committee noted Mr Mistry's letter of 10th December 2012 confirming the Trust's classification of:

- Finance: FRR3
- Governance: Green

In respect of Q2.

The Committee further noted Monitor's ***'Summary of recommendations from previous independent self-certification reviews of FTs'*** and referred this to the Audit Committee for review.

11. Matters referred to Board of Directors/ Committees

11.1 The Board is asked to consider Dr Whallett's Business Case on junior medical staff

11.2 The Audit Committee is asked to consider Monitor's ***'Summary of recommendations from previous independent self-certification reviews of FTs'***

PA Assinder
Director of Finance & Information
Secretary to the Board

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 10th January 2013

TITLE:	Infection Control Report		
AUTHOR:	Denise McMahon – Director of Nursing Dr Liz Rees - Consultant Microbiologist/ Infection Control Doctor	**PRESENTER:**	Denise McMahon – 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 is 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 COMMITTEE:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS

The Dudley Group NHS
NHS Foundation Trust

Report to: Board of Directors

Report by: Director of Nursing/DIPC & Consultant Microbiologist

Subject: Infection Prevention & Control Report

Summary

Clostridium Difficile – Annual Target 77 (Post 48 hrs)

The Trust currently stands at 42 post 48 hr cases (not locked down) which falls within trajectory.

C.Difficile Cases Post 48 hours – Ward breakdown:

Ward	Totals for 2011/2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012
A1	**1**	0	0	0	1	0	0	0	0	0
A2	**6**	0	0	3	1	1	1	1	1	2
A4	**2**	0	0	0	0	0	0	0	0	0
B1	**0**	0	0	0	0	0	0	0	0	0
B2	**9**	0	0	1	0	0	0	0	0	0
B3	**7**	0	2	0	0	0	0	0	0	1
B4	**8**	0	0	0	0	1	0	0	0	0
B5	**1**	0	0	0	0	0	0	0	0	0
B6	**1**	1	1	0	0	0	0	0	0	0
C1	**19**	1	0	1	0	0	1	0	2	1
C3	**16**	0	0	0	2	0	0	1	0	1
C4	**8**	0	0	0	0	0	0	0	1	2
C5	**6**	0	0	0	0	0	0	1	0	0
C6	**3**	1	0	0	0	0	0	1	0	0
C7	**13**	2	1	0	0	0	0	1	1	1
C8	**7**	0	0	0	0	0	0	1	0	0
MHDU	**3**	0	0	0	0	0	0	0	0	0
CCU/PCCU	**1**	0	0	0	0	0	0	0	0	0
Critical Care	**6**	0	0	0	0	0	0	0	0	0
EAU	**0**	0	0	0	0	0	0	1	0	0
SHDU	**0**	0	0	0	0	0	0	0	1	0
Total	**117**	**5**	**4**	**5**	**4**	**2**	**2**	**7**	**6**	**8**

See Appendix 1 – Board Report (2012/13)

MRSA – Annual Target 2 (Post 48 hrs)

No Further cases of post 48 hr MRSA bacteraemias have been identified since the last one reported in November 2012.

Norovirus

The Trust has experienced some Norovirus activity during December. This was particularly on C8 and C3. An aggressive approach to contain the infection was employed which involved closing clinical areas where there were cases and limiting nursing staff movements. This appears to have resulted in good control and limited spread to other ward areas. Currently no areas are closed due to Norovirus.

Enterobacter Cloacae

The Trust still continues to see occasional isolates of Enterobacter cloacae on the Neonatal Unit. On each occasion the draft guidelines are followed and no further clusters have been reported.

Bordetella pertussis (whooping cough)

There continues to be a national increase in the number of whooping cough cases and we have had a member of staff with whooping cough in a community setting which resulted in a large number of patients being identified as having had a potential exposure to this member of staff whilst still infectious. On the advice of the Health Protection Agency the patients' consultants' were advised of the potential contact in order to raise awareness of whooping cough as a potential diagnosis in these patients when they are reviewed in clinic.

TB

A case of open tuberculosis has been identified in an inpatient that had not been isolated prior to confirmation of diagnosis. In accordance with national guidance on the control of TB we are currently undertaking a small contact tracing exercise, which will involve identifying patients who were nursed in the same area as the open case for a period of 8 hours or longer and informing patient, GP and consultant responsible for their inpatient care. We will provide this information to the TB service based in the PCT as part of their responsibility for contact tracing active cases of TB.

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

(N13) Clostridium difficile infection

Monthly number of C-Diff cases

Month / Year	> 48 hrs Activity	PCT Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-12	5	7	-28.6%	5	7	-28.6%	9	10
May-12	4	6	-33.3%	9	13	-30.8%	11	12
Jun-12	5	6	-16.7%	14	19	-26.3%	6	8
Jul-12	4	6	-33.3%	18	25	-28.0%	7	9
Aug-12	2	6	-66.7%	20	31	-35.5%	5	7
Sep-12	2	5	-60.0%	22	36	-38.9%	8	9
Oct-12	7	6	16.7%	29	42	-31.0%	16	16
Nov-12	6	6	0.0%	35	48	-27.1%	8	9
Dec-12	8	7	14.3%	43	55	-21.8%	14	14
Jan-13	2	7	-71.4%	45	62	-27.4%	2	2
Feb-13	-	7	-	-	-	-	-	-
Mar-13	-	8	-	-	-	-	-	-
FY 2012-13	45	77	-41.6%				86	96

The Trust target for CDiff is 25 cases per month, with a total of 299 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.
Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours.
The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

(N1) MRSA infections

Monthly number of MRSA cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-12	-	1	-100.0%	0	1	-100.0%	-
May-12	-	0	0.0%	0	1	-100.0%	1
Jun-12	-	0	0.0%	0	1	-100.0%	-
Jul-12	-	0	0.0%	0	1	-100.0%	-
Aug-12	-	0	0.0%	0	1	-100.0%	-
Sep-12	-	0	0.0%	0	1	-100.0%	-
Oct-12	-	1	-100.0%	0	2	-100.0%	-
Nov-12	1	0	100.0%	1	2	-50.0%	1
Dec-12	-	0	0.0%	1	2	-50.0%	-
Jan-13	-	0	0.0%	1	2	-50.0%	-
Feb-13	-	0	0.0%	1	2	-50.0%	-
Mar-13	-	0	0.0%	1	2	-50.0%	-
FY 2012-13	1	2	-50.0%				2

As a Foundation Trust the regulator Monitor measures compliance against the contract with our commissioners Dudley PCT. The target in this contract is 2 bacteraemias.

MSSA infections

Monthly number of MSSA cases

Month / Year	Total	Cumulative
Apr-12	4	4
May-12	4	8
Jun-12	4	12
Jul-12	1	13
Aug-12	2	15
Sep-12	5	20
Oct-12	4	24
Nov-12	7	31
Dec-12	4	35
Jan-13	-	35
Feb-13	-	35
Mar-13	-	35
FY 2012-13	35	

E Coli infections

Monthly number of E coli cases

Month / Year	Total	Cumulative
Apr-12	15	15
May-12	13	28
Jun-12	17	45
Jul-12	14	59
Aug-12	23	82
Sep-12	22	104
Oct-12	30	134
Nov-12	20	154
Dec-12	9	163
Jan-13	-	163
Feb-13	-	163
Mar-13	-	163
FY 2012-13	163	

The Dudley Group of Hospitals NHS
NHS Trust

Public Trust Board Agenda
Thursday 20th December 2007

	Item	Time	By
1.	**Chairman's welcome and note of apologies** **Paul Harrison**	2 mins	A Edwards
2.	**Declarations of Interest**		
3.	**Announcements**		
4.	**Minutes of previous meetings** • Thursday 29th November 2007 Board Meeting **Enclosure 1**	2 mins	A Edwards
5.	**Action Sheet – Progress Report by Exception** **Enclosure 2** • Update on Cash Balance **Verbal** • Committee Representation **Verbal** • Update on Draft IT Disaster Recovery Plan **Verbal** • Timings of Meetings and Management of Information **Verbal**	5 mins	A Edwards P Assinder A Edwards P Assinder A Edwards
6.	**Matters Arising**	10 mins	A Edwards
7.	**Chief Executive's Report**	10 mins	P Farenden
8.	**Strategic Issues**	5 mins	
8.1	**Foundation Trust Update** **Verbal**		L Williams
9.	**Operational Performance** • Report from Finance and Performance Committee on 20th December 2007 **Verbal**	5 mins	P Assinder
10.	**Reports for Approval** • Human Resources Report including: **Enclosure 3** Sickness Absence Policy Capability Policy Disciplinary Policy	5 mins	J Clarke
11.	**Information Items to be noted** • Quality of Care **Enclosure 4** • Guest Hospital land sale **Verbal**	5 mins	A Close P Brennan
12.	**Any Other Business** • Limited to urgent business notified to the Chair/Trust Secretary in advance of the meeting	1 min	A Edwards
13.	**Date of Next Trust Board Meeting** • Provisionally 31st January 2008 at 11.00am in the Clinical Education Centre – to be confirmed		

Enclosure 1

The Dudley Group of Hospitals NHS
NHS Trust

Minutes of the Trust Board meeting held at 11am on Thursday, 29th November, 2007, in the Clinical Education Centre, Russells Hall Hospital

Present:

Alfred Edwards, Chairman
Kathryn Williets, Non Executive Director
Jonathan Fellows, Associate Non Executive Director
David Wilton, Associate Non Executive Director
Paul Farenden, Chief Executive
Paul Brennan, Director of Operations
Ann Close, Nursing Director
Janine Clarke, Director of Human Resources
Paul Harrison, Medical Director
Paul Assinder, Director of Finance and Information
Les Williams, Director of Corporate Development

In Attendance:

Helen Forrester, PA/Admin. Manager

07/38 Chairman's Welcome and Note of Apologies

Alfred Edwards, the Chairman, introduced David Wilton who had been appointed as Associate Non Executive Director following the selection process in November, and welcomed him to the Board.

It was noted that apologies has been received from David Badger and Ann Becke.

07/39 Declarations of Interest

There were no Declarations of Interest.

07/40 Announcements

07/40.1 Associate Non Executive Director Representation on Audit and Governance Committees

Les Williams, Director of Corporate Development asked for confirmation as to which Committees the new Associate Non Executive Directors would attend. It was agreed that the issue of Non Executive Director Representation on Committees would be subject to debate at a later date.

Chairman to look at current Committee representation and to discuss with Non-Executive Directors

07/41 Minutes of Previous Meetings

07/41.1 27th September 2007 – Public Trust Board Meeting

The minutes of the 27th September Trust Board meeting, given as Enclosure 1, were approved as a correct record and signed by the Chairman.

07/41.2 25th October 2007 – Trust Board Business Meeting

The minutes of the 25th October Trust Board business meeting, given as Enclosure 2, were approved as a correct record and signed by the Chairman.

07/42 Action Sheets – Progress Report by Exception

The Board reviewed the Action Sheets, given as Enclosure 3, as follows:

07/42.1 Action Sheet – 27th September 2007

Item 07/18 Dudley MBC Car Parking Application: The Chief Executive, Paul Farenden confirmed that the application had been submitted and would be considered at the Planning Committee meeting in January.

07/42.2 Action Sheet – 25th October 2007

Item 07/28 Timeframe for regular reviews of cash balances by Finance and Performance Committee: Paul Assinder, Director of Finance and Information, reported that a policy for investing cash balances was currently in place. It was agreed that a statement of intent was needed to reflect medium term plans and that this will emerge from IBP discussions. It was acknowledged that there had been challenge from Non Executive Directors and the Director of Finance and Information would respond to this by suggesting how much cash was required to provide for an effective contingency. It was agreed that the Director of Finance and Information would assess other FTs' provisions.

Director of Finance and Information to assess other Foundation Trusts' provisions for contingency and to suggest a level of cash to be held by the Trust for this purpose.

Item 07/32 Assessment of requirements to achieve ratings of 4 for elements of Use of Resources: The Director of Finance and Information confirmed that a working group had been established to assess what was required to achieve ratings of '4' and this group would feedback to the next Audit Committee meeting.

ALE Working Group to feedback on action required to achieve ratings of '4' to the next Audit Committee meeting

07/43 Matters Arising

None to report.

07/44 Chief Executive's Report

The Chief Executive presented his report to the Board, which included updates on the following:

Cancer Peer Review – Walsall had withdrawn from the Black Country Cancer Network. There were therefore now concerns around the criteria for population size, and this would also be an implication for Wolverhampton. It was noted that for this Trust the Upper GI service may be in jeopardy and these issues had been raised at the Cancer Network Board. A meeting was being arranged with the Chair of the Board, Paul Farenden, David Loughton and Cynthia Bower. Dr Paul Harrison, Medical Director, informed the Board that the Cancer Leads from the network were meeting to review actions to mitigate the impact of Walsall's withdrawal.

Dudley PCT Commissioning Strategy - the PCT had launched their public consultation on this. The full document was available on the Dudley PCT website. Les Williams, the Director of Corporate Development, had circulated a summary of the main points.

Chief Executives' Conference - concerns at the Centre remained Infection Control, and keeping Boards engaged with this important issue; Positive messages to the public, as it is felt that the NHS does not portray itself as providing good services effectively. It was also noted that, given the high level of surplus nationally (£1.8 billion), missing targets would not be acceptable to the Centre.

07/45 Strategic Issues

07/45.1 Foundation Trust Issues

The Director of Corporate Development reported that, as discussed in Finance and Performance Committee, Monitor had agreed that the Trust's application for FT status would be re-activated in April 2008, leading to a potential authorisation date of 1st July 2008. The Assessment Team would begin their work after the submission of the revised IBP and LTFM by the end of March 2008. The full timetable would be published in February 2008. Ernst and Young would be used by Monitor to undertake the due diligence review.

07/45.2 Strategy for 2008/09 to 2012/13

The Director of Corporate Development spoke to this paper, given as Enclosure 4, and tabled a revised appendix 6, following a meeting on 28th November 2007. This paper had been produced following the recent Board workshop sessions on Strategy. It was intended to keep this as a reference paper, when agreed, to inform the re-drafting of Section 3 of the IBP. He asked that Board members comment on the detail of the paper, and the following was noted:

Section 1 Background – add market positioning

Section 2.1 Demographics – It was agreed that specific scenario analysis of the 5 HRG areas would be undertaken within the LTFM.

Section 2.2 Policy – Following the end of the Mercury Contract it was agreed to amend the wording to remove or change the emphasis of risk involved.

Section 2.3 Commissioning – agreed.

Section 2.4 Provision – It was agreed to expand this to include the potential impact of the Darzi Review, and with reference to population changes and reinforcing market position.

Section 2.5 PEST Analysis – The Board had a discussion around the possibility of merger. It was agreed that this would have no impact in the planning period and could be removed from the PEST analysis. It was agreed to add remote condition management to 'Technological'.

Section 2.6 SWOT Analysis – The Chairman had some changes to be made which he would discuss with the Director of Corporate Development following the meeting. The Medical Director raised the issue of over reliance on multiple manual and non-integrated systems in short term and confirmed that risk assessment work was being undertaken in this area. There was some debate around existing IT infrastructure risks and where these should appear. This will be discussed further at the Risks workshop week commencing 3rd December 2007.

Section 2.7 Scenarios – Covered in revised Appendix 6 which was tabled. This will now be incorporated into the LTFM by the Director of Finance and Information.

Section 3 Profitability - take out 'Proactive about risk' and add 'Investments to secure market position'

Section 4.1 Vision – Change to 'with a range of specialist services'

Section 4.4 Productivity – add 'develop flexible and responsive workforce'. Profitability – take out 'within planned activity/income base'.

It was agreed that Executive Directors would complete the Targets/Measures and Dates in Appendices 8.1 to 8.3 and submit these to Board for approval.

With these amendments to be made, the Board approved the paper, and noted that this would form the basis of Section 3 in the IBP.

The Chairman asked about the timeframe for completion of the IBP and the Director of Corporate Development confirmed that the target was for the middle of January, so that it could be approved by the Board before the end of January.

Director of Corporate Development to collate amendments to Appendices 8.1 to 8.3 and issue to Board for approval

07/45.3 Draft IT Disaster Recovery Plan

The Director of Finance and Information spoke to this paper, given as Enclosure 5. This document is Siemens' Plan and had received significant input from the Trust since its first draft in September 2004. Business Continuity Plans are being refreshed in light of the latest version of the Disaster Recovery Plan. It was also noted that the Trust had undertaken a risk assessment in light of the Plan.

The document had been out to consultation and comments had been received from Ann Becke, Non Executive Director, and from clinical colleagues. Feedback from the consultation would be passed to Siemens to update the Plan. The Board was informed that Siemens would undertake a test of the Plan on a desktop basis every 12 months and the Director of Finance and Information will ask for feedback from Siemens on the test results. The Board also requested notification of these results.

The Chairman asked whether there was an external view about the document and the Director of Finance and Information confirmed that the auditors will make comments in the annual IT audit report, the Audit Committee will also receive assurance and the Integrated Governance Committee will receive the results of the desk top simulation. The Board was happy with this level of examination. The Chairman requested that the Board appears on the audience list for the document.

Jonathan Fellows, Associate Non Executive Directors raised the issue of triangulation of the network for the 3 sites and what happens if one site goes down. It was noted that, following this issue being identified by Ann Becke, Non Executive Director, Siemens were looking at a solution.

Director of Finance and Information to feedback to the Board on the results of desktop simulation and ensure the Board is added to the audience list on the document

07/46 Operational Performance

Report from the Finance and Performance Committee on 29th November 2007 - The Director of Finance and Information reported that the Finance and Performance Committee had, at its meeting on 29th November, discussed and noted:

- Up to the end of October the surplus year to date was £8.2m, including clinical income at £1.1m above plan. This had improved in October by £700,000
- Significant amounts had been released into the I and E position from Reserves and Provisions
- The full year forecast was £8.6m, normalised to £6.5m.
- Two CIP schemes had slipped at the end of October and these were the nurse pool and medical secretary project (shortfall of £391,000).
- Performance against non financial targets showed full compliance with HCC standards except for MRSA which was showing 17 cases to date against the target of 12.
- There were two risk issues and these were outpatient waiting times where there had been one breach over the 11 week maximum wait as a result of patient choice and pressures in A&E with the 4 hour wait target.

The Board noted this position.

07/47 Reports for Approval

07/47.1 Debt Management Policy

The Director of Finance and Information spoke to this paper, given as Enclosure 6. It was noted that this was an updated policy and the Board were asked to note Annex A which gave details on how the Trust pursues debt, the strategy in place and the escalation process.

Kathryn Williets, Non Executive Director asked why the invoices for delayed discharges to the local authority were not raised in accordance with the policy. It was noted that it had been agreed to delay raising these invoices for a period to allow negotiations on improved performance to take place. Now that they had been raised, the policy would be applied.

Jonathan Fellows, Associate Non Executive Director, raised the issue of bad debts for overseas visitors. The Director of Finance and Information explained that the approach had always been to treat patients, especially emergencies, first and then seek payment. He agreed to look again at whether it was possible to identify overseas visitors at an earlier stage to secure a commitment to pay.

The Board approved the Debt Management Policy

07/47.2 Review of Board, Finance and Performance and Governance Committee Timings

The Director of Corporate Development reminded Board members that the new arrangements for Finance and Performance Committee and Board meetings to be held on the same day were to be piloted for September, October and November, and asked if the Board wished this arrangement to continue. It had previously been agreed that Governance meetings would be moved to another Thursday in the month. The Board discussed the potential for repetition over the three meetings and it was agreed that the way information is managed needed further discussion.

The Board agreed to keep the same arrangements for the December meeting and discuss this issue again at a Non Executive Directors' meeting.

The Chairman to raise timings of meetings and management of information at the next Non Executive Directors' meeting

07/48 Information Items to be Noted

07/48.1 Patient and Public Involvement

Ann Close, Nursing Director spoke to this paper, given as Enclosure7, and it was noted that the complaints report had been integrated into this paper. The Director of Finance and Information questioned responses to the Your Stay in Hospital Questionnaire and what will be happening with the feedback. The Director of Nursing informed the Board that it was a question of resources and the willingness of patients to respond to questionnaires. A co-ordinated approach had been put in place to minimise disruption to patients. The national Maternity and Inpatients surveys were also currently being undertaken.

The Board received the paper.

07/49 Any Other Business

There being no other business, the Chairman closed the meeting.

07/50 Date of Next Meeting

The next Board meeting will be held at 11am on Thursday, 20th December, 2007 in the Clinical Education Centre.

Signed as a correct record: . . . . . **Chairman**

Date: . . . . . .

Enclosure 2

The Dudley Group of Hospitals NHS
NHS Trust

Action Sheet
Minutes of the Trust Board meeting held at 11.00 am on
Thursday 29th November 2007 in the Clinical Education Centre

Item No.	*Subject:*	*Action:*	*Responsible*	*Due Date*	*Actioned*
07/28	Finance and Performance Committee Report	Review on a regular basis the cash balance of the Trust with a view to identifying suitable investments to be made by the Board.	DFI	20/12/07	
07/42.2	Action Sheet Update	Assess other Foundation Trusts' provisions for contingency and to suggest a level of cash to be held by the Trust for this purpose.	DFI	20/12/07	
07/42.2	Action Sheet Update External Audit Letter 2006/07	ALE Working Group to feedback on action required to achieve ratings of '4' to the next Audit Committee meeting on 15/1/08	DFI	January Board	
07/40.1	Associate Non Executive Director Representation on Audit and Governance Committees	Discuss Committee representation with Non Executive Directors	C	20/12/07	
07/45.2	Strategy for 2008/09 to 2012/13	Collate amendments to Appendices 8.1 to 8.3 and issue to Board for approval	DCD	20/12/07	
07/45.3	Draft IT Disaster Recovery Plan	Feedback to the Board on the results of desktop simulation and ensure the Board is added to the audience list on the document	DFI	20/12/07	
07/47.2	Review of Board, Finance and Performance and Governance Committee Timings	Timings of meetings and management of information to be raised at the next Non Executive Directors' meeting	C	tbc	

Action Sheet
Minutes of the Trust Board meeting held at 11.00 am on Thursday 25th October 2007 in the Clinical Education Centre

The Dudley Group of Hospitals NHS
NHS Trust

Item No.	Subject:	Action:	Responsible	Due Date	Actioned YES/NO
07/27.3	Authorisation Timeframe	The Trust Board agreed that the Chief Executive would contact Miranda Carter at Monitor and agree this timeframe as well as providing an update on the appointment of the Non Executive Directors. It was noted this had to be done by 9th November 2007.	CE	9/11/07	YES
07/28	Finance and Performance Committee Report	David Badger, Non Executive Director, proposed, and the Board agreed, to review on a regular basis the cash balance of the Trust with a view to identifying suitable investments to be made by the Board.	DFI	TBA	
07/31	Healthcare Commission Report on Maidstone and Tunbridge Wells C.Difficile Outbreak	The Trust Board agreed to receive the report of the Nursing Director on the implications of the Healthcare Commission report on Maidstone and Tunbridge Wells Trust at the next meeting, and that this would include details of any additional action the Trust needs to take	ND	29/11/07	YES
07/32	External Audit Letter 2006/07	The Trust Board agreed that Paul Assinder, Director of Finance and Information, would assess what was required to achieve a rating of 4 for each of the elements, which made up the assessment for 'Use of Resources'.	DFI	TBA	
07/36.1	Telephone System Outage – 24th October 2007	The Trust Board agreed that a report on progress would be made to the next Trust Board meeting by the Director of Operations	DO	29/11/07	

Enclosure 3

The Dudley Group of Hospitals NHS
NHS Trust

REPORT TO: Trust Board, 20 December 2007.

REPORT OF: Director of Human Resources

1. Health & Safety

1.1 Health & Safety

The annual trust Health & Safety week took place week commencing 29th October 2007. The themes included:

- Musculoskeletal disorders
- Workplace hazards
- Personal protection (Infection Control and Sharps)
- Violence & Aggression
- Patient Safety (regulations, clinical negligence etc)

The event included initiatives to raise awareness of health & safety issues and competitions with prizes being generously donated by our PFI partners and local businesses.
The Health & Safety Executive also participated in this event and have provided us with very positive feedback.

1.2 Security Management

The NHS Annual Violence against NHS staff results for 2006/07 were released to the press on 8th November. The national trend indicates a 12.75% reduction in incidents.

This Trust however experienced a slight increase in reported incidents (27 incidents cf. 26 from previous year). This we believe is due to increased awareness of the need to report rather than an indication of an increased threat to staff. The situation is being monitored and conflict resolution training programme is being ramped up to equip staff to handle and diffuse potentially violent situations before they escalate.

2. Human Resources

2.1 Policies

The following policies were approved by the Joint Negotiating Committee (JNC) on 3 December 2007:-

a) Sickness Absence Policy (attachment 3a)
b) Capability Policy (attachment 3b)
c) Disciplinary Policy (attachment 3c)

The Capability policy is an entirely new policy that distinguishes under[performance due to lack of capability (skill) from underperformance arising from misconduct or attitude. The Sickness and Disciplinary policies are updated policies but mark a radical departure from their predecessors.

The Committee is requested to formally approve these Policies.

2.2 New Registration Framework

On 19 October 2007 the General Medical Council introduced a new registration framework. From this date, limited registration, a category of registration which applied to international medical graduates (IMGs), was abolished. The new framework of provisional and full registration applies equally to all doctors no matter where they qualify.

This means that all doctors granted full registration for the first time – UK graduates as well as IMGs – or those returning to the register after a prolonged period out of UK practice, will be required to work initially within an approved practice setting.

We have now been recognised as an approved practice setting that enables us to continue to employ newly fully registered doctors, or doctors returning to the register after a prolonged period out of UK practice.

2.3 Committed to Excellence Awards

As you will be aware the Committed to Excellence awards were launched early this year with the final awards ceremony being held on 4th October. The purpose of the awards scheme was to recognise employees who have made a significant contribution to the achievement of the Trust's vision, values and strategic goals. The scheme was a significant success with over 1000 staff/volunteers being nominated for awards by a mixture of patients, colleagues and managers.

The results were as follows:

Performance excellence
Winner: 48 Hour Hip Replacement Team
Runner Up: CAPD/Renal Unit

Excellence in patient care
Winner: C3 C Diff Isolation Unit
Runner Up: Rachel Willetts

Business excellence
Winner: CT Scanning Team
Runner Up: Orthotics

Excellence in teamwork
Winner: C4 Chemotherapy Day Case team
Runner Up: Take the Time Tool

Colleague of the year award
Winner: Andrew Ball
Runner Up: Denise Yates

Volunteer of the year award
Winner: Steve Ford
Runner Up: Michael Murphy

Feedback from the event was very positive with a significant number of managers noting an improvement in morale within those teams who were recognised. It is therefore planned to continue to run these awards annually.

Janine Clarke
Director of Human Resources.

The Dudley Group of Hospitals NHS
NHS Trust

SICKNESS ABSENCE POLICY & PROCEDURE

1. POLICY STATEMENT

The Trust aims to enable the attendance of all employees throughout the working week and provide a supportive framework in which sickness absence may be managed appropriately in the interests of both the individual and the service.

All members of staff are expected to provide an efficient and effective service to patients/clients of the Trust. The commitment to attend work is integral to this aim.

2. SCOPE OF THE DOCUMENT

This document applies to all employees of Dudley Group of Hospitals NHS Trust (Teaching).

3. EMPLOYEE'S RESPONSIBILITY

All employees have a responsibility to attend work on a regular and consistent basis and fulfil their contractual hours of work.

All employees are required to follow the reporting and certification procedures, set out in this document and follow local rules regarding notification of absence where they apply. Where employees fail to notify Managers of their absence, within the appropriate time limit, and/or fail to produce the appropriate certification and/or do not attend Occupational Health Service appointments, when requested, whether off sick or at work, without an acceptable reason, payment of salary/sick pay will not be made.

3.1 REPORTING ABSENCE/KEEPING IN TOUCH

All staff should ensure that they are familiar with the departmental rules regarding the reporting of absence, including to whom they should report, by what time and be aware of their responsibilities under this procedure (summarised at Appendix I). Unless there are mitigating circumstances, staff will contact the nominated person in advance of their scheduled start time. This early communication is important to enable the necessary cover arrangements to be made.

When reporting in, employees should ensure they report to the nominated person, and provide brief details of the illness and how long they expect to be absent. Whilst Departments/wards will have their own reporting arrangements, it is expected that the nominated person will be the employee's line manager or the most senior person on duty. It is not

acceptable to leave messages “with the department”, or send text messages or e-mails as this can result in a lack of clarity of information. If there is no alternative, then a message may be left with an appropriate named person in a department.

Junior Doctors must contact both their Consultant (or nominated person) and the Medical Staffing Department. Consultants must contact their Medical Head of Service and Medical Staffing.

The individual member of staff should telephone their Manager, or nominated contact, and relatives, partners or friends should only telephone on their behalf in exceptional cases. Failure to telephone will result in the time absent being classified as unauthorised (unpaid) leave.

Employee’s should keep their Manager advised of any developments with regard to their absence and in particular notify their intention to return to work in sufficient time to allow arrangements to be made, for example the cancellation of cover arrangements.

Where periods of sickness last for longer than 4 weeks the employee must communicate verbally with their line Manager at least fortnightly, or at agreed intervals.

3.2 PROVIDING SELF CERTIFICATION/MEDICAL CERTIFICATES

Employees who are away from work due to sickness, whether arising as a result of an accident or otherwise must complete an Employees’ “Statement of Sickness Form” (Self certificate) for every occasion of sickness absence (see Appendix II).

It is the employee’s responsibility to submit the Employees’ Statement of Sickness to the appropriate Manager. This should be at the end of the period of sickness absence or at the end of the 7th Calendar day of sickness where the sickness period continues for longer than 1 week, whichever is the sooner.

Where the sickness extends beyond 7 days a Medical Certificate from the employees GP must be provided, and is to be received by the Manager/head of department, as soon as possible after the 7th day and no later than the fourteenth day of sickness.

Exceptionally, a Manager may require an employee to produce a Medical Certificate before the eighth day of sickness absence, normally where there is a high rate of absence. The Trust will reimburse any charges for obtaining such certificate when evidence of payment can be provided.

Unless there are exceptional mitigating circumstances:

- Backdated Medical Certificates will not normally be regarded as valid and will not be accepted

- Where absence continues, subsequent Medical Certificates must be received, for each period within seven days of expiry of the previous Medical Certificate.

4. MANAGERS' RESPONSIBILITIES

Managers have a critical role to play in managing absence and are required to:

- Ensure a procedure exists for staff to report absence, including Identifying a nominated person/persons to whom sickness is to be notified by telephone (this is usually the individual's line Manager) and the time by which this notification must take place and advising employee's of the arrangements.
- Ensure the nominated person notes the details of absent employees when reported, along with the expected date of return and the reason for absence
- Inform all employees of the ward/departmental rules in respect of notification of absence and the detail of the policy. In addition they must ensure that all employees within their area of responsibility comply with the policy
- Monitor employee absence, including part day absences
- Conduct return to work interviews & sickness review meetings in accordance with this procedure
- Ensure that employees' health is not placed at an unacceptable level of risk due to inappropriate management of Health and Safety matters
- Provide appropriate support for employees to minimise the likelihood of absence from work
- Consider and implement reasonable adjustments to the workplace where it is appropriate, to facilitate continued employment
- Ensure completion and maintenance of appropriate records (e.g. local sickness records, turnaround documents, incident reports).
- Ensure that they document all meetings.

5. PROCEDURE

5.1 RETURN TO WORK MEETINGS

Irrespective of the period of sickness (including part day absences) all employees will have a return to work meeting with their line Manager who will complete the Return to Work Form on their first day of returning to work, or as soon as possible within 3 days of the return. For Junior Doctors their return to work meeting will be with their Consultant, for Consultants their return to work meeting will be with their Medical Service Head.

The Return to Work form should be placed on the employee's personal file. For Medical staff it should be forwarded to the Medical Staffing Department for them to put on the Doctor's personal file.

5.2 INFORMAL MANAGEMENT OF SICKNESS ABSENCE

All sickness absence that requires formal management will be initiated when any of the following situations arise:

3 absences in a 12-month rolling period

or

10 days' absence (consecutive or non-consecutive) in a 12 month rolling period

or

An unacceptable level of absence, expressed as a percentage, over the previous 12 months (rolling) employment with the Trust. If 12 months has not been served, then service to-date. "Unacceptable" would for example be a figure that exceeds the Trust's target, as set by management.

or

Insufficient improvement/failure to maintain improvement following previous management action under this procedure.

Line Managers have the right to interview and manage any member of staff whose patterns of absence, whilst not exceeding the levels above, still gives cause for concern.

STAGE 1

This informal meeting is to be held between the employee and their Manager when any of the criteria identified in the above paragraph is met. At this stage, Trade Union representatives would not normally be present. For Medical Staff their Manager is the individual who carries out their return to work meeting.

The Manager may decide that it is appropriate to refer the employee to Occupational Health at this stage or, alternatively, may wish to monitor future attendance (in which case they may set a level of required attendance) or decide that no action other than a file note is required. The employee should be advised that further absence may result in formal action being taken under this procedure.

Managers must record the details of the meeting in writing and place on the individual's personal file. For Medical staff, this should be forwarded to the Medical Staffing Department.

STAGE 2

A further meeting will be held between the employee and their Manager. At this stage members of staff have the right to be accompanied by a Trade Union representative, friend or colleague.

The meeting will be called if any of the following circumstances occur:

- Insufficient improvement in attendance after the Stage 1 meeting, or improvement followed by a deterioration in that improvement

Or

- Following stage 1, further continued absence over 4 consecutive weeks

and/or

- If the Occupational Health Service report requested at Stage 1 indicates that the employee is unlikely to return to work/full duties in the foreseeable future or that continued levels of absence would be likely to occur.

Outcomes from stage 2 may include:

Outcome	**Options to consider:**
Return to work envisaged but no specified date determined	Explore opportunity for phased return to work/rehabilitation as a means of enabling a specified date to be determined
	Refer to Occupational Health if this has not occurred already
	Decide that department cannot reasonably sustain (due to an adverse impact to patient care, financial viability or productivity is adversely affected etc.) the absence therefore terminate employment. Following process for seeking alternative employment – appendix 3.
	Arrange for a further period of monitoring, if for example awaiting a medical report. Arrange a further meeting at stage 3.
Return to work on a specified date.	Explore requirement for a phased return to work/rehabilitation programme, agree as appropriate (advice can be sought from Occupational Health as required
	Decide that department cannot reasonably sustain (due to an adverse impact to patient care, financial viability or productivity is adversely affected etc.) the absence therefore terminate employment. Following process for seeking alternative employment – appendix 3.
Return to work possible, but not on the original duties/conditions.	Short term issue - agree a phased return to work/rehabilitation programme, as appropriate (advice can be sought from Occupational Health as required.
	Longer term issue - explore reasonable adjustments, which, depending on the circumstances in the work area/department may include: change of hours, job restructuring, adapting premises/equipment, or re-training and whether these should be considered on a substantive or temporary basis taking into account the requirements of the Disability Discrimination Act, where appropriate.
	If not possible to make reasonable adjustments terminate employment. Following process for seeking alternative employment – appendix 3.

Return to work to *any* post not likely in the foreseeable future	For employees who have been in the NHS Pension Scheme for 2 years or more, advise them that they can apply for retirement on the grounds of ill health
	Terminate employment
A likelihood of continued levels of absence	Decide that department cannot reasonably sustain the likely levels of absence therefore terminate employment
	Arrange for a further period of monitoring and issue warning letter to employee. Advise employee that further formal action may result in termination of employment
Sporadic pattern of absence	Decide that department cannot reasonably sustain the likely levels of absence therefore terminate employment
	Arrange for a further period of monitoring and issue warning letter to employee. Advise employee that further formal action may result in termination of employment

Note: Where termination on the grounds of incapability is considered, the decision to dismiss must be taken by a Manager of a level at least equivalent to the Matron, Medical Service Head, Professional Clinical Service Head, Business Support manager.

STAGE 3

The next level of Manager (i.e. a manager at a level above that of the manager who dealt with this under stage 1 & 2), who will normally be Matron, Medical Service Head or Departmental Head or equivalent status, the employee and a representative of the Human Resource Department will meet at stage 3. A Trade Union Representative, colleague or friend may accompany the employee.

The meeting will be called when:

- The employee has not achieved set and agreed targets or demonstrated sufficient improvement following the Stage 2 meeting

  and/or
- It has been confirmed by Occupational health that their return to work is unlikely in the foreseeable future and it is having an adverse affect on the operation of the department

  and/or
- Phased return/rehabilitation programme has not been successful in enabling a return to normal schedules/duties

  and/or
- Trial period following redeployment has been unsuccessful

  and/or
- The individual may continue to have absences from work on a frequent or regular basis.

The outcome of this meeting may be any of the alternative options identified in stage 2 above.

The Manager must confirm details of the meeting in writing to the employee and retain a copy on the individual's personal file. For Medical Staff this should be forwarded to the Medical Staffing Department to be put on the Doctor's personal file.

5.3 TERMINATION

The decision to terminate on the grounds of incapability must be taken by a Manager of a level at least equivalent to the Matron, Medical Service Head, professional Clinical Service Head, Business Support Manager or Department Head or above. The employee will be given written confirmation of:-

- The reason for his/her termination.
- The period of contractual notice payable
- Details of his/her right of appeal, together with the name/job title of the person to whom any appeal should be made.

5.4 APPEAL MECHANISM

There will be one level of appeal against the termination of the contract of employment on the grounds of incapability, which must be lodged in writing to the relevant Executive Director within 10 days of the date of the letter confirming the decision to terminate their employment. A Manager senior to the person making the decision to terminate the contract will hear the appeal.

The letter of appeal should set out clearly the grounds upon which the employee feels the decision to terminate their contract was unfair.

An appeal hearing will then be arranged as soon as reasonably possible.

6. FURTHER PROVISIONS

6.1 HOME VISITS

Where an employee is unable, through illness, to attend a meeting with their Manager/ representative of the Trust, consideration will be given to a home visit by the Manager. The employee should be informed of his/her right to be accompanied by a Trade Union representative, colleague or friend. Appropriate records must be maintained of such meetings. For Medical staff this should be forwarded to the Medical Staffing Department to be put on the Doctor's personal file.

6.2 REFERRAL TO OCCUPATIONAL HEALTH

Managers may refer staff for an Occupational health opinion at any time during the course of their employment, whether the individual is absent from work or not.

Where the employee is referred to the Occupational Health Department, they will be informed by the Occupational Health Department whether there is a requirement to obtain a medical report from their GP, and/or Consultant relevant to their current health problem and medical history.

Where a medical report is required the employee will be required to authorise this in accordance with the Access to Medical Reports Act.

If an employee does not agree to the Occupational Health Service seeking a medical report from their GP or Consultant, the Manager will be required to make a decision regarding the absence and continued employment on the information available to them at that time. Employees are, by their contract, required to attend an appointment with Occupational Health, when requested. When an employee, who is absent from work due to sickness, fails to attend without an acceptable reason, this will result in withdrawal of occupational sick pay. Pay will not be made until such time as they have attended the Occupational Health Department and they will not be entitled to back pay for the period they failed to attend.

6.3 ALTERNATIVE EMPLOYMENT

The Trust has a duty to actively consider re-deployment to alternative employment e.g. employment which is suitable and conducive to an individual's health condition and capability. This process will be coordinated through the HR Department. This does not mean that the Trust must create a post for the employee where none exists.

6.4 PHASED RETURN TO WORK/REHABILITATION PROGRAMME

A graduated return to work over a specific time period to allow the individual to build up to working at normal duties and/or for their normal contracted hours may be considered for a maximum period of one month. In exceptional circumstances this time frame may be reviewed. Individuals will be paid for the time that they work and the shortfall in hours would need to be made up using annual leave for the duration of the graduated return.

Where there is insufficient annual leave remaining, then annual leave may be taken from the following year's entitlement, providing there remains a minimum of 24 days leave (annual and bank holiday) in the following leave year, to ensure compliance with the provisions of the Working Time Regulations.

Where any such graduated returns are agreed, the Manager should record any such agreement and set a date for a review meeting to be held. Having agreed the review date the Manager should confirm this agreement in writing to the employee. A copy should be retained on the employee's personal file. For Medical staff this should be forwarded to the Medical Staffing Department for it to be put on the Doctor's personal file.

6.5 APPLICATION FOR ILL-HEALTH RETIREMENT IN ACCORDANCE WITH THE NHS PENSION SCHEME

Under the NHS Pension Scheme, if an employee is terminated on the grounds of incapability due to ill health, and they have 2 years' service, they may qualify for early payment of a lump sum and pension. The employee must make a written application for ill health retirement and either the Occupational Health Physician or the employee's GP will need to certify that they are permanently unfit to perform the duties for which they were appointed.

When considering making an application for ill health retirement, it remains the employee's decision to make an application. The NHS Pensions Agency provisions require that retirement will only be considered where all treatment options have been exhausted and the condition is permanent up to an individual's normal retirement age. Medical evidence of this needs to be provided at the time of application.

The decision to award/ not award an ill health pension is a matter for the NHS Pensions Agency, which is independent of the Trust.

Where an employee is not a member of the NHS Pension Scheme, and their employment is terminated on the grounds of incapability, their entitlement will only be to notice of termination, which is due to them under their employment contract.

6.6 SICK PAY

Sick pay allowance is in accordance with the appropriate terms and conditions of service and is subject to the reporting requirements being complied with by the employee.

An employee's employment may be terminated irrespective of whether the employee is still in receipt of Statutory or Occupational sick pay.

6.7 STAFF ATTENDING FOR WORK BUT NOT DEEMED FIT TO WORK

From time to time there are circumstances where an individual attends for work and is not deemed by their Manager to be in a fit state to undertake their duties due to physical or mental health reasons or the individual does not feel well enough to finish their shift/duty period. On such occasions, a Manager may instruct a member of staff to go home.

In these circumstances the absence will not be recorded for payroll purposes as sick. However, the absence will be recorded on the employee's sick record to enable this to be taken into account when reviewing their sickness history. This process should also be followed for employees starting their shift late due to illness.

Employees must complete a self-certificate for this period of absence and a return to work meeting must also be held.

6.8 MANAGEMENT OF UNAUTHORISED ABSENCE

Where an employee unreasonably fails to notify their line Manager of their unavailability for work, this will be regarded as unauthorised absence and they will not receive any pay for the duration of the unauthorised absence period. The Manager will attempt to make contact with the employee. Unauthorised absence will be treated as a breach of contract, and will be dealt with under the Trust's disciplinary procedure.

6.9 MEDICAL SUSPENSION

There are a few instances where medical suspension is necessitated, for example as a result of a statutory provision.

All Managers considering this will discuss each individual case with the Occupational Health Department and where appropriate the Infection Control team. The Occupational Health Department and Infection Control team will identify if the employee could carry out any alternative work that would avoid the need for medical suspension. The Occupational Health Department and, where appropriate the Infection Control team, should then be consulted before the individual returns to their usual work.

Details on payments that the individual would be entitled to can be obtained from the HR Department.

6.10 ACCIDENTS AT WORK

Employees should inform their Manager or the person in charge immediately if they have an accident at work. An Incident report form must be completed. If they become absent due to an accident at work, they should inform their Manager of this when reporting their absence.

*6.*11 WORKING DURING SICK LEAVE

Staff are not permitted to undertake alternative or additional employment whilst on sick leave from the Trust. This includes any kind of "bank" or agency or private practice work.

Undertaking alternative or additional employment whilst on sick leave is classed as gross misconduct and such cases will be handled under the Trust's Disciplinary Procedure.

7. MONITORING & REVIEW

The Director of Human Resources will be responsible for the review and updating of the Policy through the JNC, on a 3 yearly basis or as the law necessitates.

Originator: **Janine Clarke**

Date: **October 2007**

Approver:

Date Approved;

Review Date:

APPENDIX I

SUMMARY OF SICKNESS PROCEDURE

Is this your first day of sickness?	- YES -	You must telephone your Manager/Head of Department or their nominated representative in advance of the scheduled start time.
Will you have been sick for between 1 & 7 consecutive days?	- YES -	A self certificate is required from the first day of sickness and you will receive normal pay (assuming you have sick pay entitlement remaining) provided you telephone on the first day as above. Your Manager must receive this form by the 7th calendar day of the start of the illness.
Have you been sick for more than 7 days?	- YES -	Medical Certificates are required to cover sickness beyond the 7th day and must be received within 7 days of each of the last sick note's expiry. Medical certificates can be obtained from your GP or Hospital, if an in-patient. Always send your sick notes to your Manager/Head of Department immediately.
REMEMBER **EVERY DAY COUNTS** Each day of sickness must be certified. Ensure all notes are sequential.		Remember to keep in regular contact with your Manager
		Remember to ring in when you are fit for duty even though you may not be expected to work that day

STRICTLY CONFIDENTIAL **APPENDIX II**

DUDLEY GROUP OF HOSPITALS NHS TRUST (TEACHING)

EMPLOYEE'S STATEMENT OF SICKNESS (Self certificate)

You are required to fill in this form to cover you from your first day of sickness. All sickness absence of 1-7 days duration (including part day absences) must be recorded by using this form. You should forward the form to your Manager upon completion. Failure to complete & return this form to your Manager, who must receive it by the 7th day of sickness, at the latest, will result in loss of pay. This form covers you from 1-7 days, from the 8th day you **MUST** submit a Medical Certificate (Doctors Note).

NAME : JOB TITLE :

WARD/DEPT:

DATES OF SICKNESS (to include days when you would not normally be required to work)
For part day sickness state details of time left/arrived & hours absent from duty

First day of sickness

Last day of sickness

(If you do not know when you will be returning to duty leave blank)

NATURE OF SICKNESS *(Please nature of illness or details of symptoms)*

Did you visit your Doctor? YES/NO Did you visit hospital? YES/NO

Was your sickness caused by?

An accident at work or	YES*	NO
An industrial disease or	YES**	NO
Road Traffic Accident/Accident outside work (Please state)	YES	NO

* You may be eligible for Temporary Injury Allowance. Ensure an incident form has been completed

** You may be eligible for Incapacity Benefit. See your local Social Security Office for a claim form.

I confirm that the information given is complete & accurate and I understand that if I provide any incorrect, misleading or inaccurate information it will be treated as gross misconduct and could result in my dismissal.

SIGNATURE : DATE :

Manager's Note : Date :

APPENDIX III

REDEPLOYMENT ON HEALTH GROUNDS

Introduction

The following process will apply when attempting to redeploy employees, who have been advised that their employment in their current post is to be terminated due to ill health incapability, but they may be able to undertake alternative employment in another capacity without detriment to their health. In these cases they will be placed at risk. They will remain at risk for the duration of their notice period.

The process

- Managers should notify the HR Department of the request for redeployment, enclosing a completed application form, prepared by the employee, using the Trust standard application form.

- Where staff are at risk, prior to being placed in the internal Bulletin or advertised externally, a vacant post will be ring fenced for "at risk" employees seeking redeployment due to ill health. The HR department will notify the member of staff of the vacancy and the individual will decide if they wish to be considered for the post and notify the HR department of their interest prior to the specified closing date. Where an employee meets the essential criteria on the person specification, they will be interviewed for the post and given consideration prior to any other candidate. If more than one person being redeployed meets the essential criteria, the interview will be competitive between these individuals. In all circumstances, staff subject to redeployment will have no prior claim to posts that would in effect, be a promotion.

- The Appointing Officer will inform unsuccessful individuals of the reasons.

- If an "at risk" individual is not deemed suitable the Appointing Officer can then consider other applicants.

- If the individual appears to be suitable, they will be redeployed into the vacant post, only after confirmation of their medical clearance has been received from the Occupational Health Department. There will be a suitable trial period which may be extended for up to a maximum of 3 months, for all redeployments in order to establish if the individual finds the post a suitable alternative and to confirm the individual's capability to undertake the role. Both Manager and employee will use the trial period to assess suitability for the post. During this time, if it becomes apparent that the post is not suitable or the employee is not capable of performing the role, notice will be served for their employment to be terminated.

- As an alternative to dismissal, and subject to there being a vacancy, the individual may be appointed to a post at a lower grade, with their agreement. In these cases there will be no pay protection. In these cases the trial period arrangements outlined above will apply.

The Dudley Group of Hospitals NHS
NHS Trust

Capability Policy & Procedure

1. POLICY STATEMENT

The Trust is committed to providing high quality services through competent and capable staff. It is recognised that there are clear differences between underperformance as a result of conduct and that of capability and different approaches are required to manage these issues appropriately.

The purpose of the policy is to facilitate the improvement of under performance resulting from an individual's competence or capability. This provides a framework whereby managers can work with employees to address under performance in a positive non-adversarial way, where the emphasis will lie in developing and supporting staff to help them achieve satisfactory standards of performance, where possible.

2. SCOPE & DEFINITION

2.1 Scope

This policy applies to all employees of the Trust, except Medical staff and those staff with less than 12 months service. Statutory procedures will apply for those individuals with less than 12 months service.

Incapability will be dealt with under this procedure, providing the individual member of staff recognises that there is an under performance issue and commits to achieving the standards required. The Trust will only use the disciplinary procedure if an employee refuses to acknowledge under-performance and/or will not co-operate in agreeing a development plan and/or undertaking appropriate training/learning.

Where a member of staff is unable to perform the job due to ill health, or becomes incapable due to a disability, this will be dealt with in accordance with the Trust's Sickness Absence Policy & Procedure.

2.2 Definitions

Conduct is defined as:

The standard of behaviour of an individual, measured according to the Trust's expected legal, professional and/or value based standards.

Whereas Capability is defined as:

The level of an individual's ability to perform the requirements of the job and its responsibilities. Incapability will usually occur where an employee under-performs due to lack of skill or knowledge or aptitude. It does not apply where unacceptable performance is caused by a deliberate intent on the part of the employee – which is classed as a misconduct issue.

Under performance (incapability) is the gap between the expected and actual performance.

3. THE PROCEDURE

An overview of the process is given at Appendix 1.

The policy is intended to ensure that managers and staff work through problems of underperformance in a relatively informal way. Managers will seek, through a process of regular discussion, development and monitoring, to help the individual achieve the standards of performance required. If, following this support, the individual is unable to achieve the standards agreed; the employment may be ended under stage 3 of this procedure.

However, if at any time prior to stage 3, it is recognised by the employee that he/she will not be able to achieve the required standards, the Manager and the individual may decide that the employment should end by mutual agreement. See section 4.1.

Alongside this procedure and specifically for Midwives, there is a mechanism to facilitate a period of supervised practice in order to ensure that the midwife has the necessary knowledge and skills and that continuous practice development takes place. Please refer to the Statutory Supervision of Midwives through the Local Supervising Authorities (LSA).

Stage 1 – Informal Recognition & Action Plan

In order for the employee and the Manager to try and resolve the capability concern in a supportive manner, the first stage will be conducted without the option for a representative to attend along with the employee. Therefore, the Manager and the employee must meet, on a one to one basis, and: -

- Explore the problem
- Discuss the level of competence required and set performance objectives
- Agree the support required (e.g. training)

- Establish an improvement time frame for satisfactory performance, that is reasonable considering the impact of the performance on the service and the gap between current and desired performance (which may be immediate depending on the circumstances)

- Give their commitment to addressing the underperformance

- Set progress review meetings and a time by which full performance is expected

This will be documented on their personal file.

When satisfactory performance is achieved this will also be documented and placed on the personal file.

If the individual is unable to achieve the levels of performance required or if performance subsequently deteriorates it will be necessary to proceed to stage 2.

Stage 2 – Formal Review

The employee and their Manager will meet. A Trade Union Representative or a fellow colleague may also accompany the employee.

The purpose of this meeting is to:

- Discuss areas of continued under performance

- Ensure that the appropriate level and type of support has been given/offered/taken up

- Revisit the development programme and timetable for improvement

- Determine areas of performance that need to be addressed

- Agree further performance objectives and support and set a time frame in which these should be achieved.

The Manager should also inform the employee that if satisfactory performance cannot be achieved, that they may wish to consider redeployment to a more appropriate job within the Trust. If suitable alternative employment cannot be found, or the individual does not want to consider this, then it will lead to further formal action up to and including termination.

The outcome should be documented.

When performance objectives are achieved, this will be confirmed and a note placed on the employee's personal file. This will remain on file for up to 12 months. Should performance levels not be achieved or if there is a subsequent deterioration in performance, within the 12-month period, a meeting at stage 3 will be convened.

Stage 3 – Final Review

The next level of Manager (i.e. a manager at a level above that of the manager who dealt with this under stage 1 & 2), who will normally be Matron, Medical Service Head. Professional Clinical Service Head, Business Support Manager or equivalent status, the employee and a representative of the Human Resource Department will meet at stage 3. A Trade Union Representative, colleague or friend may accompany the employee.

At the meeting consideration will be given as to whether every reasonable action has been taken to help the individual achieve the necessary level of performance.

The outcome of this may include:-

Requirement that further development and monitoring takes place

Standards of performance will be identified together with any further support that should be provided and the panel will set a timeframe for achievement of acceptable performance.

Redeployment or Termination of employment

Where the member of staff has not been able to achieve the standards of performance required and a further period of time is not felt to be appropriate, the panel can determine that the employment be terminated unless alternative employment can be found. In these cases notice to terminate will be issued and the employee placed at risk. They will remain at risk for the duration of their notice period.

The following process will apply when attempting to redeploy employees, who have been advised that their employment in their current post is to be terminated due to capability, but who may be able to undertake alternative employment in another capacity.

The member of staff should notify the HR department of their intention to seek alternative employment. The HR department will provide the member of staff with details of the current vacancies and the individual will decide if they wish to be considered for the post(s) and notify the appointing officer for the post of their interest prior to the specified closing date. Where an employee meets the essential criteria on the person specification, they will be interviewed for the post and given consideration in a competitive selection process.

The Appointing Officer will inform unsuccessful individuals of the reasons and the individual will remain at risk until the end of their notice period where their employment will be terminated.

If the individual appears to be suitable, they will be redeployed into the vacant post, following any relevant checks that may be required. There will be a suitable trial period which may be extended for up to a maximum of 3 months, for all redeployments in order to establish if the individual finds the post a suitable alternative and to confirm the individual's capability to undertake the role. Both Manager and employee will use the trial period to assess suitability for the post. During this time, if it becomes apparent that the post is not suitable or the employee is not capable of performing the role, notice will be served and employment will be terminated.

As an alternative to dismissal, and subject to there being a vacancy, the individual may be appointed to a post at a lower grade, with their agreement. In these cases there will be no pay protection. In these cases the trial period arrangements outlined above will apply.

Appeal

The employee has one right of appeal against a decision to dismiss. The grounds for appeal must be lodged with the relevant Executive Director within ten working days of the date of the decision to dismiss.

Challenges to the decision may be based on the following issues:-

- New evidence or witnesses that have come to light since the decision was made
- Failure to follow procedure
- The penalty was unduly harsh

When lodging an appeal, the employee must write to the Director setting out their wish to appeal and the grounds on which it is made. It should include, where appropriate, the name and contact point of the Trade Union representative who will be representing them in the Appeal Hearing. A written statement of case should be included setting out the details of the grounds for appeal and identifying any witness they wish to be called. If the individual fails to submit a statement of case, they will be written to and given a further period in which to provide the details.

The manager who took the decision to dismiss must prepare and submit a response to the Executive Director within ten calendar days of receipt of the employee's case.

A panel shall meet that will consist of the next level of Manager above that of the dismissing officer.

The options open to the panel will be:-

- To determine that the decision to dismiss was reasonable

- To determine that the decision was unreasonable and order re-instatement (attaching any conditions as necessary)

  Or

- Any other determination as may be fair in all the circumstances (including re-engagement on alternative duties/conditions, if the employee chooses to accept this).

4. FURTHER PROVISIONS

4.1 Agreement to End Employment

Where there is an acceptance by both the employee and the Manager that the employee would be unable to reach the standards required or that the gap between the expected and actual level of performance is unlikely to be addressed within a reasonable time and/or within reasonable resources, an agreement to terminate can be made.

It is expected that this option would be instigated instead of proceeding to an action plan or past Stages 2 and 3.

The employee and their Manager shall meet with a Senior Manager and Human Resource representative (the panel in the flow diagram in Appendix 1). A Trade Union Representative, colleague or friend, may accompany the employee

The Senior Manager/HR Representative may endorse an agreement to terminate that shall be signed at the meeting.

Although no contractual or statutory notice is due, because it is an agreement to terminate and in consideration of this, a discretionary ex-gratia payment may be made.

4.2 Removal/Withdrawal from Duty

If under-performance is such that it creates an unacceptable or serious risk to patients, or severely compromises the Trust's ability to discharge its duties, the individual may need to be removed from their duties in whole or part and may, where possible, be temporarily redeployed to other duties and /or workplace.

It is normal, although not exclusive, that for potentially serious issues, suspension of the employee from their post or posts will take place. Suspension does not, in itself, constitute disciplinary action but will enable proper investigation of the case. Full contractual pay will be made and their Manager will inform the individual of this and confirm the action in writing.

An initial inquiry will be carried out by the manager to establish whether:

a) The employee acknowledges the unacceptable performance and commits to improving

and

b) If the gap between required and actual performance can be closed within a reasonable period of time, and with reasonable support and resources.

If the employee does not acknowledge the underperformance or commit to reaching the required levels of performance the matter will be dealt with in accordance with the Trust's disciplinary procedure.

If the employee does acknowledge the under performance, the matter may be dealt with under this procedure and may necessitate a gradual managed return to full duties, to ensure that patient care and/or the Trust's ability to discharge its duties are not compromised.
If however, the gap between the actual and expected level of performance is too great to be closed (see above) then the matter will be dealt with at stage 3 of this procedure or the employment may be ended by mutual agreement, see section 4.1.

5. MONITORING AND REVIEW

The responsibility for ensuring this Policy is fully implemented lies with all Managers/Heads of Departments within the Trust.

The Director of Human Resources will monitor the effectiveness of the policy and it will be amended through JNC, as required. The policy will be reviewed at 3 yearly intervals or as the law necessitates.

Originator: **Janine Clarke**

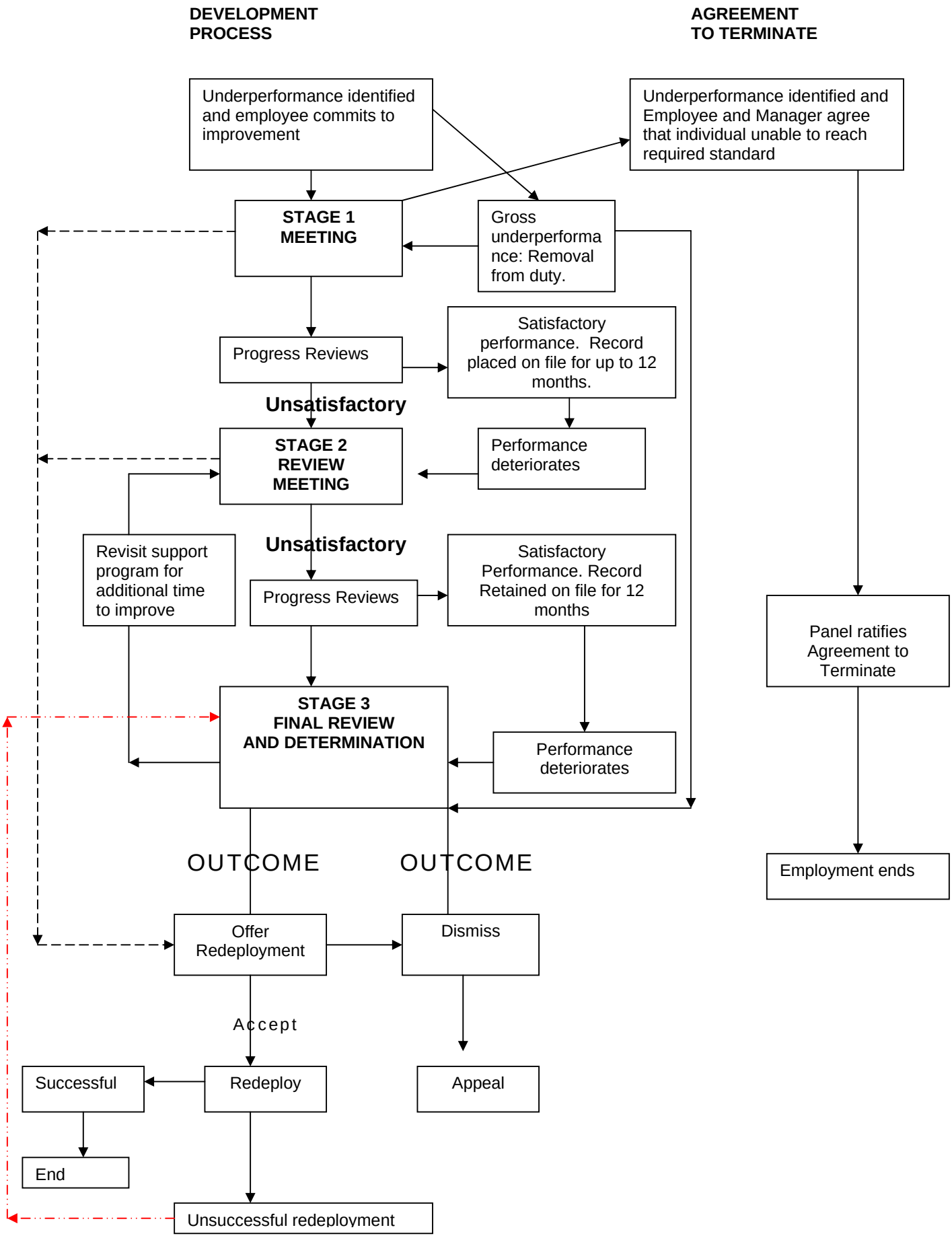
Date: **October 2007**

Approver: _____

Date Approved: _____

Review Date:

APPENDIX 1


DEVELOPMENT PROCESS
AGREEMENT TO TERMINATE
Underperformance identified and employee commits to improvement
Underperformance identified and Employee and Manager agree that individual unable to reach required standard
STAGE 1 MEETING
Gross underperformance: Removal from duty.
Progress Reviews
Satisfactory performance. Record placed on file for up to 12 months.
Unsatisfactory
STAGE 2 REVIEW MEETING
Performance deteriorates
Revisit support program for additional time to improve
Unsatisfactory
Progress Reviews
Satisfactory Performance. Record Retained on file for 12 months
Panel ratifies Agreement to Terminate
STAGE 3 FINAL REVIEW AND DETERMINATION
Performance deteriorates
OUTCOME
OUTCOME
Employment ends
Offer Redeployment
Dismiss
Accept
Successful
Redeploy
Appeal
End
Unsuccessful redeployment

The Dudley Group of Hospitals NHS
NHS Trust

DISCIPLINARY POLICY AND PROCEDURE

1. POLICY STATEMENT

The Trust expects its employees to act professionally and in accordance with Trust rules and standards of behaviour at all times. Conduct that is deemed to be not acceptable will be dealt with under this policy.

2. SCOPE & DEFINITION

2.1 Scope

The Policy applies to all employees of the Trust with 12 months or more Trust service. Statutory procedures will apply for those individuals with less than 12 months service.

However, where medical and dental staff are disciplined under this Policy, it will only be in relation to personal conduct issues. Matters concerning professional competence of medical staff is covered by a separate Trust procedure for Consultant medical and dental staff.

Under performance due to lack of capability will be dealt with under the Trust's capability Policy & procedure, (excluding medical & Dental staff) unless the employee refuses to acknowledge under-performance and will not agree co-operate in agreeing a development plan and/or undertaking appropriate training/learning.

2.2 Definition

Conduct is defined as:

The standard of behaviour of an individual, measured according to the Trust's expected legal, professional and/or value based standards.

Whereas Capability is defined as:

The level of an individual's ability to perform the requirements of the job and its responsibilities. Incapability will usually occur where an employee under-performs due to lack of skill or knowledge or aptitude. It does not apply where unacceptable performance is caused by a deliberate intent on the part of the employee – which is classed as a misconduct issue.

Under performance (incapability) is the gap between the expected and actual performance.

3. THE DISCIPLINARY PROCEDURE

3.1 THE INVESTIGATION

3.1.1 A Manager will take all reasonable steps to carry out a fair and thorough investigation before any action – informal or formal is taken.

3.1.2 The employee should be informed verbally that such an investigation is in progress, except in exceptional circumstances where this may prejudice the case (e.g. Fraud investigations that could lead to criminal proceedings being taken).

3.2 THE INFORMAL INTERVIEW

3.2.1 Dealing with matters informally may often be a more satisfactory method of resolving problems than proceeding to a formal disciplinary hearing. This process would best suit instances of minor misconduct.

3.2.2 This will entail a discussion between the employee and their line manager with the objective of advising the employee that their conduct is not acceptable and ensuring their conduct improves.

3.2.3 The Manager will note the interview having taken place on the personal file.

3.3 THE FORMAL HEARING: NOTICE OF A DISCIPLINARY HEARING

3.3.1 Where the Investigating Officer has determined that it is necessary to proceed to a Disciplinary Hearing, the Investigating Officer will write to the employee to advise that a hearing is to take place and request that the employee provides copies of any documentation that they wish to be considered and any witnesses they wish to call, within 7 days. The letter will outline the allegation(s) against the employee and documentation that Management side intend to present at the hearing and details of any witnesses they intend to call.

3.3.2 Upon receipt of the information from the employee, by the Investigating Officer, a hearing will be arranged. The Investigating Officer will write to the employee giving a minimum of 7 days notice of the date of the hearing. The letter is required to state the allegation(s) against the employee and the panel members who will hear the case. Information to be provided to the employee will include documentary evidence that is to be considered at the hearing, for example copies of statements which may be presented to the hearing and other supporting documents.

3.3.3 Where the individual, or their representative, is unable to attend the date set, the individual should immediately propose an alternative

date, to fall within 5 working days of the date originally proposed. If this is not possible or if the individual fails to propose an alternative date, management will set a second date and advise that it will be proceed in their absence if they fail to attend. If on the second date the individual is unable to attend, the Management side will proceed with the hearing in the absence of the employee.

3.4 THE FORMAL DISCIPLINARY HEARING

Each case must be considered on its own merits and if it is necessary to take action any relevant circumstances will be taken into account in determining the level of disciplinary action to be taken.

Warnings remain on an individual's personal file for the duration of the period prescribed by the Panel. This is worked time, and where an employee is absent from work due to sick leave or maternity leave for a period of one month or more, the warning will be extended by the period of absence.

3.4.1 **Formal Warning**

In cases where there is an accumulation of minor offences or where a more serious offence is committed, the individual may be given a formal warning.

Pay progression through incremental credit may also be withheld in appropriate cases during the period of the warning.

The employee will receive written confirmation, from the Chairperson of the Panel, of the decision and how long the warning will remain in force. For a formal warning this is up to 18 months.

3.4.2 Final Warning

Further misconduct of a similar nature or a serious breach of discipline may warrant a final warning.

Pay progression through incremental credit may also be withheld in appropriate cases during the period of the warning.

The employee will receive written confirmation, from the Chairperson of the Panel, of the decision and how long it will remain in force. For a final warning this is valid for up to 24 months.

3.4.3 Dismissal

In circumstances where the employee commits an offence considered as gross misconduct (see appendix I) or where the employee commits a further disciplinary offence of a similar nature

after having received a final warning, the employee may be dismissed.

The employee will be given in writing:-

- The reason for his/her dismissal.

- The period of contractual notice payable, or in the case of gross misconduct, the letter will state that the individual has been summarily dismissed i.e. without notice.

- Details of his/her right of appeal, together with the name/job title of the person to whom any appeal should be made.

3.5 APPEALS PROCEDURE

The Appeals Procedure allows an individual to put forward a case to state why the disciplinary penalty/action is inappropriate. The appeal is not a rehearing.

Challenges to the decision may be based on the following issues:-

- New evidence or witnesses that have come to light since the decision was made
- Failure to follow procedure
- The penalty was unduly harsh

There is only one level of appeal. In the case of first or final warnings, this is to the next level of Management. In the case of dismissal, the appeal will be to the relevant Executive Director.

For the appeal to be accepted the Manager/ Director must receive this letter within 10 days of the date of the letter confirming the outcome of the disciplinary hearing.

When lodging an appeal, the employee must write to the Manager/ Director setting out their wish to appeal and the grounds on which it is made. It should include, where appropriate, the name and contact point of the Trade Union representative who will be representing them in the Appeal Hearing. A written statement of case should be included setting out the details of the grounds for appeal and identifying any witness they wish to be called. If the individual fails to submit a statement of case, they will be written to and given a further period in which to provide the details.

Following receipt of the appeal and statement of case detailed above, the management side will be required to submit a statement of case in response and provide details of witnesses, within 10 days of receiving the employee's statement of case.

The Manager/Director will set an appeal hearing date as soon as practically possible.

The letter will be sent to the individual and the relevant manager by the Chair of the appeal panel, setting out the date and time of the appeal hearing and attaching documentary evidence that is to be considered, together with a list of witnesses to be called.

Outcome of Appeal Hearings

The following outcomes are possible as a result of Appeal Hearings.

i) **Decision to withdraw the warning or dismissal**

The decision overturned in favour of the employee.

ii) **Reduction in the Severity of Action Taken**

The level of disciplinary action previously taken reduced.

iii) **Decision Confirmed**

The initial decision was considered reasonable and stands.
The outcome of the appeal will normally be provided on the day of the hearing with written confirmation to follow. However, there may be instances when the panel are not immediately in a position to provide a decision. In these circumstances the outcome will be sent by recorded delivery letter as soon as possible after the hearing.

4 FURTHER PROVISIONS

4.1 RECOGNISED SHOP STEWARDS/ STAFF REPRESENTATIVES

Recognised Trade union stewards/staff representatives are subject to investigation and disciplinary action on a personal basis in exactly the same way as any other member of staff. However, before any action is taken against a trade union representative, the Trust's Human Resource Department must be contacted to ensure that early discussion of the issue with an appropriate full-time official takes place. The employee will have the option to be accompanied by the full time Trade Union Officer throughout the process.

4.2 SUSPENSION WITH PAY

It is normal, although not exclusive, that for issues of potential gross misconduct or other serious issues, suspension of the employee from their post or posts will take place. Suspension does not, in itself, constitute disciplinary action but will enable proper investigation of the case. This will be confirmed in writing.

The Trust reserves the right to withhold pay at any stage during the period of suspension if it believes that the individual is unreasonably delaying the investigation process or is in breach of the terms of the suspension.

4.3 SICKNESS OF AN EMPLOYEE

If an employee falls sick during the disciplinary process, any investigatory meeting or hearings will only be delayed (subject to only one delay) if the Trust Occupational Health Department or the individual's GP advises that attendance would be detrimental to their health.

Once approval to proceed has been obtained, a date will be set between management to continue the procedure at the appropriate stage i.e. fact finding or hearing.

In exceptional circumstances when an employee is not deemed fit to attend the process will be deferred for a reasonable period of time. After this period, the hearing will go ahead in the absence of the individual, although they may send a representative to present on their behalf.

4.4 LEVEL OF MANAGEMENT DECISION

Disciplinary action will generally be taken by Managers at the closest level to the member of staff concerned.

The authority to dismiss an employee will be held by approved dismissing managers such as Matrons, Medical Service Heads, Professional Clinical Service Heads, Business Support Managers or equivalent.

4.5 RIGHT TO BE ACCOMPANIED

It is the employee's responsibility to arrange for representation by a Trade Union representative, or the attendance of a friend or colleague at a Disciplinary Hearing or investigatory meeting.

5. MONITORING AND REVIEW OF POLICY

The responsibility for ensuring this Policy is fully implemented lies with all Managers/Heads of Departments within the Trust.

The Director of Human Resources will be responsible for monitoring and reviewing the Policy, updating as necessary and amending it through the JNC.

This policy will be reviewed at 3 yearly intervals or as the law necessitates.

Originator: Janine Clarke

Date: October 2007

Approver:

Date Approved:

Review Date:

APPENDIX I

GROSS MISCONDUCT

Gross Misconduct includes the following offences:-

a) Acts of dishonesty, including theft.

b) Malicious damage to property that belongs to the Trust, a patient or employee.

c) Fraud.

d) Falsification of time sheets, expenses claim forms or other important personal records.

e) Misuse of employee's official position for personal gain.

f) Unauthorised use or removal of the Trust's property.

g) Drug trafficking.

h) Fighting or physical assault.

i) Violent, threatening or abusive behaviour

j) Deliberate disregard of health & safety rules.

l) Repeated refusal to obey lawful orders (e.g. those orders seen within the ambit of the contract of employment) or gross insubordination .

m) Serious neglect of duty / duties.

n) Improper disclosure of confidential information.

o) Unlawful harassment, bullying or any other discrimination in contravention of Equal Opportunities provisions

p) Sexual misconduct.

q) Being under the influence of alcohol or any illegal substances.

This list of offences is neither exclusive nor exhaustive and there may be further acts of misconduct of similar gravity that would constitute gross misconduct. Further details of standards of conduct, a breach of which would constitute misconduct, can be found in Trust polices, Standing Orders, Standing Financial Instructions, Professional codes of conduct and other statutory, NHS or other Trust provisions.

Enclosure 4

THE DUDLEY GROUP OF HOSPITALS NHS TURST

Report to: **The Trust Board**
Report by : **The Nursing Director**
Subject: **Quality of Patient Care**

Introduction

This report is to inform the Board of the activities taking place in the Trust to improve the quality of patient care.

Essence of Care and Older Peoples Champions

These initiatives have been merged as there was some overlap and duplication. The aim of this work is to improve the fundamental (basic) aspects of care and thus improve the overall quality of care. This includes improving patients' nutrition, communication, privacy and dignity, health promotion, hygiene safety.

The champions programme and way of working

- Essence of Care Champions and Older Peoples Champions are continuing to work together to implement Essence of Care benchmarks and National Service framework guidance for Older People.
- Benchmarks are addressed at study days appendix 1&2. Each Study Day is repeated twice to provide access for staff. On average 30 staff attend each study day. Attendance records have been maintained.
- Agendas and lesson plans from the study days are cascaded to those Champions who are unable to attend the study days. An electronic learning package is being developed to be utilsed by Champions who are unable to attend set study days
- A quarterly network group meeting has been established to support champions, Lead Nurses and Matrons to implement the benchmarks in practice. A newsletter will be developed following each meeting and cascaded to relevant staff. The first meeting was held 23.11.2007
- Regular reports regarding Champions developments have been included in Inside Out and passed on to Communications for press release where appropriate.
- September 2007- Champions won an award at the Strategic Health Authority Conference for best innovative practice, for the implementation of the Take the Time project on C3
- As part of the implementation Older Peoples and Essence of Care Champions are helping to disseminate the best practice in each of the departments and the Trust are working in Partnership with Interserve to ensure the success of this important aspect of patient care.
- Essence of Care and Older people's information training continues to be included in the following programmes: Graduate nurse induction, pre-registration nurse Induction, Band 5 & 6 development programmes, NVQ Clinical Support Worker programmes.
- Partnership working with Matrons Kim O'Keefe and Wilma Hosany who are leading Essence of Care and Older Peoples in the Operations

Department. To ensure that objectives set at study day for each Champion are followed through into the clinical areas and that information is cascaded to other staff.
- Partnership working with outside agencies such as Age Concern continues and the use of Patient Forums used where appropriate

Nutrition

- Protected mealtimes have been implemented into all in patient areas. An audit was undertaken by dieticians at the end of October 2007. Some positive results but it highlighted areas for reeducation regarding red tray system. Training cascaded through Champions programme November 2007, and new posters for protected mealtimes ordered for all areas.
- MUST tool audited October 2007, results awaited via nutrition steering group.
- November 2007 The Water for Health (Hydration) Best Practice Toolkit has been launched for Hospitals and Healthcare by the National Patient Safety Agency and the Royal College of Nursing as part of the improving Nutrition Campaign.
- Helen Standish Bevan- Catering Services Manager (Interserve PFI Partner) is working in partnership with us and developing training packages for housekeeping staff around basic nutrition to assist patients in meal choice
- New menus for the Trust currently under review to access patient involvement once draft menus established by Interserve. Including discussion with Dietetics to ensure that all diverse and specialist menu choices available (e.g. Halal, Coeliac)

Privacy and dignity

- Privacy and dignity training on going as part of the Dignity in care campaign.

Health promotion

- November 2007 the Health Promotion study day tackled the issues around caring for obese patients and evaluated equipment available within Dudley group. A recent report showed that Dudley group spent an average of £295.000 a year in the last three years on larger sized equipment compared with an average of £60.000 in other hospitals.
- The Health Promotion Study day also covered smoking cessation for staff and patients and prevention of secondary stroke and TIA.

Infection prevention and control

- The infection prevention and control champions are in place in the high risk areas of the Trust
- Following am orientation programme they have been undertaking weekly Saving Lives audits in
    - Central line insertion and continuing care

- Peripheral line insertion and continuing care
- Perioperative care
- Care of ventilated patients
- Clostridium difficile
- Urinary catheter insertion and continuing care
- Hand hygiene

Improvements in the scores and particularly in hand hygiene have been noted.

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- An annual Quality of Care review programme is in place; there has been close liaison with the Clinical Governance coordinator to ensure that the relevant benchmarks covered are evaluated through this programme of audit. A report on the quality of Care reviews is expected but due to sickness has not been completed yet.

Meeting the Religious and spiritual needs of patients and staff
An assessment has been undertaken of the trust position against the guidance set out for providing NHS Chaplaincy services and indicates the extent that we are meeting this. In addition the action being taken to make further improvements is indicated. See Appendix 3

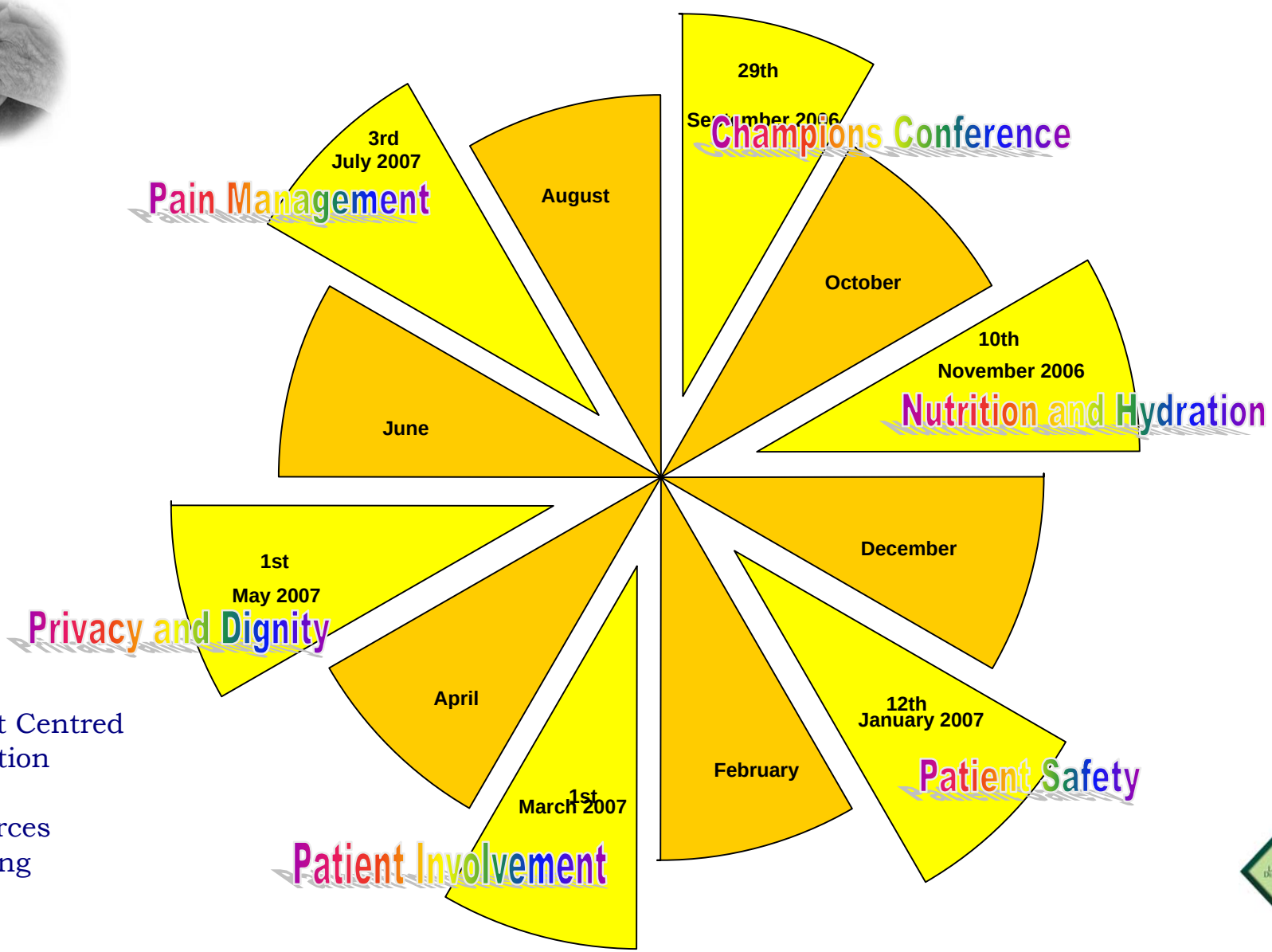
Dignity in care
The healthcare commission produced an report caring for dignity in September 2007. this was produced following the round of reviews in 2006-07 annual health check to determine the extent to which the NHS is achieving the national standards for service provision. A series of recommendations have been made at board level and at ward level. A review has now been started to assess the Trust position against these recommendations and will be reported to the Boards at a future meeting.

The Trust Board is asked to note the work being undertaken to improve the Quality of Care

Ann Close
Dec-07

The Dudley Group of Hospitals NHS
NHS Trust

Older Peoples Champions Focus Launch Dates



Patient Centred
Education
Audit
Resources
Learning
Safety

Kerry Castle
Clinical Learning and
Development Manager

Older Peoples and Essence of Care Champions
Focus Dates 07/08

The Dudley Group of Hospitals NHS
NHS Trust

Patient Centred
Education
Audit
Resources
Learning
Safety

Kerry Castle
Clinical Learning and
Development Manager

NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff
Health Care Commission Standard 13(a) section (d)

The Health Care Commission HCC Standard 13(a) section 3b(d) refers to the summary key points of the document, NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff (2003),

This document is the best practice guide intended for use by NHS Trust Boards and chaplaincy-spiritual care managers. The document is the first collaboration between the Department of Health, the Multi-Faith Group for Healthcare Chaplaincy (and its predecessor, the Multi-Faith Joint National Working Party), representing the main world faith communities and NHS Chaplaincy organisations.

The guidance sets a framework for the context and provision of chaplaincy/spiritual care services throughout the NHS. It offers guidance about providing spiritual care that is equal, just, humane and respectful, and should be discussed with the chaplaincy/spiritual care department in order to highlight areas where provision can be improved.

This guidance replaces HSG(92)2 and supports the provision of spiritual and religious care that has been part of the NHS since 1948.

All NHS Trusts provide spiritual support for patients, staff and relatives through chaplains and faith community representatives. The document sets out arrangements to ensure sufficient steps are taken to meet the religious and cultural needs of the healthcare community, whilst also acknowledging that chaplains/spiritual care givers are concerned with those who do not profess any particular faith.

The following highlighted note and subsequent key points summarise the best practice guidance.

A framework for chaplaincy-spiritual care

Experience shows that chaplaincy-spiritual care is most effective if led by a Board-level Director. The standard and quality of the service provided for patients, carers and staff by the chaplaincy team should be monitored regularly by the Trust Board and subject to regular review, which should include feedback from people who use the service.

NHS Trusts appointing chaplains-spiritual care givers should work within a suggested framework. The following best practice issues should be considered.

- The chaplaincy service is headed by a designated member of the chaplaincy–spiritual care team.

- Chaplaincy provision is made available across the organisation out of normal hours and staffing levels take account of this.

- In order to respond in the most appropriate way to the distinctive religious needs of patients and staff, each member of the chaplaincy-spiritual care team retains the religious responsibility for his/her own faith community.

- Adequate arrangements are made for the spiritual, religious, sacramental, ritual, and cultural requirements appropriate to the needs, background and tradition of all patients and staff, including those of no specified faith.

- Suitable and authorised persons are appointed to chaplaincy-spiritual care posts in partnership with representatives of the appropriate faith community (for details of whom to contact regarding appointment processes, please see the next section).

- All appointments are made in partnership with the appropriate faith community/ies (some open posts involve more than one community).

- Standard human resource procedures are followed, with the involvement of the panel of assessors as necessary.

- Clear lines of management/accountability are established to enable a consistent standard and quality of service for all patients and staff.

- Sufficient staff are available for the size and scope of the Trust's overall responsibility for all patients and staff (see Annex 1 for guidance).

- Appropriate and timely access to services from smaller faith communities is provided (as well as minorities within faith groups). It is important to know the faith needs of the patient and staff population.

- Resources and opportunities for training and professional development are provided.

1. Appointments to chaplaincy posts	Current Practice	Action For Development	Date
▪ The panel of assessors and the faith community representative are contacted at the earliest opportunity in order to gain maximum advice and support. ▪ The Human Resources Department has, via the panel of assessors and local managers, access to all appropriate support and guidance.	Though Agenda for Change does not require the use of Chaplaincy Assessors, it is viewed as good practice. The two most recent appointments to the Dudley Group of Hospitals Chaplaincy Service have made in line with MFGHC guidelines The panel has consisted of : **Chaplaincy Tem Leader** **Bishops Advisor to the Worcester Diocese (Essential for Church of England posts)** **Medical / Nursing Clinician** **Chaplaincy Assessor** **Authorised Appointing Officer** HR are consulted in all aspects of appointments.	**Compliant**	

2. Data protection	Current Practice	Action for Development	Date
▪ Wherever possible, patients have the opportunity to give their permission as to how information about them is used. ▪ Accessible information such as leaflets and welcome packs are provided, so that all patients are aware of available religious and spiritual support. ▪ Caldicott Guardians exercise responsibility for confidentiality and rule on whether sharing information is appropriate. Chaplains and Trust managers can seek their advice if they have any concerns. ▪ Robust systems should be in place to ensure explicit consent is sought before passing information to the chaplaincy service.	Information about the Chaplaincy Service and Prayer Centre facility is contained in the Trust information leaflet, Coming into Hospital. Information leaflets are available on all Ward Notice Boards. Chaplaincy Information leaflets are under currently under review. Chaplains are currently in receipt of patient information that enables Chaplains to participate in the holistic care of patients and their visitors. Roman catholic and Muslim Chaplains receive lists of Roman Catholic and Muslim Patients respectively.	Chaplaincy Team Leader is working with the DGOH Information Department to develop a means of obtaining explicit consent from patients for Chaplains to receive information that is deemed necessary for the trust to provide care.	**Jan 2008** **Team Leader**

3. Volunteers	**Current Practice**	**Action for Development**	**Date**
▪ Volunteers are selected as carefully as members of staff and their documentation is kept up to date. ▪ Induction, training and development opportunities are provided for volunteers using published examples of schemes or those tailored to local use. ▪ It is clear who the volunteers are and what they are representing. They do not have an evangelistic role but patients and their companions need to know to whom they are talking. ▪ Volunteers have the opportunity to get to know staff, especially the nurses. The volunteer team can be of great help to hospital staff – but they need to know who the volunteers are to be able to have confidence in them.	There are currently 9 Chaplaincy Volunteers. All current volunteers are members of the Mothers Union of the Worcester Diocese project run in partnership with the Chaplaincy, and provide a listening support to new parents on the Maternity Unit. Induction and documentation is administered by the DGOH Volunteer Coordinator. All volunteers are recruited, selected and trained during a 10 week training program run by the Chaplaincy Team. Further updates and supervision is provided.	A Recruitment program is planned for **Early 2008**	**Feb 2008** **Team**

4. Worship and sacred spaces	**Current Practice**	**Action for Development**	Date
▪ Good communication between all parties is established and maintained, particularly where spaces are to be shared. ▪ A code of conduct on how to use the premises is drawn up; this covers topics such as use of music, food, items on display, walking across other people praying, and use of a variety of religious leaders. ▪ Arrangements are made for secure storage of religious artefacts and symbols. ▪ There is access to equipment out of normal working hours, including Bibles, Korans, prayer mats, Hindu tapes, etc. ▪ The processes to improve worship and sacred spaces are clear and an appropriate team is assembled to conform to Trust guidance on accommodation changes.	The Prayer Centre is a Sacred Space for the whole hospital community and provides particular space for religious observance for Christians, Muslims, Hindus, Buddhists and Sikhs (the predominant religious groups within the Dudley Borough). It is open 24/7. Notices in the Prayer Centre provide guidelines to encourage respectful use of the different areas. Religious artifacts are available 24/7 for Christians, Muslims, Hindus, Sikhs and Buddhists. The original and continued development of the Prayer Centre was and is enabled by participation of a number of key reference groups within the Dudley Borough. The Dudley Borough Inter Faith Network (DBIN) was central, but other partners were also involved, namely, The Dudley Borough Churches Forum (DBCF), the Dudley Muslim Forum (DMF) and the Alliance for Community Cohesion (ACC). The Chaplaincy Service is a member community in the DBIN. The Prayer Centre has benefited greatly from the work of the Art Panel and Art Coordinator.	The DBIN is to partner the Chaplaincy Team in promoting the Prayer Centre as a creative model of good practice in Health Care and other settings. A Prayer Centre users group is proposed with and AGM **early in 2008.**	**March 2008** **Team Leader**

5. Training and development	**Current Practice**	**Action for Development**	**Date**
▪ The annual appraisal process includes identifying training needs and ways to meet them, so that these can be included in personal development plans. ▪ Journals and websites are searched regularly to identify new opportunities for development. ▪ Learning outcomes are achieved locally.	The DGOH Annual Appraisal includes all Chaplains An opportunity for regular reflective practice is provided in a group setting for all chaplains. Chaplains are encouraged to develop CPD portfolios as provided by the College of Health Care Chaplains (CHCC) and initiated by the Chaplaincy Academic and Accreditation Board (CAAB).	**Compliant**	

6. Bereavement services	Current Practice	Action for Development	Date
▪ All clinical areas have access to reliable guidance on the care of patients of differing faith communities at and after death, and of the needs of the bereaved. ▪ The Trust-wide bereavement policy committee includes a member of the chaplaincy spiritual care team. ▪ Chaplains-spiritual care givers are the Trust experts on arranging and providing liturgies and ceremonies to meet the needs of the bereaved, especially in the case of neonatal and child death and in annual services of remembrance.	The Dudley Group of Hospitals End of Life Guidelines (2F) contains guidance for the care of the dying and newly bereaved including aspects of cultural competency. The guidelines also contain details of Viewing procedures as well as procedure for Certification. A Chaplain is available for support, help and advice at all times. Chaplains provide support for all the bereaved following pregnancy loss and conduct nearly all the funerals as requested by families. Chaplains can and have provided a range of liturgies and ceremonies including no-religious ceremonies at times of death and funerals	The Chaplaincy Team Leader is currently reviewing bereavement services within the trust in line with The Department of Health document, “When a Patient Dies – Advice for the Development of Bereavement Services” (Oct 2005) . The document contains recommendations as to the management of bereavement services within Trusts.	**Dec 2007**

7. Emergency and major incident planning	**Current Practice**	**Action for Development**	**Date**
▪ Key members of the chaplaincy-spiritual care team are known in the Trust for their skills so they can be useful contributors to the variety of debriefs that occur both during and after a major incident. ▪ The spiritual care team contributes to the Trust's major incident plan and are aware of their role in the plan. ▪ Chaplaincy team members have the necessary skills for visiting people who are inpatients as a result of a major incident.	Chaplains are trained and have experience in providing crisis intervention support to staff and victims of traumatic events and deaths. The Trauma Support Model (TSM) used is an evidence based trauma support pathway continuum that can be offered to the victims of traumatic events and deaths including Major Incidents at the point of impact. The TSM is a supportive means of assessing those at risk of developing Post Traumatic Stress Disorder (about 30%). Core Chaplains are members of the Dudley Borough Crisis Support Team, which provides training and further updates of the TSM. The CST is managed by the Dudley Borough and supported by the Emergency Planning Department. The CST will provide Trauma Support within the hospital in the event of a major disaster and will be coordinated by the Chaplaincy Team. All Chaplains have attended Facing the Storm the trust Training on responding to the newly bereaved following sudden death.	**Compliant**	

The Dudley Group of Hospitals NHS
NHS Trust

Public Trust Board Agenda
Thursday 28th February 2008

	Item	Time	By
1. **2.** **3.**	**Chairman's welcome and note of apologies** **Declarations of Interest** **Announcements**	2 mins	A Edwards
4.	**Minutes of previous meetings** • Thursday 31st January 2008, Board Meeting **Enclosure 1**	2 mins	A Edwards
5.	**Presentation on Fraud Prevention by Lorna Barry, Deloitte Touche**	15 mins	L Barry
6.	**Action Sheet – Progress Report by Exception** **Enclosure 2**	5 mins	A Edwards
7.	**Matters Arising**	10 mins	A Edwards
8.	**Chief Executive's Report**	10 mins	P Farenden
9. **9.1**	**Strategic Issues** **Foundation Trust Update** **Verbal**	5 mins	P Assinder
10.	**Operational Performance** • Report to Finance and Performance Committee on 28th February 2008 **Verbal**	5 mins	P Assinder
11.	**Reports for Approval** Whistleblowing Policy **Enclosure 3** NHS Inpatient Survey **Enclosure 4** Integrated Governance **Enclosure 5** Amendment to September 2007 Trust Board Minutes **Enclosure 6** Dudley Group of Hospitals Charity – Performance Monitoring and Reporting Policy and Procedure **Enclosure 7**	15 mins	P Assinder A Close A Close P Assinder P Assinder
12.	**Information Items to be noted** Quality of Care **Enclosure 8**	5 mins	A Close
13.	**Any Other Business** • Limited to urgent business notified to the Chair/Trust Secretary in advance of the meeting	1 min	A Edwards
14.	**Date of Next Trust Board Meeting** • 27th March 2008 at 11.00am in the Clinical Education Centre (Public Meeting)		

Enclosure 1

The Dudley Group of Hospitals NHS
NHS Trust

Minutes of the Trust Board meeting held at 11am on Thursday, 31st January, 2008, in the Clinical Education Centre, Russells Hall Hospital

Present:

Alfred Edwards, Chairman
Ann Becke, Non Executive Director
David Badger, Non Executive Director
Jonathan Fellows, Associate Non Executive Director
David Wilton, Associate Non Executive Director
Paul Harrison, Medical Director
Paul Farenden, Chief Executive
Paul Brennan, Director of Operations
Ann Close, Nursing Director
Paul Assinder, Director of Finance and Information
Kathryn Williets, Non Executive Director
Janine Clarke, Director of Human Resources

In Attendance:

Helen Forrester, PA/Admin. Manager
Roger Callender, Associate Medical Director/ Caldicott Guardian

08/01 Chairman's Welcome and Note of Apologies

No apologies were received.

08/02 Declarations of Interest

There were no Declarations of Interest.

08/03 Announcements

Alfred Edwards, Chairman notified the Board of his attendance earlier in the week at the Annual Chairs Conference in London. It was noted that emphasis at the conference focussed on patient safety and mortality rates. Bill Moyes was amongst the speakers and the Chairman agreed to share the presentations from the conference with the rest of the Board. The Board was also informed that the Chairman had spoken with Marianne Loynes at the conference at it was noted that she would not be directly involved with Dudley's application this Spring.

Chairman to share presentations from Annual Chairs Conference with Board

08/04 Minutes of Previous Meetings - 20th December 2007 – Public Trust Board Meeting

The minutes of the 20th December Public Trust Board meeting, given as Enclosure 1, were approved as a correct record and signed by the Chairman.

08/05 Action Sheet – 20th December 2007 - Progress Report by Exception

The Board reviewed the Action Sheet, given as Enclosure 2, as follows:

08/05.1 Item 07/55.1 Update on Cash Balance

Discussed under item P08/04.8 of the private papers.

08/05.2 Item 07/55.2 Committee Representation

The Chairman confirmed that notes from his meeting with Non Executive Directors had been distributed to the Board.

08/06 Matters Arising

None to report.

08/07 Chief Executive's Report

Paul Farenden, Chief Executive presented his report to the Board, this included:

- NHS Operating Framework 2008/9 – It is expected that the achievement of key targets will feature in Monitors view of the Trusts application in March.

- Maternity Services Review – The Board agreed that staff should be congratulated.

- Visit to School of Nursing – The Chief Executive and Chairman had visited Prof. Linda Lang, Dean of the School. Discussions had included how to plan for nurse training and training in bedside care. Ann Close, Nursing Director informed the Board that her view on improving the education of nurses was to involve those teaching nurses in current care practices.

- Financial Position and reliance on PCT – The Chief Executive had met with Mark Cooke, PCT Chief Executive and asked for his personal assurance on behalf of the PCT that the position put to Monitor during their assessment would faithfully reflect the PCTs commitment to maintain spending with the Dudley Group of Hospitals at current levels for 2008-09 and seek to maintain rather than reduce this for the remainder of the strategy period.

08/08 Strategic Issues

08/08.1 Foundation Trust Update

Paul Assinder, Director of Finance and Information reported that, as discussed in Finance and Performance Committee, he and Sarah Briscoe had met with Piers Ricketts, KPMG Partner, as commended by Brendan Farmer at Ernst and Young. A number of issues had been agreed including:

- KPMG will be engaged to undertake a pre-Ernst and Young 'Health Check' in April prior to the Due Diligence exercise commencing in May/June. This will include a Due Diligence 'audit' on issues previously highlighted by Ernst and Young.

- KPMG will also undertake a mock Board to Board interview prior to 3rd June 2008.

- KPMG will examine and comment on the redrafted IBP for a view on whether it contains the correct political tone and covers Monitors current concerns.

08/09 Operational Performance

Report from the Finance and Performance Committee on 31st January 2008

The Director of Finance and Information reported that the Finance and Performance Committee had, at its meeting on 31st January, discussed and noted the following position up to the end of December:

- At the end of December the total surplus was £9,983,000 an improvement of £1,029,000 on the previous month. This is equivalent to an EBITDA margin of 9.3% against an annual plan of 5.7%

- The forecast outturn is now £10.5 million for year against the SHA control target of £7.5 million

- The normalised position is a surplus of £6.9 million for the year

- As at the end of December (month 9) the Trust had cash balances of £26.8 million.

- The Committee noted good waiting times performance but with some isolated long waiting times for diagnostic procedures – Isobel Rees asked to review progress

- The Board noted that the A&E 4hr wait target had not been achieved. The year to date performance stands at 97.4%

- MRSA – 1 Bacteraemia reported in December and 1 in January to date, total now stands at 19. This will result in a breach of this core target.

The Chairman asked why during recent months the Trust was failing to meet the 98% A&E target and what corrective actions had been taken. It was noted by the Board that this was due to a number of reasons, including:

- Issues with patient flows. An acting Consultant had been brought in to manage outliers and speed up patient flows.
- Staffing issues in ED including attitude towards ownership and commitment
- High sickness rates in ED middle grade staff
- Complexity switch in cases from less minor to more major

Paul Brennan, Operations Director confirmed to the Board that ED had been running at 98% for the previous 3 weeks. This was due to increased staffing and dedicated staff in Paediatric ED. It was noted that to achieve the 98% target the Trust would need to run at 99% for the remainder of the year.

It was noted by the Board that delayed discharges had reduced to 42 from approximately 100 previously. This was due to 19 extra beds in the Community purchased by the PCT and Social Services being more flexible in delivery of packages of care. Kathryn Williets, Non Executive Director, asked if the extra beds were sustainable and it was noted that there would be an incremental closedown of the beds over the next 4-6 weeks. The Board were informed that Physiotherapy Teams were being set up and it was hoped that this would reduce delayed discharges further. Interviews for the Team are scheduled to be held in two weeks time.

David Badger, Non Executive Director suggested a quarterly comparison with objectives for performance targets. It was agreed to discuss this further at the meeting scheduled for Monday, 4th February 2008.

The Board noted this position.

08/10 Reports for Approval

08/10.1 Private Patients Policy

The Director of Finance and Information spoke to this paper, given as Enclosure 3. It was noted that this updated policy is primarily covered under the NHS Act 1977 and provides guidance for Consultants and Clinicians for private practice. It was noted that changes to the policy were mainly in administration and forms. Ann Close, Nursing Director queried how complaints and claims would be handled when private patients had been treated on an NHS ward. It was discussed that claims are usually made against the Trust and not clinicians individually and these would be handled through the normal complaints/claims route.

The Board approved the policy.

The Board approved the Private Patients Policy

08/10.2 Overseas Visitors Policy and Procedure and Overseas Visitor Team – Finance Procedure

The Director of Finance and Information spoke to these papers, given as Enclosure 4. It was noted that this policy had been updated to include changes to administration and recording, but the majority of the policy remained unchanged as it is structured to meet legal requirements.

The Board noted that the document had been out to consultation and approved the policy and procedure.

The Board approved the Overseas Visitors Policy and Procedure and Overseas Visitor Team Finance Procedure

08/10.3 Amendment to Standing Financial Instructions (SFI's), Authorised Limits – Theatre Specialty Managers and Pharmacy

The Director of Finance and Information spoke to this paper, given as Enclosure 5. It was noted that the Audit Committee recommended the following changes to SFIs which had been last approved in October 2006:

- Level of authority for Theatre Specialty Managers to increase from £1,000 to £2,500

- Increased delegated authority for two Principal Pharmacists and Head of Pharmacy of up to £200,000. It was noted that a number of control measures would be put in place including providing monitoring reports to the Drugs and Therapeutic Committee and quarterly reports to the Finance and Performance Committee.

It was discussed that the Schedule of Authorised Limits should be corrected to show Theatre Specialty Manager authority at £2,500 and remove Director of Corporate Development.

With these amendments the Board approved the report.

The Board approved the amendment to Standing Financial Instructions (SFI's), Authorised Limits – Theatre Specialty Managers and Pharmacy. Director of Finance and Information to amend schedule

08/10.4 Quality of Care – Food and Nutrition Report

Ann Close, Nursing Director spoke to this paper, given as Enclosure 6. It was noted that this report was a combination of feedback from the Nutrition Steering Group and Red Tray Initiative and is a position statement and details further actions against recommendations. The Board was asked to consider:

- Signing up to the Council of Europe Alliance 10 key characteristics
- Nomination of a Non Executive Director to lead in nutritional care
- Views on whether nutrition should be part of mandatory training for specific groups of staff

The Board shared a view that nutrition training should not be mandatory but performance managed as it focuses on the assessment of patients and ensuring care needs are met and is a key component of the lead nurse role.

The Board approved signing up to the Council of Europe Alliance 10 key characteristics and supported David Badger as Non Executive Director lead.

The Board approved the Quality of Care – Food and Nutrition Report

08/10.5 Healthcare Commission Maternity Survey

The Nursing Director spoke to this paper, given as Enclosure 7. It was noted that the initial report was presented in August following the HCC findings on the maternity survey. It is a positive report and it was noted that most women perceive they experience good care in the unit, particularly for antenatal and postnatal care, in particular:

- Access to Antenatal Clinics
- Clean Wards
- Clean Toilets and Bathrooms
- Women treated with understanding

There were 5 areas for improvement and these are covered in the action plan, which the Board approved. A progress report will be submitted to the Board in May.

The Board approved the action plan. Progress report to be submitted in May 2008

08/10.6 Standard Template for Board and Committee Reports

The Chairman spoke to this paper, given as Enclosure 8. It was noted that the Board agreed to use the suggested format and monitor progress. It was noted that papers needed to be shorter and strategic in essence.

The Board approved this report.

The Board approved the Standard Template for Board and Committee Reports

08/11 Any Other Business

There being no other business, the Chairman closed the meeting.

08/12 Date of Next Meeting

The next Board meeting will be held at 11am on Thursday, 28th February, 2008 in the Clinical Education Centre.

Signed as a correct record: . . . . . **Chairman**

Date: . . . . . .

Enclosure 2

The Dudley Group of Hospitals NHS
NHS Trust

Action Sheet
Minutes of the Public Trust Board meeting held at 11.00 am on Thursday 31st January 2008 in the Clinical Education Centre

Item No.	*Subject:*	*Action:*	*Responsible*	*Due Date*	*Actioned*
08/03	Annual Chairs Conference	Presentations from Conference to be shared with the Board	C	28/2/08	
08/10.3	Amendment to SFI's	Schedule of Authorised Limits to be corrected to show Theatre Specialty Manager authority at £2,500 and remove Director of Corporate Development	DFI	28/2/08	
07/42.2	Action Sheet Update External Audit Letter 2006/07	ALE Working Group to feedback on action required to achieve ratings of '4' to the next Audit Committee meeting on 15/4/08	DFI	24/4/08	
08/10.5	Healthcare Commission Maternity Survey	Progress Report to be submitted to Board in May	ND	29/5/08	
07/55.3	Draft IT Disaster Recovery Plan	Feedback to the Board on the results of the desk top simulation exercises which will be run by Siemens in the next financial year	DFI	When available from Siemens (08/09 financial year)	

The Dudley Group of Hospitals NHS

NHS Trust

Whistle Blowing Policy
(Public Interest Disclosure)

1. POLICY STATEMENT

1.1 This Agreement is made between the Dudley Group of Hospitals NHS Trust (herein after known as "the Trust") and those staff side Organisations recognised by the Trust for the purposes of collective bargaining.

1.2 The purpose of this policy is to comply with the Public Interest Disclosure Act: 1998, which became law on 2 July 1999 and to promote a culture of openness and honesty amongst employees.

1.3 It is in the interests of all concerned that disclosure of wrongdoing or irregularity is dealt with promptly and discreetly.

1.4 Individual members of staff have a right and duty to raise with their employer any matters of concern they may have about health service issues associated with the organisation and delivery of care. All clinicians and managers at every level of the organisation have a duty to ensure that staff are provided with the opportunity to express their concerns. In order that staff can express their concerns it is important that clear principles and procedures are established.

2. SCOPE

2.1 This policy aims to:

- encourage all staff to feel confident in raising concerns and to question and act upon concerns about practice.
- provide avenues for staff to raise those concerns in confidence and receive feedback on any action taken
- ensure that staff receive a response to concerns and that they are aware of how to pursue them if they are not satisfied
- reassure staff that they would be protected from possible reprisals or victimisation if they have made any disclosure in good faith.

2.2 The policy applies to employees and every professional in the NHS. For the purposes of this policy only, this is someone who is:

- employed on a permanent or fixed term contract of employment to the Trust
- on secondment to the Trust
- on a temporary contract or employed through an agency or the internal agency (bank) to work for the Trust
- an independent consultant for the Trust
- contractors and suppliers of services to the Trust

2.3 The Whistleblowing Policy is intended to cover **public interest** concerns that fall outside the scope of other procedures. A disclosure is a 'qualifying disclosure' if the information falls within one of the following categories:

- a criminal offence has been committed, is being committed or is likely to be committed
- a person has failed, is failing, or is likely to fail to comply with a legal obligation
- a miscarriage of justice has occurred, is occurring or is likely to occur
- the health and safety of an individual has been, is being or is likely to be endangered
- sexual or physical abuse of patients, or other unethical conduct.
- poor clinical practice
- malpractice
- professional misconduct
- nepotism
- the environment has been, is being or is likely to be damaged
- information indicating the occurrence of any of the above has been, is being or is likely to be deliberately concealed.

Please note that this list is not exhaustive

An employee must have a reasonable and honest belief or suspicion that the disclosure of the information shows one of the qualifying incidents has happened, is happening, or is likely to happen. This will be more than an unsubstantiated rumour.

There are existing procedures in place to enable staff to lodge a grievance relating to their employment along with a range of policies and procedures that cover issues such as harassment, fraud and corruption, recruitment & selection and health & safety. It is important to make reference to the guidance and professional advice provided by all the relevant professional and regulatory bodies such as GMC, NMC etc. This policy does not replace the Trust's Complaints procedure.

2.4 Any concerns that staff may have about any aspect of service provision, the conduct of officers or members of the Trust or others acting on behalf of the Trust can be reported under the Whistleblowing Policy. This may be something that:

- makes individuals feel uncomfortable in terms of known standards, e.g. including professional Codes of Practice their experience of the standards they believe the Trust subscribes to; **or**
- is against the Trust's Standing Orders and other policies and procedures, **or**
- falls below established standards of professional conduct; **or**
- amounts to improper conduct.

3. ROLES AND RESPONSIBILITIES

To ensure that a concern is managed effectively it is essential that the following roles and responsibilities are undertaken:

Chief Executive is responsible for:

- Ensuring that avenues are provided for staff to raise concerns without fear of any reprisals
- Determining whether a concern is serious enough to warrant an inquiry rather than an investigation
- Ensuring that confidentiality is maintained
- Ensuring an appropriate response to the concern is provided
- Managing concerns directly if they are with regards to the Designated Officers
- Reporting to Non-Executives about concerns raised on a timely basis

Designated Officer is responsible for:

- Determining with the Chief Executive whether a case is serious enough to warrant an inquiry
- Reporting all concerns and providing investigation reports to the Chief Executive
- Ensuring the concern is investigated properly by the line manager/investigating officer
- Ensuring that any corrective action identified as being required following an investigation is undertaken
- Providing feedback to the line manager to allow the individual who raised the concern to be briefed appropriately
- Ensuring that confidentiality is maintained

Line Manager is responsible for:

- Ensuring that avenues are provided for staff to raise concerns without fear of any reprisals
- Ensuring that staff have awareness of the Whistle Blowing Policy
- Informing the Designated Officer of any concerns raised
- Investigating concerns or assign an appropriate Investigating Officer to do so
- Determining what appropriate corrective actions are required following the investigation and reporting these to the Designated Officer
- Providing feedback to the individual who raised the concern with what the outcome is of the investigation
- Ensuring that confidentiality is maintained

Employee is responsible for:

- Raising concerns, as defined as a 'public interest' concern to the employer as defined under the act that relate to the health service and the associated organisation and delivery of care.

4. PROCESS - HOW TO RAISE A CONCERN

4.1 Concerns should in all cases be raised internally with management in line with this procedure, and employees are invited to involve their Trade Union representative, Professional Association or a colleague to support them in doing so throughout the process outlined.

If two or more people share the same concern, the concern should be raised separately and not discussed further between whistleblowers.

N.B. The term Manager/Line Manager is generic and includes all clinicians with responsibility for staff and also groups of staff with supervisory roles.

4.2 The employee or their representative should put their concern to their line manager, or if they are absent, to their deputy, either verbally or in writing. Alternatively, the employee can raise their concerns with a designated officer under this policy, if they do not feel that it is appropriate to contact their line manager. The following people have been identified as designated officers for raising concerns under this policy; Deputy Associate Medical Directors, Trust Directors and Trust Non-Executives.

Letters and envelopes should be clearly marked "Private and Confidential, addressee only" and should include any dates and times of incidents and the names of any witnesses in order for a proper investigation to be carried out. Employees may wish to keep a copy of the letter for future reference.

4.3 If the concern relates to unsafe practice, an incident or accident, or is connected with Health and Safety, the employee should complete an incident form at the same time.

In the case of disclosure on alleged fraud and corruption the Chair of the Audit Committee, the Counter Fraud Specialist and External Auditors will be informed.

In the case of disclosure on professional issues or unsafe practice the relevant professional head will be notified.

4.4 The recipient will acknowledge the employees' letter within 5 working days from its receipt. A copy of this response, together with the employees' letter will also be sent to a designated officer.

Investigation

4.5 On receipt of the letter an appropriate investigating officer will be nominated to undertake a thorough investigation into the issue(s) raised. Where at all possible the nominated investigating officer will be outside of the line management structure. The identity of the individual who raised the concern will be kept confidential, in so far as possible, if he or she wishes. The designated officer will report to the Chief Executive who will be responsible for the commission of any further investigation within the Trust should it be deemed necessary.

4.6 On completion of the investigation, the nominated investigating officer will compile a report detailing the nature of the allegation, the investigation findings and recommendations for any corrective actions that are required, or reasons why no actions are recommended. This report will be forwarded to an appropriate designated officer for consideration.

The line manager will then arrange a meeting with the whistleblower to give feedback on any proposed action plans to address the concerns raised or reasons why no action has been taken. (This will not include details of any disciplinary action, which will remain confidential to the individual concerned).

The designated officer will discuss with the investigating officer to allow the line manager to give a response within a reasonable and practicable timeframe from receipt of the employees' letter.

4.7 If the result of the investigation is that there is a case to be answered by any individual, the Trust's Disciplinary Policy will be used.

4.8 Where there is no case to answer, but the employee held a genuine concern and was not acting maliciously, the designated officer should ensure that the employee suffers no reprisals.

4.9 Only where false allegations are made maliciously, will it be considered appropriate to act against the whistleblower under the terms of the Trust's Disciplinary Policy.

4.10 If the whistleblower is not satisfied with the outcome of the investigation, The Trust recognises the lawful rights of employees and ex-employees to make disclosures to prescribed persons (such as the Health & Safety Executive, the Audit Commission, or the utility regulators, or, where justified, elsewhere).

Inquiries

4.11 If the concern raised is very serious or complex, an inquiry may be held. This will be decided by a designated officer and/or the Chief Executive.

4.12 The Trust recognises the contribution the Trade Union(s) can make to an inquiry, and agrees to consult with the Trade Union(s) about the scope and details of the inquiry, including the implementation of the recommendations of the inquiry. The Trust recognises that in many cases it will be desirable that a Trade Union(s) representative will be appointed to the panel of the inquiry.

5. FURTHER PROVISIONS

Confidentiality

5.1 All concerns will be treated in the strictest confidence and every effort will be made not to reveal the identity of the employee raising the concern, if they so wish. At the appropriate time, however, the employee may need to come forward as a witness and can be supported by a colleague or Trade Union representative.

5.2 Where an individual does not wish to come forward as a witness the Trust retains the right to pursue the matter further but respecting the anonymity of the individual. The Trust encourages staff to put their name to allegations whenever possible.

5.3 Concerns expressed anonymously are much less powerful but will be considered at the discretion of the Trust. In exercising this discretion the factors to be taken into account would include:

- the seriousness of the issues raised
- the credibility of the concern

- the likelihood of confirming the allegation from attributable sources.

5.4 The confidentiality undertaken in an employee's Statement of Main Terms and Conditions does not prevent a member of staff from making a disclosure under the 'Public Interest Disclosure Act, 1999'.

Complaints about the Designated Officers or the Chief Executive

5.5 If exceptionally the concern is about the designated officers this should be raised with the Chief Executive. If about the Chief Executive, this should then be made to the Chairman of the Trust, who will decide on how the investigation will proceed. This may include an external investigation.

Raising concerns with outside bodies

5.6 In certain circumstances an employee may feel compelled to make a wider disclosure to an external organisation without first adhering to the internal reporting outlined above. Disclosures made to other parties will only be 'protected' under the Act if there is a reasonable reason for the employee failing to follow the correct internal reporting procedure and where the employee has a genuine belief that:

- they were to disclose the matter to the employer they would be subject to a detriment
- evidence relating to the subject matter of the disclosure would be concealed or destroyed if disclosure is made to the employer
- the employee has already made a disclosure to their employer

Therefore, advice may be sought from Trade Union representative, Professional Association or the Public Concern at Work (PCaW) Helpline on 0207 404 6609 or on **www.pcaw.co.uk**, before making such a disclosure. PCaW is a charity dedicated to advising both employers and employees to raise concerns about public interests at work.

5.7 Employees who feel unsure about whether or how to raise a concern, or want confidential advice can contact the independent charity PCaW as outlined above or e-mail **helpline@pcaw.co.uk**.

Free information and advice can also be obtained from the Advice, Conciliation and Arbitration Service (ACAS) on 08457 474747.

It may be more appropriate to report a matter to another organisation. Other organisations concerned with standards in the NHS include:

- Audit Commission for local authorities and the NHS in England and Wales – 0207 828 1212
- Health & Safety Executive – 0207 717 6000
- NHS Fraud & Corruption Reporting Line – 0800 028 4060 (Monday to Friday 08:00 – 18:00)

Public Concern at Work and ACAS can advise on the circumstances when it is more appropriate to contact an outside body.

6. MONITORING AND REVIEW

The responsibility for ensuring this Policy is fully implemented lies with all Managers/Heads of Departments within the Trust.

The Director of Human Resources will monitor the effectiveness of the policy and it will be amended through JNC, as required. The policy will be reviewed at 3 yearly intervals or as the law necessitates.

Date of Agreement With JNC:
Date of Approval By Integrated Governance:

Date of Review:	**Dec 2007**
Date of Next Review:	**Dec 2010**

Enclosure 4

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board February 2008**

Report by: **The Nursing Director**

Subject: **NHS Inpatient Survey 2007**

Summary

This paper provides a report on the findings of the NHS Inpatient Survey 2007 undertaken by the Healthcare Commission. Picker Europe carried out the survey on our behalf.

There are a number of improvements from the Inpatient Survey of 2006.

There were 21 areas where our performance was significantly better than the Picker average in 2007. There were only 3 areas in 2006.

There were 11 areas where our performance was significantly worse than the Picker average compared to 13 areas in 2006.

The Trust Board is asked to:

- **Receive the report for information**
- **Approve the approach to action planning**
- **Determine when the action plan is to be submitted to the Trust Board**

Background

850 patients who had been in Russells Hall Hospital in July 2007 were surveyed in October and November as part of the national survey undertaken by the Healthcare Commission. The results from this survey are taken into consideration in the HCC Annual Healthcheck.

Issues for consideration

Of the 850 patients in the original sample, 501 questionnaires were completed giving a response rate of 59.7% (the average response rate is 54.1%).

A summary of the results is attached at Appendix 1.

These are the problem scores i.e. the % of respondents for whom there was incomplete satisfaction with the service, aspects of care or treatment provided. There were a number of questions that were not asked this year that had been asked in previous years and some questions that were worded differently.

There is a comparison of our scores with the previous NHS surveys held in 2004, 2005 and 2006 including the additional survey the Trust commissioned in 2006.
In addition, there is a comparison with the average score of the Trusts who used Picker as their survey provider. However it should be noted that the comparison will

eventually be made with all Trusts but the date when the HCC releases this report is not known.

The table at Appendix 1 also shows 21 areas where we were better than the Picker average. This includes:

B2 & B4	Number of patients being upset by being on a mixed sex ward sharing sleep area with opposite sex.
B6	Hospital patient using bath or shower area who shared it with opposite sex.
B7 & B8	Patients being bothered by noise.
B9 & B10	Cleanliness of environment.
C3	Doctors talking in front of patients.
D2 & D3	Nurses - confidence and trust - talking in front of patients.
D5	Nurses - knowing enough about condition and treatment
E3, 6 &7	Care - information given on condition and treatment, privacy when discussing condition and treatment and being examined.
F8	Surgery – results explained in a clear way.
G6, G8	Discharge – information on purpose of medication, now to take
G10 & G12	medication, danger signals to look for and who to contact on discharge.
J2 & J3	Overall – doctors and nurses working together
	- Rating of care.

The table at Appendix 1 also shows the 11 areas where the Trust was significantly worse then the Picker average.

A8	Emergency Department – order in which patients seen was not fair.
A11	Emergency Department – wait 4 hrs or more for admission to bed on a ward.
A13	Planned Admission: not given choice of admission date
A17	Planned Admission: not given printed information about the hospital.
B5	Hospital: patients in more than one ward, sharing sleeping area with opposite sex.
B12	Hospital: nowhere to keep personal belongings safely.
B13	Hospital: food was fair or poor.
B14	Hospital: not always healthy food on hospital menu.
D4	Nurses: sometimes, rarely or never enough on duty.
G13	Discharge: did not receive copies of letters sent between hospital doctors and GP.
J5	Overall: not asked to give views on quality of care

Action Planning

<u>Communication and information giving – A17, G13</u>

The focus from last years results was on communication and information giving and there has been some improvement in the results. However, further work needs to be done in relation to:

- Giving written information about the hospital to planned admissions. The “Your Stay in Hospital” Booklet has just been updated. Mechanisms for ensuring it gets to all patients must be introduced.
- Action to ensure patients receives copies of letters sent between hospital doctors and GPs.

Perceptions about waiting – A11

Although there has been a very slight improvement over last years scores, this is still to be improved on.

Perceptions about food and nutrition – B13, B4

This has been highlighted as an area where the Trust is significantly worse than average for several years and is still to be improved on.

Nowhere to keep personal belongings safe – B12
This is a new element of the survey and will need to be addressed.

Perceptions of numbers of nursing staff – D4

There has been no change in the perceptions of patients for the last 3 years and the Trust continues to be significantly worse than other Picker Trusts.

Not given choice of admission date – A13

The perception of patients has deteriorated during the last 2 years.

Patients in more than one ward sharing sleeping area with opposite sex – B5

This is a new area of questioning.

Not asking patients to give views on quality of care – J5

There has been no real change over the last 3 years.

This paper is being presented to the Operations Management Team for them to consider the findings and determine the actions that need to be taken particularly in these areas to make improvements.

Recommendation

The Board is asked to:

- **Receive the report for information.**
- **Approve the approach to action planning.**
- **Determine when the action plan is to be submitted to the Trust Board.**

Appendix 1

Problem Scores

(The % respondents for whom there was incomplete satisfaction with the service, aspect of care, or treatment provided).

Q	Problem	Trust 2004	Trust 2005	Trust commissioned 2006	Trust 2006	Trust 2007	Picker Av 2007	2007 Improvement on Trust performance in 2006
A8	ED order in which pts seen not fair		7	5	N/A	11	4	
A9	ED not enough/to much info about condition & treatment	56	27	19	33	25	22	Improvement
A10	ED not enough privacy when examined or treated		23	24	27	22	22	Improvement
A11	ED waited 4 hrs for admission to bed on ward		56	50	55	42	26	Significant worse than average ↑
A12	Planned admission not given choice of hospital for first appointment with Specialist	82	17	11	N/A	64	65	Average
A13	Planning admission not given choice of admission Date		71	74	63	70	64	Significantly worse than average ↓
A15	Planned admission should have been admitted sooner		27	25	21	27	24	↓
A16	Planned admission: admission date changed by hospital		19	17	13	21	19	↓
A17	Planned admission: not given printed information about the hospital	42	37	39	N/A	25	19	↓
A18	Planned admission: not given printed information about condition	32	35	30	N/A	31	26	↓
A19	Admission had to wait long time to get room/ward bed	26	42	38	42	25	28	↓
A20	Admission: no explanation for wait in getting to room/ward	39	45	42	N/A	46	51	↑
B3	Hospital patient in mixed sex ward	44	22	24	N/A		N/A	
B4	Hospital: upset by being on mixed sex ward	33	28	29	N/A	14	28	Better than average ↑

B2	Patient sharing sleeping area with opposite sex				22	14	22	Significantly better than Picker av
B7	Hospital: bothered by noise at night from other patients	32	31	30	32	25	36	Significantly better than Picker av.
B8	Hospital: bothered by noise at night from staff	13	16	14	15	14	20	Significantly better than Picker av.
B9	Hospital: room/ward not very clean	8	6	5	4	4	7	Significantly better than Picker av.
B10	Hospital toilets not very clean	10	8	6	6	6	11	Significantly better than Picker av.
B11	Hospital: felt threatened b y other patients					4	4	Not included previously
B12	Nowhere to keep belongings safely					74	67	Not included previously and significantly worse than Picker av.
B13	Hospital: food was fair or poor	53	49	45	53	48	44	Significantly worse than Picker av.
B14	Hospital: not always healthy food on menu		44	46	26	43	34	Significantly worse than Picker av. ↓
C1	Doctors: didn't always get clear answers to questions	31	39	34	34	28	31	↑
C2	Doctors: didn't always have confidence and trust	22	26	24	21	16	19	↑
C3	Doctors: talk in front of you as if you're not there	29	30	26	29	22	27	Significantly better than Picker av. ↑
C4	Doctors: didn't always get chance to talk to when needed	35	40	36	N/A	48	47	
C5	Doctors: some/none knew enough about condition/treatment	10	14	13	N/A	9	12	
C6	Doctors: didn't always remember to wash or clean hands before touching patients		20	18	23	19	18	↑
D1	Nurses: didn't always get clear answers to questions	29	36	30	35	30	34	↑
D2	Nurses: didn't always have confidence and trust	24	35	27	26	21	26	Significantly better than Picker av. ↑
D3	Nurses: talk in front of you as if you're not there	16	23	2123	17	21		Significantly better than Picker av. ↑

D4	Nurses: sometimes, rarely or never enough on duty	41	59	51	53	48	42	Significantly worse than Picker av. ↓
D5	Nurses: some/none knew enough about condition/treatment	13	24	22	N/A	11	18	Significantly worse than Picker av. ↓
D6	Nurses: didn't always wash or clean hands between touching patients		28	19	20	20	21	
E1	Care: staff contradict each other	28	41	34	34	31	33	
E2	Care: wanted to be more involved in decisions	52	54	50	49	45	47	
E3	Care: not enough info given re conditions and treatment	19	27	26	22	16	20	Significantly better than Picker av. ↑
E4	Care: not enough chance for family to talk to doctors	39	48	41	61	57	54	
E5	Care: couldn't always find member of staff to discuss concerns with	34	41	37	58	60	58	
E6	Care: not always enough privacy when discussing condition or treatment	33	29	31	30	26	30	Significantly better than Picker av. ↑
E7	Care: not always enough privacy when being examined or treated	13	13	12	14	9	12	Significantly better than Picker av.
E9	Pain: more than 15 mins to get medicine	14	23	20	N/A	26	27	
E10	Care: didn't always get help in getting bathroom when needed					33		
E11	Care: more than 5 mins to answer call button	8	16	10	26	14	14	
E13	Tests: results not explained well or at all	45	56	51	28	46	45	
F2	Surgery: risks and benefits not fully explained	23	25	18	19	17	17	
F3	Surgery: what would be done during op not fully explained	23	34	23	26	23	23	
F4	Surgery: questions not fully answered	18	26	17	24	21	23	
F5	Surgery: not told fully how could expect to feel after	54	49	41	44	39	42	

	op or procedure							
F7	Surgery: anaesthetist did not fully explain how would be put to sleep or control pain		20	15	15	15	15	
F8	Surgery: results not explained in clear way	38	48	33	37	27	33	Significantly better than Picker av. ↑
G1	Discharge: did not feel involved in decisions about discharge from hospital							
G2	Discharge: was delayed	34	40	44	49	36	37	
G4	Discharge: delayed by 1 hour or more	82	88	87	83	84	83	
G5	Discharge: not given written or printed information	33	42	40	N/A	33	37	
G6	Discharge: not fully told purpose of medication	16	20	17	20	16	19	Significantly better than Picker av.
G7	Discharge: not fully told side effects of medications	44	52	45	52	46	46	
G8	Discharge: not told how to take medication clearly					14	17	Significantly better than Picker av.
G9	Medicines: not given completely clear written information		48	41	35	31	31	
G10	Discharge: not fully told of danger signals to look for	41	46	44	48	39	44	Significantly better than Picker av.
G11	Discharge: family not given enough info to help	34	44	39	62	49	53	
G12	Discharge: not told who to contact if worried	16.5	23	23	25	17	22	Significantly better than Picker av.
G13	Discharge: did not receive copies of letters between hospital doctors and GPs		69	69	68	72	52	Significantly better than Picker av.
J1	Overall: not treated with respect or dignity	22	28	24	25	21		↑
J2	Overall: doctors and nurses working together poor or fair	8	14	9	9	5	8	Significantly better than Picker av.
J3	Overall: rating of care poor or fair	9	14	9	11	5	8	Significantly better than Picker av.
J4	Overall: would not recommend this hospital to family and friends	10	13	9	N/A	7	7	
J5	Overall: not asked to give views on		89	85	87	84	87	

	quality of care							
J6	Overall: no posters/leaflets seen explaining how to complain about care					46	45	
J7	Overall: wanted to complain about care received.					5	7	
J8	Overall: not given enough info on how to complain					67	85	
K8	Religious beliefs: not always respected by hospital staff					11	10	
K9	Religious beliefs: not always able to practice in hospital					10	16	

Enclosure 5

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board Thursday 28th February 2008 (public meeting)**

Report by: **The Nursing Director**

Subject: **Integrated Governance**

Summary

The purpose of this report is

- to present the revised governance Strategy to the Trust Board for approval (See Appendix 1)
- to confirm with the Trust Board the timescale for making the declaration to the Healthcare Commission for the Annual Healthcheck

Back ground

Following the feedback from Board to Board meeting with Monitor the trust agreed to review and revise the Governance strategy to incorporate a revised Controls Assurance Framework. This seeks to capture Gaps in Control and Gaps in Assurance. In addition the revised strategy has been updated to take account of the changes needed for becoming a foundation trust and an updated risk management policy and procedures.

The Annual healthcheck declaration must be submitted by the 30th April 2008
It is therefore proposed to follow the following

Trust Board March 27th - Draft declaration to be considered
Trust Board April 24th – Final declaration to be agreed
Final Declaration to be made April 25th
Declaration to be sited on the web site before April 30th

The Trust Board is asked to approve the Governance Strategy and the timetable for the Annual Healthcheck declaration

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

INTEGRATED GOVERNANCE STRATEGY

1. BACKGROUND

The NHS and Community Care Act 1990 and subsequent regulations set out the legal framework within which the Trust operates. Since 1997 Chief Executives of Trusts have been required, as Accountable Officers, to sign an assurance statement, the Statement on Internal Control (SIC), on behalf of the Board to assure 'stakeholders' on the robustness of internal financial controls. Stakeholders include patients, relatives and carers, the public and partner NHS organisations. In 1999 this duty expanded beyond financial assurance to the production of a SIC covering wider organisational controls, including risk management.

Also, the 1999 Health Act placed a statutory duty of quality upon NHS Trusts. Clinical governance is the framework by which the Trust fulfils this duty. Trust Boards are now encouraged to develop integrated governance to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical and information governance. Integrated governance will better enable the Trust Board to take a holistic view of the organisation and to fulfill its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

2. INTRODUCTION

Integrated Governance is defined as: Systems, processes and behaviours by which the Trust will lead, direct and control its functions in order to achieve organisational objectives, safety and quality of service in which it relates to patients and carers, the wider community and partner organizations.

Integrated Governance provides linkages between financial management, clinical governance, risk management, and information governance and enables the Board to work more corporately and deliver objectives in a coherent way and govern effectively.

The Trust has a statutory responsibility to: -

- Produce business plans (Local Delivery Plans)
- Ensure that quality of care is delivered that meets standards laid out in statute – Standards for Better Health
- Meet National Targets
- Achieve financial balance and have annual financial plans with monthly monitoring arrangements
- Have an Assurance Framework and ensure there are effective systems in place for governance, essential for the achievement of its strategic objectives and to underpin its SIC

The purpose of this strategy is to:

- Describe the integrated governance arrangements and processes in the Trust and how these are evolving to meet the requirements of Monitor as a Foundation Trust
- Define the roles and responsibilities of key officers/ groups and the relationship between them
- Ensure that the Trust complies with its statutory responsibilities
- Develop an integrated approach to corporate and clinical governance, which embraces financial, organisational and clinical risk management and which is linked to the Trust's cycle of business
- Develop an open culture of learning and risk management across both corporate and clinical activity to ensure effective organisational and clinical performance
- Ensure that all staff are involved in and take responsibility for relevant aspects of governance through individual and team based performance objectives
- Provide a basis for performance measurement and management

This Integrated Governance Strategy and arrangements are reviewed annually to ensure they reflect current NHS guidance and requirements and meet the local needs of the Trust and the population it serves.

This document is made available to all staff within the organisation, partner organisations and the public.

3. OPERATIONAL AND STRATEGIC ACCOUNTABILITY

3.1 The Role of the Board

The role of the Trust Board is defined as: -

- *Collective responsibility for adding value to the organization* by promoting the success of the organisation by directing and supervising the Trust's affairs
- *Leadership and control* by providing active leadership of the organisation within a framework of prudent and effective controls which enable risk to be assessed and managed
- *Looking ahead* by setting the Trust's strategic aims, ensuring that the necessary financial and human resources are in place for the Trust to meet its objectives and by reviewing management performance
- *Setting and maintaining values* by setting the Trust's values and standards and ensuring that its obligations to patients, the local community and the Secretary of State are understood and met

The Code of Accountability issued by the Secretary of State (1994) sets out the corporate role of the Board. The Trust Directors have explicitly subscribed to this Code and to the Code of Conduct (2004). The Board is also taking account of the FT Code of Corporate Governance the Compliance Framework 2006 and the Intelligent Board (Monitor 2006).

In ensuring that the organisation consistently follows the principals of good governance applicable to NHS organisations, the Board of Directors has responsibility for:

- Providing active leadership of the NHS Foundation Trust within a framework of prudent and effective controls which enables risk to be assessed and managed
- Ensuring compliance by the NHS Foundation Trust with its Terms of Authorisation, its constitution, all relevant statutory requirements and contractual obligations
- Setting the NHS Foundation Trust's strategic aims, taking into consideration the views of the Board of Governors, ensuring that the necessary financial and human resources are in place and that its meets it objectives and reviews management performance
- Ensuring the quality and safety of healthcare services, education, training and research it delivers and applying the principles and standards of clinical governance set out by the Department of Health, the Healthcare Commission and other relevant NHS bodies. It should also ensure that the NHS FT exercises it functions effectively, efficiently and economically.
- Setting the Foundation Trust's values and standards of conduct and ensuring that it obligations to it members, patients and other stakeholders are understood and met.
- Making available a statement of the objectives of the Foundation Trust showing how its intends to balance the interests of patient, local community and other stakeholders
- Reporting on its approach to clinical governance and its plan for the improvement of clinical quality in accordance with guidelines set by the Department of Health, the Healthcare Commission and Monitor
- Confirming
    - For clinical quality - that it is satisfied that to the best of its knowledge and using its own processes it has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients
    - For service performance - that plans are in place to ensure compliance with all existing national core standards and targets and a commitment to comply with all known core standards and targets due to come into force within the following 12 months
    - For other risk management processes that -
        - All issues and concerns raised by external audit and external assessment groups have been addressed and resolved or action plans are in place to address the issues in a timely manner
        - All recommendations made by the Audit committee are implemented in a timely and robust manner
        - All necessary planning, performance and risk management processes are in place to deliver the annual plan
        - A Statement of Internal control is in place and the Trust is compliant with the risk management assurance framework requirements that support the SIC pursuant to most up to date guidance

        - All key risks to compliance with the authorization have been identified and addressed.
    - For other matters –
        - that it maintains its register of interests and can specifically confirm that there are not material conflicts of interest in the Board
        - that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance and ensuring management capacity and capability
        - The selection process and training programmes in place to ensure that the Non-executive Directors have appropriate experience and skills
        - The management team have the capability and experience necessary to deliver the annual plan
        - The management structure is in place to deliver the annual plan objectives for the next three years

3.2 Role of the Trust Chairman

The role of the Trust Chairman is to: -

- Lead the Board of Directors and the Council of Governors, ensuring its effectiveness on all aspects of its role and setting its agenda and ensuring the two work together effectively
- Ensure the Board of Directors and Council of Governors receive accurate, timely and clear information and that it is appropriate to their respective duties
- Ensure effective communication with staff, patients the public and stakeholders
- Facilitate the effective contribution of non executive directors and ensure constructive relationships between executive and non executive directors and between the Board of Directors and the Council of Governors

3.3 Role of the Non Executive Directors

Non-executive directors have a particular responsibility for encouraging the cultural change that is needed to ensure the full engagement of patients, staff and local communities and to provide independent scrutiny of the work of the organization and to hold executive directors to account for their performance. Their responsibilities cover: -

- *Strategy* - by constructively challenging and contributing to the development of strategy
- *Performance*- through scrutiny of the performance of management in meeting agreed goals and objectives and monitoring of the reporting of performance
- *Risk* - by satisfying themselves that financial, clinical and other information is accurate and that suitable controls and systems of risk management are robust and defensible
- *People* - by determining appropriate levels of remuneration of executive directors and having a prime role in appointing, and where necessary removing, senior management and in succession planning

- *Accountability* - Non-executive directors are appointed by the NHS Appointments Commission on behalf of the local community. They, therefore, have a responsibility for ensuring the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust and for the public funds it uses

3.4 Role of the Chief Executive

The Chief Executive helps to create the vision for the Board and the Trust to modernise and improve services. He/she is responsible for ensuring that the Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action.

The Chief Executive's roles and responsibilities cover: -

- *Leadership* - by helping to create the vision for the Board and the organisation to modernise and improve services, with the skill to communicate this vision to others and the ability to empower them to deliver the Trust's agenda
- *Delivery planning*- by ensuring that the Board has sufficient information to agree the Local Delivery Plan (LDP) and/or Service Level Agreements (SLAs) that meet the NHS Plan and other priorities and that are based on realistic estimates of physical, workforce, financial capacity and patient and public involvement
- *Performance management*- by ensuring that the Board's plans and objectives are implemented and that progress towards implementation is regularly reported to the Board using accurate systems of measurement and data management. By agreeing the objectives of the senior executive team and reviewing their performance
- *Governance*- by ensuring that the systems on which the Board relies to govern the Trust are effective. This will enable the Chief Executive to sign the Statement on Internal Control on behalf of the Board, to state that the systems of governance, including financial governance and risk management, are properly controlled.
- *Accountability*- to the Board for meeting their objectives and, as Accountable Officer, to the Chief Executive of the NHS for the performance of the Trust

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all its statutory and legal requirements and adheres to guidance issued by the Department of Health in respect of governance. This responsibility encompasses the elements of financial control, organizational control, clinical governance, Health & Safety and risk management.

Whilst this overall responsibility is maintained, responsibilities for some aspects of governance have been delegated to executive directors as follows:
• Integrated Governance (including Risk Management) to Nursing Director
• Financial Control to Finance Director
• Operational Performance to Operations Director
• Health and Safety to Human Resources Director

In order to fulfil his responsibilities for governance, the Chief Executive has agreed their input into relevant committees with the committee chairmen, and receives minutes of these committee meetings and, where not a member of the committee, has a process for meeting the committee chairmen on a regular basis. (See Appendix I for relevant committees).

3.5 Role of the Executive Team

The executive team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility and in those key functions, supported by consistent evidence. Collectively, the team is responsible for providing the systems, processes and evidence of governance.

The team are responsible for ensuring that the Board, as a whole, are kept appraised of progress, changes and any other issues affecting the Assurance Framework.

The key responsibilities of each executive director are outlined in the job description for the post. In terms of governance, the following are of particular relevance:

a. Director of Finance

The Director of Finance is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. He is, with the Chief Executive, responsible for ensuring that the statutory accounts of the Trust are prepared in accordance with Department of Health and Treasury requirements.

The Director of Finance ensures that, on behalf of the Chief Executive, the Trust has in place systems and structures to meet its statutory and legal responsibilities relating to finance, financial management and financial controls. He ensures the Trust has in place Standing Orders and Standing Financial Instructions, including a Reservation of Powers and Scheme of Delegation, which accord with the Department of Health model and takes responsibility for the financial management aspect of internal controls.

As part of the Trust's performance framework the Director of Finance, together with the Director of Operations, oversees a 'contract' between the Board and each Service based on the financial objectives and targets agreed by the Board and maintains the review/monitoring process. The outcome of the review/ monitoring process will contribute to the Board's Assurance Framework.

In addition, the Director of Finance takes responsibility for Information Governance.

The Director of Finance ensures the Trust Board receives the relevant information/annual reports according to the Board's information schedule.
He will keep the Board appraised of any changes in requirements and draw to their attention shortfalls or omissions which will/may adversely impact on the Board's ability to fulfil its governance responsibilities.

b. Nursing Director

The Nursing Director is accountable to the Chief Executive for the strategic development of:

- Risk management - clinical and non-clinical
- Integrated Governance including organisational controls – to meet national clinical standards, for examples Standards for Better Health
- Clinical Governance
- Code of practice for the Prevention and Control of Healthcare Associated Infections

She ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structures to meet its statutory and legal responsibilities relating to his/her area of accountability and that these are based on good practice and guidance from the Department of Health and other external advisory bodies. She ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. She will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention shortfalls or omissions which will/may impact adversely on the Board's ability to fulfill its governance responsibilities.

As part of the Trust's performance framework the Nursing Director oversees the review/monitoring process covering directorates' performance in clinical governance and risk management.

Within the Foundation Trust she will take on the development and responsibilities of Corporate Governance as identified in the Code of Corporate Governance for Foundation Trusts.

c. Director of Operations

The Director of Operations is accountable to the Chief Executive for ensuring that the Trust operates sound systems of operational performance, working in conjunction with the Director of Finance (see section a. above). He has a lead role in ensuring organisational progress against the Trust's Assurance Framework and risk register action plans in conjunction with the Executive team. In addition for ensuring the Trust Strategy links to risk management processes and has the lead responsibility for developing Business planning which also links to risk management

d. Director of Human Resources

The Director of Human Resources is accountable to the Chief Executive for ensuring the Trust has in place systems of both staff management and health and safety which meet legal and statutory requirements and are based on best practice and guidance from the Department of Health, the Health and Safety Executive and other external advisory bodies. Working closely with other directors she maintains a system of monitoring the application of the Trust's Human Resources Strategy, policies and procedures and, on behalf of the Board, ensures it receives the relevant information/annual reports according to the Board's information schedule. The

Trust's education function falls within the remit of the Director of Human Resources. As such, she works with relevant directors to ensure the system in place meets the educational needs of staff highlighted through the Trust's financial controls, organisational controls, risk management and clinical governance processes.

3.6. Specific Roles

There are other key individuals in post for advising on and coordinating risk management activities:

Health and Safety Adviser	-	All Aspects of Health and Safety
Manual Handling Coordinator	-	Manual Handling
Fire Safety Officer	-	Fire Safety
Medical Devices Coordinator	-	Medical Devices use and maintenance
Resuscitation Training Coordinator	-	Resuscitation equipment/ training and use
Security Manager	-	Organisation's Security
Clinical Governance Coordinator	-	Clinical Governance and Risk Management arrangements

3.7 Heads of Service/Matrons

Heads of Services/Matrons are responsible for ensuring that, within their area of responsibility, staff are aware of, and comply with, the processes for assuring sound governance. They will continue to develop local systems and structures to support the various governance strategies, policies and procedures and ensure these are monitored and audited.

As part of the Trust performance framework, the Heads of Service/ Matrons agree with the Director of Finance, the Director of Operations and Nursing Director the objectives and targets for their service based on those agreed by the Board. These are cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and directorate performance reviews.

The Heads of Service ensure their services provide the required information to support the assurance process and draw to the attention of the appropriate board director areas of shortfall or omissions which will/may adversely impact on the Board's ability to fulfil its governance responsibilities and which impact upon the Assurance Framework.

The services/departments are supported and facilitated to meet their governance requirements by the Associate Nursing Director, Associate Director – Professional Clinical Services, Associate Director – Performance Delivery, Associate Medical Directors, Head of Pharmacy Services and staff from the Corporate Directorates.

3.8 All Staff

This framework is aimed at achieving an integrated approach to governance, which engages all staff members.

All staff members employed by this Trust have a responsibility to perform their duties in accordance with the values, policies and procedures of the organisation, national good practice standards, professional requirements and to contribute to the achievement of the Trust's objectives and targets. In the context of this framework all staff members are expected to fulfill their responsibilities as identified within the supporting strategies identified within this document.

4. ORGANISATIONAL FRAMEWORK

Structures and systems have been established to enable the Board to fulfill its governance requirements.

4.1 Core Governance Committees Structure

The main Committees in the Integrated Governance Structure together with the terms of reference are included in Appendix 1. In addition a summary of the remaining committees are included. A chart of the overall structure is provided in Appendix 2.

The Integrated Governance Committee has an annual cycle of requirements to enable it to carry out its work and provide information to the Trust Board. This also provides a timetable for the other committees and groups that report into the Integrated Governance Committee (Appendix 3).

The Chief Executive and relevant director, on behalf of the Trust Board, will ensure the structure is in place and each committee has complementary terms of reference which are reviewed annually as part of the assurance process.

4.2 Supporting Policies and Strategies

This document provides the overarching framework for governance within the Trust. It is supported by the following policies and strategies:

- Strategic Plan
- Trust Performance Plan
- Assurance Framework
- Standing Orders and Standing Financial Instructions
- Reservation of Powers and Scheme of Delegation
- Trust Board Information Schedule
- Clinical Governance Development Plan
- Health & Safety Policies
- Incident Reporting Policy
- Infection Control Strategy and Annual Programme
- Research and Development Strategy
- Learning and Development Strategy
- Patient and Public Involvement Strategy
- Clinical Audit Strategy and Plan
- Human Resources Strategy
- Information Strategy

• Nursing and Midwifery Strategy
• Customer Care strategy

5. ASSURANCE FRAMEWORK

The Assurance Framework provides the structure by which the Trust Board's responsibilities are fulfilled. It encompasses the Trust's strategic objectives and the identification of potential risks to their achievement and any gaps in assurance on which the Board relies. The risks are outlined in the Trust's Risk Register, together with the action plans to address these. The Framework and Register are subject to regular review by the Trust Board and Integrated Governance Committee.

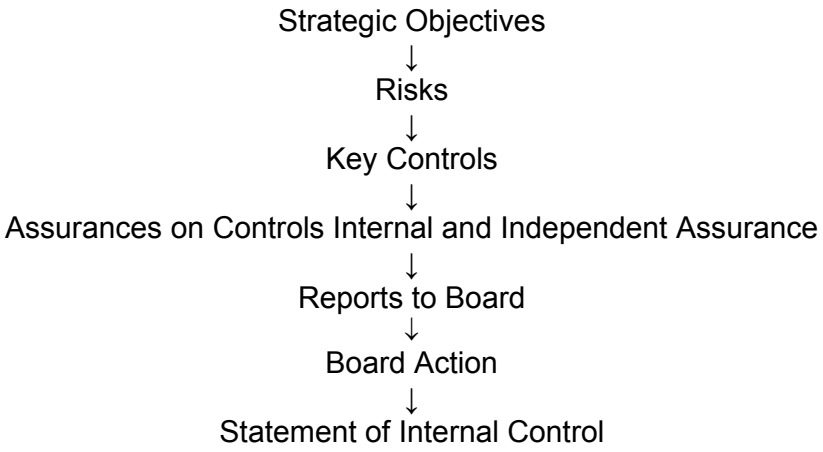
In accordance with Department of Health guidance, all NHS Trusts are required to submit an annual Statement on Internal Control signed by the Chief Executive underpinned by a supporting Assurance Framework. This should provide the Trust with confidence that systems are safe and subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the Trust.

The Trust Board uses the Assurance Framework to manage risks as follows. It:

- Conducts an annual review of the strategic objectives which are agreed by the Trust Board. The strategic objectives have been identified but are likely to change over time as the strategic imperatives of the Trust change focus. They are linked to key plans so that they are consistent with external strategic objectives, including the NHS Plan, compliance with governance and risk standards, staff focus and partnership working.
- Identifies and assesses the risks to achieving these objectives through workshops and discussions involving all the Trust Board members
- Uses the High Level Governance Framework challenge (see Appendix 4)
- Identifies the key controls intended to manage these risks, any gaps in controls and further action required with timescales and responsibilities agreed where gaps have been agreed. This work is led by the Executive directors and agreed by the Trust Board.
- Identifies external and internal assurances available relating to these objectives and risks, evaluates the efficacy of the modes of assurance and any gaps in assurance identified.
- Records the risks on the Risk Register
- Completes the Assurance Framework proforma (Appendix 5)

The framework, including the high risk register, is reported to the Trust Board and the Integrated Governance committee annually with progress reviewed and additional risks identified quarterly (updates).

The following flowchart simplifies the process:



6. RISK MANAGEMENT

Principles

- The Trust has processes in place, which includes both top down and bottom up approaches to managing risks.

- Each Directorate will have a risk management strategy based on the principles and processes outlined in this document.

- It is the Trust's policy to minimise levels of risk across the full range of its activities, thereby ensuring high quality services and protecting the interests of our patients, staff and visitors. This is achieved through a consistent and integrated approach to identifying risks and potential risks and making appropriate arrangements for dealing with them.

- All risks are identified and assessed but the focus of action are those identified as High Risks. High risks are those which threaten the achievement of the organisation's objectives. It is acknowledged that it is not possible to remove all risk from any organisation, and that ability to respond to risk is always constrained - for example by funding or staff time. Hence it is important to prioritise risks and actions. For instance, at the level of "very low" risk it would be realistic to take no action (unless this was easy to take), effectively "accepting" the risk; equally it is reasonable to expect that there will be action plans linked to all risks assessed as "High".

- Risks will be managed proactively rather than the organisation solely reacting to the consequences of risk exposure.

- Risk should always be seen in the context of the organisation's objectives - whether these are quantifiable (e.g. to achieve a measurable target) or less specific (e.g. to deliver high quality patient care).

- All staff have a duty to identify and minimize risk and either undertake risk assessments or bring the issue to the attention of their line manager.

- Any department/member of staff with a concern over an apparently unaddressed risk should raise such a concern with either their directorate risk management contact (see Appendix 7) or their line manager/director.

Process
This is set out in Appendix 6 with a summary below:

Risk Identification

- Risks will be identified in the following ways including:

    - actual risks (or near misses) already incurred – these can be extracted by reference to incident reports, claims or complaints

    - potential risks can be identified by such processes as Infection Control/Health and Safety audits, or by "brainstorming" processes (self assessments) undertaken by groups. The latter can be undertaken in a wide context e.g. what could prevent a service from achieving its business plan objectives or linked to a specific service development or change.

    Given the complexities and interdependencies of many of our services and the possible diversity of action plans it is important to ensure that an appropriate mix of skills is involved.

Risk Assessment

- A review/reassessment of risks already on the risk register must take place at regular intervals and at least annually.

- Assessment (i.e. scoring) of risks to identify which are of greater/lesser concern, and hence which are most important to address will use the standard Trust approach (Appendix 6). This system developed by the National Patient Safety Agency uses a combination of likelihood and potential consequence to come to an overall assessment of impact - either to the individual or the organisation. It is important to note that the assessment of potential impact - and, indeed any consequent action plan - should be linked to an evaluation of the risk after taking account of how any existing controls are operating. All risks should therefore identify the likelihood, possible consequence and the overall risk assessment which will range from "very low" to "high".

Key Controls

- The key controls to be identified are those which, when taken together, support staff in the achievement of the organisation's objectives and reduce the threat of risk. These include:

    - Management structure and accountabilities
    - Policies, procedures and guidelines

- Clinical Governance processes
- Incident reporting and risk management processes
- Complaints and other patient and public feedback procedures
- Staff training and education
- Statutory frameworks, for instance the Standing Orders, Standing Financial Instructions and associated Scheme of Delegation
- Communications processes
- Internal audit

- Gaps in controls
  This identifies areas where further action can be taken to reduce or minimise the risk further.

Action Plans

- Action plans are drawn up to either reduce or remove the risk. Action plans should be absolutely clear as to what the action is, who is responsible for taking the action, and the deadline for completion. It is important that all responsible parties agree to the action plan and its deadline especially when individuals with action items are from outside the area where the risk has been identified

- All action plans must be agreed and subsequently monitored by directorate risk management teams, the Integrated Governance Committee or the Trust Board. In addition, these groups and their chairs will ensure that the information gained from the risk management process links into business planning and service development.

- It is not feasible to centrally define "acceptable" risk and it is for those involved in the assessment process to determine the extent of action plans in the knowledge that no action plan = accepted risk. Directorate risk management groups are responsible for ensuring that action plans are appropriate and assesses the completeness of the action plans against both risk assessments and national requirements. The Integrated Governance Committee is responsible for monitoring that action plans have been achieved and that further action is taking place when adverse exceptions are reported

- As a marker, the Integrated Governance Committee as a minimum requires to be notified of action plans against all risks assessed as ‘High’.

Assurances

The way in which the Board gains assurance that the risk is being managed should be listed and any gaps in assurance should be identified

Maintaining and Monitoring Risk Registers

Risk registers are kept at Trust and directorate levels. The risk registers contain the following: -

- Category of risk
- Description of risk
- Date of assessment (to be updated at each reassessment)
- Likelihood
- Possible consequence
- Overall assessment (score)
- Residual Risk score

Where an action plan is agreed, the following information should be included:

  - Individuals responsible (name and title)
  - Timescales for completion
  - Facility to allow for regular updates on progress

The Trust maintains an organisation wide risk register and action plan summary.

This includes:

- All High-level risks - identified at directorate level and through the Assurance Framework process. This is reported to the Integrated Governance Committee and Trust Board annually with quarterly updates.

In producing the corporate summary, the Nursing Director, in conjunction with others, takes a view of the sources of independent assurance that may be available and advises the Integrated Governance Committee - and, hence, the Trust Board - accordingly.

Each directorate maintains a risk register and action plan of all its risks. This includes:

- All high level risks – which are included on the Trust Risk Register and are reported to the Trust Board and Integrated Governance annually with quarterly updates.
- All moderate, low and very low risks, which are summarized and reported to the Integrated Governance Committee annually.

<u>Reporting</u>

Exceptions and concerns are reported at every meeting and formal summaries are reported to the Integrated Governance Committee quarterly. The reports will ensure that deficiencies, action plans and progress against these are highlighted.

Additional responsibilities for risks

- In addition, Directors have been allocated responsibility for a number of specific areas of risk (see Appendix 8) and so will provide the Integrated Governance Committee with copies of an annual risk assessment, the consequent action plans, and quarterly progress reports against such plans.

- Quarterly summary reports on incidents, claims and complaints, identifying trends and any action required to address the issues are provided to the Integrated Governance Committee.

Services Provided by Summit Healthcare

In order to ensure that the Trust's approach to risk management is comprehensive, links with risk management processes undertaken by Summit (and/or its sub contractors) in respect of services provided to the Trust have been developed and will be maintained. These include the following: -

Incident recording	Summit has instituted an incident recording system in respect of all its services and provides summaries - including action plans - on a monthly basis. These are monitored by the Trust's Facilities services Development Manager
General Risk assessments	Summit has instituted appropriate arrangements to assess risk in its own services provided to the Trust, to develop and implement action plans for significant risks, and to keep the Trust informed on progress. To the extent that Summit/Interserve need to involve Trust staff in risk assessments/action planning/ implementation, the Trust co-operates. The converse also applies (ie where a "Trust" risk involves staff from Summit)
Specific Areas of Risk	A number of these topics are in respect of functions provided by Summit. The Trust remains responsible for ensuring risk assessments are undertaken and requires the co-operation of Summit to ensure action plans are undertaken (Appendix 8)

For all aspects outlined above, the Director of Operations is responsible for ensuring that Summit is complying with the Trust's requirements and that all significant risks and action plan items in respect of Summit's services are included in the appropriate directorate's risk register and risk management action plans.

7. AWARENESS TRAINING – GOVERNANCE AND RISK MANAGEMENT

All Staff

- All members of staff are required to attend induction training which includes basic awareness of governance and risk management.
- Additional training for staff will be identified through the Performance Management process, based on mandatory training and other requirements and incorporated into Personal Development Plans

Board Members and Senior Managers

- Training for Board Members and senior managers (i.e. Associate Directors) will be undertaken annually and provide an update on Risk Management, the

Integrated Governance Strategy and relevant national policy changes. This will be organized and records maintained by the Nursing Director.

8. MONITORING OF INTEGRATED GOVERNANCE

Organisational Framework

An annual review of the organizational and committee structures will be undertaken to determine fitness for purpose and will include:

1. Review against cycle of requirements for Integrated Governance Assurance Framework to check activities, reporting and monitoring has occurred.
2. Review work of Integrated Governance, Audit Committee and Finance and Performance Committee to determine if these are functioning as described in the terms of reference
3. Review attendance at Integrated Governance committee, Audit committee and Finance and Performance Committee against the details in the Terms of Reference
4. Review contributions of each Directorate, with risk assessments being undertaken in all areas and action plans being implemented.

Other monitoring

5. Undertake Self-Assessment Maturity Matrix – Integrated Governance (Appendix 9)
6. Review roles and responsibilities of key individuals. This will be undertaken through the Trust's Performance Review and Development process
7. Review Partnership working between PFI partners and the Trust
8. Review policies and strategies identified in this document to ensure they have been updated in line with any latest guidance.
9. Review this Strategy and local Directorate risk management strategies annually to ensure they are fit for purpose
10. Consider the internal auditor's opinion statement to improve the robustness of the Assurance Framework
11. The attendance of Board Members and Senior Managers at the annual updating training for risk management and integrated governance will be monitored and checks made on the content against the strategy.
12. An annual report of Integrated Governance work will be produced incorporating key components of the work throughout the year.

9. CONCLUSION

Effective governance and assurance arrangements are critical in ensuring the confidence of the Board, staff, patients and the public and partner organisations in the Trust and for the effective delivery and execution of its functions. Developing a culture of openness and transparency is integral to assuring all of the effectiveness of these arrangements, together with an environment that fosters and develops personal and organisational growth as a key to success.

Originator: Ann Close, Nursing Director

Approver: Paul Farenden, Chief Executive

Date of Approval: January 2008

Date for Review: January 2011

REFERENCES

Code of Practice on Openness in the NHS. DoH April 1994
Code of Conduct. Code of Accountability. In the NHS 2nd rev ed DoH 2004
Internal Control – Guidance for Directors on the Combined Code. The Institute of Chartered Accountants - England, Wales September 1999
NHS foundation Trust Code of Corporate Governance, Monitor 2005
Governance in the new NHS (HSC 1999/123) NHS Executive May 1999
Governance in the NHS (HSC 2001/005) NHS Executive February 2001
Governance in the NHS: Towards Convergence: Strategic Direction and Guidance for Boards Department of Health Draft May 2001
Governance in the NHS Statement on Internal Control 2001/2002 and Beyond (Including Controls Assurance – Supplementary Guidance) NHS Executive March 2002
Corporate Governance Framework Manual for NHS Trusts Department of Health
Draft Version I July 2002
The Intelligent Board – Monitor (no date)
Assurance: The Board Agenda Department of Health Governing the NHS – A Guide for NHS Boards Department of Health NHS Appointments Commission 2003

Appendix 1

Board Committees – Membership and Terms of Reference

1. Finance and Performance Committee

<table>
<tr><td>Members:</td><td>Chairing:</td></tr>
<tr><td>Chairman
Non-Executive Directors
Chief Executive
Executive Directors</td><td>Trust Chair
When absent, chaired by Deputy Chair or, if not available, a Non Executive Director</td></tr>
<tr><td>Quorum:</td><td></td></tr>
<tr><td colspan="2">Trust Chair or Deputy Chair plus two Non Executive Directors and three Executive Directors</td></tr>
<tr><td colspan="2">Regularly receives:</td></tr>
<tr><td>• Strategic and Business Planning
<u>Annually</u>
o Annual Plan
o Income and Expenditure Plan
<u>Quarterly</u>
o Exceptions Report on Annual Plan
<u>As required</u>
o Business Cases

• Performance Management
<u>Monthly</u>
o Operations Director report
o Financial Performance Report
o Service line accounting report
o Forecast outturn
o Cost Improvement Programme performance
o Cash flow and balance sheet
o Other Working Capital
o Capital Programme
o Investment Performance
o Access and Other Target Performance Report, including HCC targets, Workforce Targets, Local Clinical Performance Indicators
o Benchmarking/efficiency reports, including NIII Indicators Scorecard
o Sign off Trust report to Monitor</td><td>• Legally Binding Contracts with Third Parties
<u>Monthly</u>
o Contract performance exception report

• Financial Accounting
<u>Annually</u>
o Annual Accounts
<u>Monthly</u>
o Current topics report
<u>As required</u>
o Changes in guidance and accounting policies

• Business Risks
<u>Monthly</u>
o Business risks report
o Market share/penetration review
<u>Quarterly</u>
o Review of risk reduction/mitigation action plans
o Competitor analysis
<u>As required</u>
o Relevant external auditors reports (eg Acute Hospitals Portfolio)</td></tr>
<tr><td colspan="2">Co-opting:</td></tr>
<tr><td colspan="2">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</td></tr>
<tr><td colspan="2">Exclusions:</td></tr>
<tr><td colspan="2">None</td></tr>
</table>

Frequency:
Monthly scheduled meetings within 20 working days of month end Ad hoc meetings can 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 is to be made to the Trust Chair.
Notification of meetings:
Agenda to be circulated with papers 3 days before the meeting Ad hoc meetings to be arranged within 28 days of the Trust Chair's decision or the request from at least three members of the Committee, including at least one Non Executive Director and one Executive Director
Terms of Reference
The Committee will: **Strategic and Business Planning** 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 Review the Trust Annual Plan and Annual Budgets before submission to the Board of Directors Monitor performance compared with the Annual Plan and Budgets and to investigate variances from these 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 Review such Business Cases retrospectively for return on investment/benefits realisation Review opportunities for increasing activity/income from market intelligence analyses **Performance Management** Monitor the financial performance of individual Clinical Units and Directorates Consider regular performance management reports from individual Clinical Units and Directorates 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 Develop a strategic approach to managing cost improvement programmes Agree the annual cost improvement programme, monitor performance against it and take appropriate action Consider performance against external performance targets set by the Healthcare Commission, Monitor and as agreed in legally binding contracts Develop, implement and maintain an effective service line accountability framework **Legally Binding Contracts with Third Parties** Consider regular reports of Trust and Directorate performance in respect of contracts agreed with third party organisations and to take appropriate action Ensure that Local Delivery Plans and contracts with Primary Care Trusts and other bodies are determined, managed and delivered **Financial Accounting** Consider the likely impact of technical changes to accounting policy or practices and agree significant changes to accounting practice in advance Consider detailed expenditure, cash flow and working capital plans and forecasts Consider regular financial performance reports and forecasts, focusing particularly on risks and assumptions Commission and consider various financial reports and analyses, as appropriate Consider other topics or matters, as directed by the Board of Directors

Business Risks Consider the short to medium term impact on current performance of internal and external business risks Review Monitor's risk rating and instigate appropriate action 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
Conflict of Interests
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders.

2. Audit Committee

Members:	**Regularly receives:**
Three Non-Executive Directors In attendance: Finance and Information Director Internal Auditors External Auditors NB • Chair of Audit Committee is an ex-officio member of the Integrated Governance Committee • All Non Executive Directors are ex-officio members of the Finance and Performance Committee	• Internal Audit progress report • External Audit VFM progress report • Internal/External Audit joint meeting notes • Information Governance Group (Dudley health economy-wide group) reports relating to Dudley Group • Internal Audit Opinion Statement • LCFS Annual Report • External Audit Management Letter • Audit Plans • Individual Audit reports • Integrated Governance Strategy • Assurance Framework • SAS 610 report of External Auditors on the annual accounts
Quorum:	**Chairing:**
Two Non Executive Directors	Non Executive Director (CCAB qualified) When absent, chaired by another Non Executive Director
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary	
Exclusions:	
Trust Chairman The Committee will exclude the Finance and Information Director and any other Trust employee from its meeting with Internal and External Auditors for a minimum of one meeting per year	
Frequency:	
Four scheduled meetings per year Ad hoc meetings can be called by the Chair or as a result of a request from at least two members of the Committee. The request is to be made to the Chair.	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting Ad hoc meetings to be arranged at the latest within 28 days of the Chair's decision or the request from at least two members of the Committee	

Terms of Reference

Internal Control, Risk Management and Governance

The Committee will review the establishment and maintenance of an effective system of internal control, risk management and governance. In particular, the Committee will review the adequacy of:

- all risk and control-related disclosure statements, including the Statement on Internal Control, together with an accompanying Head of Internal Audit statement, prior to endorsement by the Board of Directors
- policies for ensuring compliance with regulatory, legal and code of conduct requirements as set out in the Controls Assurance Standards and other relevant guidance
- operational effectiveness of internal controls and procedures
- policies and procedures relating to counter-fraud and corruption
- the Assurance Framework and the Integrated Governance Strategy (reviewed annually)
- the integrity of the financial statements, as required by Monitor's Code of Corporate Governance and Audit Code

Internal Audit

The Committee will:

- consider all matters in connection with the appointment of, or changes in, the Trust's Internal Audit service
- determine the role of Internal Audit with regards to consultancy related work and the impact on independence
- review the Internal Audit Strategy and plan its implementation
- consider the findings of internal audit reports
- ensure co-ordination between Internal and External Audit
- recommend to the Board of Directors the appointment of, and review the performance of, Internal Auditors
- ensure that adequate relationships exist between the Head of Internal Audit and the Accountable Officer (or designated officer)

External Audit

The Committee will:

- review the External Auditor's Audit Strategy Memorandum, including the level of reliance to be placed on work undertaken by internal audit
- review external audit reports, including in particular:
  - Report on Examination for the Annual Accounts (SAS 610)
  - The Management Letter (including any management response)
- review the performance of External Audit and report to the Council of Governors

Other

The Committee will:

- receive proposed amendments to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation; and to make recommendations to the Board of Directors on such proposed amendments
- publish an annual report on the work of the Audit Committee (June each year) to the Board of Directors and the Council of Governors, to include an assessment to the Council of Governors of the performance of the external Auditors
- consider the impact of any changes in accounting policy, advising the Board of Directors as appropriate
- consider other topics, and initiate any investigation or review, as it deems fit, and on behalf of the Board of Directors

Conflict of Interests

These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders.

3. Remuneration Committee

Members:	**Normally receives:**
Chairman Non-Executive Directors By invitation: Chief Executive Director of Human Resources	• Salary information and details of Trust Chief Executive and Executive Directors' remuneration packages • Reports and guidance on pay levels and non pay benefits in the NHS and private sector for comparable roles
Quorum:	**Chairing:**
Three Non Executives	Trust Chair When absent, chaired by Deputy Chair
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff or appropriate advisor, as felt necessary	
Exclusions:	
No Executive Directors will be in attendance for decisions on their remuneration	
Frequency:	
One scheduled meeting per year Ad hoc meetings can be called by the Trust Chair or as a result of a request from at least two members of the Committee or the Chief Executive. The request is to be made to the Trust Chair.	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting Ad hoc meetings to be arranged within 28 days of the Trust Chair's decision or the request from at least two members of the Committee or the Chief Executive	
Terms of Reference	
The Committee will: • Determine the terms and conditions and pay levels and non pay benefits for the Trust Chief Executive and Executive Directors • Determine any monetary severance arrangements for the Trust Chief Executive and Executive Directors • Determine the implementation of the agreed policy for any performance-related pay scheme applicable to the Trust Chief Executive and Executive Directors • Review pay levels annually in line with inflation and relevant labour markets • Review and determine expenses payable to Governors • The scope of the Committee's remit is: o The Chief Executive o The Executive Directors employed by the Trust o In respect of the Medical Director, to consider the non-consultant contract element of remuneration of the role. Regard will be given to the specific nature of his/her clinical and non-clinical responsibilities and the structure of his/her overall remuneration package o Governors' expenses	
Conflict of Interests	
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders.	

4. Nomination Committee

Members:	**Regularly receives:**
Chairman Non-Executive Directors Chief Executive Directors of Human Resources and Corporate Development by invitation (for first 12 months of FT operation) Trust Secretary – advisory role	• Information on current skills, knowledge and experience of the Board of Directors • Updates on the challenges and opportunities facing the Foundation Trust • Guidance from Monitor on relevant corporate governance issues
Quorum:	**Chairing:**
Three Non Executives	Trust Chair When absent, chaired by Deputy Chair or a Non Executive Director
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff, or external advisor, as felt necessary	
Exclusions:	
The Committee will exclude the Chief Executive from discussions relating to his/her post	
Frequency:	
Two scheduled meetings per year Ad hoc meetings can be called by the Trust Chair or as a result of a request from at least two members of the Committee. The request is to be made to the Trust Chair.	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting Ad hoc meetings to be arranged within 14 to 28 days of the Trust Chair's decision or the request from at least two members of the Committee	
Terms of Reference	
• To operate as a formal Committee of the Board of Directors • To review regularly the size, structure and composition of the Board of Directors and make recommendations • To evaluate the balance of skills, knowledge and experience on the Board of Directors and to identify those required for appointments of the Trust Chair, Non Executive Directors, Chief Executive and Executive Directors • To review the skills and expertise needed on the Board, taking account of current and future challenges and opportunities • For the appointment of the Chief Executive and Executive Directors, to agree a job description and person specification for the role and capabilities required • To identify and nominate suitable candidates for Chief Executive and Executive Director vacancies • To agree and manage the nominations, appointments and re-appointments processes for: o Chief Executive o Executive Directors • To agree the size and composition of the selection panel for these appointments • To recommend its proposed appointment for the Chief Executive post to the Council of Governors for approval • To meet, without the Chair, Chief Executive and Director of Human Resources, to review the performance of the Chair on a regular basis.	
Conflict of Interests	
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders.	

5. Integrated Governance Committee

Members:	**Regularly receives:**
Chief Executive Executive Directors : Nursing, Finance and Information, Human Resources, Operations, Corporate Development, Medical Three Non-Executive Directors, including Chair of Audit Committee Two Associate Medical Directors Associate Nursing Director Associate Director PCS PALS Manager Director of Research and Development Clinical Governance Co-ordinator Clinical Audit Lead Lead Cancer Clinician	• Reports from subgroups as outlined in the Governance Strategy • Reports and action plans from external visits and reviews • Reports and action plans from national enquiries and reports • Risk management reports, risk registers and the Assurance Framework. • Serious incidents and incident trends • Reports on the HCC Core and Developmental Standards • NHS patient and staff surveys
Quorum:	**Chairing:**
6 members, three of which must be clinical staff	Chief Executive When absent, chaired by the Nursing Director
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary	
Exclusions:	
See conflict of interest below	
Frequency:	
Minimum 9 meetings per year Ad hoc meetings can be called by the Chief Executive or Governance Lead (Nursing Director) if there are urgent issues of clinical governance or risks to the Trust identified.	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting Ad hoc meetings to be arranged as necessary to ensure a quorum is achieved	
Terms of Reference	

• To oversee the development and implementation of an integrated governance strategy and action plan and ensure this reflects the Trust's objectives.
• To coordinate the development of related strategies and action plans e.g. audit, clinical effectiveness, patient and public involvement, education and training, information use, research and development and risk management, to ensure they fit with the overarching strategy and to monitor implementation.
• To establish an annual cycle of requirements for governance, monitor progress, be informed of adverse performance and ensure action is taken in relation to:
  • Assurance Framework and Statement of Internal Control
  • Risk Management
  • Business capacity and capability
  • Clinical Governance
  • Standards for Better Health
  • Healthcare Commission Annual Healthcheck
  • Patient Safety Group
  • PPI agenda
  • Workforce and HR issues	

- Research Governance
- Information Governance
- Health and Safety
- Infection Control
- External visits and reviews

- Prepare reports for the Board of Directors
  - Quarterly on integrated governance to include any updates on high risks and the assurance framework
  - Annually to ensure compliance with Assurance Framework.
  - Annually for declaration of Standards for Better Health.
- To ensure information about Governance in the Trust is communicated internally and externally.
- To ensure there is a link with the Audit Committee and Finance and Performance Committee through common membership.

Conflict of Interests

These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders.

6. Appointments Committee for Non Executive Directors

Members:	**Regularly receives:**
Chair or Deputy Chair (when considering post of Chair) 1 public governor 1 staff governor 1 appointed governor Chief Executive	• Information on current skills, knowledge and experience of the Non Executive Directors • Updates on the challenges and opportunities facing the Foundation Trust • Guidance from Monitor on relevant corporate governance issues
Quorum:	**Chairing:**
Chair or Deputy Chair and two governors	Trust Chair When absent, chaired by Deputy Chair
Co-opting:	
The Committee has the power to co-opt, or to require to attend, any member of Trust staff, or external advisor, as felt necessary	
Exclusions:	
The Committee will exclude the Chair from discussions relating to his/her post, with the Deputy Chair chairing the Committee	
Frequency:	
As required Ad hoc meetings can be called by the Trust Chair or as a result of a request from at least two members of the Committee. The request is to be made to the Trust Chair.	
Notification of meetings:	
Agenda to be circulated with papers 7 days before the meeting Ad hoc meetings to be arranged within 28 days of the Trust Chair's decision or the request from at least two members of the Committee	
Terms of Reference	
• To operate as a formal Committee of the Board of Directors • For the appointment of the Trust Chair and Non Executive Directors, to prepare a job description and person specification for the role and capabilities required, including an assessment of the time commitment, for agreement by the Council of Governors • To propose the nominations, appointments and re-appointments processes for agreement by the Council of Governors for: o Trust Chair o Non Executive Directors • To identify and nominate suitable candidates for the Trust Chair and Non Executive Director vacancies for appointment by the Council of Governors • To undertake the recruitment and selection of the Chair and Non Executive Directors and to recommend their appointment or re-appointment for decision by the Council of Governors at a General meeting	
Conflict of Interests	
These will be managed in accordance with Standing Order 6 of the Board of Directors' Standing Orders. For this Committee, the term 'Director' is interpreted to mean any member of the Committee, including Governors. Please see note below.	

7. Patient Safety Group

This group brings together the activities from the operational groups and address all aspects of patient safety. The **terms of reference** are:

- To identify common risks and trends across the organisation that impact on patient safety, ensure that action plans are developed to minimise the risk and monitor implementation.
- To monitor serious untoward incidents and trends in incidents across the organisation, ensure root cause analyses are undertaken and action plans are implemented.
- To track targets in action plans on a regular basis.
- To monitor complaints and trends in complaints across the organisation and ensure action is taken to make improvements.
- To identify issues raised by patients and their representatives, agree action to be taken and monitor progress.
- To share good practice and ensure there is learning across the organisation from incidents, complaints and health and safety issues.
- To identify patient safety alerts and medical devices alerts relevant to the Trust and ensure actions are taken to meet the requirements.
- To review and agree clinical policies, guidelines and Patient Group Directions and ensure these are updated according to Trust policy.
- To ensure the organisation is prepared for external reviews e.g. CNST Healthcare Commission reviews, StHA reviews.
- Consider, agree and monitor action from the following groups:

Infection Control	Blood Transfusion Group
Resuscitation Committee	Medical Devices Steering Group
Medicines Management (inc. Drugs and Therapeutics)	Decontamination Group
	Thrombosis Committee
Medical Records	Falls Group
QPDTs	Nutrition Steering Group

- Provide a monthly written report to the Integrated Governance Group.

Membership of the Patient Safety Group: (Deputies may attend)

- Associate Directors from operational directorate
- Representatives from operational groups (1 per group)
- Clinical Governance/Assistant C. Governance Co-ordinators
- PALS Manager
- Representatives from ICT/Representation from decontamination, blood transfusion, Resuscitation team and Health and Safety, Medical devices (attendance quarterly to provide reports)
- Complaints and Claims Manager.

The chair of this group is the Associate Nursing Director. The Nursing Directorate will undertake the administration of the Committee. The Associate Nursing Director and the Clinical Governance Co-ordinator prepare a report for the Integrated Governance Committee.

8. Other Committees/Groups

Those reporting through the Patient Safety Group:

Operations Directorate Risk Management Groups – there are four groups:

- Medicine/Maternity and Children's service
- Surgery and Critical Care/Professional Clinical Services

These groups identify assess and manage risks and keep local risk registers, address and take action on medical devices and patient safety alerts, identify, assess and monitor health and safety, review complaints and take action to make improvements, investigate incidents and take action to minimise risks of recurrence, provide a route for sharing information ensuring that individual members of staff to the Trust Board have access to risk management information, ensure feedback is provided to individuals and/or groups on matters relating to governance and report to the Patients Safety group.
Contacts Yvonne O'Connor (Extension 2016) and Svea Martinson (Extension 5298)
Medical Devices Steering Group - is responsible for leading and coordinating the purchase and maintenance of medical devices and for ensuring there are training programmes for staff to operate them. The group is also responsible for the progress towards achieving the Controls Assurance Standard for Medical Devices.
Contact MarkTindall Consultant Anaesthetist (Chair Extension 2076) or Bal Kainth, Medical Devices Coordinator (Extension 3296)
Quality and Practice Development Teams - are multidisciplinary groups set up to improve the quality of care delivered to specific groups of patients. The groups ensure that the principles of clinical governance are applied including the development and implementation of evidence and research based practice, audit of practice, ensuring patients are involved in shaping services and giving feedback, identifying and managing risks and ensuring staff are appropriately educated and trained to deliver a high standard of care.
Contact Yvonne O'Connor (Extension 2016)
Resuscitation Committee - is a Trust wide Committee with responsibility for developing resuscitation policy and recommending good practice in resuscitation and the equipment used. It also ensures training programmes at different levels are developed and provided for staff and audits the outcome of resuscitation events.
Contact Paul Innes Consultant Anaesthetist (Chair Extension 2076) or Ros Clarke Resuscitation Training Officer (Extension 3956)

Medicines Management/Drugs and Therapeutics Committees - have a role to promote a rational and cost effective approach to drug use and policies effecting drug use throughout the Trust and the local health economy. A key component of its activity is to encourage the safe and economic use of drugs.
Contact Richard Cattell Head of Pharmacy Services (Extension 3430)
Medical Records Committee – a multidisciplinary, representative group comprising of Trust and Interserve staff which agrees and monitors the structure, composition and availability of clinical records. *Contact Adnand Mohite, Consultant Paediatrician (ext. 3367) or Isobel Rees Associate Director (Extension 2212)*
Cleanliness Group – a liaison group between Trust and Interserve staff which ensures and monitors environmental cleanliness.
Contact Andrew Rigby, Facilities Services Development Manager (Extension 1019.)
Decontamination Group – a co-ordinating group to ensure that all areas of the Trust comply with all relevant legislation and maintains good practice in decontamination of equipment.
Contact Bal Kainth, Consultant Paediatrician (Extension 3296) or Yvonne O'Connor, Associate Nursing Director (Extension 2016)

Blood Transfusion Group – a co-ordinating group ensuring the Trust complies with national blood transfusion directives and implements and monitors good practice.
Contact Craig Taylor, Consultant Haematologist (Extension 2490) or Caroline Stone, Transfusion Practitioner, (Extension 2758)
Thrombosis Committee – a multidisciplinary group set up following the recommendations of the House of Commons Select Committee report to raise best practice by adapting accepted risk assessment, treatment and monitoring guidelines and be a source of education and training for all staff dealing with patients at risk of venous thromboembolism. *Contact Dr Paul Harrison, Consultant Haematologist ext.* 2239
Nutrition Steering Committee – a multidisciplinary group to co-ordinate a systematic approach to the nutritional screening, treatment and monitoring of all patients *Contact Dr BJM Jones, Consultant Gastroenterologist ext. 3433/2074*

Those reporting straight to the Integrated Governance Committee:

Health and Safety Committee - this monitors the performance of the Trust against health and safety requirements, and requires departments/directorates to undertake annual risk assessments and to develop action plans to address health and safety issues.
Contact Graham Dunn, Health and Safety Advisor (Extension 3464)

Fire Safety Committee (sub-committee of the H&S Committee) - reviews the Trust's fire precaution policy and operational arrangements, reviews risk assessments and assesses fire safety training.
Contact Jim Hebberts, Fire Officer (Extension 3823)
New Interventions and Materials Group – a multidisciplinary group which assesses clinicians requests to introduce new procedures and materials in line with national Health Circular and NICE requirements.
Contact Ann Close (Extension 3577) or Lawrence Emtage, Consultant Urology Surgeon (Extension 2203)
Infection Control Committee - is a broad based multidisciplinary group that supports the Infection control team in its work across the Trust. This involves setting policies, standards and guidelines for the prevention and control of infection, identifying and managing risk, providing education and training programmes for staff, and the surveillance, audit and monitoring of infections.
Contact Elizabeth Rees, Consultant Microbiologist (Extension 2473) or Infection Control Nursing Team (Extension 2807)
Research and Development Committee - is a multidisciplinary group responsible for the governance of all research carried out within the Trust. It operates within a Research Governance Policy agreed by the Trust Board, and works closely with the Local (District-wide) Research Ethics Committee.
Contact George Kitas, Consultant Rheumatologist (Extension 5842) or Margaret Marriott, Research & Development Facilitator (Extension 1224)
Clinical Audit Leads Committee - is responsible for developing a culture where evaluation is seen as important, ensuring clinicians evaluate their clinical practice, assist departments and specialties to draw up programmes of clinical audit and ensure that national standards and guidelines are available to and used by clinicians. There is a lead consultant for Clinical Audit within each Division.
Contact Elizabeth Rees, Consultant Microbiolgist (Chair Extension 2473) or Derek Eaves Clinical Audit Department Manager (Extension 3418)
Patient and Public Involvement Group - is a Trust wide Committee that develops the Trust's strategy for patient involvement. It develops standards and guidelines for patient information and feedback and is encouraging the involvement of patients and the public in planning services in the future. It is closely linked with the PALS.
Contact Ann Close, Nursing Director (Extension 3170)

Cancer Core Group/Local Implementation Group – a co-ordinating group liaising with national and local network bodies to ensure that the Trust complies with national standards/cancer plan and effective cancer care is in place across all specialities.
Contact Nick Whear, Consultant Max Fax (Extension 2492)

Information Governance and Caldicott Group - to co-ordinate and monitor the Information Governance programme of work across the Trust, including the production of polices and procedures, submitting the annual compliance requirements in the IG Toolkit, undertaking audit and investigating incidents
Contact John Uttley, Deputy Director of Information (Extension 1010)

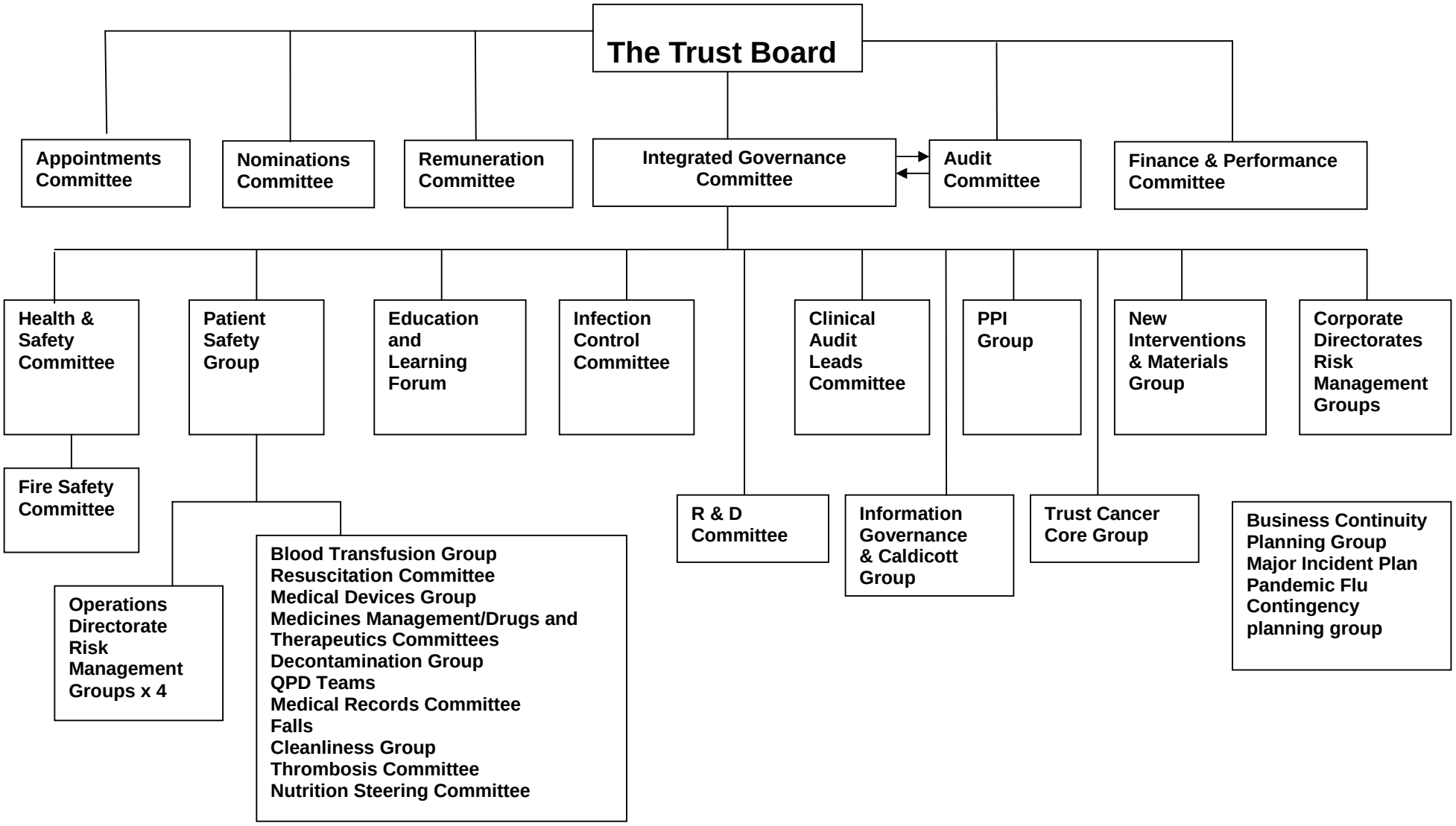
Corporate Directorate Risk Management Groups – these are fundamental to the Trust's policy to achieve an integrated approach to risk management. Each corporate directorate has a forum for identifying and assessing and managing risks and will keep a local risk register. In addition incidents and accidents will be investigated and action taken to minimise risk of recurrence. These will be reported directly to the Integrated Governance meetings
Contact relevant director

Business Continuity Planning Group - The following groups report into the Business continuity Group – the Major Incident Planning Group (Internal and External Incidents) and the Pandemic Flu Contingency Planning group.
Contact Paul Oxley Project Manager Operations Directorate Ext 1203

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

INTEGRATED GOVERNANCE STRUCTURE/COMMITTEES

Appendix 2



Appendix 3

Annual Cycle of Requirements for Integrated Governance

No	Component	Lead	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1	Purpose and Values	JC						Review annually						
2	Strategic & operational objectives / priorities	PB						Review annually						
3	Annual (Business) Plan	PB										Review		
4	LDP	PA	→	→	→	→	→	→	→	→	→	→	→	→
	Assurance Framework Risks	AC		Update			Update				Annual review		To Board	Board sign off
5	Directorate risk management	All	Exceptions	Exceptions	Update report	Exceptions	Exceptions	Update report	Exceptions	Exceptions	Annual review		Exceptions	Update report
6	Core Standards	AC/ All	Declaration	Exceptions	Except	Exception	Exceptions	Exception	Mid year review	Excepts	Excepts	Except	Exceptions	Final report
7	Developmental Standards	AC	Declaration											Final report
8	Finance targets	PA	Declaration	F &P	F & P	F &P	F&P	F &P	Mid year review	F&P	F &P	F&P	F &P	Final report
9	NHSLA	AC	in Pt safety	In Pt safety	In Pt safety	In Pt safety	In Pt safety	In Pt safety	In Pt safety	In Pt safety	In Pt safety	In Pt safety	In Pt safety	In Pt safety
10	Patients Safety	AC	Report	Report	Report	Report	Report	Report	Report	Report	Report	Report	Report	Report
11	Incident trends	AC	Report			Report			Report			Report		
12	NICE	AC	Report	Report	Report	Report	Annual Report	Report	Report	Report	Report	Report	Report	Report
12	Clinical Governance	AC	Action plan		Annual Report									
13	PPI	AC	Action plan		Annual report			Update	Annual patient survey		Update	Results	Action plan	
14	Staff survey	JC							Annual staff survey			Results	action plan	
15	Infection Control	AC	Report	Report plus Annual prog	Report & Annual report	Report	Report	Report	Report	Report	Report	Report	Report	Report
16	External visits and reviews	AC	Concordat List & Reports	→	→	→	→	→	→	→	→	→	→	→
17	Info. Governance	PA			Annual Report			Report			Report			Report
18	Business Continuity/Major Incident	PB			Annual Report			Report			Report			Report
19	Sub group reports not listed above	ALL		Report			Report			Report			Report	
20	PFI Partnership	PB												Report
21	Board Reports	AC		Annual report	Board report			Board report			Board report			Board report

Appendix 4

The eight elements of Integrated Governance which constitute the High Level Governance Framework

1. **Resources –** be financially sustainable (probity, regularity, balance at year end), sufficient human resources, estate fir for purpose appropriate information technology

2. **Efficiency and Economy, Effectiveness and Efficacy (4Es) –** the organisation can be run effectively, efficiently and economically and challenged – why are we doing this activity could someone else do it and do it better?

3. **Compliance with authorisations –** will be compliant at all times with its authorisation to operate (Monitor, Health and Safety Drug and Research Management)

4. **Compliance with Standards for better Health and national targets –** meet and exceed core standards and demonstrate progress with the developmental standards

5. **The duty of quality as reflected in clinical governance –** continue to improve services for patients and be governed in accordance with current best practice

6. **The duty of partnership –** cooperate with local health economies

7. **The duty of patients and public involvement (Section 18 of the NHS Act) –** have a growing and representative membership to which it is responsible and accountable. In particular in the planning of services

8. **The ongoing development of the Board**

Appendix 5

SYSTEM FOR THE IDENTIFICATION, ASSESSMENT, REPORTING AND MINIMISING OF ALL RISKS

1. INTRODUCTION

Risk management is a series of processes that identify risks, assess the potential impact of such risks and plan and implement actions to reduce risk within an overall management and monitoring framework.

2. IDENTIFICATION OF RISKS

- Risks will be identified from both local complaints, claims, incidents, accidents and concerns raised by staff (from specific major ones or from trends) as well as from national issues/directives and from risks to achieving the Trust objectives.
- Corporate and operations directorates risk management groups are responsible for having systems in place to ensure the following processes occur.
- The Lead for Governance will be responsible for ensuring the Board has systems in place to identify, assess and manage the strategic risks

3. ASSESSING RISK

All staff, managers and risk leads are required to ensure that risk assessment is documented on the attached proforma It is important that those undertaking the assessment ensure that the outcome is shared with the designated Risk Management lead for the directorate concerned. The process and proforma to record the risk assessment includes:

- The Source of the risk/Trust objective
- Description of risk e.g. what can go wrong, how can it happen, what could be the effect
- Risk score – Likelihood, Consequence and overall score
- Controls already in place
- The residual risk with these controls in place
- Gaps in controls
- Action Plans to mitigate risk with target dates
- Sources of Assurance and
- Gaps in Assurance
- Date of review

a. Source of Risk/Trust Objective

As indicated above, the source of the risk may be from one or more of the following: local events (complaints, incidents, claims – specific or trends) or from national issues. This should be documented on the proforma. It also needs to be documented which Trust objective is at risk of not being met.

b. Description of Risk

As well as indicating the topic of the risk, it is necessary to indicate the nature of the risk (What could go wrong? How could it happen? What could be the effect?).

c. Risk Score

It is necessary to score the risk at this stage i.e. the inherent (or Gross) risk which is the risk score in the absence of controls/actions which management have or might take

The system developed by the National Patient Safety Agency for scoring incidents has been adopted by the Trust for all risk assessments.

The scoring is undertaken in two parts: likelihood and potential consequence.

Likelihood (How often is it likely to go wrong?)

You should use a combination of professional judgement and information on, say, claim and adverse incidents recorded over the past year to determine an average of how often the risk occurs. Your score should take account of existing controls (how they actually operate - not how they might have been planned to operate)

From this analysis you should identify the most appropriate score.

LIKELIHOOD RATING	DESCRIPTION
Certain	**Will occur, possibly frequently**
Likely	**Will probably occur, but it is not a persistent issue/concern**
Possible	**May occur occasionally**
Unlikely	**Do not expect it to happen**
Rare	**Can't believe such an event will happen**

Potential consequence

As shown below, there are potentially three ways in which this may be assessed:

Impact on the individual
Numbers of people affected
Impact on organisation

Also shown are examples of the types of consequence that might constitute "catastrophic", "major" etc.

It should be noted that the descriptions - which were specifically designed in respect of patient incidents - will not necessarily be directly applicable to the risk you are assessing. You may need to think in equivalent terms.

A risk should be scored by reference to the whole grid, with the final score being determined by the "worst" assessed impact.

DESCRIPTION	IMPACT ON INDIVIDUAL (e.g. patient, staff member etc) (actual or potential)	SCORE OF IMPACT IN TERMS OF VOLUME OF PEOPLE PER INCIDENT (actual or potential)	IMPACT ON ORGANISATION (actual or potential)
Tragic	**Unexpected death Suspected Homicide**	**>50 E.g. cervical screening concern, vaccination error**	**- International adverse publicity - Extended service closure - High litigation costs**
Major	**Permanent injury (physical or psychological)/ill health/damage/loss of function**	**>16-50**	**- National adverse publicity - Temporary service closure - Increased length of stay >15 days**
Moderate	**Semi-permanent damage to patient (emotional, psychological or physical) For patients, likely to resolve within one year. For staff, likely to result in > 3 days absence**	**>3-15**	**- Local adverse publicity - Increased length of stay >8-15 days - Staff sick leave**
Minor	**No permanent damage. Patient Injury (emotional or physical) will probably resolve in about one month. Staff Injury likely to result in up to 3 days absence.**	**<1-2**	**- Increased length of stay <7days**
Insignificant	**No identifiable damage to patients. Injury to staff not resulting in absence.**	**N/A**	**- Minimal impact, no service disruption.**

Overall score

Both the likelihood and Potential Consequence Ratings are plotted on the following matrix to give an overall risk rating:

Likelihood	CONSEQUENCE				
	Insignificant	Minor	Moderate	Major	Tragic
Almost Certain					
Likely					
Possible					
Unlikely					
Rare					

Very Low Low Moderate High

d. Controls already in place
The next stage is to describe the controls already in place to minimise the risk. e.g. policies, procedures, training etc

e. Residual risk
The residual risk score is the risk with the present controls in place.

f. Gaps in control
This identifies areas where further action can be taken to reduce or minimise the risk further.

g. Mitigating actions
After describing the risk and scoring it, the plans should be drawn up to minimise the risk e.g. training, staff awareness, new equipment, new policy and procedures etc. In some cases you may have established that controls originally designed to reduce the risk (e.g. policies/procedures) are not working appropriately, and your action plan will need to address this issue. It is expected that the prioritisation of action plans will be driven by the overall risk rating; for example it would be expected that action plans would be produced and implemented for all assessments in the "high" category.

Action plans should include target dates, persons responsible and a date for review.

h. Sources of assurance

This refers to the ways in which the Trust board is able to assure itself that the risks are being managed effectively and will include external and internal assurances. External assurances may be from agencies that undertake audits reviews and inspection visits and provide reports e.g. Internal and External auditors, Royal College Visits, Health Care Commission reports. Internal assurances may be via internal reports to the Board e.g. audits of policies, procedures and guidelines, performance monitoring data. These should be specific and identify where possible the frequency of when the Board is likely to receive the reports.

i Gaps in assurance

This identifies where the Board is not receiving any assurance that the risk is being managed.

Risk Acceptance

In some instances it may not be possible to put action in place to reduce the risk or the degree of action and effort is greater than likely outcome to make it not worth the effort. In these instances the Board may accept that there has to be some degree of risk

4. RISK REPORTING AND COMMUNICATION

Copies of the whole risk assessment should be kept at ward/departmental level, with copies being sent to the designated Risk Management lead within the Directorate and being made available to other designated officers such as the Health and Safety manager on request. For all risks categorised as "High" your Directorate Risk Management lead should be notified immediately to ensure that the agreed actions are suitable and/or to make a decision about acceptance of the risk if immediate action cannot be taken.

All high risks must be reported to the Integrated Governance Committee and reported in the high-risk register to the Trust Board.

Identified risks are communicated at a number of levels. Within Directorates, all risk assessments are seen by the relevant group (for the Operations Directorate, one or all of the 4 risk management groups). The Patient Safety Group is a forum for risks relating to the Operations Directorate and Trustwide clinical issues to be shared with relevant groups. Members must ensure that they communicate risks and action plans raised at this meeting with their own directorate Risk Management Group.

The Integrated Governance Group if a forum for sharing and learning from risks of both a clinical and non-clinical nature and action taken across the whole Trust and from the wider NHS. Members must ensure that these are communicated to their own team to ensure learning takes place.

All action plans must be agreed and subsequently monitored by directorate risk management teams, the Integrated Governance Committee or the Trust Board. In addition, these groups and their chairs will ensure that the information gained from the risk management process links into business planning and service development.

Appendix 6

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Directorate: Trust strategic objective **Department/specialty N/A**

Trust objective

Describe / identify the risk			Describe controls as they actually work	Risk assessment			Gaps in control
What could go wrong	How could it happen	What could be the effect		Cons	Like	Score	

Mitigating actions	Date	Lead	Residual risk			Sources of assurance	Gaps in Assurance
			Cons	Like	Score		

Date of Assessment **Person undertaking risk assessment** **Date for review**

Manager **Director**

Appendix 7

DIRECTORATE RISK MANAGEMENT LEADS

Operations	- Paul Brennan	(Extension 1001)
Nursing	- Ann Close	(Extension 3170)
Human Resources	- Janine Clarke	(Extension 3443)
Finance	- Paul Assinder	(Extension 1059)

Appendix 8

FRAMEWORK FOR RISK MANAGEMENT

1.	Buildings, Land, Plant and Non-Medical Equipment	Paul Brennan
2.	Catering and Food Hygiene	Paul Brennan
3.	Decontamination of Re-usable Medical Devices	Paul Brennan
4.	Emergency Planning	Paul Brennan
5.	Environmental Management	Paul Brennan
6.	Financial Management	Paul Assinder
7.	Fire Safety	Paul Brennan
8.	Fleet and Transport Management	Paul Brennan
9.	Governance	Ann Close
10.	Health and Safety Management	Janine Clarke
11.	Human Resources	Janine Clarke
12.	Infection Control	Ann Close
13.	Information Management and Technology	Paul Assinder
14.	Management of Purchasing and Supply	Paul Assinder
15.	Medical Equipment and Devices	Ann Close
16.	Medicines Management	Paul Brennan
17.	Professional and Advice Services	Paul Assinder
18.	Records Management	Paul Brennan
19.	Research Governance	P Harrison/G Kitas
20.	Risk Management System	Ann Close
21.	Security Management	Janine Clarke
22.	Waste Management	Paul Brennan

Appendix 1: Self Assessment Maturity Matrix – Integrated Governance

Version 4.2 Oct 2005	NHS Boards: Integrated Governance Self assessment maturity matrix		Produced by John Bullivant, NHS CGST
Boards need to demonstrate clarity of purpose, transparency in decision making, and accountability. The Matrix identifies ten key areas for individual and collective attention in delivering the Integrated Governance. In relation to each element try and assess your own perspective on the level to which you have progressed and are assured. Then share and seek common ground for current positions and action to improve the collective position. If you feel you have not yet reached basic level, mark the NO column. Revisit at regular intervals.			
Progress **Key Elements**	**No**	**Basic level – agreement of commitment and direction**	**Firm progress in development**	**Maturity – comprehensive assurance**
1. Clarity of Purpose	_	Purpose debated and agreed; priorities and drivers expressed	National targets and local priorities agreed with stakeholders and plans in place	Evidence that national targets and local priorities are being met and strategy review in place
2. Strategic annual agenda cycle with all agendas Integrated encompassing activity, resources and quality	_	Annual cycle of Board activity reviewed	Annual cycle of Board activity in place; reporting format and strategic prioritisation in place	Clarity of action and follow up in place. Improvement framework in place
3. Integrated Assurance System in place	_	Assurance Framework covers activity, quality and resources and realigned to targets, standards and local priorities	Control mechanisms in place for all elements of the Assurance Framework	Annual audit of follow up of SUIs, complaints etc. Board assured Assurance Framework reporting reflects priority areas
4. Decision making supported by intelligent information	_	Information processing and analysis overhauled	Intelligent information for Boards, stakeholders and regulators	Evidence based decision making in place
5. Streamlined committee structure; clear terms of reference and delegation; time limited	_	Committee structure reviewed with expectation of minimum (3?) standing committees and time limited task groups	Streamlined committee structure in place with clear terms of reference and scheme of delegation and reporting	Temporary committees/task groups report annually on progress and need for extension if necessary
6. Audit Committee strengthened to cover all governance issues	_	Audit committee role reviewed to take on independent scrutiny function	Audit committee workload and agendas under control. Internal external and auditors and advisors aligned to agenda & role	Committees reviewed and working effectively within scrutiny regime
7. Appoint Board supports eg company secretary to support Board, Committees and head compliance unit	_	Company /corporate secretary role defined & located in organisation	Company/corporate secretary appointed /trained assumes compliance unit role	Company /corporate secretary role reviewed
8. Selection, development review of board members,	_	Non Exec competences known and gaps identified, Execs trained in Board role & corporacy	Exec contribution reviewed at least annually	Board fit for purpose, succession planning in place
9 Board etiquette agreed	_	Board has discussed its values and the way it wants to work	Etiquette agreed & board reviews performance after each meeting	Board improves its working & Values & Etiquette reviewed annually
10. Development f individual Executive Directors and NEDs by the trust to ensure board corporacy	_	Terms of reference developed for training needs	Corporate induction systems in place for new directors – annual corporate review workshop established	Clear corporate performance objectives of all directors reviewed by Chair and CEO in line with performance assessment system
Maturity Matrices have been developed under license from the Benchmarking Institute				

February 2006

Enclosure 6

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Trust Board - 28 February 2008**

Report of: **Director of Finance and Information**

Subject: **Amendment to September 2007 Trust Board Minutes**

1. MINUTES

It has come to light that there was an omission in the minutes regarding the approve to write off bad debt detailed in my report to the September 2007 Trust Board. I detail below the original minute and suggested amendment below:

Original minute under 07/20 Operational Performance

The Board received the report of the Director of Finance and Information, given as Enclosure 7. This had been debated in detail at the Finance and Performance Committee held earlier that morning. The significant points of note, by exception, were:

- I & E Surplus to date at the half year is £6.2m
- Forecast Outturn for the year is a surplus of £9.2m (with a risk banding of £8m to £9.5m - the key drivers being Q3 and Q4 trading and spending of reserves)
- This outturn normalises to a surplus of £4.7m
- There is pressure from the SHA to review the financial position in the context of the Clean Hospital and 18 weeks initiatives.
- Our Business Risks profile remains largely unchanged.
- The half year and forecast balance sheet is strong with liquidity at 30th September at 23.5 days.
- ED 4 hours performance dipped below target in September for the first time this year.
- Waiting targets are being met with increased pressures noted in some diagnostic specialties.
- MRSA numbers (although low in absolute numbers) are above target.

Suggested amended minute

The Board received the report of the Director of Finance and Information, given as Enclosure 7. This had been debated in detail at the Finance and Performance Committee held earlier that morning. The significant points of note, by exception, were:

- I & E Surplus to date at the half year is £6.2m
- Forecast Outturn for the year is a surplus of £9.2m (with a risk banding of £8m to £9.5m - the key drivers being Q3 and Q4 trading and spending of reserves)
- This outturn normalises to a surplus of £4.7m
- There is pressure from the SHA to review the financial position in the context of the Clean Hospital and 18 weeks initiatives.
- Our Business Risks profile remains largely unchanged.
- The half year and forecast balance sheet is strong with liquidity at 30th September at 23.5 days.

- ED 4 hours performance dipped below target in September for the first time this year.
- Waiting targets are being met with increased pressures noted in some diagnostic specialties.
- MRSA numbers (although low in absolute numbers) are above target.

The Trust Board noted bad debts written off under delegated powers of £3,637.20 and approved the write off of debt to the value of £6,867.64.

2. Recommendation

The Board is asked to approved the suggested amendment to the September 2007 Trust Board minute 07/20.

Paul Assinder
Director of Finance and Information
And Secretary to the Board

Enclosure 7

Dudley Group of Hospitals Charity
(1056979)

Performance Monitoring and Reporting Policy and Procedure

1. Introduction

The performance monitoring and reporting policy will include the management of cash flows, analysis of 3 year expenditure plans, and investment of surplus funds.

The policy should ensure that the effective management of all Charity Fund money takes place within an overall framework of objectives and purpose set out by the Charitable Fund Committee.

The following Policy and Procedures were approved by the Charitable Fund Committee at its 28th February 2008 meeting.

2. Policy

In operating the procedures outline below, the Charity will be acting within the following guiding principles:-

(i) the Charity's core purpose is to enhance and further improve the high quality services provided by the Trust, providing additional comfort and benefit to its patients and staff, by focusing fund expenditure on areas not covered or fully supported by NHS funds

(ii) the Charity accepts that it is a significant consumer of local goods and services, and will honour ifs financial obligations to both staff and suppliers.

(iii) Ensure effective returns, with minimum risk, are made on Charitable Fund investments.

Within these overriding principles, the policies specific to Charitable Fund investments, Performance Monitoring and Reporting are as follows:-

(a) for monies due to the Charity, invoices will be raised promptly and income will be collected when due.

(b) the charity will ensure the prompt payment of funds due for goods and services received.

(c) the charity will maintain systems to forecast, monitor and manage cash flow with the provision of expenditure plans provided by the Medical Service Heads and Matrons on an annual basis, identifying opportunities for investment.

(d) in making investments the Charity will not place its funds at risk, and ensure that investments are not placed in areas that conflict with the Trust core business, healthcare ie Tobacco industry.

(e) the charity will ensure that periods of investment are consistent with the Charity's cash flow needs.

(f) investments will be monitored quarterly, comparing current investment management returns against World Market Group comparisons.

Whilst personal responsibility for Charitable Funds lies with the Charitable Fund Committee, the day to day managerial responsibility for operating this policy will be delegated to the following:-

Financial Services Manager
Treasury Manager
Treasury Officer (Non NHS)
Assistant Treasury Officer (Non NHS)

In the absence of the above, their designated deputies will assume responsibility.

3. Procedures

The procedures set out below inter alia:-

(i) require adequate financial controls over the Charitable Funds function.
(ii) will be kept under regular review.

3.1 Cash Flow Forecasting

Income to Charitable Funds will be receipted on a daily basis and banked weekly to the Trusts Bank Account.

The bank statements are produced electronically on a daily basis, cross referenced and verified to the Charitable Funds banking documentation.

Charitable Funds payments are made fortnightly, usually on a Monday. Payments are made via cheque as BACS is not used for Charitable Funds, due to low volume.

The Treasury Officer (Non NHS) will review the Bank statement balance to the Charity Cashbook to ensure the balance is as expected. (Uncleared cheques are not notified until the month end)

The cash book and Bank statements are reconciled to the Charity General Ledger monthly by the Treasury Officer (Non NHS).

The Treasury Manager will prepare monthly cash statements and taking account of expected receipts and payments, using historical information to assist in the forecast.

3.2 <u>Investments – Cash accounts</u>

The Treasury Manager will determine appropriate investment based upon the rate available at the Trust Bank or Charity Fund Deposit Account.

If the deposit account is offering a higher interest rate and if cash flow and cash requirements allow, the surplus money will be transferred from the bank account to the deposit account and vice versa.

A "Charity Investment Details Form", (Annex 1), should be completed by the Treasury Manager. The value of the interest earned will be noted on Annex 1 and then authorised by an approved signatory.

The Director of Finance and Information or in his absence an approved signatory, will authorise the planned investment.

The Treasury Manager will arrange for transfer of the agreed sum to the Deposit account by raising a cheque request (Annex 2), authorised by an approved signatory and forwarding to the deposit fund with the relevant banking documentation.

3.2 Investments – Common Investment Fund

The Investment Managers will provide a quarterly report identifying the current value of investments and projected interest income.

The Treasury manager will review the report and monitor the current levels of expected income to ensure they are within the overall target predicted by the Investment Managers.

The Treasury Manager will compare the current Investments with the World Market Report which is also provided quarterly.

If there appears to be a significant variance between the Charity's current investment plans and those in the World Market Report, the Treasury Manager will seek clarification from the Investment Managers.

The Treasury Manager will provide a quarterly report to the Charitable Funds Working Group, with a full status report.

The Investment Managers will be invited to attend a meeting of the Charitable Funds Working Group to review expenditure plans and investment strategy annually, every February.

Originator: Paul Assinder
Director of Finance and Information

Approver: Charitable Funds Committee

Date of Review: February 2009

Date of review thereafter: February 2012

Appendix 1

CHARITY INVESTMENT DETAILS FORM

Date:

Completed By:

DETAILS OF INVESTMENT:

Trust Bank Cash Book Balance:
Commitments outstanding:

Balance available to be invested:

Deposit Fund

Interest Rate:

Interest Earned pa:

Bank account

Interest Rate:

Interest Earned pa:

Additional Interest Earned:

AGREED BY TREASURY MANAGER: ..... Date: .....

AUTHORISED FOR INVESTMENT BY : APPROVED SIGNATORY

Authorised By:

Signed:

Date:

Enclosure 8

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board February 28th 2008 (Public)**

Report by: **The Nursing Director**

Subject: **Quality of Care**

Summary

The purpose of this report is to keep the Trust Board up to date on actions being taken to improve the quality of care for patients. This includes

- Progress made in implementing Quality Care Reviews
- Progress with the Review of dignity in care

The Board is asked to receive the report

Background

Quality Care Reviews

A rolling programme of inspection and review of all clinical areas in the Trust has been agreed and is in progress. The programme started in September 2007 and is due to complete in August 2008 by which time all in patient wards and departments and outpatients area will have been reviewed. Following the reviews the ward/ department receives a report and has a 4 week period to develop and agree an action plan which is submitted to the Matron and the Nursing directorate for collation.

Dignity in care

Following the Health care commission report into Dignity in care issued in 2007 the trust undertook a review of its position and a report was presented to the Board. This area of work is being led by the Matron for Older People who has a lead across the Trust for Dignity in Care

Issues for consideration

Quality Care Reviews

Although most of the in-patient areas have now been reviewed action plans are not available for all the areas. There fore an overview of the results is being presented and a more detailed report will be provided at the March Board meeting

Areas reviewed to date include:

- Neonates and paediatrics
- Orthopaedics
- GI surgery and medicine
- Stroke and Rehab
- Rheumatology

Findings:

- Essence of Care
    - Privacy and Dignity implemented
    - Red Tray system in operation
    - MUST screening evident

    - Protected meal times implemented with some unavoidable interruptions e.g. patients returning from theatre
    - Food in general was rated by patients as good

- Communication
    - Generally excellent communication between Nurses, Medics and AHP's
    - Patients interviewed comment that staff are polite, friendly, and helpful

- Infection Control
    - All wards had hand gel available which was used appropriately by the majority of people.
    - Correct practices were being undertaken
    - Not all staff were challenging people who were non-compliant

- Patient Information
    - Limited in some areas, currently being addressed and available Trust Wide via Carenet.
    - Patients interviewed responded positively to discussions about their condition and treatment with both medics and doctors.

- General Issues:
    - Ward areas clean and tidy
    - Patients allowed to dress during the day where appropriate
    - Access to telephones, radio, television and newspapers
    - Difficult to identify 'who's who' as all the uniforms are the same
    - Provision of hairdressing facilities requested by some patients

Dignity in care

Older Peoples' Services

Older Peoples' Services have a Privacy and Dignity Team, which was commenced in October of 2007. This team is lead by a Band 6 Sister.
They provide training sessions for all staff within the Units using patient/relative concerns to illustrate failures and commend good practice.
Regular recorded meetings are held.
Resource Folders are available in each area.
Work they have introduced so far is the "Don't Peep" signs for bedside curtains and clear identification of who is in charge each shift.

Due to the enthusiasm of the team some funding as been released to support their improvement programme. This enables the purchase of badges for the team and then for other teams, which we will establish in other specialities, notice boards, posters and resource folders for use throughout the Trust.

The Team have also been put forward for a Health and Social Care award.

Trust Wide

New bedside curtains purchased by the Trust have Velcro fastenings and a loop to attach “Don’t Peep” signs.

Larger theatre gowns for obese patients have been introduced in X-Ray and Day Case Theatres. A supply will now also be available in Main Theatres and ED/EAU.

Work is being undertaken to identify suitable larger nightwear for this group of patients.

The plan is now to develop teams in other specialities. The Matrons for C1 and ED/EAU have been contacted for a Lead person to take it forward. The Older Peoples’ Champion in the X-Ray Department who has already undertaken work in this area as been contacted with a view to developing this work further.

The Behind Closed Doors audit is to be undertaken throughout the Trust by 30th April 2008.

Working in Partnership

From the beginning there has been partnership working with Age Concern and the PCT.

Discussions are now underway with our partners to train all of their front line staff.

The Board is asked to receive the report

Nursing Director
February 18th 2008

The Dudley Group of Hospitals NHS
NHS Trust

TRUST BOARD AGENDA
Thursday 31 July 2008 at 11.00am
Clinical Education Centre

	Item		By
1.	**Chairman's Welcome and Note of Apologies**		A Edwards
2.	**Declarations of Interest**		A Edwards
3.	**Announcements**		A Edwards
4.	**Minutes of Previous meetings:** • Thursday 26 June 2008 Public Board Meeting	Enclosure 1	A Edwards
5.	**Action Sheet - Progress Report by Exception**	Enclosure 2	A Edwards
6.	**Other Matters Arising**		
7.	**Chief Executive's Report**	Verbal	P Farenden
8.	**Strategic Issues** • To be Advised		
9.	**Operational Performance** • Corporate Performance Report Period to 30 June 2008	Verbal Report	P Assinder
10.	**Reports for Approval** • To be Advised		
11.	**Information Items to be Noted** • To be Advised		
12.	**Any Other Business** • Limited to urgent business notified to the Chair/ Corporate Secretary in advance of the meeting		A Edwards
13.	**Date of Next Trust Board Meeting (AGM)** • September 2008 (Date to be Confirmed)		
14.	**Meeting Closes**		

The Dudley Group of Hospitals NHS
NHS Trust

Minutes of the Public Trust Board meeting held at 11.00 a.m. on Thursday, 26th June, 2008, in the Clinical Education Centre

Present:

Alfred Edwards, Chairman
Ann Becke, Non Executive Director
Ann Close, Nursing Director
Paul Brennan, Operations Director
Kathryn Williets, Non Executive Director
David Wilton, Associate Non Executive Director
Paul Farenden, Chief Executive
Paul Harrison, Medical Director
Jonathan Fellows, Associate Non Executive Director
Janine Clarke, Director of Human Resources
Paul Assinder, Director of Finance and Information

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Customer Relations and Communications

08/68 Chairman's Welcome and Note of Apologies

Apologies were received from David Badger, Non Executive Director and Denise Mcmahon, Nursing Director. Alf Edwards, Chairman welcomed the attending staff and reporter from the Express and Star.

08/69 Declarations of Interest

There were no Declarations of Interest.

08/70 Announcements

This was Ann Close's last meeting after 14 years as Nursing Director. The Board wanted to convey their great appreciation and acknowledged Ann's true professional dedication.

08/71 Minutes of the Previous Meeting – 29th May, 2008 – Trust Board Meeting

The minutes of the 29th May, 2008, Trust Board meeting, given as Enclosure 1, were approved as a correct record and signed by the Chairman.

08/72 Action Sheet – 29th May, 2008 – Progress Report by Exception

The Board reviewed the Action Sheet, given as Enclosure 2, as follows:

08/72.1 Action Item 08/58.4 Linkage between Directors and Governors

Covered under agenda item 21 (Enclosure 12) of the private agenda.

08/72.2 Action Item 08/38.1 Quality of Care Report

Covered under agenda item 23 (Enclosure 15) of the private agenda.

08/73 Matters Arising

None to report.

08/74 Chief Executive's Report

Paul Farenden, Chief Executive gave a verbal report, which included:

- Investing for Health - the SHA had produced the latest 'Investing for Health' document which describes how they intend to pursue key challenges and priorities. The Chief Executive to distribute copies to Board members.

- Review of Provision of Critical Care for Children – review of 2 years ago identified a number of challenges. The team had revisited and results were very positive, with no areas of concern and a number of areas of good practice. The whole team congratulated the Trust on improvements in Emergency Care, Outpatients, Theatres and on wards.

Distribute copies of new 'Investing for Health' report to Board members

08/75 Strategic Issues

08/75.1 Ernst & Young Stage 2 Report and Trust Action Plan

Paul Assinder, Director of Finance and Information reported to the Board on the Ernst & Young Stage 2 Report. Ernst and Young were commissioned by Monitor to report on the accuracy of the Trust's working capital and financial reporting procedures, they had submitted their final report on 19th June, 2008. The Board noted that the contents of the report was very positive. The Chairman confirmed that Board members had received an earlier version of the report but the final version included the Executive Summary. The report had now been formally submitted to Monitor.

08/75.2 Update on Monitor Assessment process

Paul Assinder, Director of Finance and Information gave a verbal report. The Board noted that the Trust was now in the final stages of the assessment process. The Director of Finance and Information thanked everyone involved in the process for their help. The assessment continues until the end of the month when the outcome will be awaited.

08/75.3 Scheduled meeting of the Council of Governors – 1st July, 2008 (Enclosure 4)

The Director of Finance and Information reported on the scheduled meeting of the Council of Governors, the draft agenda was given as Enclosure 4.

The Board noted that one further item had been added and this was the Council of Governors effectiveness assessment process which will be presented by Janine Clarke, Director of Human Resources and the Board agreed that it was important that the Council of Governors review is coterminous with the Board of Directors review. Other agenda items were standing issues.

08/76 Operational Performance

08/76.1 Corporate Performance Report Period to 31 May 2008

The Director of Finance and Information tabled the Trust performance for the 2 months period to 31st May, 2008. The Board discussed and noted the following position up to the end of May (Month 2):

- Income and Expenditure – Income up, expenditure marginally under plan as discussed in the Finance and Performance Committee. EBITDA better than plan and retained surplus is £1.5m, slightly ahead of plan.
- Balance Sheet – healthy position.
- Cost Improvement Plan – exceeding plan by £1.8m.
- HCC and other key Performance Targets – performing well. Infection Control improved in June.
- Forecast for the year – on course to deliver all targets

The Board noted the strong performance in the first 2 months of the year.

08/76.2 Capital Programme Update

This has been included in Elaine Williams, Associate Director of Finance, Capital Programme Report to the Finance and Performance Committee. Working to £12.2, spend at £1.3m at this stage.

08/76.3 Service Development Update

The Director of Operations gave an update on Service Developments, the Board noted that it was too early to provide detail and projects were being taken forward, including:

- Technical solution to 2nd MRI Scanner – costed and working out implementation – ahead of schedule.
- Infection Control Programmes – all now implemented.
- Combined PET/CT Scanner – work started on plan to determine bringing combined scanner on site.

08/77 Reports for Approval

No reports for approval.

08/78 Information Items to be Noted

No new items to note.

08/79 Any Other Business

Paul Harrison, Medical Director, asked the Board to note that the husband of a member of nursing staff had been recently killed in Afghanistan. The Board expressed their sincere condolences and regrets to the member of staff and her family and confirmed their support in any way possible.

There being no other business, the Chairman closed the meeting.

08/80 Date of Next Meeting

The next Board meeting will be held at 11.00am on Thursday, 31st July, 2008 in the Clinical Education Centre.

Signed as a correct record: …… Chairman

Date: ……

The Dudley Group of Hospitals NHS
NHS Trust

Action Sheet
Minutes of the Trust Board
Held on 26 June 2008

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
08/74	Chief Executive's Report	Distribute copies of new 'Investing for Health' report to Board members	CE	31/7/08	
08/37.1	Research and Development	Prof. G Kitas to be invited to the October Board meeting to report on clinical trials	PH	30/10/08	

The Dudley Group of Hospitals NHS
NHS Trust

Public Trust Board Agenda
Thursday 27th March 2008
11.00am
Clinical Education Centre

	Item	Time	By
1. 2. 3.	**Chairman's welcome and note of apologies – D. Wilton** **Declarations of Interest** **Announcements**	2 mins	A Edwards
4.	**Minutes of previous meetings** • Thursday 28th February 2008, Board Meeting **Enclosure 1**	2 mins	A Edwards
5.	**Presentation on Corporate Manslaughter by Ian Mayers, Mills & Reeve** **Questions/Answers**	30 mins 10 mins	I Mayers
6.	**Action Sheet – Progress Report by Exception** **Enclosure 2**	2 mins	A Edwards
7.	**Matters Arising**	2 mins	A Edwards
8.	**Chief Executive's Report**	5 mins	P Farenden
9. 9.1	**Strategic Issues** **Foundation Trust Update** **Verbal**	5 mins	P Assinder
10.	**Operational Performance** • Report to Finance and Performance Committee on 27th March 2008 **Verbal**	15 mins	P Assinder
11.	**Reports for Approval** • Research and Development **Enclosure 3**	15 mins	P Harrison
12.	**Information Items to be noted** • Quality of Care **Enclosure 4** • Human Resources Report **Enclosure 5** • PALS Report **Enclosure 6**	10 mins	A Close J Clarke A Close
13.	**Any Other Business** • Limited to urgent business notified to the Chair/Trust Secretary in advance of the meeting	1 min	A Edwards
14.	**Date of Next Trust Board Meeting** • 24th April 2008 at 11.00am in the Clinical Education Centre		
15.	**Meeting Closes**	12.30pm	

The Dudley Group of Hospitals NHS
NHS Trust

Minutes of the Trust Board meeting held at 12.00 noon on Thursday, 28th February, 2008, in the Clinical Education Centre, Russells Hall Hospital

Present:

Alfred Edwards, Chairman
Paul Harrison, Medical Director
David Badger, Non Executive Director
Jonathan Fellows, Associate Non Executive Director
David Wilton, Associate Non Executive Director
Roger Callender, Associate Medical Director
Paul Farenden, Chief Executive
Paul Brennan, Director of Operations
Ann Close, Nursing Director
Paul Assinder, Director of Finance and Information
Kathryn Williets, Non Executive Director
Janine Clarke, Director of Human Resources

In Attendance:

Helen Forrester, PA
Lorna Barry, Deloitte Touche
Sarah Briscoe, FT Project Officer

08/13 Chairman's Welcome and Note of Apologies

Apologies were received from Ann Becke. The Chairman welcomed Lorna Barry to the meeting.

08/14 Declarations of Interest

There were no Declarations of Interest.

08/15 Announcements

The Chairman reminded the Board that photographs of Board members were being taken in the Library directly after the meeting.

08/16 Minutes of Previous Meetings - 31st January 2008 – Trust Board Meeting

The minutes of the 31st January Trust Board meeting, given as Enclosure 1, were amended at item 08/10.4 to read "It was noted that this report was a combination of feedback from the Nutrition Steering Group and Essence of Care Initiative and is a position statement and details further actions against recommendations." With this amendment the minutes were approved as a correct record and signed by the Chairman.

08/17 Presentation to the Board on Fraud Prevention by Lorna Barry, Deloitte Touche

Lorna Barry our local Counter Fraud Specialist from Deloitte Touche presented to the Board on fraud prevention. Following the presentation a number of issues were raised including:

- In the instance of fraud being committed by nursing staff this would require reporting to the Nursing and Midwifery Council, when during the investigation should this be undertaken? It was noted that this should be at the point of criminal conviction.

- Where the occurrence of a fraud may result in an effect on patient care, the suspected member of staff should be suspended immediately.

- What is the amount of recent fraud enquiries being reported within the Trust. It was noted that there had been 5 cases within the last 4 weeks.

- There was discussion around the ability and sensitivity of monitoring Consultants hours.

The Board thanked Lorna for her informative presentation and she then left the meeting.

08/18 Action Sheet – 31st January 2008 - Progress Report by Exception

The Board reviewed the Action Sheet, given as Enclosure 2, as follows:

08/18.1 Item 08/03 Annual Chairs Conference

Presentations from the Conference had been circulated to Board members.

08/18.2 Item 08/10.3 Amendment to SFIs

The amendments to the Schedule of Authorised Limits had been undertaken.

08/19 Matters Arising

None to report.

08/20 Chief Executive's Report

Paul Farenden, Chief Executive presented his report to the Board, this included:

- The unannounced visit by the HCC had been undertaken on Friday, 22nd and Monday, 23rd February 2008. This was a comprehensive test of the Trusts compliance to the Hygiene Code and a number of wards had been visited. Feedback had been received on the evening of the 23rd February 2008, and initial comments were positive with no significant areas for concern. It was, however, noted that Ann Close, Nursing Director was still providing additional evidence that had been requested. A draft report from the HCC was expected by 28th March 2008 for our initial comments.

- The Trust has invited a team to visit to look at our infection control arrangements on Friday, 29th February 2008. It was hoped that we can learn from their discoveries and best practice methods from other hospitals.

The Chairman asked the Board to note that the Hygiene Code is legally enforceable and the Nursing Director requested that it was documented that responsibility for meeting the Hygiene Code standards rested at Board level. The Chairman asked the Nursing Director to produce a short synopsis of the Code for the benefit of the Board.

Nursing Director to produce synopsis of the Hygiene Code for Board members

08/21 Strategic Issues

08/21.1 Foundation Trust Update

Paul Assinder, Director of Finance and Information reported that there were 2 Foundation Trust items to note:

- The Communications Department is currently working on an FT Communications Strategy to cover the period between now and authorisation on 1st July 2008. This would include a series of presentations to existing staff groups, articles in Inside Out, dedicated FT pages on the Trust Internet and Intranet, a Frequently Asked Questions page and it was also noted that Paul Brennan, Operations Director was investigating ways of providing briefings for Clinicians.

- Individual presentations would be arranged for key health economy leaders

- There had been a meeting to look at the roles and responsibilities of providing support to Governors and Members and a table of responsibilities agreed at the meeting was distributed to the Board for information. The following items were noted:

  - The Membership Officer was arranging an ongoing programme of Trust tours for members and this would occur every other month.

  - A validation exercise of current Trust members would be completed in 12 months time.

  - A rolling programme of training had been scheduled for Governors, with the first session arranged for Friday, 7th March 2008.

  - The next Shadow Council of Governors meeting was being held at 6.00pm on 20th March 2008 in the Clinical Education Centre.

  - Elections for the 3 vacant Governor seats were commencing next week.

  - It was noted by Paul Brennan, Operations Director that the Trust is extremely committed to the proactive engagement of members as current and potential service users in the running of the Trust.

08/22 Operational Performance

Report to the Finance and Performance Committee on 28th February 2008

The Director of Finance and Information briefed the Board on his report to the Finance and Performance Committee later that afternoon, when the report will be considered in more detail. The Board discussed and noted the following position up to the end of Month 10 (January):

- At the end of January the total surplus was £10,772,000, an improvement of £789,000 on the previous month. This is equivalent to an EBITDA margin of 8.8% against an annual plan of 5.7%.

- The forecast outturn remains at £10.5 million for the year.

- The normalised position is a surplus of £7.4 million for the year.

- The Trust is ahead of planned surplus by £3,665,000, made up of an over-performance of £2,090,000 on operating activities (EBITDA), and other variances of £1,575,000. These include lower than planned depreciation of £300,000 and additional interest received above plan on investments of £907,000. Estimated income is above plan by £2,520,000.

- The Board noted that performance against the A&E 4hr wait target had improved and this was due to a significant increase in clinical staffing and additional validation work undertaken by A&E and Information staff. The year to date performance now stands above 98%.

- MRSA – performance continues to be on trajectory for the 4th consecutive month and there had been just 1 further MRSA bacteraemia in January 2008.

- Delayed Discharges – concern was expressed by the Board over the number of Delayed Discharges currently being experienced within the Trust and the problems associated with these patients. A lengthy debate was undertaken to establish what further actions the Board could take. The suggestion of charging the PCT for each delayed discharge was noted and would be investigated. It was agreed by the Board that there was a need for high level debate within the Health Economy to resolve the issues and the suggestion of a meeting with Non Executives from the Trust, PCT and Council was welcomed.

David Badger, Non Executive Director asked the Board to look again at agenda structure to report on recent trends in Operational Performance and suggested that this should be undertaken before the Board to Board meeting. The Chairman confirmed that work was currently being undertaken on producing an annual agenda and this would be available for the next Board meeting. The Operations Director stated that it would be valuable to pick up key indicators and have them trended to debate performance in May 2008.

The Board noted this position.

Further discussion to be undertaken on delayed discharges and reported back to next Board meeting. Draft Annual Agenda to be provided for March Board meeting. Key Indicators trended in May for performance debate.

08/23 Reports for Approval

08/23.1 Whistleblowing Policy

The Director of Finance and Information spoke to this paper, given as Enclosure 3. It was noted that the policy had been reviewed and consultation had occurred with the staff side and no problems had arisen. Janine Clarke, Human Resources Director asked that the policy be amended at section 4.2 to read "The following people have been identified as designated officer for raising concerns under this policy: Trust Associate Directors and Trust Non-Executives." It was also agreed to remove sections 4.11 and 4.12 under Inquiries.

With these amendments the Board approved the report.

With the noted amendment the Board approved the Whistleblowing Policy

08/23.2 NHS Inpatient Survey

Ann Close, Nursing Director spoke to this paper, given as Enclosure 4. It was noted that the Board was asked to receive the report, approve the approach to action planning and determine when the action plan is to be submitted to the Board.

David Badger, Non Executive Director asked as a Foundation Trust, what information must we collect and does this feedback provide us with all the information we need from patients. It was noted that it is not comprehensive but we do receive other flows of information and it would be the role of the new Head of Communications and Public Relations to ensure that such strategies are put in place.

The Board agreed that the approach to action planning should be made through the Operations Management Team and the action plans should be presented to the April Board as due to meeting timings a shorter timeframe was not feasible.

The Board received the report and action plans to be provided to the April meeting

08/23.3 Integrated Governance

The Nursing Director spoke to this paper, given as Enclosure 5. It was noted that this report included the revised Governance Strategy for Board approval which incorporated the revised Controls Assurance Framework and the Board were asked to confirm the timescale for making the declaration to the HCC for the Annual Healthcheck.

The Board approved the report and the timescale for submitting our declaration to the HCC by 30th April was agreed as:

Draft Declaration to Trust Board – Board meeting on 27th March 2008
Final Declaration to Trust Board for agreement – Board meeting on 24th April 2008
Final Declaration made to HCC – 25th April 2008
Declaration to be sited on Trust website before 30th April 2008

It was noted that following Board approval the revised Governance Strategy would be sent to PWC for review as a source of positive Board assurance.

It was also noted that on 1st April 2008, Monitor would be sent last years submission.

The Board approved the revised Governance Strategy. Draft Declaration to March Board, and final Declaration to April Board.

08/23.4 Amendment to September 2007 Trust Board Minutes

The Director of Finance and Information spoke to this paper, given as Enclosure 6. It was noted that this report highlighted an inaccuracy in the September 2007 minutes at item 07/20 Operational Performance. It had come to light that detail surrounding bad debt write off had been omitted.

The Board was asked to ratify the amended minutes as described in the report.

The Board approved the amendment to the minutes.

The Board approved amendment to the September 2007 minutes

08/23.5 Dudley Group of Hospitals Charity – Performance Monitoring and Reporting Policy and Procedure

The Director of Finance and Information spoke to this paper, given as Enclosure 7. It was noted that this policy had been approved at the Charitable Fund Working Group the previous week. It covered the protocol for active fund management and how to determine investment policy.

The Chairman asked where the report was derived from and it was noted by the Board that this was largely drawn from HFMA standard documentation as well as local input.

The Board supported the document.

The Board approved the Dudley Group of Hospitals Charity Performance Monitoring and Reporting Policy and Procedure

08/24 Information Items to be Noted

08/24.1 Quality of Care

The Nursing Director spoke to this paper, given as Enclosure 8. The Board were asked to note the progress made in implementing Quality of Care and Dignity in Care Reviews.

The Director of Finance and Information asked if the reviews were unannounced and it was noted that this was the case. They followed a rolling programme from September until August.

The Board received the report and noted that a further report will be available at the next meeting.

The Board noted the Quality of Care paper. Board to receive further report at its March meeting

08/25 Any Other Business

There being no other business, the Chairman closed the meeting.

08/26 Date of Next Meeting

The next Board meeting will be a public meeting held at 11am on Thursday, 27th March, 2008 in the Clinical Education Centre.

Signed as a correct record: . . . . . **Chairman**

Date: . . . . . .

Enclosure 2

The Dudley Group of Hospitals NHS
NHS Trust

Action Sheet
Minutes of the Public Trust Board meeting held at 12.00 noon on Thursday 28th February 2008 in the Clinical Education Centre

Item No.	*Subject:*	*Action:*	*Responsible*	*Due Date*	*Actioned*
08/20	Hygiene Code - Raised under Chief Executive's Report	Synopsis of Hygiene Code to be produced for Board Members	ND	27/3/08	
08/22	Operational Performance	Further discussion on delayed discharges to be undertaken and reported back to Board.	PB/NEDs	27/3/08	
08/22	Operational Performance	Draft Annual Agenda to be provided to Board Members	C	27/3/08	
08/23.1	Whistleblowing Policy	To be amended as per the HR Director's suggestion	DFI	27/3/08	
08/24.1	Quality of Care	Further report to March Board	ND	27/3/08	
07/42.2	Action Sheet Update External Audit Letter 2006/07	ALE Working Group to feedback on action required to achieve ratings of '4' to the next Audit Committee meeting on 15/4/08	DFI	24/4/08	
08/23.2	NHS Inpatient Survey	Actions Plans to be provided to the Board	ND	24/4/08	
08/22	Operational Performance	Key Indicators trended for performance debate	PA	29/5/08	
08/10.5	Healthcare Commission Maternity Survey	Progress Report to be submitted to Board in May	ND	29/5/08	
07/55.3	Draft IT Disaster Recovery Plan	Feedback to the Board on the results of the desk top simulation exercises which will be run by Siemens in the next financial year	DFI	When available from Siemens (08/09 financial year)	

Enclosure 3

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board**
Report by: **The Medical Director**
Subject: **Research & Development**
Date: **27 March 2008**

Summary

It has been a very busy 6 months as we continue to commission equipment for the Clinical Research Unit and make minor adjustments to consulting rooms and offices. The official opening of the unit will take place on 7 March 2008.
Obstacles to increasing recruitment to oncology trials remain, due to service capacity and research nurse numbers. We do now have a half time research pharmacist in post which will assist with the set-up for non oncology studies.
A short Good Clinical Practice (GCP) course ran successfully at a local conference and this will be expanded for general use from March onwards.
The Trust has secured its first commercial agreement to benefit financially from Trust-owned intellectual property. This relates to software developed by the Learning & Development Department.

(a) Funding: Extra funding of £20K was allocated to Dudley on 25/02/2008 by the Birmingham and Black Country Comprehensive Local Research Network (BBC CLRN) to be spent by 31/03/2008.

(b) Activity: There are currently >115 active studies and approximately 50 research active professionals. Despite a fall in recruitment to randomised controlled oncology trials this Trust continues to be the best recruiter in the Greater Midlands Cancer Research Network during 2007-08 (110 randomisations to date). TRACE RA, the rheumatology study co-sponsored by the Trust, continues to recruit steadily (69 randomisations to date in Dudley since June 2007) and 9 centres open to recruitment nationwide.
A number of new commercial studies will be opening to recruitment during 2008 in the specialties of cardiology, haematology, oncology and rheumatology. Surgical specialties are becoming involved in research, a welcome development.
There have been several publications arising from research work within the Trust, from the departments of rheumatology, haematology, oncology, surgery and GUM, amongst others.

(c) Education and Training: 25 members of staff will have completed the 3-day research and audit methodology course during 2007/2008. The March course will include a 1.5 hour GCP training session for the first time. The full course will run twice during 2008/2009. Online GCP training continues to be available.

(d) Research Governance Implementation: A total of 22 projects were assessed by the protocol review sub-committee from 23/08/2007 to 03/03/2008; 21 were approved.
Reported Serious Adverse Events: 4 relating to the TRACE RA study locally and nationally; 16 relating to other (oncology) studies.
The informed consent policy will be revised to cover studies where participants temporarily lack capacity to consent. The indemnity policy will be revised to incorporate the use of NHS R&D Forum approved model clinical trial agreements.

(e) Issues: DH transition funding for 2008/09 will be £71K, 42% of the 2005/06 allocation. Part of the shortfall will come from BBC CLRN, a figure still to be decided. The CLRN has already acknowledged that Dudley is underfunded for the work carried out, but we have yet to see the verbal acknowledgement translated into more resources. The most crucial thing is to maintain good recruitment levels to studies that are recognised as eligible to receive CLRN funding. We have already had to turn down one eligible study due to uncertainty in resourcing.
Research & Development are taking on half the R&D auditing work, due to the loss of a clinical audit officer. It remains to be seen whether the work can be completed within the 2007/08 timeframe.

Recommendations

The Board acknowledges this report and asks to be kept apprised of Research & Development issues on a six monthly basis.

Enclosure 4

THE DUDLEY GROUP OF HOSPTIALS NHS TRUST

Report to: **The Trust Board**

Report by: **The Nursing director**

Subject: **Quality of care**

Summary

The purpose of this report is to inform the Board of aspects of quality of care and in particular:

- Initiatives to improve the quality of mental health care for older people both across the Trust and in the older peoples unit specifically.
- The Quality of Care Review system and results following the assessment for the period September – December 2007 – Appendix 1
- The Clinical support systems in place to support nurses in delivering quality of care Appendix 2 & 3
- The end of year report for Essence of care Appendix 4

Back ground

Mental Healthcare for older people

The trust has received a number of reports previously on actions to improve dignity in care, particularly for older people Another element of improving dignity is to ensure older people who experience mental health problems are treated sensitively and with respect by staff who recognise their specific needs. The Matron for older people takes a Trust wide lead in this initiative and is support by a Clinical Nurse Specialist with expertise in caring for older people with mental health problems.

Quality care review

This is one of the ways by which the Trust measures the quality of care in both in-patient and outpatient settings. A summary report was provided in February 2008. a report of the results of the reviews undertaken between September and December 2008 is provided at appendix 1.

Clinical support

Providing effective clinical support and supervision will help nursing staff to provide good quality of care. Currently the Trust provides preceptorship support for newly registered nurse and clinical supervision for graduates and more experienced nurses. Appendix 2 provides the findings of an audit on preceptorship that was completed in August 2007 and the action plan that has been put in place to make improvements. Appendix 3 provides an update report on clinical supervision.

Essence of care

Essence of care was first launched in 2001 to reinforce the importance of getting the basics right and improving patient experience. It provides a tool to help practitioners take a patient focused and structured approach to sharing

and comparing practice. The Trust has used the bench marks to develop areas of practice that it considers are priorities for improvement i.e.

- Food and nutrition
- Privacy and dignity
- Pressure ulcers
- Health promotion
- Patient involvement

Issues for consideration

Older Peoples Mental Health Activity Report.
Trust wide Initiatives.

- *Mental Health Assessments*. - Patients are reviewed on a referral basis. Referrals are accepted from any member of staff who has concern's about an older persons mental health whilst they are being cared for in Russells Hall Hospital. Ward based assessments are carried out and staff are advised on appropriate care and treatment of the patient, follow up is arranged as appropriate. (Referral criteria: patients must be over 65 or have a diagnosis of dementia)
- *Training and development*
  Mental Health Awareness Workshops (held monthly). Open to all trust staff of any grade or discipline, covering topics including "The Experience of Dementia", "Care of the Confused Older Person in an Acute Hospital Setting" and "Depression and Anxiety".
  Total Attendance to Date-217
  Places Reserved for 2008 (to date)- 60
- Sessions on other training including Clinical Support Worker and Higher Clinical Support Worker Training; Newly Registered Nurses.
- Elderly Mentally Ill Intermediate Care. Responsible for assessment and referral of patients to specialist intermediate care beds.
- Liaison with local Mental Health Trust. Transfer protocol written and in use throughout the trust, work closely with Bushy fields Hospital keeping abreast of changes and developments and providing input as appropriate.
- Older Peoples Mental Health Conference. Held in October 2007, opportunity for trust staff to learn more about mental health initiatives within the local area, attended by 80+ staff of all disciplines and from all areas of the trust.

Initiatives within the Older Peoples Unit.

- Take the Time - An information gathering questionnaire devised by a multi-disciplinary team and trialled on C3 and latterly on A2. The questionnaire devised for use with any patient with communication difficulties, used primarily for patients with confusion/dementia. As the tool has proved successful it will be rolled out trust wide in the near future.

- Risk Assessment and Observation Training. Training provided for all staff within the Older Peoples Unit related to risk assessment and observation of people with mental health needs.
- Mental Health Input into Student Nurse Training.- It has been recognised that student nurses completing their adult nurse training receive limited mental health training. Work has therefore been completed in partnership with the local university to provide students on placement within the older peoples unit with some insight into the mental health needs of older people. Each student has the opportunity to attend the Mental Health Awareness Workshop, to work with the Clinical Specialist for Older People and to spend a shift on one of the Older Peoples wards at Bushy fields Hospital. The student nurse has a responsibility to complete brief competencies and some reflective work.

Plans are in place for a four-bedded area to open within the Older Peoples Unit in April 2008; patients with acute confusion of those with dementia with specific needs will be cared for within this area. (Primarily patients with extreme distress or agitation). These nurses will be cared for 24/7 by staff who have a specific interest in older adult mental health. Guidelines and Care Pathway have been formulated, staff induction to take place in March 2008.

Quality of Care Reviews
See appendix 1

Clinical Support
The board should note the audit results and the action being taken to improve the quality of clinical support through the preceptorship and clinical supervision processes. (see appendices 2 &3)

Essence of Care
The Board should consider

- The results of the audit on protected mealtimes, red tray use and checking of meal trays that shows the majority of patients are getting support for feeding.
- Actions are being taken to improve nutrition assessment and ensure hydration.
- The actions to improve privacy and dignity
- That patients are generally well informed about their condition and treatment
- The health promotion study days that have raised awareness about secondary prevention of heart disease, stroke, smoking cessation, nutrition and hydration
- The improvements in pressure ulcer prevention

Appendix 4

Recommendations
The Trust Board is asked to receive the report and note:

- **The work being undertaken to improve the mental health of older people**

- **The report on the Quality Care reviews September – December 2007**
- **The audits and action being taken to improve clinical support for nurses**
- **The Essence of care end of year report and the benchmark areas being considered by the Trust**

Nursing director
March 18th 2008

Appendix 1

The Dudley Group of Hospitals NHS
NHS Trust

QUALITY OF CARE REVIEW REPORT

FIRST QUARTER SEPTEMBER - DECEMBER 2007

Report compiled by Karen Day- Nursing Practice Development Coordinator

<u>The Quality of Care Review system</u>:

The Quality Care review (QCR) system is an annual rolling programme to evaluate the quality of care in both in-patient and out-patient areas across the Trust.

The QCR was introduced to provide a system of audit and evaluation which would provide qualitative data, taking into consideration "what really matters to patients". The quality of care review audit tool was developed to incorporate the DOH Essence of Care Benchmarks (2001) and the current Health Care Commission Standards. The review consists of an observational audit of the clinical area and of practice, plus interviews with staff and service users. An example of the QCR Audit tool can be found in appendix 2.

The QCR review teams are from both clinical and non-clinical backgrounds, with a lead assessor and one or two support assessors; the reviews of each area are unannounced. Following the QCR the Lead Nurse for each clinical area is required to develop an action plan in order to respond to any areas for improvement, which have been identified.

This report will comprise of the QCR's completed within the first quarter, September 2007- December 2007 highlighting both areas for improvement and areas of good practice. The report will summarize themes from each of the nine clinical in-patient areas that were reviewed during September 2007- December 2007.

General Observation of the clinical areas and facilities available:

Areas of good practice:

- In general the observations noted that patients appeared well cared for and comfortable, with adequate access to facilities
- Evidence of positive staff approach to promoting privacy and dignity for patients
- The majority of patients had all the correct information on their wrist bands and there was evidence of appropriate use of the red alert wrist bands
- Equipment for patients was readily available (e.g walking aids)
- Very good information available for patients and relatives
- Clean and warm environment for patients

Key areas for action:

- Ensure fire doors are not blocked open
- Ensure call bells are always in reach for patients
- Comment cards to be readily available for patients/ relatives
- To avoid using bathrooms as storage areas (it is noted from the QCR's that availability of storage appears to be a problem in most areas).

Medicines management and equipment:

Areas of good practice:

- Drug rounds were carried out at appropriate times
- Equipment was very clean (e.g. syringe drivers)
- Effective use of red alert wrist bands
- Appropriate use of oral syringes
- Medicines trolley's locked and contents clean and tidy
- CD keys/ Drug keys held in accordance with Trust policy

Key areas for action:

- Legibility of handwriting on drug charts could be improved
- Ensure that maintenance dates on medical equipment are clearly labeled
- Consider options to increase storage within clinical areas to avoid use of corridors to store medical equipment (e.g. Dynamaps)
- Ensure controlled drug register checks are kept up to date
- Ensure fridge checks are up to date

Essence of Care:

Areas of good practice:

- Good visual information available for patients and staff
- Protected mealtimes and the Red Tray system in place (in accordance with Trust policy) Adapted principles of protected mealtimes where it cannot be fully implemented due to the nature of care (paediatrics)
- Assistance given to relevant patients at mealtimes
- Food choices offered to patients
- Wipes offered to patients for hand washing prior to mealtimes
- Designated separate male/female bays (in accordance with Trust policy)
- Rooms available for private discussion in some areas
- Overnight facilities available for relatives in some areas
- Separate area identified for adolescents on paediatric ward to promote privacy and dignity
- Side rooms available to promote privacy and dignity
- Evidence of Essence of Care and Older Peoples Champions working closely with Lead Nurses and the clinical team to implement Trust wide incentives

Key areas for action:

- Ensure all areas offer wipes or facilities for hand washing prior to meals
- Ensure clear and consistent documentation of patient nutritional intake across all clinical areas
- Ensure patients are offered hair washing assistance or facilities
- Ensure visual displays are available in all areas to promote Essence of care and care of Older People
- Ensure all patients are aware of menu choices available
- Ensure 'water for hydration' in place in all areas. Offer cool drinks for patients in addition to tea/coffee rounds

Communication:

Areas of good practice:

- Polite acknowledgement of visitors to the areas
- Polite and courteous staff
- Evidence of effective teamwork
- Positive customer care from nursing staff and ward clerks
- Team meetings in most areas
- Good team spirit in most areas despite difficulties with staffing levels
- Appropriate use of interpreter services
- Polite telephone manner
- Good communication between the wider multi-disciplinary team

- Good explanation of conditions and treatment to patients
- Tolerance and support for confused patients

Key areas for action:

- It was noted from some of the patient discussions that medics sometimes talk to each other over the patient, rather than direct to the patient
- Ensure comment cards are available for use by relatives and patients
- Notice boards to be maintained on a regular basis to ensure information is clear and current
- Ensure telephones are answered promptly (it was identified that there are sometimes only ½ ward clerks to 4 stations, which may cause a delay in answering the telephone)

Nursing staff uniform:

Areas of good practice:

- The review noted that the uniform policy is adhered to and nursing staff appear very smart in appearance
- No wrist watches were worn when delivering patient care
- Aprons were always used when carrying out clinical duties

Key areas for action:

- It was noted that the new uniforms do not have id badges printed on, and that ID cards cannot be worn on lanyards when delivering care. To ensure that replacement badges are available for staff

Infection control and waste disposal:

Areas of good practice:

- Clean and tidy clinical areas
- Effective sharps disposal in accordance with Trust Health and Safety and Infection Control policy
- Appropriate use of gloves and aprons by clinical staff
- Appropriate use of gloves by portering staff
- Evidence of staff encouraging visitors to use hand gel

Key areas for action:

- Ensure all visitors are encouraged to used hand gel, including visiting staff members

- Domestic staff to use gloves appropriately when cleaning between isolation areas
- Hand washing prior to mealtimes to be encouraged with all patients, provide hand wipes
- Ensure hand gel is accessible for all users (too high for wheelchair users in some areas)
- Storage is generally a problem, leading to inappropriate areas used for storage at times e.g. bathrooms

Themes from staff discussions:

- Staff felt that the patient care they delivered was of a high standard but could be improved with better staffing levels, not all areas to full establishment which in turn could negatively affect staff morale
- It was noted that staff appraisals are not up to date in all areas which may also affect morale and prohibit identification of staff training needs
- There was a proactive and positive approach to Essence of Care and care of Older People
- Storage is often a problem in the clinical areas
- Senior staff sometimes feel under pressure to meet the needs of the 'shop floor' and management pressures and demands
- Nursing staff felt that Essence of Care, particularly privacy and dignity could be enhanced with better engagement from medical staff (sometimes signs are ignored)
- Demands of documentation can sometimes be difficult and compromise time spent with patients
- Enthusiasm and commitment of staff, proud of the care they deliver

Examples from patient discussions:

- "It is sometimes difficult to identify who wears what uniform".
- "I have had things explained to me in a way that was easy to understand".
- "My pain has been well controlled since I arrived here".
- "Access to more showers would be better".
- "Availability of lighter meals such as soup would be good".
- "Availability of cool drinks in addition to tea and coffee".
- "Privacy of a side room is nice but can also feel quite lonely".
- "It sometimes seems that there are too few nurses and too much to do".
- All staff are caring and deserve a congratulations".

Summary:

The report highlights some very positive areas of clinical care within this first quarter, alongside positive feedback from service users. The individual action plans for areas for improvement from each clinical are under progress. The action plans are initiated by each Lead Nurse and supported by their respective Matrons. In addition themes noting areas fro action will also be acknowledged by the Essence of Care and Older Peoples Champions education programme.

Appendix 2

Preceptorship implementation audit results

A comprehensive support systems must be provided for its nurses and midwives during periods of transition e.g. newly qualified, newly appointed to the Trust and newly promoted, irrespective of whether this involves entering or re-entering the profession. Each area has a nominated Lead Preceptor who should co ordinate all preceptorship activity in their area and ensures that staff are made aware of staff requiring preceptorship and their role in doing this. The lead Preceptor should have received training in preparation for this role.

The following audit was completed in May-August 2007 and the enclosed action plan compiled and implemented. 10 inpatient areas and 1 outpatient area were audited. The areas for audit were selected at random

Question	**Result**	**Comments**
Are you familiar with the Trusts Preceptorship Policy and Learning Contract	90% were familiar with the policy. 10% claimed to be unaware of its existence.	Although the results appeared favourable the majority of staff were aware that the policy existed but less familiar with its contents and how this policy should be being used in practice.
How do you feel Preceptorship works within your department?	45% of areas feel preceptorship works well. 55% feel that it is variable or does not work well at all	Of the areas preceptorship was perceived to be working well there was little adherence to the policy and the majority of preceptees were graduates only.
What problems do you have facilitating preceptorship?	20% had no problems facilitating preceptorship 80% felt that there was insufficient staff to implement preceptorship effectively.	

Who is the Lead Preceptor for your area and what is their role?	80% were unable to name their areas Lead Preceptor and had no awareness of the role.	A comprehensive training programme had been put into place previously and Lead preceptors had been identified from most areas.
Are preceptorship contracts photocopied and put on personal files? Check two sets of personal files	**No preceptorship files were found in the personal file examined**	**Staff were unaware [including those who were familiar with policy] that completed preceptorship documentation were to be placed on the individuals personal file.**

Results

The results indicate a lack of awareness of the responsibility of staff in the implementation of preceptorship in the Trust despite training sessions and supporting policy and guidelines being available. The audit also showed that staff were confused about preceptorship and student mentorship thinking that the two were the same and the documentation was identical.

Action Plan

Issue to be addressed

Staff are unfamiliar with the preceptorship policy and its associated documentation and there is confusion regarding preceptorship and mentorship preparation.

Goal	Action	Resources	Success Criteria	Review Date
Raise awareness of the Trust policy and documentation relating to preceptorship	Use the confusion between preceptorship and mentorship to streamline the training of both. Many of the principles of both mentorship and preceptorship are similar and the repetition of 2 separate sessions could be avoided by combining the 2. This	Practice Placement Manager Lecturer Practitioner Clerical support	Combined Practice assessor and preceptorship workshops available for all staff. Live	March 08

	would also allow for the first time, the maintenance of a live preceptorship register alongside the mentorship register, which has to be kept lie for university.		preceptorship register.	

Issue to be addressed

Lack of role clarification for the Lead Preceptor

Goal	**Action**	**Resources**	**Success Criteria**	**Review Date**
Clarify the role of the Lead Preceptor	Contact all previously identified Lead preceptors to assess current preceptorship activity.	Lecturer Practitioner Clerical support	More effective use of the Lead Preceptor and a more coordinated approach to facilitating preceptorship	April 08

Issue to be addressed

Completed preceptorship documents are not being placed on personal files.

Goal	Action	Resources	Success Criteria	Review Date
All completed preceptorship documentation to be placed ion individual personal file for future reference.	All Lead Nurses should audit their own areas bi annually to check staff's compliance with this requirement. Continued annual audit by the Lecturer Practitioner re compliance with this	Lead Nurse Lecturer Practitioner	All completed preceptorship documentation to be placed on the individuals personal file	August 08

Additional Notes

To further facilitate preceptorship implementation the document has been placed at the front of the generic competency document that is completed by all graduates

Appendix 3

Clinical Supervision Update March 2008

Implementation of clinical supervision continues at a steady pace. Policy, guideline for implementation and a list of available supervisors is available on Carenet. Posters re-circulated to wards and departments to raise awareness of clinical supervision.

Graduates are still the main recipients of clinical supervision but recently had their supervision reduced to 2 sessions in a 6-month period compared to the previous monthly sessions for six months. Following review this was changed and the next group of graduates commencing April 2008 will get 6 shortened clinical supervision sessions. This also helps the facilitation of novice supervisors. These novice supervisors are presently working with more experienced supervisors during graduate supervision and will be usually be supervising independent by the end of the sessions.

Each of these supervisors will be concentrating on setting up supervision in their own areas but will be available to supervise in other areas. The 2-day clinical supervisor workshops continue to be held bi annually and evaluations and feedback continues to be positive. The workshops due to their nature can only accommodate a maximum of 12 participants. The next workshop will be held in June. All participants attending the clinical supervisor workshops will be placed on a clinical supervisor register that will be available via the carenet system.

There are plans to get the supervisor course academically accredited, as clinical supervision is now a mandatory component of the revised honours degree pathway.

Critical care continue to have an excellent system of clinical supervision and Orthopaedics and Out Patients are training supervisors to help set up their own systems of supervision.

The main issue around implementing supervision more fully is the staffing levels and the release of staff from clinical areas. However, areas are trying to address this by planning supervision into off duties well in advance.

Appendix 4

The Dudley Group of Hospitals NHS
NHS Trust

ESSENCE OF CARE AND OLDER PEOPLE: END OF YEAR REPORT 2007/2008

Report prepared by Karen Day, Nursing Practice Development Coordinator, March 2008

Background:

The NHS Plan (2000) reinforced the importance of 'getting the basics right' and of improving the patient experience. Essence of care was launched in February 2001 to support the NHS plan and to provide practitioners with a structured approach to sharing and comparing practice.

Within the Trust we have adapted the way in which we implement Essence of Care in order to meet the needs of the service in a proactive approach. In November 2006 we joined together the Champions for Essence of Care and Older People to form a team of 120 multidisciplinary staff across the Trust with a common goal - to improve the patient's experience.

Education:

The ethos of Essence of care is to improve and share good practice, therefore education is essential to this process. Essence of Care and Care of Older People is incorporated into the following ongoing education programmes:

- Band 5/6 Development programme
- Graduate nurse induction programme
- Pre-registration student nurse induction programme
- Graduate nurse induction pragramme
- HLCSW/CSW training programme

To support the Champions within the Trust an ongoing education programme has been developed to reflect the Essence of Care benchmarks and current Department of Health recommendations. Through 2007/2008 the following subjects are being addressed:

- Nutrition and Hydration
- Health Promotion
- Patient Involvement
- Privacy and Dignity
- Pain Management
- Communication

- Continence
- End of Life Care
- Pressure area care

The study days have been supported by our community agencies such as Age Concern, the Pocklington Trust and local social services in order to promote partnership working. Service users have also attended some of the days in order to demonstrate the reality of the patient experience.
Following each of the study days the Champions are set specific objectives to achieve within their own clinical areas. In addition to this a separate programme is available to the Champions to develop their skills around team work, leadership, motivation and change management in order to support them in their role.

Progress within the clinical areas to date:

Nutrition and Hydration:

- May 2007 saw the introduction of Protected Mealtimes (lunchtime) and the Red Tray system to improve patient nutrition. An audit in October 2007 identified:
- 88% of the clinical areas were still effectively implementing the protected mealtime initiative (at lunchtime as directed by Trust policy).
- 82% had implemented the red tray system and the remaining areas had implemented principles of the system to best suit the needs of their patients (e.g. paediatrics).
- 70% of areas checked the amount of food eaten by patients at the end of the meal; this identifies further area for improvement.
- In February 2008 new posters were commissioned and distribute to all clinical areas using protected mealtimes to raise awareness for staff and patients
- An audit of the use of the MUST tool in October 2007 recognized a need to improve this process particularly in the in patient areas. The Trust Nutrition steering group is currently addressing this with the dietetic department.
- A voucher system has been introduced in the x-ray department to provide meals for patients waiting for ambulance transport.
- In November 2007 the Hydration for Health initiative was launched, as supported by the Healthcare Commission, the RCN and the NPSA. A stand was set up in the main hospital entrance to inform both visitors and staff and information given at the Champions study day. As a result of this the clinical areas were encouraged to change water jugs twice daily and to offer cold drinks at regular drinks rounds. In the EAU water jugs have now been purchased for each individual patient where previously only cups were available.

Outpatient areas now offer water for patients whilst waiting for appointments.

- Introduction of ‘milk rounds’ twice daily on B2 to increase calcium intake and promote ‘healthy bones’
- In November 2007 two Health promotion study days were held highlighting the importance of ‘five a day’. Interserve catering management were involved in this day and have incorporated many of the recommendations into the new menus, due for launch March 2008. Including availability of soft fruit options for patients on special diets.

Privacy and Dignity:

- The recent QCR’s have noted some excellent practice in relation to privacy and dignity particularly in the way in which patients are communicated with. There are still some unresolved issues around logistical problems, for example conversations can still sometimes be heard through curtains. However there are not enough side rooms to offer all patients this facility. Interview rooms/relatives rooms are utilized where possible when delivering sensitive news to patients or relatives.
- Patients are offered 2 gowns in the x-ray department to avoid the split showing at the back of the gown. Also larger sized nightwear has been ordered across the Trust to meet the needs of patients requiring these.
- Clips on curtains used and signs to promote privacy and dignity in use across the Trust.
- Use of patient questionnaires/comment cards in B2, A!, A2, OPD, EAU to provide feedback and ongoing evaluation.
- Single sex bays promoted as per Trust policy, principles upheld in critical areas where possible.

Patient Involvement:

- Plans to use patient focus group to feedback on new menus in conjunction with Interserve
- Service user involvement in forthcoming communication study day to gain an understanding into the experience of service users with partial or complete visual impairment.
- Generally the QCR’s noted that patients and relatives were well informed regarding their condition and treatment, in both in patient and out patient areas
- Use of PALS comment cards and inclusion of PALS staff in study days
- Designated room decorated and designed for use by children in the department; stickers for children following x-rays.
- Use of notice boards to provide information for patients and relatives

Health Promotion:

- The Health promotion study days included prevention of secondary heart disease and stroke, smoking cessation and nutrition and hydration
- Champions were asked to develop notice boards within their areas for patients and staff, to include posters and leaflets provided on the day
- Matrons have been asked to provided a dedicated notice board for Champions within each area to improve communication of information

Pressure area care:

- Promotion of the use of the Waterlow score in the assessment process
- Critical care currently reviewing the adapted Waterlow score for use in critical care areas
- Study day in conjunction with tissue viability service to promote correct wound assessment and treatment
- Incident reports used where wounds are grade 2 or above (C6)
- Promotion of use of pressure relieving equipment
- Procedures in place in order to secure pressure reliving mattresses where required
- Mandatory moving and handling continued across the Trust

Audit and Evaluation:

Some individual clinical areas have conducted their own audits against specific Essence of Care benchmarks; A1, OPD and Trauma/Orthopedics have established a group to work jointly in this regard. A2 have developed a working group to improve privacy and dignity through training and education. Each clinical area both in-patient and out patient, is currently evaluated on an annual basis through the Quality of Care review process. The Quality of Care review process was designed to reflect the Essence of Care benchmarks. The QCR's completed to date have identifies many positive improvements to patient car within the Trust.

Communication:

In addition to the Champions study days a quarterly network group is held to share and compare practice. Regular updates are provided for the Trust Inside-out news bulletin.

Regular meetings are held with the regional group for Essence of Care

Achievements:

At the end of each year the Trust has held a Champions conference to celebrate good practice and to share improvements with fellow clinical colleagues. The conference in September 2007 also recognized external achievement as a group of Champions from C3 won first prize in the category for innovation in practice, at the Strategic Health Authorities Older People's Conference.

Their contribution was a project entitles 'Take the Time'. This project has had a positive impact upon the treatment of patients with extra needs relating to communication and disorientation; it has been noted to assist patients in their 'thinking'. It has also been very well received by relatives and carers who are given the opportunity to advise on the best way to care for their loved one.

Breast Screener, Rose Isaacs in radiographer won 'radiographer of the year' for her work in promoting the availability and uptake of the breast screening programme to people with learning difficulties

More recently we have recently placed an entry to the National Health and Social Care awards, within the category of Leadership for Improvement, in order to raise the profile of the Trust and share good practice.

March 2008

Enclosure 5

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Trust Board, Thursday 27 March 2008**

Report of: **Director of Human Resources**

Subject: **HR Report**

1. Summary

This paper provides a summary of key workforce issues and is for information only.

2. Background

Not Applicable

3. Issues for Information

The following policies were approved by the integrated \Governance Committee on 13 March 2008:

- Updated First Aid Policy
- HR Business continuity plan.

4. Recommendation

The Board is requested to note this report.

Name: **Janine Clarke**
Title: **Director of HR**
Date: **14 March 2008.**

Enclosure 6

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board (Public) March 2008**

Report of : **The PALS Manager**

Subject: **PALS Report – March 2008**

Summary
This report provide the Baord with an update of information on PALS services and activities including:

- The number and type of contact of patients accessing PALS with more details at Appendix 1
- PALS awareness week
- Patient Feedback and comment cards
- Staff training
- Volunteers activities

Background

The role of PALS

The PALS service is provides support to patients, carers and relatives when they have concerns or queries about their healthcare.

PALS offers this support in a variety of ways:

- Providing information about the Trust, the NHS or other related organisations such as Social Services, Housing, Voluntary Organisations etc

- Helping to resolve concerns quickly and efficiently and so improve the outcome of care in the process

- Helping the Trust to learn from patients' experiences and so improve services

- Acting as the visible contact point to enable patients and the public to access easily the new system of patient and public involvement enabling the NHS to learn from patients

Issues for consideration

PALS Activity

The number of new patient contacts requiring PALS assistance in January & February 2008 was156, bringing the total since April 2007 to the end of February 2008 to 755.

The types of issue for which patients request PALS support varies considerably. A breakdown of the categories is attached for the year to date but examples include:-

- Patient concerned that the nature of her disability meant the diagnostic test she underwent led to some discomfort.
  Consultant contacted who revised procedures in department and wrote to patient with apology and detail of action taken.

- Patient unhappy with treatment at neighbouring Trust for ongoing issue, would like to know if he can transfer care to Russells Hall.
Checked with Manager that service is available and advised patient how to request for care to move to this Trust.

- Woman concerned that her mother had been waiting for an operation as an in-patient for some days but has been cancelled.
PALS brought to the attention of medical and nursing staff. Operation went ahead next day – issue brought to the attention of Matron who is implementing audit.

- 'War veteran' concerned that staff not aware of the priority given to service personnel and that his procedure may be overly delayed.
PALS checked Department of Health guidance and ensured all staff were aware of patient's status.

- Patient was confused and concerned after appointment in clinic. Feels unsure whether to go ahead with operation.
Appointment arranged for patient to see consultant to clarify for patient.

- Relative concerned that elderly patient could not be given prescription in 'Blister Packs' on discharge as in the community.
Referred to Head Pharmacist who is working on this issue with colleagues from community.

PALS Awareness week

A PALS Awareness week was held first week in February 2008 to inform staff, patients and visitors of what the service can offer. Staff were encouraged to visit the PALS stall in Main Reception to meet the PALS Manager, Karen Moore and PALS Officer, Denise Yates. Volunteers were also hand to meet staff, patients and visitors and explain their role.

Staff also distributed pens and key fobs with the PALS 'Freephone Number' so that patients and visitors are aware how to contact PALS easily.

On Tuesday 5th February staff were joined by representatives from Dudley Voices for Choice, a group of people with learning disabilities, who have been working closely with PALS.

Patient Feedback

The Trust is keen to ensure that it learns from the experiences of patients, and measures their level of satisfaction about our services. The PALS service analyses the comment cards - 'Your Views on Our Service'. The total number of comment cards received year to date (Jan & Feb 2008) were 75. In this period, a total of 44 patients (64%) rated Trust services as 'Good' or 'Very Good'. The number of patients rating the services as 'Poor' or 'Very Poor' were 21 (28%) which is a marked improvement on the previous figures (shown below the ratings for Apr 07 – Dec 07)

We continue to encourage staff to suggest patients use the Comment Cards to give positive feedback, as well as negative, and this is beginning to be reflected in the Comment Cards received this year. However, many patients who verbally tell us of their good experience say they prefer to send a 'Thank You Card' directly to staff, so it is important to remember that patients choose different ways of complimenting staff that we cannot always record.

Most Recent Comment Cards – Jan & Feb 2008

Service Rating	Number	%
Very Good	34	45.3%
Good	14	18.7%
Average	2	2.7%
Poor	4	5.3%
Very Poor	14	18.7%
Missing Value	7	9.3%
Total	***75***	***100.0%***

Comment Cards Apr – Dec 2007

Service Rating	Number	%
Very Good	136	33.6%
Good	38	9.4%
Average	19	4.7%
Poor	36	8.9%
Very Poor	136	33.6%
Missing Value	40	9.9%
Total	***405***	***100.0%***

Staff Training

PALS Awareness Training for staff is offered through the Trust's in-house training programme, with numerous other training and information sessions for specific staff groups.

PALS also takes part in the regular Induction Days for all new staff, not only ensuring staff are aware of how PALS can help patients, so that they refer people to the service, but also to encourage staff to deal with issues themselves

The training involves using anonymised case studies, relating situations from the patient's point of view to enable staff to think how they themselves may have been able to deal with concerns and when they would need to refer on to PALS.

Hospital Volunteer Service

The Volunteer Co-ordinator is part of the PALS team. The service is very successful in recruiting people from the local community who are willing to offer their time and expertise to support the Trust, patients and visitors. The base figure of approximately 330 volunteers remains but this includes a constant rolling recruitment to replace volunteers that move on (often to paid employment or higher education).

Volunteers have expanded their 'Way-Finding Service' to not only cover the Main Reception but also the Main Corridor, which is the point most people feel they may be 'lost'. This is now a very popular service.

Volunteers also be support the new Cancer Information Service which is being run in partnership with Dudley Cancer Support, located in the Pod near C4.

Some of the tasks volunteers undertake include:

Wayfinding	Activity group helpers	X Ray Department
Clinic hosts	Reception volunteers	Advice/support groups
Ward volunteers	Dudley Hospital Radio	Chaplaincy
Administration	Art Projects	Corbett League of Friends
Emergency Department	Patient visitors	Complementary therapies
Audits/surveys	Meal/refreshment helpers	Fundraising

The Trust Board is asked to receive the report and note the activities

- **The number and type of contact of patients accessing PALS with more details at Appendix 1**
- **PALS awareness week**
- **Patient Feedback and comment cards**
- **Staff training**
- **Volunteers activities**

The Dudley Group of Hospitals NHS Trust

New PALS Issues Jan & Feb 2008

Issue	Number	%
Negative		
Personal Privacy	1	0.6%
Privacy & Dignity	1	0.6%
Staff Attitude/Behaviour		
Medical Staff	4	2.6%
Nursing Staff	1	0.6%
Poor Communication	4	2.6%
Staff/general	1	0.6%
Improving Access & Waiting		
Access to Services		
Bed availability	1	0.6%
Call handling issues	2	1.3%
Cancellation of Operation	3	1.9%
Appointments		
Administration	1	0.6%
Cancellation of appointment	8	5.1%
Waiting		
Waiting as Inpatient - Op/Test	2	1.3%
Waiting for results	2	1.3%
Waiting for tests	1	0.6%
Waiting op/procdure(not in-pt)	8	5.1%
Waiting Time for Appointment	2	1.3%
More Information, More Choice		
Choose & Book	13	8.3%
Patient Choice Query	2	1.3%
Communication	2	1.3%
Consent to Treatment	1	0.6%
Safe, High Quality,Co-ord care		
Clinical Risk	2	1.3%
Unsafe discharge	1	0.6%
Patient's Property & Expenses		
Lost or damaged property	1	0.6%
Quality of medical care		
Admin issues affecting care	2	1.3%
Confidence in health prof	2	1.3%
Diagnosis	3	1.9%
Medical care	16	10.3%
Medical Records not avail	1	0.6%

Nursing care	7	4.5%
Organisation of care	1	0.6%
Staffing Levels	4	2.6%
Transfer/discharge arrangement	2	1.3%
Neutral		
Advice required	12	7.7%
Information Required	41	26.3%
Positive		
Nursing Care	1	0.6%
Total	***156***	***100.0%***

The Dudley Group of Hospitals NHS Trust

Comments Received Jan & Feb 2008

Issue	Number	%
Negative		
Staff Attitude/Behaviour		
Nursing Staff	1	1.0%
Staff/general	1	1.0%
Total for Staff Attitude/Behaviour	***2***	***2.1%***
Hotel services/environment		
Facilities eg seating etc	1	1.0%
Ward Food	1	1.0%
TV/Telephones	1	1.0%
Total for Hotel services/environment	***3***	***3.1%***
Improving Access & Waiting		
Delay in Treatment	1	1.0%
Mobility/Wheelchair Issues	1	1.0%
Total for Access to Services	***2***	***2.1%***
Appointments		
Cancellation of appointment	3	3.1%
Total for Appointments	***3***	***3.1%***
Parking	**10**	**10.3%**
Patient Transport (Non-emerg)	**1**	**1.0%**
Waiting		
Waiting as Inpatient for Dr	2	2.1%
Waiting for porter	1	1.0%
Waiting Time in Clinic	11	11.3%
Total for Waiting	***14***	***14.4%***
Way-finding/Signage	**1**	**1.0%**
More Information, More Choice		
Choose & Book	3	3.1%

Communication	4	4.1%
Information for patients	1	1.0%
Missing records	2	2.1%
Total for More Information, More Choice	***10***	***10.3%***
Safe, High Quality,Co-ord care		
Personal hygiene/care	1	1.0%
Quality of medical care		
Medical care	1	1.0%
Medical Records not available affecting care	2	2.1%
Nursing care	1	1.0%
Staffing Levels	1	1.0%
Total for Quality of medical care	***5***	***5.2%***
Total for Safe, High Quality,Co-ord care	***6***	***6.2%***
Total for Negative	***52***	***53.6%***
Neutral		
Suggestion	1	1.0%
Total for Neutral	***1***	***1.0%***
Positive		
Building Closer Relationships		
Medical Staff	5	5.2%
Nursing Staff	5	5.2%
Staff/general	9	9.3%
Total for Staff	***19***	***19.6%***
Total for Building Closer Relationships	***19***	***19.6%***
Hotel Services/environment		
Cleanliness/Hygiene	1	1.0%
Food	2	2.1%
Total for Hotel Services/environment	***3***	***3.1%***
Improving Access & Waiting		
Access to Services	2	2.1%
Total for Improving Access &	***2***	***2.1%***

Waiting		
Safe,High Quality,Co-ord care		
Quality of Medical Care		
General care	4	4.1%
Medical Care	11	11.3%
Nursing Care	5	5.2%
Total for Safe,High Quality,Co-ord care	***20***	***20.6%***
Total for Positive	***44***	***45.4%***
Total	***97***	***100.0%***

The Dudley Group of Hospitals NHS
NHS Trust

Public Trust Board Agenda
Thursday 29th May 2008
11.00am
Clinical Education Centre

	Item		Lead By
1. 2. 3.	**Chairman's welcome and note of apologies** **Declarations of Interest** **Announcements**		A Edwards
4.	**Minutes of previous meetings** • Thursday 24th April, 2008, Board Meeting	**Enclosure 1**	A Edwards
5.	**Action Sheet – Progress Report by Exception**	**Enclosure 2**	A Edwards
6.	**Other Matters Arising**		A Edwards
7.	**Chief Executive's Report**	**Enclosure 3**	P Farenden
8. 8.1	**Strategic Issues** **Foundation Trust Update** • Update on Monitor Assessment Process • Update on Governor Training/Sandwell PCT	 **Verbal Report** **Verbal Report**	 P Assinder P Assinder
9.	**Operational Performance** • Corporate Performance Report Period to 30th April 2008	**Verbal Report**	P Assinder
10.	**Board Development** • Update on Board Development Matters	**Verbal Report**	A Edwards
11.	**Reports for Approval** • Patient and Public Involvement Annual Report • Complaints Annual Report • HCC Review of Maternity Service Response and Action Plan • Patient Survey	 **Enclosure 4** **Enclosure 5** **Enclosure 6** **Enclosure 7**	 A Close A Close A Close P Brennan
12.	**Information Items to be noted** • Healthcare Commission Declaration	 **Enclosure 8**	 A Close
13.	**Any Other Business** • Limited to urgent business notified to the Chair/Corporate Secretary in advance of the meeting		 A Edwards
14.	**Date of Next Trust Board Meeting** • 26th June, 2008, at 11.00am in the Clinical Education Centre		
15.	**Meeting Closes**		

The Dudley Group of Hospitals NHS
NHS Trust

Minutes of the Trust Board meeting held at 11.00 a.m. on Thursday, 24th April, 2008, in the Clinical Education Centre

Present:

Alfred Edwards, Chairman
David Badger, Non Executive Director
Paul Brennan, Operations Director
Kathryn Williets, Non Executive Director
David Wilton, Associate Non Executive Director
Janine Clarke, Director of Human Resources
Ann Becke, Non Executive Director
Jonathan Fellows, Associate Non Executive Director
Paul Assinder, Director of Finance and Information

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Customer Relations and Communications
Amanda Pritchard, Communications Manager
Derek Eaves, Clinical Governance Co-ordinator

08/41 Chairman's Welcome and Note of Apologies

Apologies were received from Paul Harrison, Paul Farenden and Ann Close.

08/42 Declarations of Interest

There were no Declarations of Interest.

08/43 Announcements

There were no announcements.

08/44 Minutes of the Previous Meeting – 27th March, 2008 – Trust Board Meeting

The minutes of the 27th March Trust Board meeting, given as Enclosure 1, were approved as a correct record and signed by the Chairman.

08/45 Action Sheet – 27th March, 2008 – Progress Report by Exception

The Board reviewed the Action Sheet, given as Enclosure 2, as follows:

08/45.1 ALE Working Group Feedback to Audit Committee

Paul Assinder, Director of Finance and Information, confirmed that the ALE Working Group had updated the Audit Committee at its meeting 15th April, 2008, on the actions required to achieve ratings of 4. It was noted that the Trust had been invited by Price Waterhouse to submit 3 national 'noticeable practice' examples which it was hoped would result in being awarded a rating of 4 in some aspects of the 2007-8 ALE.

08/45.2 Operational Performance – Delayed Discharges

Paul Brennan, Operations Director reported that there had been very little development. It was discussed that the PCT could be used as a lever, due to financial implications, to place pressure on Dudley MBC to respond. The Operations Director was not hopeful of a positive response.

The Board noted that the end of year target was to have all patients discharged within 48 hours of when the decision to discharge is made.

It was also discussed that as a consequence of becoming an FT possibilities around discharge may become available that are not presently possible.

Kathryn Williets, Non Executive Director asked what penalties were in place for delayed discharges and the Board noted that these were c£100 per delayed day, but that there was set discharge criteria and the charge only comes into place after 28 days.

Mr Assinder, Finance Director, advised that there were no net benefits to the Trust financially in imposing fines since the PCT had covered costs through excess bed day payments and 'recovered fines' would have to be reimbursed to the relevant PCTs.

The Operations Director noted that the Non Executives Directors would be happy to be involved in the debate with the PCT and MBC.

The Board also agreed to pursue other means of debate through the Health and Wellbeing Partnership and Health Select Committee. The Chairman agreed to make contact with these organizations to get the issues raised on their agenda. The Operations Director will contact clinicians with a view to them presenting at these meetings on the consequence of delayed discharges.

Chairman to contact Health Select Committee and Health and Well Being Partnership to raise delayed discharges as an agenda item.
Operations Director to arrange for clinicians to present at meetings

08/45.3 Operational Performance – Draft Annual Agenda

It was noted that the Chairman, Chief Executive and Director of Finance and Information had met to produce the initial draft Annual Agenda, which was tabled at the meeting.

The Chairman briefed the Board on the contents of the new agenda and it was noted that more than 50% of Board meeting time should cover Quality, Marketing and Financial Strategy items. The Key Performance Indicators would be provided with traffic lights and commentary as necessary and should focus on forecasting and future trends. The meeting should last no more than 2 hours and where possible reports formatted in the agreed style and made available in a timely manner.

A main task would be to get the volume of material out of the agenda. Modified policies could now go to the Finance and Performance or Integrated Governance Committees. The Board would only receive new policies for approval and some statutory items.

It was noted that there was a need for space on the agenda to cover issues such as Enterprise, Workforce and HR and it was agreed to reinstate 'Directorate Reports' although these would not be monthly, but as and when required.

David Badger, Non Executive Director asked that the agenda be forward planning showing agenda items by month for the coming 12 months, and asked that previous agendas from the last year be examined to pick up missing items. The Chairman confirmed that this was the plan.

It was also noted that the Chairman would continue to pursue external input into Board meetings as he felt this was essential for Board development, and David Wilton, Associate Non Executive Director agreed that linkage with other Committees both internal and external was essential.

It was agreed that the Board need to hold a session for developing KPIs and confirming strategy. An away day should be arranged before the Monitor Board to Board meeting and Board members should attend the session with ideas ready for debate, and if available circulate to other Board members in advance of the meeting.

The Chairman to meet with the Director of Finance and Information to produce annual agenda with allocated monthly items.

Board Workshop on Strategy/Annual Agenda/KPIs to be arranged before Board to Board with Monitor.
Chairman and Director of Finance and Information to meet to produce agenda.

08/45.4 NHS Inpatient Survey

Reported on private agenda at Item 22, Enclosure 9.

08/45.5 Presentation on Corporate Manslaughter

An electronic copy of the presentation on Corporate Manslaughter had been received from Ian Mayers of Mills & Reeve & Co and circulated to Board members.

08/45.6 Action Item 07/55.3 Disaster Recovery Plan

The Board noted that the 2007/08 Plan had been completed and reported to an earlier meeting. The Trust is currently being consulted on the 2008/09 Plan.

08/46 Matters Arising

None to report.

08/47 Chief Executive's Report

The Chief Executive was not present at the meeting.

The Director of Finance & Information asked that the progress on the car parking scheme be duly noted by the Board. The Operations Director reported that planning consent had been received for a new 700 space car park. The car park would take 1 year to deliver and the Trust would lose 300 car parking spaces in this period, although the Board noted that permission had been given for 500 interim spaces, therefore an additional 200 car parking spaces would become available while the new car parking was under construction. Visitor car parking would be maintained and briefings would be undertaken with staff. The Operations Director and Head of Customer Relations and Communications to produce briefing.

08/48 Strategic Issues

08/48.1 Foundation Trust Update

The Director of Finance and Information asked the Board to note the following:

- The Monitor Assessment phase is currently in process. A teleconference had been undertaken with Ernst and Young and the Due Diligence exercise will commence in mid May. The Due Diligence report will be available for mid June.

- The most recent Shadow Council of Governors meeting was held on Wednesday, 23rd April, 2008. Areas to note include the move from 8 working groups previously suggested to 2 core working groups:

  - Membership
  - Patient Access/Information

  These two groups could be split into further working groups on a limited basis if issues so demanded. The Governors will be contacted to confirm the remit and operating principles of the new groups.

  The Board also noted that there had been discussion with Governors about linkage to the Board and it had been agreed to split the Governors into groups of 3 and offer these groups linkages with Executive and Non Executive Directors. David Badger expressed that parameters would need to set around the expectations on these linkages.

  The Director of Finance and Information also informed the Board that one of the key role of Governors is to advise on strategic developments and the first stage of this process is to present them with elements of the IBP which would feed into the development of the Annual Plan. The Director of Finance and Information to discuss presenting to the Governors with the Chief Executive.

The Board asked if Monitor would wish to attend a future Board meeting and it was noted that they had expressed an interest in attending the meeting of the May Board. It was noted that the Board Memorandum would also be discussed at the meeting in May.

The Director of Finance and Information to write to Governors regarding the arrangements for the Working Groups/Mentoring
Director of Finance and Information to discuss presentation of the IBP to Governors with the Chief Executive

08/49 Operational Performance

Report to the Finance and Performance Committee on 24th April, 2008

The Director of Finance and Information briefed the Board on his report to the Finance and Performance Committee. The Board discussed and noted the following position up to the end of March (year end):

- At the end of March the total retained surplus was £10.5 million.
- Clinical income increased by 3.5% in full year to £198 million.
- 12.3% EBITDA
- The Trust maintained a strong balance sheet and the year end Cash Balance was £10.4 million

Performance against Targets:

- All core targets achieved in year except for MRSA where the Trust reported 20 cases against a target of 12, but it was noted that the Trust had been on trajectory since October (and since May for pre 48 hour bacteraemias).
- 18 Week Waits. Performance reported at just over 86% for the year against the 85% target for unadmitted care and 93% against the 90% target for admitted care.
- 4 Hour ED Waits. 98.32% against the target of 98%.

The Board noted the excellent performance for the year.

08/50 Reports for Approval

No reports for approval.

08/51 Information Items to be Noted

No information items to note.

08/52 Any Other Business

There being no other business, the Chairman closed the meeting.

08/53 Date of Next Meeting

The next Board meeting will be held at 11.00am on Thursday, 29th May, 2008 in the Clinical Education Centre.

Signed as a correct record: …… Chairman

Date: ……

The Dudley Group of Hospitals NHS
NHS Trust

Action Sheet
Minutes of the Trust Board meeting held at 11.00am on Thursday, 24th April, 2008, in the Clinical Education Centre

Item No.	*Subject:*	*Action:*	*Responsible*	*Due Date*	*Actioned*
08/10.5	Healthcare Commission Maternity Survey	Progress Report to be submitted to Board in May	ND	29/5/08	
08/45.2	Operational Performance – Delayed Discharges	Contact Health Select Committee and Health and Well Being Partnership to raise delayed discharges as an agenda item. Arrange for Clinicians to present.	C OD	29/5/08	
08/45.3	Operational Performance – Annual Agenda	Board Workshop on Strategy/Annual Agenda/KPIs to be arranged before Board to Board with Monitor. Meeting to produce agenda	C C/DFI	29/5/08	
08/48.1	Foundation Trust Update	Write to Governors regarding the arrangements for the Working Groups/Mentoring. Discuss presentation of the IBP to Governors with the Chief Executive.	DFI DFI	29/5/08	
08/38.1	Quality of Care	Further Quality of Care Report to be provided to the Board in June	ND	26/6/08	
07/55.3	Draft IT Disaster Recovery Plan	Feedback to the Board on the results of the desk top simulation exercises which will be run by Siemens in the next financial year	DFI	When available from Siemens (08/09 financial year)	
08/37.1	Research and Development	Prof. George Kitas to be invited to September Board meeting to report on clinical trials	PH	25/9/08	

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Trust Board, Thursday, 29th May, 2008**

Report of: **Chief Executive**

Subject: **Chief Executives Report**

- The Strategic Health Authority's response to Darzi will be published on the 3rd June, 2008. Conversations with senior executives within the SHA indicate no major plans for service reconfiguration or amalgamation and more of a continuation of the themes shared in their existing strategy document 'Investing for Health'.

- A statement predicting the next set of HCC ratings has been issued to each Trust with Dudley predicted as maintaining its good/good rating achieved last year. Clearly, these predictions are subject to confirmation by the HCC.

- Consultation on our Foundation Trust Application has been undertaken with Dudley, Sandwell and Worcester PCTs and the SHA since the last Trust Board meeting, with no major issues raised and much support for the success of our application, particularly from the SHA.

- The Trust has now received the formal report on our compliance with 3 components of the Hygiene Code and full compliance was confirmed.

- Data received by the SHA from MORI relating to a series of patient experiences across health organisations from a pan SHA plus area have shown Dudley Group in a very positive light, particularly in comparison with near neighbours/competitors.

Name: **Paul Farenden**
Title: **Chief Executive**
Date: **28 May 2008**

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: The Trust Board

Report of: The Nursing Director

Subject: Annual report for Patient and Public Engagement

Attached is the report on Patient and public engagement for 2007-08. This is divided into 2 sections

- **PPI activities**
- **PALS and volunteers report**

The Committee is asked to receive the report

Nursing director
May 2008

The Dudley Group of Hospitals NHS Trust

PALS The Patient Advice and Liaison Service

Annual Report April 2007 to March 2008

The role of PALS

PALS provides support to patients, carers and relatives when they have concerns or queries about their healthcare at Dudley Group of Hospitals.

PALS offers this support in a variety of ways:

- Providing information about the Trust, the NHS or other related organisations such as Social Services, Housing, Voluntary Organisations etc
- Helping to resolve concerns quickly and efficiently and so improve the outcome of care in the process
- Helping the Trust to learn from patients' experiences and so improve services
- Acting as the visible contact point to enable patients and the public to access easily the new system of patient and public involvement enabling the NHS to learn from patients

PALS staff team consists of Karen Moore, PALS Manager, and Denise Yates, PALS Officer. The Volunteer Co-ordinator, Jane Pilsbury is also part of the PALS team.

2007/08 Activity

The number of patients contacting PALS for support and advice in 2007/08 has increased slightly on the previous year to a total of 835. This represents a rise of 8% on the 2006-2007 figure which was 775.

The reasons for which patients request PALS support vary considerably and a full breakdown of the categories of issues is attached. Some examples of the type of issues PALS have supported include:-

- Son concerned that his elderly father had been seen by a 'nurse' and not doctor when he attended clinic. Feels he should have been seen by a doctor. *PALS investigated and patient had actually been seen by Clinical Nurse Specialist but when staff aware that patient was not fully confident in care, arranged soon appointment to be reviewed by a doctor.*

- Patient concerned that the nature of her disability meant the diagnostic test she underwent led to some discomfort.
Consultant contacted who revised procedures in department and wrote to patient with apology and detail of action taken.

- Patient unhappy with treatment at neighbouring Trust for ongoing health condition, would like to know if he can transfer care to Russells Hall.

Checked with Manager that service is available and advised patient how to request for care to move to this Trust.

- 'War veteran' concerned that staff not aware of the priority given to service personnel and that his procedure may be overly delayed.
PALS checked Department of Health guidance and ensured all staff were aware of patient's status.

- Patient was confused and concerned after appointment in clinic. Feels unsure whether to go ahead with operation.
Appointment arranged for patient to see consultant to clarify treatment plan and discuss options.

- Relative concerned that elderly patient could not be given prescription in 'Blister Packs' on discharge as in the community.
Referred to Head Pharmacist who is working on this issue with colleagues from community.

- Patient's family anxious about his condition and wanting more information about the specialist unit to which he will be transferred.
PALS supplied family with information and contacts from local Voluntary Group that supports patients with this condition. Liaised with PALS in other Trusts and obtained information about specialist units, including an open invitation to tour the unit for the family to assess facilities for patient.

- Concerned that daughter who has a learning disability will find her Day Case Procedure distressing and confusing.
Liaised with Matron for Day Case who informed anaesthetist of situation. Patient was then put first on the list to limit waiting and all staff informed. Father subsequently rang and thanked for 'First Class' treatment by staff PALS working with IT Department to record information regarding patients' disability/special needs.

As well as attempting to resolve concerns for individual patients, PALS feeds back to appropriate managers those matters that require more investigation, or have raised wider issues that merit a review of practice or policies.

If the concern cannot be resolved to the patient's satisfaction and they wish to take the matter further, PALS is happy to give advice on making a formal complaint and how to obtain independent support from ICAS (Independent Complaints Advocacy Service).

Patient Feedback

The Trust is keen to ensure that it learns from the experiences of patients, and measures their level of satisfaction about our services. The PALS service analyses the comment cards - 'Your Views on Our Service'. The total number of comment cards received during 2007/08 was 523, with 46% patients rating Trust services as 'Good' or 'Very Good'.

A total of 85% of the positive comments related to general good quality of care or nursing and medical staff. The remainder complimented the Trust on the facilities, cleanliness and food.

The largest categories causing concern related to parking issues and waiting times in out-patient clinics. It is hoped that the parking will improve when the recently approved new tiered parking is completed. The waiting times issue is part of a wider project being undertaken by Project Enterprise. The Project is looking at redesigning Out-Patient Services so that facilities are used effectively, creating capacity and running scheduled clinics.

Service Rating	**Number**	**%**
Very Good	186	35.6%
Good	53	10.1%
Average	22	4.2%
Poor	47	9.0%
Very Poor	166	31.7%
Missing Value	49	9.4%
Total	***523***	***100.0%***

A full breakdown of the categories of comments received is attached.

Although PALS encourage the use of Comment Cards to give positive feedback as well as relating concerns, many patients still prefer to send a 'Thank You Card' directly to staff who cared for them. It is important to remember that patients choose different ways of complimenting staff that are not always recorded formally.

Staff Training

PALS Awareness Training for staff is offered through the Trust's in-house training programme, with numerous other training and information sessions for specific staff groups.

Whilst the training is about ensuring staff are aware of how PALS can help patients, so that they refer people to the service, it is about much more than that. This Trust has always felt it important that PALS is not viewed as a service in isolation to help patients and carers, but rather as a 'way of working'. All staff are expected to see it as part of their role to put patients at the centre of what they do and when possible help resolve issues patients may raise with them when they are able. To support this philosophy, PALS Training uses anonymised case studies, relating situations from the patient's point of view to enable staff to think how they themselves may have been able to deal with concerns and when they would need to refer on to PALS.

During 2007-2008 a total of 515 staff received basic awareness training on PALS through 18 different sessions. A total of 36 staff also attended PALS Half-Day Workshops as part of the In-House Training Programme.

Publicity and Awareness Raising

PALS continues to raise the profile of the service with patients and the public in a number of ways: -

- Distributing leaflets describing the service to every ward and department within the Trust as well as community venues such as libraries etc. Volunteers have been recruited to support this aspect of the work.

- Leaflets are available in 6 languages other than English, as well as a large print version for the visually impaired

- Following work with Dudley Voices for Choice (user group for adults with a Learning Disability) a more concise pictorial version of the PALS leaflet is available

- PALS posters are displayed throughout all hospital sites

- A 'Freephone' telephone number and 'Freepost' address are available for patients

- A specific PALS email address is available and a 'PALS page' is available on the Dudley Health Economy website. (http://www.dudley.nhs.uk/pals/). The National PALS Development Group also supports a website with contact details of all PALS (http://www.pals.nhs.uk/)

PALS Awareness week

A PALS Awareness week was held first week in February 2008 to inform staff, patients and visitors of what PALS can offer. Staff were encouraged to visit the PALS stall in Main Reception to meet the PALS Manager, Karen Moore and PALS Officer, Denise Yates. Volunteers were also hand to meet staff, patients and visitors and explain their role.

Staff also distributed pens and key fobs with the PALS 'Freephone Number' so that patients and visitors are aware how to contact PALS easily and without cost.

On Tuesday 5th February staff were joined by representatives from Dudley Voices for Choice (DVC), a group of people with learning disabilities, who have been working closely with PALS on raising awareness of their particular needs.

DVC helped launch a Hospital Communication Booklet as part of PALS Awareness Week. The Booklet supports communication with people who are having difficulties and has been introduced Trustwide.

Learning Disability Liaison Group

PALS continues to facilitate a Learning Disability Liaison Group which aims to improve health services for people who have a learning disability. The Group is chaired by the PALS Manager and includes professionals from Dudley Group of Hospitals, Dudley South PCT, Provider Organisations and Voluntary Organisations and crucially a representative of Dudley Voices for Choice (for adults who have a learning disability).

The PALS Manager is part of the Learning Disability Partnership Board which helps the Trust develop more opportunities of joint working to improve services for people who have a learning disability.

This year the Group recommended the use of a Hospital Communication Booklet. The Booklet can aid communication with patients who are having difficulties through the use of pictures and recognised sign language. The Group was pleased that the Trust purchased over 30 of these Booklets which are now available for use in all areas of the hospital. Early anecdotal evidence suggests they have been well received by staff and patients alike.

The Group also supported training sessions on Learning Disability Awareness which were organised in conjunction with a Consultant from the Emergency Department. Members were pleased with the numbers of staff from the Department that were keen to learn how they can better support people who have a learning disability.

Comments from Patients about PALS

The PALS team work hard, along with a great deal of help and support from many other staff in the hospital to resolve concerns for patients, so are pleased when their efforts are effective. The following comments are from some patients supported in 2007/2008.

'Thank you for your hard work to help and support us through our difficulties'

'Thank you for all your help with Dad, we really, really appreciate it!'

'Thank you for all the time you spent on my behalf when I needed you most'

Hospital Volunteer Service

The Hospital Volunteer Service is part of PALS service and is managed by the Volunteer Co-ordinator, Jane Pilsbury. The service is very successful in recruiting people from the local community who are willing to offer their time and expertise to support the patients, visitors and staff at the Trust. The base figure of approximately 330 volunteers remains but this includes a constant rolling

recruitment to replace volunteers that move on (often to paid employment or higher education).

Volunteers have expanded their 'Way-Finding Service' to not only cover the Main Reception but also the Main Corridor, which is the point most people feel they may be 'lost'. This is now a very popular service.

Volunteers also support the new Cancer Information Service which is being run in partnership with Dudley Cancer Support, located in the Pod near C4.

Volunteers were also trained to assist patients at mealtimes and there are plans to expand this much needed service in the year ahead.

Some of the tasks volunteers have undertaken include:

Wayfinding	Activity group helpers	X Ray Department
Clinic hosts	Reception volunteers	Advice/support groups
Ward volunteers	Dudley Hospital Radio	Chaplaincy
Administration	Art Projects	Corbett League of Friends
Emergency Department	Patient visitors	Complementary therapies
Audits/surveys	Meal/refreshment helpers	Fundraising

Comments from Volunteers

The dedicated work of all our volunteers is highly valued by the Trust, but it also pleasing to realise that volunteers also get satisfaction from their role. The following comments were received from volunteers:

'Thank you for sorting out my voluntary work so efficiently as I know it has helped 100% with my job search!'

'Thank you for the help throughout my volunteering, I am grateful for the experience.'

'I really enjoyed my time here…and it is going to help me when I go to university.'

Contact Details

Anyone who has concerns or queries about their healthcare at Dudley Group of Hospitals can contact PALS for help and advice. Call on Freephone 0800 073 0510 or email pals@dgoh.nhs.uk

Anyone interested finding out about volunteering at the Trust can contact the Volunteer Co-ordinator on 01384 456111 ext 1887 or email volunteering@dgoh.nhs.uk

Karen Moore
PALS Manager

The Dudley Group of Hospitals NHS Trust			
New PALS Issues –Apr 07 – Mar 08			
Issue		**Number**	**%**
Negative			
Building Closer Relationships			
Confidentiality		3	0.4%
Dignity, Privacy & Respect			
Personal Privacy		1	0.1%
Privacy & Dignity		1	0.1%
Total for Dignity, Privacy & Respect		***2***	***0.2%***
Diversity Issues			
Interpreting Services		1	0.1%
Learning Disability		1	0.1%
Total for Diversity Issues		***2***	***0.2%***
Staff Attitude/Behaviour			
AHP Staff		2	0.2%
Medical Staff		25	3.0%
Nursing Staff		10	1.2%
PFI Contracted staff		2	0.2%
Poor Communication		21	2.5%
Staff/general		2	0.2%
Total for Staff Attitude/Behaviour		***62***	***7.4%***
Total for Building Closer Relationships		***69***	***8.3%***
Clean, Comfortable, Friendly			
Hotel services/environment			
Cleanliness/Hygiene		1	0.1%
Facilities eg seating etc		1	0.1%
Food			
Ward Food		1	0.1%
Total for Food		***1***	***0.1%***
Maintenance		1	0.1%
Total for Hotel services/environment		***4***	***0.5%***

Total for Clean, Comfortable, Friendly	***4***	***0.5%***
Issue	**Number**	**%**
Improving Access & Waiting		
Access to premises/building		
Ward Visiting	1	0.1%
Total for Access to premises/building	***1***	***0.1%***
Access to Services		
Bed availability	2	0.2%
Call handling issues	6	0.7%
Cancellation of Operation	11	1.3%
Delay in Treatment	4	0.5%
Diversity Issues		
Mobility/Wheelchair Issues	2	0.2%
Total for Diversity Issues	***2***	***0.2%***
Total for Access to Services	***25***	***3.0%***
Appointments		
Administration	30	3.6%
Cancellation of appointment	27	3.2%
Choice of convenient time/day	2	0.2%
Total for Appointments	***59***	***7.1%***
Parking	2	0.2%
PatientTransport		
Patient Transport (Non-emerg)	1	0.1%
Total for PatientTransport	***1***	***0.1%***
Referrals		
Delay/prob referral process	5	0.6%
Total for Referrals	***5***	***0.6%***

Issue	Number	%
Waiting		
Waiting as Inpatient - Op/Test	6	0.7%
Waiting as Inpatient for Dr	2	0.2%
Waiting for results	18	2.2%
Waiting for tests	7	0.8%
Waiting op/procdure(not in-pt)	22	2.6%
Waiting Time for Appointment	18	2.2%
Waiting Time in Clinic	9	1.1%
Total for Waiting	***82***	***9.8%***
Way-finding/Signage	1	0.1%
Total for Improving Access & Waiting	***176***	***21.1%***
More Information, More Choice		
Choice		
Choose & Book	57	6.8%
Patient Choice Query	2	0.2%
Total for Choice	***59***	***7.1%***
Communication	13	1.6%
Consent to Treatment	1	0.1%
Information for patients	6	0.7%
Personal Records/Patient Info		
Access to/copy of records req	1	0.1%
Total for Personal Records/Patient Info	***1***	***0.1%***
Total for More Information, More Choice	***80***	***9.6%***
Safe, High Quality,Co-ord care		
Aids, Appliances & Equipment		
Delay in obtaining	1	0.1%
Faulty	1	0.1%

	Total for Aids, Appliances & Equipment	***2***	***0.2%***
	Infection Control		
	Standards of Infection Control	1	0.1%
	Total for Infection Control	***1***	***0.1%***
	Patient Safety		
	Clinical Risk	3	0.4%
	Escorts for pateints	1	0.1%
	Unsafe discharge	3	0.4%
	Total for Patient Safety	***7***	***0.8%***
	Patient's Property & Expenses		
	Lost or damaged property	4	0.5%
	Total for Patient's Property & Expenses	***4***	***0.5%***
	Personal hygiene/care	2	0.2%
	Quality of medical care		
	Admin issues affecting care	10	1.2%
	Confidence in health prof	15	1.8%
	Diagnosis	13	1.6%
	Medical care	94	11.3%
	Medical Records not available	7	0.8%
	Nursing care	33	4.0%
	Organisation of care	15	1.8%
	Staffing Levels	6	0.7%
	Transfer/discharge arrangement	9	1.1%
	Waiting for Medication	1	0.1%
	Waiting for Results	2	0.2%
	Total for Quality of medical care	***205***	***24.6%***
	Total for Safe, High Quality,Co-ord care	***221***	***26.5%***
	XTERNAL to DGH Trust		
	Non-NHS	1	0.1%

Other PCT Trust	3	0.4%
Total for XTERNAL to DGH Trust	***4***	***0.5%***
Total for Negative	***554***	***66.3%***
Neutral		
Advice required	64	7.7%
Information Required	211	25.3%
Not Stated	1	0.1%
Suggestion	2	0.2%
Total for Neutral	***278***	***33.3%***
Positive		
Building Closer Relationships		
Staff		
Staff/general	1	0.1%
Total for Staff	***1***	***0.1%***
Total for Building Closer Relationships	***1***	***0.1%***
Safe,High Quality,Co-ord care		
Quality of Medical Care		
Nursing Care	2	0.2%
Total for Quality of Medical Care	***2***	***0.2%***
Total for Safe,High Quality,Co-ord care	***2***	***0.2%***
Total for Positive	***3***	***0.4%***
Total	***835***	***100.0%***

The Dudley Group of Hospitals NHS Trust

Comments Received Apr 07 - Mar 08

Issue	Number	%
Negative		
Building Closer Relationships		
Confidentiality	1	0.2%
Staff Attitude/Behaviour		
Medical Staff	5	0.9%
Nursing Staff	10	1.8%
Poor Communication	6	1.1%
Staff/general	3	0.5%
Total for Staff Attitude/Behaviour	***24***	***4.3%***
Total for Building Closer Relationships	***25***	***4.4%***
Clean, Comfortable, Friendly		
Hotel services/environment		
Cleanliness/Hygiene	2	0.4%
Facilities eg seating etc	9	1.6%
Food		
Lack of refreshments	1	0.2%
Restaurant	1	0.2%
Ward Food	19	3.4%
Total for Food	***21***	***3.7%***
Maintenance	1	0.2%
Temperature, Noise, etc.	2	0.4%
TV/Telephones	2	0.4%
Total for Hotel services/environment	***37***	***6.6%***
Smoking Facilities	2	0.4%
Total for Clean, Comfortable, Friendly	***39***	***6.9%***

	Improving Access & Waiting		
	Access to Services		
	Delay in Treatment	4	0.7%
	Diversity Issues		
	Mobility/Wheelchair Issues	3	0.5%
	Weekend/Evening Services	2	0.4%
	Total for Diversity Issues	***5***	***0.9%***
	Total for Access to Services	***9***	***1.6%***
	Appointments		
	Administration	19	3.4%
	Cancellation of appointment	15	2.7%
	Total for Appointments	***34***	***6.0%***
	Parking	47	8.3%
	PatientTransport		
	Patient Transport (Non-emerg)	2	0.4%
	Total for PatientTransport	***2***	***0.4%***
	Waiting		
	Waiting as Inpatient for Dr	5	0.9%
	Waiting for porter	2	0.4%
	Waiting for results	4	0.7%
	Waiting for tests	3	0.5%
	Waiting op/procdure(not in-pt)	3	0.5%
	Waiting Time for Appointment	3	0.5%
	Waiting Time in Clinic	93	16.5%
	Total for Waiting	***113***	***20.0%***
	Way-finding/Signage	13	2.3%
	Total for Improving Access & Waiting	***218***	***38.7%***
	More Information, More Choice		
	Choice		

	Choose & Book	4	0.7%
	Total for Choice	***4***	***0.7%***
	Communication	7	1.2%
	Information for patients	1	0.2%
	Personal Records/Patient Info		
	Missing records	5	0.9%
	Total for Personal Records/Patient Info	***5***	***0.9%***
	Total for More Information, More Choice	***17***	***3.0%***
	Safe, High Quality,Co-ord care		
	Aids, Appliances & Equipment		
	Unsatisfactory for patient	1	0.2%
	Total for Aids, Appliances & Equipment	***1***	***0.2%***
	Infection Control		
	Standards of Infection Control	1	0.2%
	Total for Infection Control	***1***	***0.2%***
	Patient Safety		
	Clinical Risk	2	0.4%
	Total for Patient Safety	***2***	***0.4%***
	Patient's Property & Expenses		
	Lost or damaged property	1	0.2%
	Total for Patient's Property & Expenses	***1***	***0.2%***

	Personal hygiene/care	1	0.2%
	Quality of medical care		
	Confidence in health prof	1	0.2%
	Diagnosis	1	0.2%
	Medical care	12	2.1%
	Medical Records not available	12	2.1%
	Nursing care	7	1.2%
	Organisation of care	2	0.4%
	Staffing Levels	4	0.7%
	Waiting for Medication	5	0.9%
	Total for Quality of medical care	***44***	***7.8%***
	Total for Safe, High Quality,Co-ord care	***50***	***8.9%***
	Total for Negative	***349***	***61.9%***
	Neutral		
	Information Required	2	0.4%
	Not Stated	1	0.2%
	Suggestion	10	1.8%
	Total for Neutral	***13***	***2.3%***
	Positive		
	Building Closer Relationships		
	Staff		
	Medical Staff	16	2.8%
	Nursing Staff	36	6.4%
	Staff/general	57	10.1%
	Total for Staff	***109***	***19.3%***
	Total for Building Closer Relationships	***109***	***19.3%***
	Clean, Comfortable, Friendly		
	Hotel Services/environment		
	Cleanliness/Hygiene	8	1.4%
	Food	9	1.6%
	Total for Hotel Services/environment	***17***	***3.0%***
	Total for Clean, Comfortable,	***17***	***3.0%***

	Friendly		

	Improving Access & Waiting		
	Access to Services	2	0.4%
	Total for Improving Access & Waiting	***2***	***0.4%***
	More Information, More Choice		
	Information for patients	1	0.2%
	Total for More Information, More Choice	***1***	***0.2%***
	Safe,High Quality,Co-ord care		
	Quality of Medical Care		
	General care	19	3.4%
	Medical Care	45	8.0%
	Nursing Care	9	1.6%
	Total for Quality of Medical Care	***73***	***12.9%***
	Total for Safe,High Quality,Co-ord care	***73***	***12.9%***
	Total for Positive	***202***	***35.8%***
Total		***564***	***100.0%***

THE DUDLEY GROOUP OF HOSPITALS NHS TRUST

ANNUAL REPORT

PATIENT AND PUBLIC ENGAGEMENT

2007-08

Nursing director
May 2008

Introduction

This report comprises of 2 sections

Section 1
The work coordinated by the patient and public involvement steering group including

- surveys and action plans,
- quality care reviews and action plans
- involvement in patient safety
- reducing in equalities
- links with shadow Council of Governors and membership of the Trust
- reduction on inequalities

Section 2
The PALS and volunteers report

Section 1

NHS Surveys

The trust is required to participate in surveys each year run by the Healthcare Commission. This year there have been two surveys.

Maternity Survey

As part of a national survey of maternity services by the Health Care Commission, an audit of women delivered with Maternity Units in the month of May 2007 was commissioned and undertaken by Picker.

The results for Dudley maternity services are very favourable, with many scores being better than the average in the following areas.

Antenatal
- Good continuity of care - seeing the same Midwife every time
- Being able to telephone the Midwife directly
- Antenatal clinics are accessible; there are enough clinics available running at convenient times and partners are able to attend.

Postnatal
- Ward is clean
- Toilets and bathrooms are clean
- Women are treated with kindness and understanding

The maternity unit identified 5 areas where improvements could be made in the care delivered to women and agreed an action plan that will be monitored by both the Finance and Performance Committee and the Trust Board. The 5 areas were

- Choice of where to have the baby
- Choice of home birth
- Choice of where to have antenatal care
- Choice of who carried out check up
- Advice about contraception

In- patient survey

Unlike other surveys the in-patient survey is undertaken every year. The 2006 survey results were disappointing

- There were13 areas where we were significantly worse than the Picker average
- 3 areas where we were significantly better than the Picker average (these related to the environment)
- 38 areas where the Trust had not made any improvement (including staying the same score)
- The 14 areas where the Trust had made improvement (even slightly) since the previous survey

The main problems were identified as

- Communication
- Information giving
- Perceptions around waiting
- Hospital food
- Privacy
- Hand washing
- Staffing levels

Action carried out during 2007 included

- The introduction of a 'Dear patient' letter – given to each patient providing them with information they had identified they would find useful
- Further implementation of the customer care strategy including a focus on communication and information giving and customer care training for specific groups of staff.
- Further development of the essence of care / older peoples champions with a particular focus on communication, privacy, dignity and health promotion.
- Introduction of Infection control champions whose work focuses on improving hand hygiene in addition to other elements of infection control.
- The establishment of a nutrition steering group to make improvements on all aspects of nutrition,

The 2007 survey results showed a number of improvements with the trust having 21 area were the scores were better than average including improvements in

- Privacy – not sharing areas with members of the opposite sex and privacy when discussing treatment and being examined
- Cleanliness of the environment
- Communication and information about condition and treatment and on the purpose of medication and danger signals to look for. Results of surgery were explained in a clear way

- Confidence and trust in nurses and doctors and them knowing enough about each patients condition and treatment
- Doctors and nurses working well together
- Patient not being bothered by noise

There were 11 areas where the Trust was significantly worse then average including

- Order in which patients seen was not fair
- Emergency Department – wait 4 hrs or more for admission to bed on a ward.
- Not given information beforehand about the hospital
- Hospital food
- No where to keep personal belongings
- Not asked to give views on quality of care
- Insufficient nurses on duty.

Detailed action are now being planned including

- Review and revision of hospital menus
- Revision of the 'Your stay in hospital' booklet
- New mechanisms for patient feedback

In house surveys

Feedback from patients regarding their satisfaction with aspects of their care in hospital especially around information given, cleanliness and infection control measures is collected over a 2 month period. A total of 508 patients were asked to complete the surveys and 185 patients (36%) responded

Overview of the findings

General

Some of the findings confirmed those in the NHS in patient survey

- Information about the ward was not always given
- Few had access to a working radio by their bed.
- Most (but not all) patients had access to a television.
- The majority of patients found the ward quiet at night.
- The majority of patients found the quality of food available good or excellent. This is contrary to the results of the NHS Survey
- Many patients and visitors had not been instructed on the use of the alcohol hand gel. Patients generally were not told about reminding the staff to wash their hands.
- Not all patients knew about protected mealtimes and very few patients had knowledge of the red tray system.
- Almost half the patients did not know about arrangements for leaving the ward.
- Most patients know about the No Smoking Policy.
- Patients were pleased at the way their privacy and dignity was respected and found staff polite and courteous.
- The majority of patients said they had been told about their condition, but in most areas there was still a lack of written information.

In addition to the action described in the NHS survey above

- Trust volunteers have been trained to maintain bed side radios and show patients how to use radios

- Improved information about protected meal times and red tray system through Essence of care and Older peoples champions.

Quality Care reviews

Quality Care Reviews

A rolling programme of Quality care reviews commenced in September 2007 and is ongoing To date the findings are

- Essence of Care
  - Privacy and Dignity implemented
  - Red Tray system in operation
  - MUST screening evident
  - Protected meal times implemented with some unavoidable interruptions e.g. patients returning from theatre
  - Food in general was rated by patients as good

- Communication
  - Generally excellent communication between Nurses, Medics and AHP's
  - Patients interviewed comment that staff are polite, friendly, and helpful

- Infection Control
  - All wards had hand gel available which was used appropriately by the majority of people.
  - Correct practices were being undertaken
  - Not all staff were challenging people who were non-compliant

- Patient Information
  - Limited in some areas, currently being addressed and available Trust Wide via Carenet.
  - Patients interviewed responded positively to discussions about their condition and treatment with both medics and doctors.

- General Issues:
  - Ward areas clean and tidy
  - Patients allowed to dress during the day where appropriate
  - Access to telephones, radio, television and newspapers
  - Difficult to identify 'who's who' as all the uniforms are the same
  - Provision of hairdressing facilities requested by some patients

Each ward / department area develops and implements an action plan and common Trust wide issues are considered by the aptients and public Involvement Group

Involvement in patient safety
A number of patient safety indicators have been agreed that will be included in the trust Integrated Performance report from May 2008.A patient Safety day was held during Health and Safety week to raise awareness of patient safety issues

Reducing Inequalities
Discussions have been held with Dudley Partnership inequalities officers who will provide a link to the Trust rather that work on specific projects. Impact assessment are continuing for people with disability and diversity issues. Specific work has been undertaken to

- Make adjustments in the IT system to produce large print letters
- Increase the size of some wheelchairs in x-ray to accommodate wheelchairs
- Review the provision of induction loops

Links with shadow Council of governors and membership of the trust
A programme of development to help governors understand the work of the trust has been running through out the year and has included Trust strategy, vision and values, staff development and improving public health. This is part of an ongoing programme

Engagement with members of the Trust has included, providing newsletters, information on the web site, 'get to know us' sessions, trust tours, involvement in focus groups and evaluating specific trust services, acting as mystery shoppers and providing advice on customer relationship training and patient information materials.

Patient information materials
A number of improvements have been made to the presentation of patient information including the design of a corporate template for information materials and high quality printers have been made available in each clinical area so that patient leaflets can be produced on demand.

A process has been put in place so that information for patients can be quickly produced in other languages on request. In addition the information booklet for all in-patients ' Your stay in Hospital' has been revised and updated. Further work next year will focus on the production of more condition and treatment based information materials

May 2008

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Trust Board**

Report by: **Nursing Director**

Subject: **Complaint Report for Year ending 31 March 2008**

The complaints report for the year ending 31 March 2008 is attached.

A total of **415** complaints were received during the year. However, 3 of these were withdrawn by the complainants and 18 were closed when no authorisation from the patient was received.

A total of **358** complaints were investigated and concluded during the period, with **36** complaints, received during March, to be concluded within 25 working days of receipt.

- 5 responses were concluded after 25 working days, ***without*** consent
- 57 responses were concluded after 25 working days, ***with*** consent
- 296 responses were concluded ***within*** 25 working days

During the period, 44 meetings were held with complainants.

The Complaints and Claims Department would like to express thanks to the Consultants, Matrons, Lead Nurses and Departmental Managers who attended the local resolution meetings and who assisted in the complaints investigations.

Complainants have commented that they find the local resolution meetings extremely beneficial in resolving their concerns. At the end of the meetings, very few continue to remain dissatisfied with the outcome.

It is pleasing to report a **99%** response time overall, for the 12 month period. Again, our thanks to those staff who assisted the Complaints and Claims team to achieve this target.

The Board is asked to receive the report

The Dudley Group of Hospitals NHS
NHS Trust

COMPLAINTS REPORT

1. Introduction

This report outlines the Trust's performance in handling complaints during the 12 months ending March 2008. Actions taken to improve services or changes made as a result of complaints are shown at paragraph 12 below.

It is pleasing to report that the past twelve months has also seen a big reduction in the number of cases referred and accepted by the Healthcare Commission and in 3 cases complaints were not upheld.

No new complaints have been accepted by the Ombudsman.

2. Complaints received during period

A total of **415** complaints were received during the period.

- **413 (99.5%)** were received and acknowledged within two working days of receipt

However, **3** complaints were withdrawn and **18** were closed when no authorisation was received, despite two requests. **36** complaints, received during March, will be concluded in the next financial year.

Therefore, **358** complaints were investigated and concluded during the period.

- **5** (1%) complaints were concluded in more than 25 working days

- **353** (99%) complaints were concluded within the period, either within 25 working days, or by the extension date agreed with the complainant.

3. Outcome of complaints received within period

The following outcomes should be noted -

Dissatisfied – further response sent before complaint closed	Local resolution meeting arranged	Ref to HCC for Indep review	Taking legal action	Withdrawn/ authorisation not received	Extn agreed with compl-ainant	Concl without further contact	C/Fwd	Total no. complaints received during Year
15 (3%)	44 (11%)	6 (1%)	4 (1%)	21 (5%)	57 (14%)	232 (56%)	36 (9%)	415 (100%)

5. Negotiated extensions

The NHS (Complaints) Amendment Regulations 2006 allows the Trust to contact complainants to negotiate an extension to their response. This has given the complaints team more time to comprehensively investigate complaints, particularly the more complex ones involving a number of staff. During the period, **57** (14%) complainants were contacted and all agreed to an extension of the complaint response time.

6. Category of complaint received by KO41 subject

There has been little change in complaints relating to clinical treatment during the year. It is pleasing to note a small reduction in complaints relating to communication to patients, although there has been little improvement in those complaints relating to staff attitude. Complaints relating cancelled outpatient appointments (which sometimes can occur on a number of occasions), still cause concern.

	Q1	**Q2**	**Q3**	**Q4**	**TOTAL**
	2007/8	2007/8	2007/8	2007/8	2007/8
Admission, discharge transfer	1 (1%)	5 (4%)	4 (4%)	4 (4%)	14 (3%)
Aids appliances/equipment	1 (1%)	0	0	2 (2%)	3 (1%)
Clinical treatment	51 (57%)	53 (44%)	59 (56%)	56 (54%)	219 (53%)
Staff attitude	14 (16%)	18 (15%)	8 (8%	15 (14%)	55 (13%)
Communication to patients	10 (11%)	16 (13%)	8 (8%)	9 (9%)	43 (10%)
Failure to follow procedure	3 (4%)	0	4 (4%)	3 (3%)	10 (2%)
Hotel services	0	2 (2%)	0	1 (1%)	3 (1%)
Indep sector service Trust	0	1 (1%)	0	0	1 (0.5%)
Inpatient appointment delay/canc	2 (2%)	2 (2%)	0	1 (1%)	5 (1.5%)
OPD appointment delay	6 (7%)	8 (7%)	13 (12%)	8 (8%)	35 (8%)
Patient privacy and dignity	0	4 (3%)	1 (1%)	0	5 (1.5%)
Patient property and expenses	0	2 (2%)	1 (1%)	0	3 (0.5%)
Personal records	1 (1%)	5 (4%)	5 (5%)	2 (2%)	13 (3%)
Transport (Ambulance)	0	1 (1%)	0	0	1 (0.5%)
Mortuary & PM arrangements	0	0	0	1 (1%)	1 (0.5%)
Other	0	2 (2%)	1 (1%)	1 (1%)	4 (1%)
Total	**89** (100%)	**119** (100%	**104** (100%)	**103** (100%)	**415** (100%)

7. Trends by Ward/Department

Appendix 1 shows complaint trends by wards and department over the past two years.

8. Healthcare Commission

Comp rec'd during period	Referrals to HCC	Closed	Active
Year ending 31.3.03	1 (0.2% of total)	1	0
Year ending 31.3.04	5 (2% of total)	5	0
Year ending 31.3.05	27 (8% of total)	27	0
Year ending 31.3.06	20 (4.25% of total)	20	0
Year ending 31.3.07	8 (2% of total)	5	3
Year ending 31.03.08	6 (1.5% of total)	0	6
TOTAL	**67 (3% of total)**	**58**	**9**

9. Ombudsman

During the year ending 31 March 2008, no complaints were referred to the Ombudsman.

10. Taking Legal Action

During the year ending 31 March 2008, 4 complainants have concluded the complaints procedure and instructed a Solicitor**.**

11. Activity

The table overleaf compares the number of complaints received against the total number of patient contacts. The complaints to activity ratio continues to remain at between 0.06% and 0.08%.

	Q1	Q2	Q3	Q4	TOTAL
Activity	2007/8	2007/8	2007/8	2007/8	01/04/07 – 31/03/08
Total inpatient episodes	17499	17730	18470	17831	71530
Day case episodes	7899	8169	8612	8973	33653
Renal attendees	3060	3090	3080	3204	12434
Outpatient attendees	87431	92891	97475	98952	376749
A & E	24875	24321	23843	23528	96567
Births	1056	1147	1121	1195	4519
Total Patient Activity	141820	147348	152601	153683	595452
Complaints as % activity	**0.06%**	**0.08%**	**0.07%**	**0.07%**	**0.07%**

12. Changes made as a Result of Complaints during the period

It is noted that the following changes are to be made, or have been made, as a result of complaints.

- Waste bins to be provided in cubicle areas
- All pt trolleys in department to be tagged by domestics when cleaned.
- Cleanliness of trolleys to be monitored
- Rapid response team available on request to maintain cleanliness standards when department domestics have completed shifts
- Champion Infection control nurses based within departments to monitor standards of cleanliness
- Notices displayed to remind staff refreshments must not be consumed at nurse base
- All staff reminded of infection control guidelines
- Glove and apron holders installed in department
- Each nurse station has senior nurse responsible for nursing care within his/her team and for monitoring standards
- Ward piloting ‘take the time’ questionnaire, which is completed by pt and family to give staff additional information to assist in providing pt care
- Lead nurses to undertake regular ward rounds at visiting times to enable family members to highlight concerns
- Booklet produced by ward to identify nursing and medical teams and explain ward routine
- Centralisation of secretaries in one area to enhance/expedite communication process
- Temporary staff recruited to resolve backlog of secretarial work
- Review secretarial procedures
- Review trends surrounding admission delays

- Raise profile of orthotic referral process within division
- Produce discharge booklet to improve electronic handover
- Improve tracking of junior doctors at induction
- Mark availability of slots in consultant clinics
- Highlight areas of good practice with staff
- Staff reminded of discharge procedure during staff meetings
- Spot checks to be undertaken by shift leads after patients have been discharged
- Nursing teams to raise awareness and prompt professional and caring responsibilities
- Ensure end of life policy available to all staff
- Chaplain to discuss use of green form with Registrar's Office
- Staff to routinely offer relatives opportunity to remain with extremely ill pts.
- All telephone calls to be documented in nursing process
- Midwife asked to reflect on care provided and to consider how she gives women information
- Bounty representative to undergo customer care training, relative to role
- Reinforce process for Bounty representative to gain access to patient rooms
- Staff to be reminded that women should be made aware that they should ring for assistance, if required.
- Improve record keeping and training for community midwives
- Undertake internal audit of all cases of laparoscopic cholecystectomy carried out by locum surgeon
- Discharge facilitators to be responsible for collecting and checking discharge information and home circumstances

13. Outcome from Healthcare Commission Independent Reviews received during period

Complaint 187/06-7
Complaint was upheld. Following recommendations were made –

Trust should review policies/procedures relating to record keeping and ensure a thorough awareness and training provided. Midwife to meet with supervisor to discuss importance of accuracy within written records. [Maternity notes fell below standards required by NMC's guidelines].

Complaint 015/07-8
Complaint was upheld. Following recommendations were made –

Trust to carry out investigation regarding policy on discharge of potentially vulnerable patients. Remind staff of importance of good record keeping and need to complete documentation in accordance with NMC's guidelines. Explanation required regarding monitoring compliance with benchmarks set out in Essence of Care.

Complaint No. 093/06-7
Complaint not upheld.

Complaint No. 398/06-7
Complaint not upheld.

Complaint No. 194/06-7
Complaint not upheld.

Complaint No. 040/06-7
Complaint upheld. Following recommendations were made –

Review and amend, if necessary, provision of service for colorectal cancer patients. Train line management staff regarding cancer waiting times and in the monitoring and tracking of patients through their hospital journey.

Complaint No. 354/06-7
Complaint upheld. Following recommendations were made –

Copy protocols regarding the physiotherapy assessment of patients who have had a stroke. Audit current nurse record keeping practice on ward, to ensure compliance with Essence of Care. Improve communication between ward, nursing staff and relatives.

Maria Smith
Complaints and Claims Manager
April 2008

Complaint Trends by Wards and Departments to 31 March 2008 **APPENDIX 1**

		2006/7	2007/8
Ambulance Service		1	0
Centafile - Records		2	2
Corbett	Day Case Unit	1	0
	Outpatients	8	7
	Pathology Lab	2	0
	Radiology - X-Ray	0	0
	Ward 18	0	1
Guest	Diabetic Centre	0	0
	G.U.M. Clinic	0	0
	Ophthalmology	10	2
	Outpatients	1	0
Home visit	Home Visit	0	1
Russells Hall	Anti coag clinic	2	1
	Bereavement Office	0	1
	Car park/grounds	2	0
	Cardiology	6	0
	CCU	0	2
	Childrens Unit	0	1
	Day Case Unit	4	9
	Discharge Lounge	0	1
	EAU	18	34
	Em Dept	29	57
	ENT	0	1
	Fracture Clinic	2	5
	G I Unit	8	5
	Gen Office/Recept	1	0
	Gynae OPD	1	3
	H.D.U. Critical Care	2	1
	DRAS & Lung Func	2	0
	Maternity Unit	30	28
	Medical HDU	1	0
	Onc/Georgina Ward	8	3
	Outpatients	89	94
	DVT/Outreach clinic	1	0
	Pathology	0	4
	Pharmacy	0	1
	Physiotherapy	0	2
	Private Hospital (NHS	1	0
	Radiology X-Ray	4	5
	Trauma & Ortho	2	2
	Urology	2	1
	Ward A1	1	4
	Ward A2	22	13
	Ward A4 Stroke Unit	5	5
	Ward B1	9	9
	Ward B2	23	23
	Ward B3	14	12
	Ward B4	8	11
	Ward B5	11	9
	Ward B6	10	5
	Ward East C1	2	7
	Ward East C2	9	5
	Ward East C3	19	14
	Ward East C5	14	9
	Ward C6	6	8
	Ward C7	2	6
	Ward C8 - GI	1	1
Neth Green	Stepdown	2	0
	Facilities Mngt	1	0
	Security	1	0
TOTAL		**400**	**415**

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board May 2008-05-16**

Report by: **The Nursing Director**

Subject: **HCC Review of Dudley Group of Hospitals Maternity Service response and action plan.**

The above was reported to the Trust Board in January 2008 and the Board required that an updated report by provided in May 2008.

This is attached

The Board is asked to receive the report

Nursing Director
May 2008

The Dudley Group of Hospitals NHS
NHS Trust

Healthcare Commission Report
Review of Dudley Maternity Services 2007

Response and Action Plan
April 2008

Steph Mansell
Head of Midwifery

Contents

Introduction

This report is the assessment and action plan for Dudley Group of Hospitals NHS Trust Maternity Services based on the results from the Healthcare Commission Review of Maternity Services 2007.

The assessment framework is grouped under three themes:
1. Clinical Focus
2. Women Centred Care
3. Efficiency and capability

Each theme is divided into indicators.
Each indicator is scored on a scale of 1 to 5 with 1 representing poor performance and 5 the best performance. A score of 3 is set to represent the acceptable level of performance.

The Healthcare Commission has aggregate (by means of an average) the themed indicator results to give an overall score for the review. The Dudley Group of Hospitals Maternity Service overall score was classified as 'Excellent' with an average score of 3.315 thus placing the Trust in the 'Best Performing' Trust category, the only Trust in Birmingham and the Black Country to achieve this 'top' score.

The tables below highlight issues, suggested actions, resources needed and time frame for each indicator. The aim of this review is to clarify areas where improvements can be made, in order to continue to provide a high quality, value for money maternity service.

The appendix contains the review and action plan from the Picker NHS Maternity Survey 2007, the results of which were used by the Healthcare Commission to compile their report. The report focuses on women's experience of maternity care and was based on the results of a survey of women who gave birth in February 2007.

Action Plan based on the findings of the Maternity Services Review Health Care Commission Report 2007

Clinical Focus

Overall Statement:

Does the organisation have strong processes and practices to ensure the maternity service is safe and effective?

Statement	Theme Assessment Indicators	Score out of 5	Issues	Suggested Action	Resource Needed	Lead/ Review Time
1. Are there high levels of antenatal monitoring?	%Women not receiving NICE recommended number of Antenatal appointments	5	Women are receiving the recommended number of antenatal appointments	Continue to monitor compliance through audit of clinical notes. Continue to ensure universal antenatal care pathway is reviewed in-line with changes to NICE guidance	Supervisors of Midwives (SOM) and Audit time	SOM/ Lead Midwives Community Nov 2008
2. How effective is the test and screening programme?	Availability of NICE recommended screening	3	Currently do not provide Nuchal Screening for women	Introduction of Nuchal Screening in 2008	Sonography service business case for introduction of Nuchal screening	Julie Whiles Nov 2008
3. Are there appropriate levels of intervention during delivery?	Appropriate use of Caesarean sections	3	DGOH C/S rate at the time of the survey was 29%, above the national average. Limited service for ECV	Action plan for Normality Toolkit Introduce Post dates clinic Introduce VBAC clinic Review of accessibility to ECV service for all breech pregnancies	Midwife and Obstetrician time. Lead to develop service	Steph Mansell/ Adrian Warwick Nov 2008

4. Are there good outcomes for delivery?	Maternal Morbidity	4	Ongoing incident review and audit	Audit in process for standard: perineal suturing within 1 hour Improvement of OASIS data	Audit time OASIS data	Justine Edwards Aug 2008
5. Are there high standards of postnatal care?	Postnatal care of mothers and babies	4	None specifically identified	Develop postnatal clinics with Children's Centres Secure permanent MSW in community to support this service	Work with Children's Centres and PCT	Lead Midwives Community/ Steph Mansell Nov 2008
6. Is there adequate service provision for additional needs?	Progress on implementing Mental Health NICE guidance	3	Improve perinatal mental health service – access to a specialist psychiatrist. Mother and baby unit service	Joint guidelines and pathway developed. Training being implemented Antenatal Mental Health screening in place	Specialist Midwife in post but long term funding not secured – PCT to review Guideline and training to be launch June 2008	PCT commissioner/Sally Burns/Steph Mansell Nov 2008
7. Do staff have adequate training and recent experience?	Extent at which staff are trained in core maternity skills	3	Improvement in attendance at training by Obstetricians and Midwives	Ongoing review based on CNST Improve training database Increase opportunity for staff to attend training	Increase Midwife and Obstetric staffing levels Review database Implement OESD to replace ALSO course	Amanda Hackett/ Steph Mansell/ Adrian Warwick Aug 2008
8. Does the organisation have a strong safety culture?	Team working and supervision	4	Despite high levels of attendance at multi-professional meetings midwives report less favourably for team working	Better feedback to all staff of aims and direction of the service.	Open forums for midwives	Lead Midwives/ Yvonne Jones/ Steph Mansell Sept 2008

Action Plan based on the findings of the Maternity Services Review Health Care Commission Report 2007

Women Centred Care

Overall Statement:

Are women informed, counselled and supported to ensure that they have a positive maternity experience?

Statement	Theme Assessment Indicators	Score out of 5	Issues	Suggested Action	Resource Needed	Time Frame
9. How readily can women access maternity care and information?	Average time between making first contact and booking appointment	3	Data collection must reflect first contact – not booking	New documentation system in place Data entry needs review	Changes to OASIS	Janet Powell July 2008
10. How much choice do women have in how their antenatal care is provided?	Choice and continuity for antenatal care	3	Continuity of care scored high but choice of venue was poor.	Further developments with Children's Centres, while not compromising care, to be explored. Option for 34 week community visit at Children's Centres is being implemented in some locations – limited by the Children's Centre resources	Community Midwife, Community MSW Adequately equipped Children's Centres	Children's Centre Managers/Lead Midwives Community Nov 2008

11. How much choice do women have for tests and scans?	% of women offered informed choice for screening tests.	2	The average score for this indicator was 84%, DGOH scored 81%, therefore the low score is questionable.	Screening Midwife to ensure all midwives is aware of the choices during annual updates.	Improve training knowledge	Sue Glover Nov 2008
12. Do antenatal classes meet the women's and their partner's needs?	% of women attending antenatal classes who wanted to	3	Demand for classes is high and current resourced are not always able to meet demand.	Review links with voluntary groups e.g. NCT. Community Midwives are developing classes with Children's Centres.	Support for vulnerable groups needs resources Undertake a further audit of antenatal women	Gill Cheadle /PCT commissioner & Children's Centres/ Teenage Pregnancy service
13. How much choice do women have in the delivery of their babies?	Extent of choice in labour 1. % women who got pain relief they wanted 2. % women mobile in labour 3. % women left alone and worried	3	Pain relief including access to Epidural was identified High % of women report that then were able to be mobile while in labour Women identified that they were left alone and were worried about this	Review issues around availability of epidurals for women Review 'Pain Relief in Labour' Leaflet Explore the option of having a second birthing pool Explore the option of introducing alternative therapies e.g. Aromatherapy + training for midwives Continue to review the birth to midwife staffing ratio and development of the higher MSW role	Unit review of the ability to provide 1:1 care in active labour for all women. This will enable adequate pain relief choices and give better support	Catherine Brennan/Justine Edwards/ Gill Cheadle/ Andrea Batty/ Yvonne Jones/Steph Mansell Nov 2008
14. How well are women supported to care for their	Support for infant feeding	2	This was a worryingly low score and not reflective of data that	Review current data entry on OASIS	OASIS changes	Jenny Sutherland/ Janet

babies?			supported the unit retaining Baby Friendly status in Nov 2007	Specialist Midwife and Feeding MSW ensure staff have appropriate training		Powell Nov 2008
15. How effective is the discharge process?	Quality of support in caring for the baby after discharge.	3	Average for quality of post natal support	Postnatal Clinics planned for 2008 to enable women to access midwife at a Children's Centre MCA in community	Resources for MSW in community required	Steph Mansell/ PCT commissioner Nov 2008
16. Are stakeholders engaged effectively to help improve services?	Stakeholder involvement in service planning	4	Above average representation of users on the MSLC. Commissioner and voluntary groups represented.	Continue to develop user engagement	Develop MSLC website and interface with DGOH website	PCT & DGOH communications officers July 2008

Action Plan based on the findings of the Maternity Services Review Health Care Commission Report 2007

Efficiency and Capability

Overall Statement: Is there adequate funding to provide an acceptable service and are management and improvement processes ensuring women get the best care for the money spent?

Statement	Theme Assessment Indicators	Score out of 5	Issues	Suggested Action	Resource Needed	Time Frame
17. Does the Unit have an appropriate number of staff to support their deliveries?	1. % Midwives per 1000 births 2. % Appropriate Obstetric and Anaesthetic consultant presence	3	Compromised midwife staffing levels have been identified through risk management and business cases Good scores achieved for Obstetrician and Anaesthetist availability	HCC survey based on national averages. Safer childbirth has identified 1: 28 as a minimum ratio. Currently DGOH ratio is 1: 37.2 Continue to monitor activity and report to the Ops Director	Increased midwife levels	Steph Mansell/ Adrian Warwick July 2008
18. Are MCA's used appropriately enabling midwives to spend more time with women and improved cost effectiveness?	1. % MCA's per 1000 births 2. % Tasks supported by MCA's	4	Score reflects good use of this role and appropriate staffing per 1000 births	Continue to monitor activity and ratio per 1000 births. Continue development programme		Amanda Hackett Nov 2008

19. Are costs managed to an acceptable level?	Average cost per delivery	2	Reference costs and high cost of N12s – care provided that does not result in a birth – being reviewed	Future apportioned N12 costs in line with PBR phase 4		Jim Thom Nov 2008
20. Are antenatal inpatient admissions appropriate and are Day Assessment facilities used effectively?	1.Antenatal admissions per delivery 2.Weekday opening hours of EPAC 3. Weekday opening hours of Day Assessment Unit	3	1. slightly above national average 2. in line with national average 3. Well below average opening in DAU	Re-pilot extending DAU opening hours – relieving Triage in the early evenings and weekends. Develop business case for staffing resource Consider scanning implications	Improved staffing for extending DAU opening hours	Gerry Thurley/ Steph Mansell/ Adrian Warwick Aug 2008
21. Is maternity related data routinely collected and analysed?	1. Completeness of HES Mat data 2. % women with no ethnic coding 3. Baby morbidity outcomes	4	Data entered is above average for completeness	Continue to review OASIS against required statistics		Supervisor of Midwives/ Adrian Warwick Nov 2008
22. Is there appropriate involvement of obstetricians and midwives in ANC?	1. Average AN obstetric attendances per women 2. % women seeing only midwives for check ups	4	Above average in both indicators	Good system in place for appropriate referral. Some concerns around the referral system for women living in Sandwell – system to be reviewed with Sandwell Community Midwives	Improved service for Sandwell women	Gerry Thurley/Sue Glover/ Sandwell Midwives Aug 2008
23. Is the length of PN in stay	% women who considered length	2	Below average score	Review bed capacity in line with rising activity	Increased bed capacity	Paul Brennan/

satisfactory to women?	of stay about right					Trust Board July 2008
24. Is the birthing environment conductive for supporting natural birth?	Homeliness of delivery rooms	4	Above average score reflective of the unit facilities	Explore option for 2nd birthing pool Continue to develop midwifery led unit		Andrea Batty Nov 2008
25. Do women consider the unit clean?	Women's view of cleanliness of delivery and PN areas	5	Although recent cleaning audit have been below expectancy, women's perception is that the standard is high.	Continue environment audits		Yvonne Jones/Lead Midwives Nov 2008

Appendix A

Summary Report of Finding
Survey of Women's Experience of Maternity Care
NHS Patient Survey Programme September 2007 Picker Results

The Picker Institute carried out a Maternity Survey in February 2007, asking women's views on their experiences during pregnancy, birth and the postnatal period. This report was published in September 2007 and has provided information to the Healthcare Commission. The Healthcare Commission Report, 'Maternity Services 2007' was published in November 2007 and is used as an external benchmarking tool.

The initial mailing of this Picker Survey was to 292 women and 156 women returned the survey. The response rate of 53.6% was below the national average of 56%
A total of 70 Trusts participated in the survey.

The Picker Report uses Problem Scores to highlight areas were improvement could potentially improve the woman's experience using the Maternity Services in Dudley and maps them against the average of other Trusts involved in the survey.

The survey findings show that there are good levels of satisfaction with maternity services in Dudley, with the Trust scoring significantly better than average in 8 of the questions and the responses to 5 questions fell below the national average.

Positive feedback was report in the following areas:

- Antenatal
    - Good continuity of care, seeing the same midwife each visit
    - Being able to telephone the midwife directly
    - Antenatal clinics are accessible, there are enough classes at convenient times, with partners able to attend
- Postnatal
    - Ward is clean
    - Toilets and bathrooms are clean
    - Women are treated with kindness and understanding

Please review the full report for further details of analysis.

The table below highlights areas where the problem scores indicate that improvements could be made. Due to the questions being phrased in the negative sense, (ie 'not') **the lower percentage scores** signify a better result.

Please note that the Health Care Commission Report has standardised the results with maternal age and parity. Therefore that report will have slightly altered percentage scores to this Picker Report. This has no impact on the findings below.

Steph Mansell
Head of Midwifery
January 2008

Appendix B

The Dudley Group of Hospitals NHS
NHS Trust

HCC National Maternity Survey 2007
Action plan response to women's experience of maternity care in the NHS - survey findings 2007

Identified Issue	Objective/Goal	Work Needed	Timescale	Responsibility	Monitoring	Link with other work groups
1. B5+ Not given a choice of where to have baby	Improve women's perception and understanding of the choices offered	Review 'Choices' leaflet given to all women at booking Ensure midwives discuss and record choice options	Complete July 2008	A Batty/G Cheadle Lead CMW/Lead MW Mat OPD	Lead CMW meeting/ Antenatal QPDT	Documentation Group
2. B6+ Not given a choice of home birth	Ensure women are provided with the information for choice of place of birth	As point 1 Ensure all midwives continue to provide written homebirth information Continue to ensure mw attend homebirth workshop updates Ensure non-Dudley resident women are appropriately referred to a CMW when they request home birth	Complete Ongoing Ongoing	Lead CMW Lead CMW/A Hackett Lead MW Mat OPD	Lead CMW meeting Database Lead MW meeting	Mandatory training Cross-boarder meetings
4. B12 Not given choice about who carries out the check up	Ensure primary care provider is discussed with the woman	Continue to use clinical risk assessment to determine the most appropriate care Continue to discuss lead carer role with the woman and again consent for referral Continue to provide at least 75% of community care by the named midwife	Ongoing	Community MW/Lead CMW Community and hospital OPD MW Community MW/Lead CMW	Lead CMW meeting Audit	NICE AN care guidelines (2003) Maternity Matters (DOH 2007) SHA reducing perinatal mortality strategy (2005)
3. B10 Not given a choice of where to have antenatal	Ensure women are aware of any options of the place where care could be provided	Continue to develop services within Children's Centres Ensure women are provided care within the most appropriate setting for their needs Review midwifery caseloads and establishment to reflect additional services	Ongoing Ongoing July 2008	Lead CMW Lead CMW HOM/PCT	Lead CMW meeting Lead CMW meeting Clinical unit meeting/Lead CMW meeting	LIG meetings Children's Centre meetings SLA/Commissioning for community midwifery Maternity Matters (DOH 2007)

Appendix B

The Dudley Group of Hospitals NHS
NHS Trust

Identified Issue	Objective/Goal	Work Needed	Timescale	Responsibility	Monitoring	Link with other work
5. H8 Not given advice about Contraception.	Ensure women receive written information and have the opportunity to discuss contraceptive needs	Review documentation provided to women Ensure midwives have knowledge to provide appropriate information/sign-posting	Complete Ongoing	Lead MW/ Lead CMW/ A Hackett	Review /monitor postnatal information packs	Documentation Group Training needs Orientation for CMW
6. Disseminate action plan and the positive aspects of the survey	Ensure feedback on the action plan and the positive aspects of the survey is appropriately disseminated	Disseminate to staff through meetings and 'Chatter' newsletter Disseminate to users and the public	Complete Complete	HOM/Matron/HOS HOM/Trust Communications	Clinical unit meeting	Staff meetings MSLC

Steph Mansell
Head of Midwifery

April 2008

The Dudley Group of Hospitals NHS
NHS Trust

Report to: Trust Board

Report by: Operations Director

Date: 29/05/08

Subject: Comparison of DGoH with other local providers against the Healthcare Commission Inpatient survey report 2007.

Detail: The HCC inpatient survey report is the fifth survey of adult inpatient's in NHS Trusts in England. It shows how each trust scored for each question in the survey in comparison with national benchmark results. It should be used to understand the trust's performance, and to identify areas for improvement.

This is a high level overview comprising:

- Comparison against the 2006 DGoH patient survey
- Comparison against the other hospitals in the local area.

To understand the detailed survey results for each individual trust, there are national spreadsheets available on the Health Care Commission website. These show the percentage of respondents from each trust that provided a particular response to all survey questions. There is also a set of tables showing the national results for the 2007 survey, compared with the results for previous years where possible.

Recommendation The Trust's vision is 'Your Hospital of Choice… tailored care and clinical expertise designed to meet your need'. Patient's perception of care is important in shaping our services therefore this report should be used as a driver to improve our services.

Action plans should be implemented for the areas highlighted within the worst performing trusts as highlighted in the report.

The report should be shared with the Clinical Directors to identify other areas of improvement within their own directorates to move the Trust from Intermediate to best performing Trust.

Risk: Information is becoming increasingly accessible and important for patients when choosing their health care provider. It is important to see year on year improvement in all areas within the Trust otherwise the Trust's aspiration of serving a population of 500,000 may not be realized.

About the survey

The fifth survey of adult inpatients reports on165 acute and specialist NHS trusts. The responses were from 76,000 patients, a response rate of 65%. Patients were eligible for the survey if they were aged 16 years or older, had at least one overnight stay and were not admitted to maternity or psychiatric units. Full details of how the benchmark reports are calculated can be seen within the Patient survey report and on the Health Care Commission website.

The areas covered within the questionnaire are:

- Admission to hospital
- The hospital ward
- Doctors
- Nurses
- Your care and treatment
- Operations and procedures
- Leaving hospital
- Overall

An overview position of the Trust in 2006 and 2007 and the other local hospital positions across the 62 questions in the 8 areas are included in the appendix.

Key to reviewing position within appendix		**2006 position within the 62 question**	**2007 position within the 62 question**
Best performing 20% Trusts		2	12
Intermediate 65% Trusts		37	45
Worst performing 20% Trusts		15	4
Question not reported			1
Not included in 2006		8	

DGOH comparison with other Trusts in the area

	Key	**DGOH**	**S&WB**	**RWH**	**UHB**	**Walsall**	**Worcs**
Best performing 20% Trusts		**12**	**4**	**12**	**5**	**3**	**3**
Intermediate 65% Trusts		**45**	**44**	**49**	**41**	**24**	**57**
Worst performing 20% Trusts		**4**	**14**	**1**	**16**	**35**	**2**
Question not reported		**1**					

DGoH areas reported as being in the worst performing 20% Trusts within 2007 report.

Admission to hospital Question within report	**Position change from 2006**	**Action required**
How long did you wait before being admitted to a bed on the ward?	Remained the same	Enterprise Team to address with Unscheduled care workstream

The Hospital Ward Question within report	**Position change from 2006**	**Action required**
Did you feel threatened during your stay in hospital by other patients or visitors?	New question	Local patient survey to understand reason(s) for concern

Nurses **Question within report**	**Position change from 2006**	**Action required**
In your opinion, were there enough nurses on duty to care for you in hospital	Remained the same	Review of nurse staffing levels is already being undertaken by Matrons. Full implementation of electronic roster system by October 2008 will improve deployment and utilization.

Leaving Hospital **Question within report**	**Position change from 2006**	**Action required**
Did you receive copies of letters sent between hospital doctors and your family doctor	Positioned worse	Action plan to be agreed with Clinical Directors.

Appendix 1 – Patient Survey Analysis

Health Care Commission In-patient Survey comparison analysis								
		Dudley Group of Hospitals NHS Trust 2006 survey	**Dudley Group of Hospitals NHS Trust 2007 survey**	**Change**	**Sandwell and West Birmingham NHS Trust 2007**	**The Royal Wolverhampton NHS Trust 2007**	**University Hospital Birmingham NHS Foundation Trust 2007**	**Walsall Hospital NHS Trust 2007**
Admission to hospital								
How much information about your condition did you get in the Emergency Department?				?				
Were you given enough privacy when being examined in the emergency Department?				?				
How long did you wait before being admitted to a bed on the ward?				?				
Were you offered a choice of hospital for your first hospital appointment?		not included in 2006						
Were you given a choice of admission dates?				?				
Overall, how long did you wait to be admitted to hospital?				?				
How do you feel about the length of time you were on the waiting list?				?				
Was your admission date changed by the hospital?				?				
Upon arrival, did you feel that you had to wait a long time to get to a bed on a ward?				?				
The Hospital Ward		**Dudley Group of Hospitals NHS Trust 2006 survey**	**Dudley Group of Hospitals NHS Trust 2007 survey**	**Change**	**Sandwell and West Birmingham NHS Trust 2007**	**The Royal Wolverhampton NHS Trust 2007**	**University Hospital Birmingham NHS Foundation Trust 2007**	**Walsall Hospital NHS Trust 2007**
Did you ever share a sleeping area with patients of the opposite sex?				?				
Did you ever use the same bathroom or shower area as patients of the opposite sex?				?				
Were you ever bothered by noise at night from other patients?				?				
Were you ever bothered by noise at night from hospital staff?				?				
In your opinion, how clean was the hospital room or ward that you were in?				?				
How clean were the toilets and bathrooms that you used in hospital?				?				
Did you feel threatened during your stay in hospital by other patients or visitors?		not included in 2006						
Did you have somewhere to keep your personal belongings whilst on the ward?		not included in 2006						
How would you rate the hospital food?				?				
Were you offered a choice of food?				?				
Did you get enough help from staff to ear your meals?				?				

		Dudley Group of Hospitals NHS Trust 2006 survey	Dudley Group of Hospitals NHS Trust 2007 survey	Change	Sandwell and West Birmingham NHS Trust 2007	The Royal Wolverhampton NHS Trust 2007	University Hospital Birmingham NHS Foundation Trust 2007	Walsall Hospital NHS Trust 2007
Doctors								
When you had questions to ask a doctor, did you get answers you could understand?				?				
Did you have confidence and trust in the doctors treating you?				?				
Did Doctors talk in front of you as if you weren't there?				?				
As far as you know, did doctors wash or clean their hands between touching patients?				?				
		Dudley Group of Hospitals NHS Trust 2006 survey	**Dudley Group of Hospitals NHS Trust 2007 survey**	**Change**	**Sandwell and West Birmingham NHS Trust 2007**	**The Royal Wolverhampton NHS Trust 2007**	**University Hospital Birmingham NHS Foundation Trust 2007**	**Walsall Hospital NHS Trust 2007**
Nurses								
When you had questions to ask a nurse, did you get answers you could understand?				?				
Did you have confidence and trust in the nurses treating you?				?				
Did nurses talk in front of you as if you weren't there?				?				
In your opinion, were there enough nurses on duty to care for you in hospital?				?				
As far as you know, did nurses wash or clean their hands between touching patients?				?				
Your care and treatment		**Dudley Group of Hospitals NHS Trust 2006 survey**	**Dudley Group of Hospitals NHS Trust 2007 survey**	**Change**	**Sandwell and West Birmingham NHS Trust 2007**	**The Royal Wolverhampton NHS Trust 2007**	**University Hospital Birmingham NHS Foundation Trust 2007**	**Walsall Hospital NHS Trust 2007**
Did a member of staff say one thing and another say something different?				?				
Were you involved as much as you wanted to be in decisions about your care?				?				
How much information about your condition or treatment was given to you?				?				
Did your family or someone close to you have enough opportunity to talk to a doctor?				?				
Did you find someone on the hospital staff to talk to about your worries and fears?				?				
Were you given enough privacy when discussing your condition or treatment?				?				

		Dudley Group of Hospitals NHS Trust 2006 survey	Dudley Group of Hospitals NHS Trust 2007 survey	Change	Sandwell and West Birmingham NHS Trust 2007	The Royal Wolverhampton NHS Trust 2007	University Hospital Birmingham NHS Foundation Trust 2007	Walsall Hospital NHS Trust 2007
Operations and procedures								
Did a member of staff explain the risks and benefits of the operation or procedure?				?				
Did a member of staff explain what would be done during the operation or procedure?				?				
Did a member of staff answer your questions about the operation or procedure?				?				
Were you told how you could expect to feel after you had the operation or procedure?				?				
Did the anesthetists explain how he or she would put you to sleep or control your pain?				?				
Afterwards, did a member of staff explain how the operation or procedure had gone?				?				
		Dudley Group of Hospitals NHS Trust 2006	Dudley Group of Hospitals NHS Trust 2007		Sandwell and West Birmingham NHS Trust 2007	The Royal Wolverhampton NHS Trust	University Hospital Birmingham NHS Foundation Trust	Walsall Hospital NHS Trust
Leaving hospital								
Did you feel you were involved in decisions about your discharge from hospital?		not included in 2006						
What was the main reason for the delay?				?				
How long was the delay to discharge?				?				
Were you given any written information about what you should do after leaving hospital?		not included in 2006						
Did hospital staff explain the purpose of the medicines you were to take home?				?				
Did a member of staff tell you about medication side effect to watch for?				?				
Were you told how to take your medication in a way you could understand?		not included in 2006						
Were you given clear written information about your medicines?				?				
Did a member of staff tell you about any danger signals you should watch for?				?				
Did hospital staff give your family or someone close to you all the information they needed?				?				
Did hospital staff tell you who to contact if you were worried about your condition?				?				

			Dudley Group of Hospitals NHS Trust		Sandwell and West Birmingham NHS Trust	The Royal Wolverhampton NHS Trust	University Hospital Birmingham NSH Foundation Trust	Walsall Hospital NHS Trust
Overall								
Did you feel you were treated with respect and dignity while you were in the hospital?				?				
How would you rate how well the doctors and nurses worked together?				?				
Overall, how would you rate the care you received?				?				
While in hospital, were you ever asked to give your views on the quality of your care?		not included in 2006						
Did you see any posters or leaflets explaining how to complain about the care you received?		not included in 2006						
If you wanted to complain, did hospital staff give you the information you needed to do this?								
Key								
Best performing 20% Trusts								
Intermediate 65% Trusts								
Worst performing 20% Trust								
The Trust's results are not shown if there are fewer than 30 respondents								

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board (Public) May 2008**

Report by: **The Nursing Directorate**

Subject: **Health Care Commission – Annual Healthcheck**

Attached at Appendix 1 is a copy of the Annual health check declaration against the core standards submitted from this Trust. A copy has been posted on the Trust web site

The core standards declaration forms only part of the annual healthcheck. Also included are the 'new and existing targets' for 2007/08.
Attached at appendix 2 is information on how the HCC calculates the scores relating to the new and national targets. There is a process for ratification of the data relating to the targets and this will continue throughout the summer prior to the ratings being issued in the autumn.

The planned timetable for publication of the annual healthcheck is as follows:

- Tuesday 14th October 2008 – each Trust gets access to own results under embargo and via a password protected website
- Wed 15th October 2008 am – all ratings available under embargo to trusts STHAs and the media
- Wednesday 15th October 2008 pm – all trusts able to brief their staff under emargo
- 00.01 Thursday 16th October 2008 – ratings made available to the public.

Reviews and studies relevant to this Trust

- Review of urgent and emergency care services – The report is being finalized and a short report will be published alongside the final scored assessment once the ratification and extenuating circumstances processes are completed
- Survey of acute in-patients – results just published
- National study of how healthcare organizations engage with patients and the public - scoping work for this study has been completed and is now in progress
- Research study on how NHS boards use information on safety to assure themselves that services are safe. This is with a view to sharing best practice and developing and publishing a set of benchmarked safety indicators

The Board is asked to receive the report

Nursing Director
May 2008

Scoring methodology for new national targets for 2007/2008

The Healthcare Commission reserves the right to modify its scoring methods in light of experience. Any changes made would be transparent and intended to promote fairness in the results of the assessment. Rule changes would either apply across all healthcare organisation types, or might be specific to a particular healthcare organisation type.

This document describes how the Healthcare Commission will calculate scores for performance relating to new national targets for each NHS organisation in the 2007/2008 annual health check. Assessment of performance against the new national targets is one component of the quality of services part of the Healthcare Commission's 2007/2008 annual health check performance rating and covers the targets published by the Department of Health in *National Standards, Local Action: Health and Social Care Standards and Planning Framework 2005/2006 – 2007/2008.*

This document includes the following details:

1. Outline of the new national targets scoring methodology

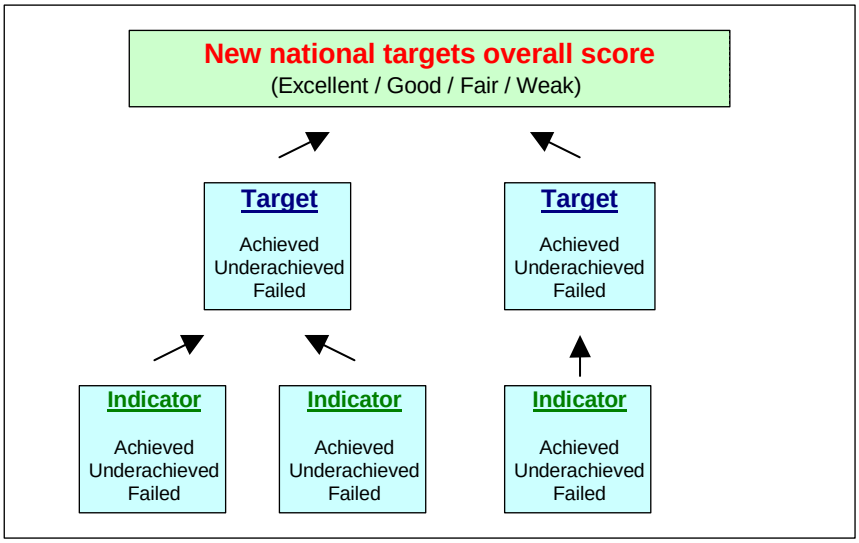
The scores for each new national target are aggregated into one overall score, which then contributes to the overall quality of services part of the annual health check performance rating. The new national targets component of the 2007/2008 annual health check is scored on the following four-grade scale:

- **Excellent**
- **Good**
- **Fair**
- **Weak**

The following four types of trust are assessed against the new national targets in the 2007/2008 annual health check – acute and specialist, mental health, ambulance, and primary care trust (PCT). Each trust is assessed within its own group by a set of performance indicators, specifically designed to measure the new national targets that apply to it. Combined trusts (PCTs that provide mental health services and the Isle of Wight NHS PCT, which incorporates acute, ambulance, mental health and primary care functions) are assessed on the performance indicators that apply to them from each relevant organisation type set.

In the 2007/2008 annual health check, the Healthcare Commission is using 59 different performance indicators to measure performance against the new national targets. Some new national targets are measured by one performance indicator and others are measured by more than one (see Figure 1 below).

Figure 1 Illustration of new national targets scoring methodology



Not all the new national targets (and the indicators of performance used to assess them) are applicable to all trusts. This varies according to the type of trust. It may also vary between trusts of the same type, depending on the services provided. Trusts will only be assessed against the targets and indicators that are applicable to them. For example, if a mental health trust does not provide older people mental health services, the performance indicator '*CMHT integration (older people)*' will not apply.

See Appendices 2 to 6 for full lists of new national targets and relevant performance indicators by organisation type.

2. Key principles of scoring new national targets

The following key principles underpin the new national targets scoring methodology:

i. Scores of 'excellent', 'good', 'fair' and 'weak' for new national targets are based on cumulative scores from all the individual new national targets.

ii. All individual new national targets are equally weighted.

iii. Where there is more than one performance indicator used to assess a new national target, then all performance indicators within the target are equally weighted.

iv. Performance relating to each performance indicator is assessed as '**achieved**', '**underachieved**' or '**failed**'. This is based on expected levels of performance using two defined thresholds; the first threshold distinguishes between 'achieved' and 'underachieved', the second distinguishes between 'underachieved' and 'failed'.

v. Performance relating to each new national target is also assessed as '**achieved**', '**underachieved**' or '**failed**'. Where only one performance indicator is used to assess a new national target, the individual target score will mirror the performance indicator score (i.e. underachieving the performance indicator results in underachieving the relevant target). Rules for scoring a target where there are two or more performance indicators used to assess the target are detailed in Appendix 1.

vi. For each individual new national target, a trust is allocated points in relation to its performance level using the following rules:

Achieved target:	3 points
Underachieved target:	2 points
Failed target:	0 points

Therefore, a trust that fails one target fails to score 3 available points. This is equivalent to the number of available points not scored if a trust underachieves three targets. This reflects the severity of failing to meet a target.

vii. Overall scores of 'excellent', 'good', 'fair' and 'weak' on new national targets are calculated by comparing the number of points scored with the maximum number of points available to the trust. Please refer to sections 3 to 8 for full details of the required points to score 'excellent', 'good', 'fair' and 'weak' for acute and specialist, primary care, ambulance and mental health trusts respectively.

viii. Trusts are only assessed against the indicators/targets that are applicable to them. Indicators or targets that are not applicable are not included in the calculation of the overall score for new national targets.

ix. If an indicator is applicable to a trust but data are not available (through no fault of the trust), a category of 'data not available' will be awarded and the indicator will not be included in the calculation of the overall score for new national targets.

x. If a trust has low activity, such that there is not sufficient data to adequately assess them against an indicator, a category of 'data not available' will be

awarded and the indicator will not be included in the calculation of the overall score for new national targets.

xi. If an indicator is constructed such that actual performance is assessed against planned performance and a trust has been authorised to not plan any performance in 2007/2008, a category of 'data not available' will be awarded and the indicator will not be included in the calculation of the overall score for new national targets.

xii. Trusts that submit incomplete data, or miss the published deadline for data submission, will be awarded the lowest score available for the relevant indicator(s).

3. Allocation table for acute and specialist trusts

Acute and specialist trusts have up to 10 new national targets that apply for scoring, which are measured by 13 performance indicators. For seven of the targets, one indicator is used to assess the target. For three targets, two indicators are used to assess the target. See Appendix 2 for a full list of the new national targets and relevant performance indicators applicable to acute and specialist trusts.

The number of targets applicable to acute and specialist trusts may vary and this is reflected in the methodology to derive the new national targets overall score. Table 1 below shows the number of points required to score 'excellent', 'good', 'fair' or 'weak' depending on the number of targets that apply.

Table 1. Acute & Specialist Trusts – new national targets overall scoring allocation table

Number of targets that apply	Maximum Points Available	Excellent	Good	Fair	Weak
10	*30*	>=28	>=25	>=22	<22
9	*27*	>=26	>=23	>=20	<20
8	*24*	>=23	>=20	>=18	<18
7	*21*	>=20	>=18	>=16	<16
6	*18*	>=17	>=15	>=14	<14
5	*15*	>=14	>=13	>=11	<11
4	*12*	=12	>=10	>=9	<9

Therefore, when all **10** new national targets apply to an acute or specialist trust, scoring is as follows:

Excellent >=28 out of 30 points
(i.e. tolerance for two underachieved targets only)

Good >=25 out of 30 points
(i.e. tolerance for one failed target and two underachieved targets only or five underachieved targets only etc)

Fair >=22 out of 30 points
(i.e. tolerance for two failed targets and two underachieved targets only or eight underachieved targets only etc)

Weak <22 out of 30 points
(i.e. greater than two failed targets and two underachieved targets or greater than eight underachieved targets etc)

4. Allocation table for PCTs

PCTs have up to 13 new national targets that apply for scoring, which are measured by 32 performance indicators. For two of the targets, one indicator is used to assess the target. For four of the targets, two indicators are used to assess the target. For six of the targets, three indicators are used to assess the target. Finally, for one target, four indicators are used to assess the target. See Appendix 3 for a full list of the new national targets and relevant performance indicators applicable to PCTs.

The number of targets applicable to PCTs may vary and this is reflected in the methodology to derive the new national targets overall score. Table 2 below shows the number of points required to score 'excellent', 'good', 'fair' or 'weak' depending on the number of targets that apply.

Table 2. Primary Care Trusts – new national targets overall scoring allocation table

Number of targets that apply	Maximum Points Available	Excellent	Good	Fair	Weak
13	*39*	>=36	>=32	>=29	<29
12	*36*	>=33	>=30	>=27	<27
11	*33*	>=30	>=27	>=24	<24
10	*30*	>=27	>=24	>=21	<21
9	*27*	>=25	>=22	>=19	<19
8	*24*	>=22	>=20	>=17	<17
7	*21*	>=19	>=17	>=15	<15
6	*18*	>=17	>=15	>=13	<13
5	*15*	>=14	>=12	>=11	<11
4	*12*	>=11	>=10	>=9	<9

Therefore, when all **13** new national targets apply to a PCT, scoring is as follows:

Excellent >=36 out of 39 points
(i.e. tolerance for one failed target only or three underachieved targets only)

Good >=32 out of 39 points
(i.e. tolerance for two failed targets and one underachieved target only or seven underachieved targets only etc)

Fair >=29 out of 39 points
(i.e. tolerance for three failed targets and one underachieved target only or 10 underachieved targets only etc)

Weak <27 out of 36 points
(i.e. greater than three failed targets and one underachieved target or greater than 10 underachieved targets etc)

5. Allocation table for ambulance trusts

Ambulance trusts have up to four new national targets that apply for scoring, which are measured by five performance indicators. For three of the targets, one indicator is used to assess the target. For one target, two indicators are used to assess the target. See Appendix 4 for a full list of the new national targets and relevant performance indicators applicable to ambulance trusts.

The number of targets applicable to ambulance trusts may vary and this is reflected in the methodology to derive the new national targets overall score. Table 3 below shows the number of points required to score 'excellent', 'good', 'fair' or 'weak' depending on the number of targets that apply.

Table 3. Ambulance Trusts – new national targets overall scoring allocation table

Number of targets that apply	Maximum Points Available	Excellent	Good	Fair	Weak
4	12	=12	=11	>=9	<9
3	9	=9	=8	=7	<7

Therefore, when all **four** new national targets apply to an ambulance trust, scoring is as follows:

Excellent =12 out of 12 points
(i.e. no tolerance to underachieve or fail any targets)

Good =11 out of 12 points
(i.e. tolerance for one underachieved target only)

Fair >=9 out of 12 points
(i.e. tolerance for one failed target only or three underachieved targets only etc)

Weak <9 out of 12 points
(i.e. greater than one failed target or greater than three underachieved targets etc)

6. Allocation table for mental health trusts

Mental health trusts have up to eight new national targets that apply for scoring, which are measured by nine performance indicators. For seven of the targets, one indicator is used to assess the target. For one target, two indicators are used to assess the target. See Appendix 5 for a full list of the new national targets and relevant performance indicators applicable to mental health trusts.

The number of targets applicable to mental health trusts may vary and this is reflected in the methodology to derive the new national targets overall score. Table 4 below shows the number of points required to score 'excellent', 'good', 'fair' or 'weak' depending on the number of targets that apply.

Table 4. Mental Health Trusts – new national targets overall scoring allocation table

Number of targets that apply	Maximum Points Available	Excellent	Good	Fair	Weak
8	24	>=23	>=21	>=18	<18
7	21	>=20	>=18	>=16	<16
6	18	=18	>=16	>=14	<14
5	15	=15	>=13	>=12	<12
4	12	=12	=11	>=9	<9

Therefore, when all **eight** new national targets apply to a mental health trust, scoring is as follows:

Excellent >=23 out of 24 points
(i.e. tolerance for one underachieved target only)

Good >=21 out of 24 points
(i.e. tolerance for one failed target only or three underachieved targets only etc)

Fair >=18 out of 24 points
(i.e. tolerance for two failed targets only or six underachieved targets only etc)

Weak <16 out of 21 points
(i.e. greater than two failed targets or greater than six underachieved targets etc)

7. Allocation table for PCTs that provide mental health services

Primary care trusts providing mental health services will be assessed against up to 13 new national targets as a PCT and up to eight new national targets as a mental health provider. They will, therefore, be scored overall as having up to 21 new national targets that apply for scoring, which are measured by a total of 41 performance indicators. For 9 of the targets, one indicator is used to assess the target. For five of the targets, two indicators are used to assess the target. For six of the targets, three indicators are used to assess the target. Finally, for one target, four indicators are used to assess the target. See Appendices 3 and 5 for full lists of the new national targets and relevant performance indicators applicable to PCTs that also provide mental health services.

The number of targets applicable to PCTs that also provide mental health services may vary and this is reflected in the methodology to derive the new national targets overall score. Table 6 below shows the number of points required to score 'excellent', 'good', 'fair' or 'weak' depending on the number of targets that apply.

Table 6. Primary Care Trusts (providing mental health services) - new national targets overall scoring allocation table

Number of targets that apply	Maximum Points Available	Excellent	Good	Fair	Weak
21	63	>=59	>=53	>=47	<47
20	60	>=56	>=51	>=45	<45
19	57	>=53	>=48	>=42	<42
18	54	>=51	>=46	>=41	<41
17	51	>=48	>=43	>=39	<39
16	48	>=45	>=41	>=36	<36
15	45	>=42	>=38	>=34	<34
14	42	>=39	>=36	>=32	<32

Therefore, when all **20** new national targets apply to a primary care trust (also providing mental health services), scoring is as follows:

Excellent >=56 out of 60 points
(i.e. tolerance for one failed target and one underachieved target only or four underachieved targets only etc)

Good >=51 out of 60 points
(i.e. tolerance for three failed targets only or nine underachieved targets only etc)

Fair >=45 out of 60 points
(i.e. tolerance for five failed targets only or fifteen underachieved targets only etc)

Weak <45 out of 60 points
(i.e. greater than five failed targets or greater than fifteen underachieved targets etc)

8. Allocation table for combined trusts, which incorporate acute, ambulance, mental health and primary care functions

A trust, which incorporates acute, ambulance, mental health and primary care functions, has up to 10 new national targets applicable as a provider of acute services, eight new national target applicable as a mental health provider, four new national targets applicable as a provider of ambulance services and up to 13 new national targets applicable in relation to its primary care functions. They will, therefore, be scored overall as having up to 35 new national targets that apply for scoring, which are measured by a total of 59 performance indicators. For 19 of the targets, one indicator is used to assess the target. For nine of the targets, two indicators are used to assess the target. For six of the targets, three indicators are used to assess the target. For one target, four indicators are used to assess the target. See Appendices 2, 3, 4 and 5 for full lists of the new national targets and relevant performance indicators applicable to the Isle of Wight NHS PCT.

The number of targets applicable for this type of trust may vary and this is reflected in the methodology to derive the new national targets overall score. Table 7 below shows the number of points required to score 'excellent', 'good', 'fair' or 'weak' depending on the number of targets that apply.

Table 7. Combined trust, which provides acute, ambulance and mental health services – new national targets overall scoring allocation table

Number of targets that apply	Maximum Points Available	Excellent	Good	Fair	Weak
35	105	>=99	>=89	>=78	<78
34	102	>=96	>=86	>=76	<76
33	99	>=93	>=83	>=73	<73
32	96	>=90	>=80	>=70	<70
31	93	>=87	>=78	>=68	<68
30	90	>=84	>=75	>=65	<65
29	87	>=82	>=72	>=62	<62
28	84	>=79	>=70	>=60	<60

Therefore, when all **35** new national targets apply to this type of trust, scoring is as follows:

Excellent >=99 out of 105 points
(i.e. tolerance for two failed targets only or six underachieved targets only etc)

Good >=89 out of 105 points
(i.e. tolerance for five failed targets and one underachieved target only or 16 underachieved targets only etc)

Fair >=78 out of 105 points
(i.e. tolerance for nine failed targets only or 27 underachieved targets only etc)

Weak <78 out of 105 points
(i.e. greater than for nine failed targets or greater than 27 underachieved targets etc)

Appendix 1. Scoring rules for a new national target where there are two or more performance indicators used to assess the target

Key to table:
A = Achieved performance indicator
U = Underachieved performance indicator
F = Failed performance indicator

Table 8. Scoring of a new national target consisting of two or more performance indicators

New national target consisting of 2 indicators		New national target consisting of 3 indicators		New national target consisting of 4 indicators		New national target consisting of 5 indicators	
Indicator Scores	Target Score	Indicator Scores	Target Score	Indicator Scores	Target Score	Indicator Scores	Target Score
AA	Achieved	**AAA**	Achieved	**AAAA**	Achieved	**AAAAA**	Achieved
AU	Underachieved	**AAU**	Achieved	**AAAU**	Achieved	**AAAAU**	Achieved
UU	Underachieved	**AUU**	Underachieved	**AAUU**	Underachieved	**AAAUU**	Achieved
AF	Failed	**AAF**	Underachieved	**AUUU**	Underachieved	**AAUUU**	Underachieved
FU	Failed	**UUU**	Underachieved	**AAAF**	Underachieved	**AAAAF**	Underachieved
FF	Failed	**AUF**	Failed	**AAUF**	Underachieved	**AUUUU**	Underachieved
		UUF	Failed	**UUUU**	Underachieved	**AAAUF**	Underachieved
		AFF	Failed	**AUUF**	Failed	**AAUUF**	Underachieved
		UFF	Failed	**UUUF**	Failed	**UUUUU**	Underachieved
		FFF	Failed	**AAFF**	Failed	**AAAFF**	Underachieved
				AUFF	Failed	**AUUUF**	Underachieved
				UUFF	Failed	**AAUFF**	Failed
				AFFF	Failed	**AUUFF**	Failed
				UFFF	Failed	**UUUUF**	Failed
				FFFF	Failed	**AAFFF**	Failed
						UUUFF	Failed
						AFFFU	Failed
						UUFFF	Failed
						AFFFF	Failed
						UFFFF	Failed
						FFFFF	Failed

Appendix 2. New national targets applicable to acute and specialist trusts

New national target		Performance indicator	
1	Achieve year on year reductions in methicillin resistant Staphylococcus aureus (MRSA) levels, expanding to cover other healthcare associated infections as data from mandatory surveillance becomes available.	1	MRSA Bacteraemia
		2	Clostridium difficile data quality
2	Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.	3	Drug misusers: information, screening and referral
3	Reduce health inequalities by 10% by 2010 as measured by infant mortality (from a 1997 - 1999 baseline) and life expectancy at birth (from a 1995 - 1997 baseline).	4	Data quality on ethnic group
		5	Infant health & inequalities: smoking during pregnancy and breastfeeding initiation
4	Reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.	6	Access to genito-urinary medicine (GUM) clinics
5	Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys.	7	Experience of patients
6	Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	8	Participation in audits
7	Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%.	9	Self harm: compliance with NICE guidelines
8	To ensure that by 2008 nobody waits more than 18 weeks from GP referral to hospital treatment.	10	Waiting times for diagnostic tests
		11	Referral to treatment times milestones
9	To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the 2003/2004 baseline) through improved care in primary care and community settings for people with long term conditions.	12	Emergency bed days

New national target		Performance indicator	
10	Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.	**13**	Obesity: compliance with NICE guidelines

Appendix 3. New national targets applicable to primary care trusts

New national target		Performance indicator	
1	Achieve year on year reductions in methicillin resistant Staphyloccus aureus (MRSA) levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available.	1	Infection control
2	Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008, and increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	2	Community equipment
		3	Older people's mental health: assessment of needs and services
3	Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.	4	Drug misusers sustained in treatment
		5	Drug misusers in treatment
4	Reduce health inequalities by 10% by 2010 as measured by infant mortality (from a 1997 - 1999 baseline) and life expectancy at birth (from a 1995 - 1997 baseline).	6	Data quality on ethnic group
		7	Infant health & inequalities: breastfeeding initiation rates
		8	Infant health & inequalities: smoking during pregnancy
5	Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups (from 31% in 2002) to 26% or less.	9	Four week smoking quitters
		10	Smoking status among the population aged 16 and over
6	Reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.	11	Access to genito-urinary medicine (GUM) clinics
		12	Access to reproductive health services
		13	Teenage conception rates
7	Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys.	14	Experience of patients

8	Substantially reduce mortality rates by 2010 (from the 'Our healthier nation' baseline, 1995 - 1997) from suicide and undetermined injury by at least 20%.	**15**	CPA 7-Day follow up and suicide audit
		16	Commissioning of early intervention in psychosis services
		17	Community development workers
9	Substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	**18**	Breast cancer screening for women aged 50 to 70 years
		19	Improving cancer services
		20	Cancer mortality rate
10	Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	**21**	Blood pressure
		22	Cardiovascular disease mortality
		23	Cholesterol levels
		24	Practice-based registers
11	Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.	**25**	GP recording of body mass index (BMI) status
		26	National Child Measurement Programme (NCMP): data quality
		27	Obesity: compliance with NICE guidance 43
12	To ensure that by 2008 nobody waits more than 18 weeks from GP referral to hospital treatment.	**28**	Referral to treatment times milestones
		29	Waiting times for diagnostic tests
13	To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/2004 baseline) through improved care in primary care and community settings for people with long term conditions.	**30**	Community matrons & additional case managers
		31	Emergency bed days
		32	Number of very high intensity users

Appendix 4. New national targets applicable to ambulance trusts

New national target		Performance indicator	
1	Achieve year on year reductions in methicillin resistant Staphylococcus aureus (MRSA) levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available.	1	Infection control
2	Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.	2	Obesity: compliance with NICE guideline 43
3	Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	3	Participation in audits
		4	Emergency response to stroke and transient ischaemic attack
4	Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%	5	Self harm: compliance with NICE and JRCALC guidelines

Appendix 5. New national targets applicable to mental health trusts

New national target		Performance indicator	
1	Achieve year on year reductions in methicillin resistant Staphylococcus aureus (MRSA) levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available.	1	Infection control
2	To improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by: increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008; and increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	2	CMHT integration (older people)
3	Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.	3	Drug misusers sustained in treatment
4	Reduce health inequalities by 10% by 2010 as measured by infant mortality (from a 1997 - 1999 baseline) and life expectancy at birth (from a 1995 - 1997 baseline).	4	Data quality on ethnic group
5	Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.	5	Obesity: compliance with NICE guideline 43
6	Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys.	6	Experience of patients
7	Substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%	7	Audit of suicide prevention
		8	Schizophrenia: improvement towards compliance with NICE guidelines
8	To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the 2003/2004 baseline) through improved care in primary care and community settings for people with long term conditions.	9	Care in the community

WORKED EXAMPLE

Detailed below is a worked example of scoring a primary care trust against the new national targets.

Any Town Primary Care Trust is a primary care trust, which has achieved the following scores on the performance indicators used to assess the new national targets:

- **Achieved** the indicator *'Infection control'*
- **Achieved** the indicator *'Community equipment'*
- **Achieved** the indicator *'Older people's mental health: assessment of needs and services'*
- **Achieved** the indicator *'Drug misusers sustained in treatment'*
- **Achieved** the indicator *'Drug misusers in treatment'*
- **Achieved** the indicator *'Data quality on ethnic group'*
- **Underachieved** the indicator *'Infant health & inequalities: breastfeeding initiation rates'*
- **Achieved** the indicator *'Infant health & inequalities: smoking during pregnancy'*
- **Achieved** the indicator *'Four week smoking quitters'*
- **Underachieved** the indicator *'Smoking status among the population aged 16 and over'*
- **Achieved** the indicator *'Access to genito-urinary medicine (GUM) clinics'*
- **Failed** indicator *'Access to reproductive health services'*
- **Underachieved** the indicator *'Teenage conception rates'*
- **Achieved** the indicator *'Experience of patients'*
- **Achieved** the indicator *'CPA 7-Day follow up and suicide audit'*
- **Achieved** the indicator *'Commissioning of early intervention in psychosis services'*
- **Achieved** the indicator *'Community development workers'*
- **Achieved** the indicator *'Breast cancer screening for women aged 50 to 70 years'*
- **Achieved** the indicator *'Improving cancer services'*
- **Achieved** the indicator *'Cancer mortality rate'*
- **Achieved** the indicator *'Blood pressure'*
- **Failed** the indicator *'Cardiovascular disease mortality'*
- **Achieved** the indicator *'Cholesterol levels'*
- **Achieved** the indicator *'Practice-based registers'*
- **Achieved** the indicator *'GP recording of body mass index (BMI) status'*
- **Achieved** the indicator *'National child measurement programme (NCMP): data quality'*
- **Achieved** the indicator *'Obesity: compliance with NICE guidance 43'*
- **Achieved** the indicator *'Referral to treatment times milestones'*
- **Underachieved** the indicator '*Waiting times for diagnostic tests'*
- **Achieved** the indicator *'Community matrons and additional case managers'*
- **Achieved** the indicator *'Emergency bed days'*
- **Achieved** the indicator *'Number of very high intensity users'*

Table 9 below details Any Town Primary Care Trust's scores for the above performance indicators and the new national targets they assess. (N.B. refer to Section 2, key principle (v) and Appendix 1 with regards to scoring of individual new national targets).

Table 9. Any Town Primary Care Trust – Performance Indicator and New National Target Scores				
Performance Indicators	**Indicator Score**	**New National Targets**	**Target Score**	**Points Scored**
Infection control	**Achieved**	Achieve year on year reductions in methicillin resistant Staphyloccus aureus (MRSA) levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available.	**Achieved**	**3**
Community equipment	**Achieved**	Improve the quality of life and independence of vulnerable older people by supporting them to live in their own homes where possible by increasing the proportion of older people being supported to live in their own home by 1% annually in 2007 and 2008, and increasing by 2008 the proportion of those supported intensively to live at home to 34% of the total of those being supported at home or in residential care.	**Achieved**	**3**
Older people's mental health: assessment of needs and services	**Achieved**			
Drug misusers sustained in treatment	**Achieved**	Increase the participation of problem drug users in drug treatment programmes by 100% by 2008 (from a 1998 baseline); and increase year on year the proportion of users successfully sustaining or completing treatment programmes.	**Achieved**	**3**
Drug misusers in treatment	**Achieved**			
Data quality on ethnic group	**Achieved**	Reduce health inequalities by 10% by 2010 as measured by infant mortality (from a 1997 - 1999 baseline) and life expectancy at birth (from a 1995 - 1997 baseline).	**Underachieved**	**2**
Infant health & inequalities: breastfeeding initiation rates	**Underachieved**			
Infant health & inequalities: smoking during pregnancy	**Achieved**			
Four week smoking quitters	**Achieved**	Reducing adult smoking rates (from 26% in 2002) to 21% or less by 2010, with a reduction in prevalence among routine and manual groups (from 31% in 2002) to 26% or less.	**Underachieved**	**2**
Smoking status among the population aged 16 and over	**Underachieved**			
Access to genito-urinary medicine (GUM) clinics	**Achieved**	Reducing the under-18 conception rate by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.	**Failed**	**0**
Access to reproductive health services	**Failed**			
Teenage conception rates	**Underachieved**			
Experience of patients	**Achieved**	Secure sustained national improvements in NHS patient experience by 2008, ensuring that individuals are fully involved in decisions about their health care, including choice of provider, as measured by independently validated surveys.	**Achieved**	**3**

Table 9. Any Town Primary Care Trust – Performance Indicator and New National Target Scores				
Performance Indicators	**Indicator Score**	**New National Targets**	**Target Score**	**Points Scored**
CPA 7-Day follow up and suicide audit	**Achieved**	Substantially reduce mortality rates by 2010 (from the 'Our healthier nation' baseline, 1995 - 1997) from suicide and undetermined injury by at least 20%.	**Achieved**	**3**
Commissioning of early intervention in psychosis services	**Achieved**			
Community development workers	**Achieved**			
Breast cancer screening for women aged 50 to 70 years	**Achieved**	Substantially reduce mortality rates by 2010 from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	**Achieved**	**3**
Improving cancer services	**Achieved**			
Cancer mortality rate	**Achieved**			
Blood pressure	**Achieved**	Substantially reduce mortality rates by 2010 from heart disease and stroke and related diseases by at least 40% in people under 75, with a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole.	**Underachieved**	**2**
Cardiovascular disease mortality	**Failed**			
Cholesterol levels	**Achieved**			
Practice-based registers	**Achieved**			
GP recording of body mass index (BMI) status	**Achieved**	Tackle the underlying determinants of ill health and health inequalities by halting the year on year rise in obesity among children under 11 by 2010 (from the 2002/2004 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.	**Achieved**	**3**
National Child Measurement Programme (NCMP): data quality	**Achieved**			
Obesity: compliance with NICE guidance 43	**Achieved**			
Referral to treatment times milestones	**Achieved**	To ensure that by 2008 nobody waits more than 18 weeks from GP referral to hospital treatment.	**Underachieved**	**2**
Waiting times for diagnostic tests	**Underachieved**			
Community matrons	**Achieved**	To improve health outcomes for people with long term conditions by offering a personalised care plan for vulnerable people most at risk; and to reduce emergency bed days by 5% by 2008 (from the expected 2003/2004 baseline) through improved care in primary care and community settings for people with long term conditions.	**Achieved**	**3**
Emergency bed days	**Achieved**			
Number of very high intensity users	**Achieved**			

Therefore, 13 out of the 13 new national targets are applicable for scoring Any Town Primary Care Trust. In the above example, Any Town Primary Care Trust scored a total of 32 out of 39 possible points.

According to the new national targets overall scoring allocation table (see Section 4 above or table 10 below) for primary care trusts, Any Town Primary Care Trust's score of 32 points is equal to the 32 points required to be 'good' but less than the 36 points required to be 'excellent'.

Any Town Primary Care Trust therefore scores '**good**' for new national targets.

Table 10. Primary care trusts – new national targets overall scoring allocation table

Number of targets that apply	Maximum Points Available	Excellent	Good	Fair	Weak
13	*39*	>=36	>=32	>=29	<29
12	*36*	>=33	>=30	>=27	<27
11	*33*	>=30	>=27	>=24	<24
10	*30*	>=27	>=24	>=21	<21
9	*27*	>=25	>=22	>=19	<19
8	*24*	>=22	>=20	>=17	<17
7	*21*	>=19	>=17	>=15	<15
6	*18*	>=17	>=15	>=13	<13
5	*15*	>=14	>=12	>=11	<11
4	*12*	>=11	>=10	>=9	<9

Inspecting Informing Improving

Webforms Output: Core standards declaration 2007/2008 April 2008

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Confirmation

* Please enter the postcode for your organisation. This must be in capital letters and be in the format EC1Y 8TG.

- END OF PAGE -

This is the information that we have for your organisation.

If this information is incorrect please contact the Healthcare Commission at forms@healthcarecommission.org.uk

Organisation Name:	Dudley Group Of Hospitals NHS Trust
Chief Executive's First Name:	Paul
Chief Executive's Surname:	Farenden
Chief Executive's Email:	paul.farenden@dgoh.nhs.uk
Organisation Code:	RNA

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If your organisation is any of the following please select the option PCT or Community Trust:

PCT
Community Trust
PCT with Mental Health
Care Trust with PCT

If your organisation is any of the following please select the option Mental Health or Learning Disability

Mental Health
Learning Disability
Care Trust with Mental Health

* Please enter your type of organisation

- **O Acute**
- O Mental Health/Learning Disability
- O PCT
- O Ambulance
- O Isle of Wight NHS PCT
- O NHS Direct
- O Health Protection Agency
- O NHS Blood and Transplant

General Guidance

You might find it helpful to print the following instructions (a printable version is available here) so you can refer to them easily while you are completing the declaration form.
The declaration form is divided into the following sections:
1. General statement of compliance
2. Statement on measures in place to meet the provisions of the Hygiene Code
3. Domain pages for core standards
4. Sign off
5. Comments from third parties

Your declaration will be the basis of your score for the assessment of core standards.

For core standards, your declaration should cover the period from April 1st 2007 to March 31st 2008. The statement on the Hygiene Code should set out whether the appropriate measures are in place to ensure that the provisions of the Hygiene Code were being observed during 2007/2008.

There will not be a specific developmental standards assessment as part of the 2007/2008 annual health check. Instead, we will issue a small set of comparative, or benchmark, indicators to trusts to show their position relative to similar trusts within specific domains (safety, clinical and cost effectiveness or public heath). We expect that trust boards will use this information along with the local data that trusts already use when reviewing their performance and considering their compliance with the core standards.

Please note you are only able to access sections applicable to your trust type.

1. General statement of compliance

The general statement is an opportunity for trusts to place in context the detail of the domain pages and the comments received from the specified third parties. Each trust should use the general statement of compliance to present a summary of its declaration. It is important for the statement to be consistent with the detail presented in the rest of the declaration.

2. Statement on measures in place to meet the Hygiene Code

Trusts are asked to provide a short statement outlining whether the trust considers it has appropriate measures in place to ensure that the provisions of the Hygiene Code were being observed during March 2007/ 2008. This year, we have been inspecting acute trusts as part of our duty under the Hygiene Code. If you have the results of a Hygiene Code inspection, you must include a short summary of the findings and any actions taken as a result of the inspection. This statement is also intended to provide assurance to patients and the public that trusts have taken due account of their new duties under the Code.

Please note - the Health Protection Agency and NHS Direct are not required to provide a statement on measures in place to meet the Hygiene Code.

3. Domain pages for core standards

Separate sections have been set up for each domain.

For each part standard (for example, C7b), you must categorise your trust under one of the following headings:

Compliant - a declaration of 'compliant' should be used where a trust's board determines that it has had 'reasonable assurance' that it has been meeting a standard, without significant lapses, from April 1st 2007 to March 31st 2008.

Not met - a declaration of 'not met' should be used where the assurances received by the trust's board make it clear that there has been one or more significant lapses in relation to a standard during the year.

Insufficient assurance - a declaration of 'insufficient assurance' should be used where a lack of assurance leaves the trust's board unclear as to whether there have been any significant lapses during 2007/2008. Please note, in circumstances where a trust is unclear about compliance for a whole year but has good evidence about the occurrence a significant lapse during the year, the trust should consider whether a declaration of 'not met' is more appropriate.

For each standard, the boards of trusts need to decide whether any identified lapses are significant or not. In making this decision, we anticipate that boards will consider any potential risks to patients, staff and the public, and the duration and impact of the lapse. The declaration should not be used for reporting isolated, trivial or purely technical lapses in respect of the core standards.

If one or more standards within a domain is declared as 'not met' or 'insufficient assurance', please record the details for each of these standards, including the following items of information:

Start date - the date at the start of the period for which the trust has:
- identified a lack of assurance to determine whether there have been any significant lapse(s)
or
- identified one or more significant lapses which means that the trust has not met the standard

End date (planned or actual) - the date by which the trust plans to have:
- assurances in place to enable it to determine whether the standard has been met
or
- addressed the issues identified as one or more significant lapse(s)

Issue - a statement detailing:
- why the trust does not have assurance to determine their level of compliance
or
- the details of the significant lapse(s) that have been identified

Action plan - an outline of the steps the trust is taking, or has taken, to:
- address an issue of 'insufficient assurance' (that is, the actions in place to gain assurances of whether or not the trust is meeting the standard) or
- address an issue of 'not met' (that is, the actions in place to address the areas for which the trust has identified one or more significant lapse(s))

This year, where applicable, we will ask you for additional information where:
- the standard was declared as 'not met' or insufficient assurance' in 2006/2007 and
- there was an action plan with an end date before 31st March 2007 and
- the standard has again been declared as 'not met' or 'insufficient assurance' for 2007/08.

Please describe the circumstances for this second consecutive declaration of non-compliance in light of the action plan.

Some standards are not included in the declaration, as separate assessments for them are being undertaken elsewhere in our overall assessment process or where these have been judged to not be applicable to the trust type. These standards are:

C7d - this relates to financial management and will be measured through the use of resources assessment for which we will rely on the findings of the Audit Commission or Monitor.

C7f - this relates to existing performance requirements and will be measured through the existing targets assessment.

C19 - this relates to access to services with nationally agreed timescales and will be measured through the existing targets and new national targets assessments.

In addition there are standards which are not applicable for certain trust types and as such will only be shown on the declaration form where applicable:

C3 - regarding NICE interventional procedures, we are not assessing ambulance trusts, mental health services, primary care trusts and learning disability services on this standard for 2007/2008.

C4c - regarding reusable medical devices, we are not assessing ambulance trusts, mental health services and learning disability services on this standard for 2007/2008.

C15a and C15b - regarding provision of food for patients, we are not assessing ambulance trusts on these standards.

C22b - regarding local health needs, we are not assessing acute trusts, ambulance trusts, mental health services and learning disability services on this standard for 2007/2008

HPA / NHSD and NHSBT - Some standards are not included in the declaration for your trust. These will have been agreed with you and the reasons for their exclusion are documented on our website

4. Sign off

The Healthcare Commission recommends that all members of the trust board, including the non-executive directors (for foundation trusts this should be the board of directors), should sign off the declaration in the space provided below. Here, sign off is achieved by recording the name(s) and position(s) of the individual(s) concerned. We do not require scanned signatures.

As a minimum, we require the declaration to be signed off by an appropriate officer(s) with delegated authority from the board.

The completion of the sign off page will be taken as verification that the individual(s) who are recorded as signing off the declaration have reviewed the contents of the declaration form and are certifying that:

- the general statement of compliance, and information provided for each standard, are a true representation of the trust's compliance for the core standards

- the statement of the measures in place to meet the requirements of the Hygiene Code are a true representation of the trust's position

- any commentaries provided by specified third parties have been reproduced verbatim. Specific third parties are: strategic health authority, and foundation trust board of governors, where relevant, and patient and public involvement forums and overview and scrutiny committees

- they are signing off the declaration form on their behalf and with delegated authority on behalf of all members of the trust board as referred to above

5. Comments from specified third parties

Trusts are required to invite comments on their performance against the core standards, from specified third parties. These comments must be reproduced verbatim in the relevant sections of the form. The specified partners are:

- for all NHS trusts, except foundation trusts, third parties must include the strategic health authority, the local authority's overview and scrutiny committee, the trust's patient and public involvement forum and the local safeguarding children board

- for foundation trusts, third parties must include the local authority's overview and scrutiny committee, the patient and public involvement forum and the local safeguarding children board. We also encourage foundation trusts to seek, if they wish, comments from their board of governors and strategic health authority

- for the Health Protection Agency, NHS Direct and the NHS Blood and Transplant, organisations are required to invite comments on their performance against the core standards from specified third parties. These have been agreed with you. These comments must be reproduced verbatim in the relevant sections of the form. At the top of the section, please record the name of the commentator.

A trust may have more than one overview and scrutiny committee within its catchment area. If this is the case, it should invite comments from those committees it deems most relevant. In addition, a committee may specifically ask to comment on the performance of a trust against core standards. Where this is the case, the trust should accept comments from such a committee and include them on their declaration form. In some locations, overview and scrutiny committees will have joint working arrangements. Where this is the case, the trust may wish to use those arrangements to gain comment.

Where a specified local partner declines to comment, a statement to this effect must be included in the declaration, along with any reasons cited by the local partner for their lack of comment.

Please note that Frequently Asked Questions are available by clicking the link within the 'Completer Information' section.

General statement of compliance

* Please enter your general statement of compliance in the text box provided. There is no word limit on this answer.

Board members have considered the evidence during Board meetings, Integrated Governance meetings and Finance and Performance Committee meetings throughout the year. The Board members have reasonable assurance that the core standards have been met throughout the year.

This year's results for the Patients survey (2007) show improvements on the overall scores of the previous surveys. The statement from the STHA does not reflect the prevailing position with respect to the 18 week referral to treatment, A/E waits and patients satisfaction survey. The ongoing annual programme of infection prevention and control activities has been subjected to external review and has resulted in a significant reduction in the number of MRSA bacteraemia and clostridium difficile cases in the year although targets levels have not been met.

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There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Statement on measures to meet the Hygiene Code

* Please enter this statement in the box provided. There is no word limit on this answer.

The Dudley Group of Hospitals recognises that the Health Act 2006 introduced a statutory duty on organisations to observe the provision of the Code of Practice on Healthcare Associated Infections. The Board has continued to review its arrangements on a regular basis and is assured that it has all the suitable systems and arrangements in place to ensure that the Code is being fully observed at this Trust

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Please note some standards may not appear on the declaration form as they are not applicable to your trust type. Please refer to the guidance for further information.

Safety domain - core standards (C1a - C3)

Please declare your trust's compliance with each of the following standards:

* C1a: Healthcare organisations protect patients through systems that identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice based on local and national experience and information derived from the analysis of incidents.

- O **compliant**
- O not met
- O insufficient assurance

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* C1b: Healthcare organisations protect patients through systems that ensure that patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.

- O **compliant**
- O not met
- O insufficient assurance

---

* C2: Healthcare organisations protect children by following national child protection guidelines within their own activities and in their dealings with other organisations.

- O **compliant**
- O not met
- O insufficient assurance

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* C3: Healthcare organisations protect patients by following National Institute for Clinical Excellence (NICE) interventional procedures guidance.

- O **compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

Safety domain - core standards (C4a - C4e)

Please declare your trust's compliance with each of the following standards:

* C4a: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the risk of healthcare acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year on year reductions in Methicillin-Resistant Staphylococcus Aureus (MRSA).

- **O compliant**
- O not met
- O insufficient assurance

* C4b: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all risks associated with the acquisition and use of medical devices are minimised.

- **O compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

* C4c: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed.

- **O compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

* C4d: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that medicines are handled safely and securely.

- **O compliant**
- O not met
- O insufficient assurance

* C4e: Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that the prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to the health and safety of staff, patients, the public and the safety of the environment.

- **O compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Clinical and cost effectiveness domain - core standards (C5a - C6)

Please declare your trust's compliance with each of the following standards:

* C5a: Healthcare organisations ensure that they conform to National Institute for Clinical Excellence (NICE) technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care.

- **O compliant**
- O not met
- O insufficient assurance

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* C5b: Healthcare organisations ensure that clinical care and treatment are carried out under supervision and leadership.

- **O compliant**
- O not met
- O insufficient assurance

---

* C5c: Healthcare organisations ensure that clinicians continuously update skills and techniques relevant to their clinical work.

- **O compliant**
- O not met
- O insufficient assurance

---

* C5d: Healthcare organisations ensure that clinicians participate in regular clinical audit and reviews of clinical services.

- **O compliant**
- O not met
- O insufficient assurance

---

* C6: Healthcare organisations cooperate with each other and social care organisations to ensure that patients' individual needs are properly managed and met.

- **O compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Governance domain - core standards (C7a - C9)

Please note some core standards do not appear on the declaration form as they are assessed through other components of the annual health check:

Standard C7f is assessed through the existing targets component of the annual health check.

Standard C7d is assessed through our use of resources component which uses information from assessments undertaken by the Audit Commission and Monitor.

Standards C7f and C7d are not applicable to the Health Protection Agency, NHS Direct or NHS Blood and Transplant.

Please declare your trust's compliance with each of the following standards:

* C7a and C7c: Healthcare organisations apply the principles of sound clinical and corporate governance and Healthcare organisations undertake systematic risk assessment and risk management.

- **O compliant**
- O not met
- O insufficient assurance

---

* C7b: Healthcare organisations actively support all employees to promote openness, honesty, probity, accountability, and the economic, efficient and effective use of resources.

- **O compliant**
- O not met
- O insufficient assurance

---

* C7e: Healthcare organisations challenge discrimination, promote equality and respect human rights.

- **O compliant**
- O not met
- O insufficient assurance

---

* C8a: Healthcare organisations support their staff through having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services.

- **O compliant**
- O not met
- O insufficient assurance

* C8b: Healthcare organisations support their staff through organisational and personal development programmes which recognise the contribution and value of staff, and address, where appropriate, under-representation of minority groups.

- O **compliant**
- O not met
- O insufficient assurance

* C9: Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.

- O **compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

Governance domain - core standards (C10a - C12)

Please declare your trust's compliance with each of the following standards:

* C10a: Healthcare organisations undertake all appropriate employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies.

- O **compliant**
- O not met
- O insufficient assurance

* C10b: Healthcare organisations require that all employed professionals abide by relevant published codes of professional practice.

- O **compliant**
- O not met
- O insufficient assurance

* C11a: Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare are appropriately recruited, trained and qualified for the work they undertake.

O **compliant**
O not met
O insufficient assurance

---

* C11b: Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in mandatory training programmes.

O **compliant**
O not met
O insufficient assurance

---

* C11c: Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare participate in further professional and occupational development commensurate with their work throughout their working lives.

O **compliant**
O not met
O insufficient assurance

---

* C12: Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.

O **compliant**
O not met
O insufficient assurance

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Please note some standards may not appear on the declaration form as they are not applicable to your trust type. Please refer to the guidance for further information.

Patient focus domain - core standards (C13a - C14c)

Please declare your trust's compliance with each of the following standards:

* C13a: Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect.

- **O compliant**
- O not met
- O insufficient assurance

---

* C13b: Healthcare organisations have systems in place to ensure that appropriate consent is obtained when required, for all contacts with patients and for the use of any confidential patient information.

- **O compliant**
- O not met
- O insufficient assurance

---

* C13c: Healthcare organisations have systems in place to ensure that staff treat patient information confidentially, except where authorised by legislation to the contrary.

- **O compliant**
- O not met
- O insufficient assurance

---

* C14a: Healthcare organisations have systems in place to ensure that patients, their relatives and carers have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services.

- **O compliant**
- O not met
- O insufficient assurance

---

* C14b: Healthcare organisations have systems in place to ensure that patients, their relatives and carers are not discriminated against when complaints are made.

O **compliant**
O not met
O insufficient assurance

* C14c: Healthcare organisations have systems in place to ensure that patients, their relatives and carers are assured that organisations act appropriately on any concerns and, where appropriate, make changes to ensure improvements in service delivery.

O **compliant**
O not met
O insufficient assurance

- END OF PAGE -

Patient focus domain - core standards (C15a - C16)

Please declare your trust's compliance with each of the following standards:

* C15a: Where food is provided, healthcare organisations have systems in place to ensure that patients are provided with a choice and that it is prepared safely and provides a balanced diet.

O **compliant**
O not met
O insufficient assurance

* C15b: Where food is provided, healthcare organisations have systems in place to ensure that patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.

O **compliant**
O not met
O insufficient assurance

- END OF PAGE -

* C16: Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care.

- **O compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Accessible and responsive care domain - core standards (C17 - C18)

Some core standards do not appear on the declaration form as they are assessed through other components of the annual health check.

Standard C19 is assessed through the existing targets component of the annual health check.

Please declare your trust's compliance with each of the following standards:

* C17: The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services.

- O **compliant**
- O not met
- O insufficient assurance

---

* C18: Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.

- O **compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Please note some standards may not appear on the declaration form as they are not applicable to your trust type. Please refer to the guidance for further information.

Care environment and amenities domain - core standards (C20a - C21)

Please declare your trust's compliance with each of the following standards:

* C20a: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation.

- **O compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

* C20b: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being supportive of patient privacy and confidentiality.

- **O compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

* C21: Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.

- **O compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Please note some standards may not appear on the declaration form as they are not applicable to your trust type. Please refer to the guidance for further information.

Public health domain - core standards (C22a - C24)

Please declare your trust's compliance with each of the following standards:

* C22a and C22c: Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by cooperating with each other and with local authorities and other organisations and healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by making an appropriate and effective contribution to local partnership arrangements including local strategic partnerships and crime and disorder reduction partnerships.

- O **compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

* C23: Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the national service frameworks (NSFs) and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.

- O **compliant**
- O not met
- O insufficient assurance

* C24: Healthcare organisations protect the public by having a planned, prepared and, where possible, practised response to incidents and emergency situations, which could affect the provision of normal services.

- O **compliant**
- O not met
- O insufficient assurance

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Electronic sign off page

The Healthcare Commission recommends that all members of the trust board, including the non-executive directors (for foundation trusts this should be the board of directors) should sign off the declaration in the space provided below. Here, sign off is achieved by recording the name(s) and position(s) of the individual(s) concerned. We do not require scanned signatures.

As a minimum, we require the declaration to be signed off by an appropriate officer(s) with delegated authority from the board.

The completion of the sign off page will be taken as verification that the individual(s) who are recorded as signing off the declaration have reviewed the contents of the declaration form and are certifying that:

- the general statement of compliance, and information provided for each standard, are a true representation of the trust's compliance

- the statement on measures to meet the Hygiene Code are a true representation of the trust's position

- any commentaries provided by specified third parties have been reproduced verbatim. Specified third parties are: strategic health authority, foundation trust board of governors (where relevant), patient and public involvement forums, overview and scrutiny committees and local safeguarding children boards

- they are signing off the declaration form on their behalf and with delegated authority on behalf of all members of the trust board as referred to above.

- END OF PAGE -

Electronic sign off - details of individual(s)

	Title:	Full name:	Job title:
1	Mr	Alfred Edwards	Chairman
2	Mr	Johnathan Fellows	Non Exec Director
3	Mr	David Badger	Non Exec Director
4	Mrs	Katherine Williets	Non Exec Director
5	Mrs	Ann Becke	Non Exec Director
6	Mr	David Wilton	Non Exec Director
7	Mr	Paul Farenden	Chief Executive
8	Mr	Paul Assinder	Finance Director
9	Mr	Paul Brennan	Operations Director
10	Dr	Paul Harrison	Medical Director
11	Mrs	Janine Clarke	Human Resources Director
12	Mrs	Ann Close	Nursing Director
13			
14			
15			
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There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Comments from specified third parties

Please enter the comments from the specified third parties below.

* Please enter the name of the strategic health authority that has provided the commentary

NHS West Midlands

* Strategic health authority comments. There is no word limit on this answer.

NHS West Midlands

Annual Health Check 2007/08

SHA Commentary

Dudley Group of Hospitals NHS Trust

The SHA has not had the opportunity to review the Trust's draft declaration for 2007/08.

The Trust has reported to its Board on actions being taken to comply with the core standards with which it was not compliant in 2006/07.

In the 2006/07 patient survey, the Trust's overall scores were slightly below that of both the England and the West Midlands average in all areas with the exception of 'clean, comfortable friendly place to be' where the core was slightly better than average. The scored categories were:
o Access and waiting
o Safe, high quality coordinated care
o Better information, more choice
o Building relationships
o Clean, comfortable, friendly place to be

At the time of writing this commentary, data on end of year performance against national targets was not available and statements are based on the latest position in March 2008.

The Trust is struggling to achieve some key national targets and milestones including; the planned 2007/08 reductions in MRSA and C Difficile, maximum 18 week referral to treatment wait and A&E waits.

Although the MRSA year end target has been missed Q3 and Q4 trajectories were achieved, C diff plan was not attained.

* Please enter the name of the patient and public involvement forum that has provided the commentary

Dudley Group of Hospitals NHS Trust PPI forum

* Patient and public involvement forum comments. There is no word limit on this answer.

Dudley Group of Hospitals PPI Forum Annual Healthcare Declaration

C9 Records Management

It was brought to the Forum's attention that patients' data had been sold on a website. This issue was raised with the Trust, who informed the Forum that they were aware of the situation; and as a result safeguards had been implemented to ensure that the situation would not be repeated. The Trust has strengthened its policy on computer use; storage of information and disposal of hardware. All disposals will be handled exclusively by Siemens who will employ a degausser, a device which applies high frequency magnetic charges to scramble and destroy all data on the computers hard disk.

In the future the Trust will comply with the highest international levels of security when disposing of sensitive equipment.

C4a Hygiene and cleanliness

A cleanliness Audit Inspection was shadowed by a Forum member. The Trust has received impressive results on cleanliness and is continuously improving. However, it was raised at a Forum meeting that patients with infections such as CDIFF and MRSA are able to mix freely with other patients and visitors. One patient was seen sitting in the Hospital CafÃ©. The Forum wrote to the Trust, stating their concerns. A response was received, stating that there are procedures put into place, but if a patient refuses to be in isolation, staff are not able to restrain them. In these circumstances staff try and get them home as soon as possible.

C15a/b Food and Nutrition

A dietician from DGoH attended a Forum meeting. The dietician confirmed that when a patient is admitted they should be weighed and notes should be taken about their eating habits. These notes are updates and monitored weekly and a card is completed at meal times stating if meals were eaten or left.

The Forum has concerns with this process and feels that a better system needs to be put into place if the current procedure is not followed by staff.

C17 views of patients, their carers and others sought and taken into consideration in designing, planning, delivering and improving healthcare services

Forum members were invited by the Trust, to attend an event to gain their views about the delivery of health care in the West Midlands.

The Forum has a good working relationship with the Trust, representatives attend meetings when requested and queries are answered promptly.

C21 Environment

The Forum has expressed concerns about the temporary location of the Discharge Lounge. Although a permanent location has been decided, it will not be functioning until October. The current temporary location has poor signage. The Forum have requested for a sign to be put up at the main reception. The Trust has taken forward the concern and has agreed to improve signposting. The Trust has also put into place an enquiry desk for patients trying to locate the Discharge Lounge. The enquiry desk is run by volunteers.

* Please enter the name of the local child safeguarding board that has provided the commentary

dudley Safeguarding Children Board

* Local child safeguarding board comments. There is no word limit on this answer.

No comments have been received

Please enter the name of the organisation that has provided the first commentary

Please enter the first commentary for this organisation

Please enter the name of the organisation that has provided the second commentary

Please enter the second commentary for this organisation

Please enter the name of the organisation that has provided the third commentary

Please enter the third commentary for this organisation

Please enter the name of the organisation that has provided the fourth commentary

Please enter the fourth commentary for this organisation

Please enter the name of the organisation that has provided the fifth commentary

Please enter the fifth commentary for this organisation

Please enter the name of the organisation that has provided the sixth commentary

Please enter the sixth commentary for this organisation

Please enter the name of the organisation that has provided the seventh commentary

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Please enter the name of the organisation that has provided the eighth commentary

Please enter the eighth commentary for this organisation

Please enter the name of the organisation that has provided the ninth commentary

Please enter the ninth commentary for this organisation

Please enter the name of the organisation that has provided the tenth commentary

Please enter the tenth commentary for this organisation

Please enter the name of the organisation that has provided the eleventh commentary

Please enter the eleventh commentary for this organisation

Please enter the name of the organisation that has provided the twelth commentary

Please enter the twelth commentary for this organisation

Please enter the name of the organisation that has provided the thirteenth commentary

Please enter the thirteenth commentary for this organisation

Please enter the name of the organisation that has provided the fourteenth commentary

Please enter the fourteenth commentary for this organisation

Please enter the name of the organisation that has provided the fifteenth commentary

Please enter the fifteenth commentary for this organisation

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There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Overview and scrutiny committee comments

* How many overview and scrutiny committees will be commenting on your trust? (maximum of 10)

- **O 1**
- O 2
- O 3
- O 4
- O 5
- O 6
- O 7
- O 8
- O 9
- O 10

- END OF PAGE -

Overview and scrutiny committee comments

Name of overview and scrutiny committee 1

dudley MBC select committee on Health and Adult Social care

Comments. There is no word limit on this answer.

Agenda Item No.

Select Committee on Health and Adult Social care (HASC)
Annual Health Check statement 2007/8
Dudley Group of Hospitals

Introduction

The HASC and Dudley Group of Hospitals (DGOH) have a good working relationship. Senior board level officers are in regular contact with the Chair and Vice Chair and answer the Committee's queries promptly. The Committee consults DGOH about the development of it's work programme. The Committee had excellent support and cooperation from DGOH while carrying out it's review of the integrated Stroke Service in Dudley. The Committee have also had excellent support in tracking the recommendations of the Committee's review into Maternity Services.

DGOH summary report on compliance

In March 2008 the Committee considered a summary report by DGOH highlighting the extent of the Trusts compliance against the core standards. The Committee was informed that the Trust is on track to meet all associated targets with the exception of target for MRSA bacteraemia. The committee noted that that the target set for the Trust was very low at a rate equivalent to one per month, and of the 19 cases, 10 were classed as 'pre-48 hour' cases i.e. they were admitted to the Trust with the infection. The Committee acknowledged that the trust had been on trajectory of 1 case less per month since October 2007.

Arising from the report a HASC Member queried the process when admitting patients and asked if all patients were checked or whether it was only those suspected of having MRSA. In responding, DGOH advised that if admissions were planned all patients were screened and if a patient was found to have MRSA the patient would be treated accordingly and then screened again following treatment. However, if the patient was an emergency admission, high-risk patients would be screened and if found to have the infection they would be treated in isolation.

Commentary on Core Standards

Please Appendix 1

Appendix 1 Annual Health Check - DGOH comments

Domain Core Standard HASC comment

Clinical and cost effectiveness

Domain Outcome:

Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services, based on what assessed research evidence has shown provides effective clinical outcomes
Core Standard C6

Healthcare Organisations co -operate with each other and social care organisations to ensure that patients' individual needs are properly managed and met

...

...

The HASC has received evidence to suggest this standard is being met.

The HASC is aware through its work on its Review of Integrated Stroke Service that DGOH was represented on the multidisciplinary team of clinicians, managers to review key aspects of the patient pathway and how the provision of care could be improved over the next three years.

Patient Focus

Domain Outcome:

Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, and in partnership with other organisations (especially social care organisations) whose services impact on patient well being.
Core Standard C14

Healthcare organisations have systems in place to ensure that patients, their relatives and carers
a) have suitable and accessible information about, and clear access to , procedures to register formal complaints and feedback on the quality of services

The HASC is aware, through its Review of Stroke Services, of processes allowing patients carers or relatives to register formal complaints directly with the Matron or Ward/Department Manager. Alternatively Individuals can contact the Trust's PALS service (based at the largest site) in person, by free-phone or email. The service is promoted in a variety of means across the hospital and other health networks. .

As above
Core Standard C16
Healthcare organisations make information available to patients and the public on their services, provide patients with suitable accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after care.
The HASC has received evidence to suggest this standard is being met.

The HASC is aware through its Review of Stroke Services that prior to discharge relevant professionals discuss the social services resources and potential arrangements with patients, as required. On discharge patients are given a stroke pack and contact number of the community rehabilitation team. The pack includes information on how to reduce the risk of another stroke as well as contacts and further information.

Accessible and responsive care

Domain outcome:

Patients receive services as promptly as possible, have choice in access to services and treatments and do not experience unnecessary delay at any stage of service delivery or the care pathway.

Core Standard 17
The views of patients, their carers and others are sought and taken into account in designing, planning, delivering and improving healthcare services

The HASC has received evidence to suggest that this standard is being met.

The HASC is aware through its Review of Stroke services that the Trust invites patients within the Acute Rehabilitation ward, and their families, to participate in their care reviews..

The HASC is also aware as a result of its Stroke Review that the patient experience is enhanced by a facilitator employed by Dudley Stroke...

... Association.

Public Health

Domain Outcome:

Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.

Core Standard C 22

Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by:

a) co-operating with each other and with local authorities and other organisations

The HASC considers that there is evidence within its work that DGOH is collaborating with the Council and partner organisations.

In January 2008 the HASC considered a progress report on recommendations set out in it's Review of Maternity Services conducted in 2006/07, together with an action plan, informed by HASCs findings. It was noted that some actions required multi-disciplinary development and inter-agency working and, therefore, other agencies involved had been forwarded a copy of this action plan and invited to comment by updating their individual identified action. It was particularly noted that as a direct result of the recommendations in the review, the Specialist Midwife on substance misuse and vulnerable women has enhanced service provision for these women and has enabled cooperative interagency care to improve outcomes.

As above

As a

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

Board of governors' comments

Please enter the comments from the board of governors in the box below. There is no word limit on this answer.

This is not a Foundation Trust

- END OF PAGE -

There are no further questions in this section. Please press either the Save and Quit button or the Finish button to return to the main section list

The Dudley Group of Hospitals NHS
NHS Trust

TRUST BOARD AGENDA
Thursday 26 June 2008 at 11.00am
Clinical Education Centre

	Item		By
1. **2.** **3.**	**Chairman's Welcome and Note of Apologies – P. Farenden, D. Badger** **Declarations of Interest** **Announcements**		A Edwards
4.	**Minutes of Previous meetings:** • Thursday 29 May 2008 Board Meeting	Enclosure 1	A Edwards
5.	**Action Sheet - Progress Report by Exception**	Enclosure 2	A Edwards
6.	**Other Matters Arising**		
7.	**Chief Executive's Report**	Verbal	P Assinder
8.	**Strategic Issues** • Ernst & Youngs Stage 2 Report and Trust Action Plan • Update on Monitor Assessment process • Scheduled meeting of the Council of Governors 1 July 2008	Enclosure 3 Verbal Report Enclosure 4	P Assinder P Assinder P Assinder
9.	**Operational Performance** • Corporate Performance Report Period to 31 May 2008 • Capital Programme Update • Service Development Update	Verbal Report Enclosure 5 (to follow) Enclosure 6 (to follow)	P Assinder P Brennan P Brennan
10.	**Reports for Approval** • To be Advised		
11.	**Information Items to be Noted** • To be Advised		
12.	**Any Other Business** • Limited to urgent business notified to the Chair/ Corporate Secretary in advance of the meeting		A Edwards
13.	**Date of Next Private Trust Board Meeting** • 31 July 2008 at 11.00am in the Clinical Education Centre		
14.	**Meeting Closes**		

The Dudley Group of Hospitals NHS
NHS Trust

Minutes of the Trust Board meeting held at 11.00 a.m. on Thursday, 29th May, 2008, in the Clinical Education Centre

Present:

Alfred Edwards, Chairman
David Badger, Non Executive Director
Paul Brennan, Operations Director
Kathryn Williets, Non Executive Director
David Wilton, Associate Non Executive Director
Paul Harrison, Medical Director
Denise McMahon, Nursing Director
Paul Farenden, Chief Executive
Ann Becke, Non Executive Director
Jonathan Fellows, Associate Non Executive Director
Paul Assinder, Director of Finance and Information
Janine Clarke, Director of Human Resources
Ann Close, Nursing Director

In Attendance:

Helen Forrester, PA

08/54 Chairman's Welcome and Note of Apologies

There were no apologies received.

08/55 Declarations of Interest

There were no Declarations of Interest.

08/56 Announcements

The Chairman welcomed Denise McMahon to the meeting.

The Chairman confirmed to the Board that Kathryn Williets had been reappointed as Non Executive Director with the Trust for a further 4 years.

08/57 Minutes of the Previous Meeting – 24th April, 2008 – Trust Board Meeting

The minutes of the 24th April, 2008, Trust Board meeting, given as Enclosure 1, were approved as a correct record and signed by the Chairman.

08/58 Action Sheet – 24th April, 2008 – Progress Report by Exception

The Board reviewed the Action Sheet, given as Enclosure 2, as follows:

08/58.1 Action Item 08/10.5 Healthcare Commission Maternity Survey

Covered under agenda item 11 (Enclosure 6).

08/58.2 Action Item 08/45.2 Operational Performance – Delayed Discharges

The Chairman reported that the issue had been added to the Health and Well Being Partnerships agenda.

08/58.3 Action Item 08/45.3 Operational Performance – Draft Annual Agenda

Board members had recently attended a Workshop on Strategy.

Board Annual Agenda covered under item 23 (Enclosure 18).

08/58.4 Action Item 08/48.1 Foundation Trust Update

The Chairman reported to the Board that engagement with Governors was becoming a priority. Paul Assinder, Director of Finance and Information confirmed that Governors had been helping with the recruitment of members and were keen to be involved.

The Chairman to produce a plan detailing linkages between Governors and Directors and discuss with Liz Abbiss and the Director of Finance and Information. It was agreed that this plan would not offer mentoring to the Governors due to time constraints on Directors portfolios and there was a need for clear definition on how the linkage should be structured. The Board recognized that there was a need for a reporting mechanism of issues not appropriate for consideration at the Council of Governors meetings.

The Chairman to bring proposal on linkages to the next Board meeting.

Chairman to bring proposal on linkages between Directors and Governors to June Board

08/59 Matters Arising

08/59.1 The Director of Finance and Information reported to the Board on the ALE assessment scores (achieving scores of 4) and confirmed that the process was ongoing and was currently with the Audit Commission. The Trust had been invited to submit a further area from the 5 ALE bandings for a Notable Best Practice award in year end accounting. This now meant that the Trust had submitted 4 out 5 areas for best practice recognition.

08/60 Chief Executive's Report

The Chief Executive was given at Enclosure 3. The Board noted the contents of the report and no comments were received.

08/61 Strategic Issues

08/61.1 Foundation Trust Update

The Director of Finance and Information asked the Board to note the following:

- As discussed in the Finance and Performance Committee it was noted that the Assessment process was coming to an end although the Board recognized that there would be ongoing information requests following the Board to Board meeting on 3rd June, 2008, as Month 2 data became available.

- The Board noted that following the resignation of Claire Molloy, Sandwell PCT had confirmed the appointment of Bev Hill, Operations Director as Sandwell PCT Governor representative.

08/62 Operational Performance

Report to the Finance and Performance Committee on 29th May, 2008

The Director of Finance and Information briefed the Board on his report to the Finance and Performance Committee. The Board discussed and noted the following position up to the end of April (Month 1):

- Income on plan at £17.8million

- EBITDA ahead of plan at £1.2million

- Income and Expenditure surplus of £761,000

- Surplus ahead of plan by £220,000

- Normalised surplus of £554,000

- CIP Performance on plan

- Balance sheet as at end of April reports cash balance of £28.4million

Performance against Targets:

- 18 Week Waits – 85.5% admitted and 91.6% unadmitted patients being seen which is in compliance with national target

- 4 Hour ED Waits at 98.6%

The Board noted the performance.

08/63 Board Development

08/63.1 Update on Board Development Matters

The Chairman confirmed that there were no further developments. Item for discussion on future agenda.

08/64 Reports for Approval

08/64.1 Patient and Public Involvement Annual Report

Ann Close, Director of Nursing reported on the Patient and Public Involvement Annual Report, given as Enclosure 4. It was noted that this report was in two parts:

- PPI activities
- PALS and volunteers report

The Board received the report, no comments were made.

08/64.2 Complaints Annual Report

The Nursing Director reported on the Complaints Annual Report, given as Enclosure 5. It was noted that the Board had previously received the half yearly and the Board were asked to note the response rates detailed within the full year report.

Janine Clarke, Director of Human Resources asked how the number of complaints compared to previous years. It was noted that numbers were similar, 400 last year, so up minimally by a further 15 complaints.

David Badger, Non Executive Director asked if it was possible to benchmark performance against other Trusts and it was noted that the Trust no longer receives the comparison report.

The Board received the report.

08/64.3 HCC Review of Maternity Service Response and Action Plan

The Nursing Director reported on the HCC Review of Maternity Services, given as Enclosure 6. It was noted that the HCC review of the Maternity Service was reported to Trust Board in January. The review included the perceptions of staff and patients towards out Maternity Service. This report provided an update on actions identified.

The Board received the report.

08/64.4 Patient Survey

Paul Brennan, Operations Director reported on the Patient Survey, given as Enclosure 7. It was noted that the report gave comparisons against other local providers against the HCC Inpatient Survey Report 2007. The Board noted that the Trust was joint top in its performance against other local providers and had performed extremely well nationally with the majority of results being placed in the top 20%.

Paul Farenden, Chief Executive asked Denise McMahon if the results were the same as the MORI survey she had been reviewing. It was noted that the results were different but showed similarities, particularly around patients perceptions.

The Board received the report and agreed its usefulness for marketing purposes.

08/65 Information Items to be Noted

08/65.1 Healthcare Commission Declaration

The Nursing Director reported on the Healthcare Commission Declaration, given as Enclosure 8. The Board received the report for information.

08/66 Any Other Business

There being no other business, the Chairman closed the meeting.

08/67 Date of Next Meeting

The next Board meeting will be held at 11.00am on Thursday, 26th June, 2008 in the Clinical Education Centre.

Signed as a correct record: …… Chairman

Date: ……

The Dudley Group of Hospitals NHS
NHS Trust

Action Sheet
Minutes of the Trust Board
Held on 29 May 2008

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
08/58.4	Foundation Trust	Chairman to bring proposal on linkages between Directors and Governors to June meeting	C	26/6/08	
08/38.1	Quality of Care	Further Quality of Care Report to be provided to the Board in June	ND	26/6/08	
08/37.1	Research and Development	Prof. G Kitas to be invited to the October Board meeting to report on clinical trials	PH	30/10/08	

The Dudley Group of Hospitals NHS
NHS Trust

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First meeting of the Council of Governors
Tuesday 1 July 2008, 6.00 – 8.00pm at the Clinical Education Centre,
Russells Hall Hospital, Dudley

AGENDA

1.	Apologies		
2.	Minutes of the Shadow Council of Governors meeting 23 April 2008	Enclosure 1	Chairman
3.	Matters Arising 3.1 Foundation Trust Status	Enclosure 2	Chairman
4.	Approval of Foundation Trust Constitution	Enclosure 3	P Assinder
5.	Adoption of Standing Orders for the Foundation Trust	Enclosure 4	P Assinder
6.	To note the Monitor Code of Conduct for Foundation Trust Governors	Enclosure 5	P Assinder
7.	To note the appointment of the Chairman of the Foundation Trust	Enclosure 6	P Assinder
8.	Approval of the appointment of Mr David Wilton, Mr Jonathan Fellows, Mrs Ann Becke, Mrs Kathryn Williets and Mr David Badger as Non Executive Directors of the Foundation Trust	Enclosure 7	P Assinder
9.	Approval of the Deputy Chairman for the Council of Governors	Enclosure 8	P Assinder
10.	To note the appointment of Chief Executive of the Foundation Trust	Enclosure 9	P Assinder
11.	To approve the appointment of PricewaterhouseCoopers as external auditors to the Foundation Trust for the current financial year	Enclosure 10	P Assinder
12.	Agree nominations of Governor Representatives to the Council of Governors: 12.1 Nominations Committee 12.2 Remuneration Committee		Chairman
13.	To note the Register of Interests for the Council of Governors	Enclosure 11	
14.	To consider arrangements for Council of Governors Working Groups: 13.1 Membership Development 13.2 Patient Services 13.3 Service Strategy Development		
15.	The Foundation Trust's Strategy 2008/09 to 2012/13 A presentation by Paul Farenden		
16.	Meeting dates for the year including Annual Members Meeting	Enclosure 12	
17.	Any Other Business		
18.	Date of the next meeting: The next meeting of the Council of Governors will be held on ???		

The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 7th February 2013 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item		By	Time
1.	**Chairmans Welcome and Note of Apologies**		J Edwards	9.30
2.	**Declarations of Interest**		J Edwards	9.30
3.	**Announcements**		J Edwards	9.30
4.	**Chief Executives Overview Report**	Enclosure 1	P Clark	9.30
5.	**Quality** 5.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 2	D Bland	9.40
6.	**Productivity** 6.1 Matters Arising from Finance and Performance Committee by Exception Report	Enclosure 3	D Badger	9.50
7.	**Prevention** 7.1 Infection Prevention and Control Exception Report 7.2 Audit Committee Exception Report	Enclosure 4 Enclosure 5	D Mcmahon J Fellows	10.00 10.10
8.	**Corporate and Strategic** 8.1 Board Secretary's Report	Enclosure 6	P Assinder	10.20
9.	**Date of Next Board of Directors Meeting** 8.30am 7th March, 2013, Clinical Education Centre		J Edwards	10.30
10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards	10.30

Enclosure 1

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 7th February 2013

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Report
- BBC Inside Out programme feature re Pressure Sores
- Capacity Pressures
- Second Francis Report

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
NHS Foundation Trust

Chief Executive Update – February 2013

Friends and Family Report:

	Apr-12	May 12 overall	June 12 overall	July 12 overall	Aug 12 overall	Sept 12 overall	Oct 12 overall	Nov 12 overall	Dec 12 overall	Jan 13 overall
Date range	Baseline Month	29/04/2012 – 26/05/2012	27/05/2012 – 30/06/2012	01/07/2012 – 28/07/2012	29/07/2012 – 25/08/2012	26/08/2012 – 29/09/2012	30/09/2012 – 27/10/2012	25/10/2012 – 24/11/2012	25/11/2012 – 29/12/2012	30/12/2012 – 26/01/2013
Organisation NPS - weekly	52	77*	76*	73*	77*	77*	76*	76*	75*	71*
% of footfall (inpatient discharges - Min'm 10%)	12%	15%	12%	19%	18%	18%	22%	29%	21%	26%

* CQUIN upper quartile achieved

NPS Score	>= 71
	52** to 70
	< 52
% of footfall	>= 10%
	< 10%
** 52 is DGH baseline set in April	

The Trust continues to perform well in the Friends and Family test achieving a score of 71 in January from 26 per cent of our inpatients discharged during the reporting period (30.12.12 to 26.01.13) and maintaining a green status on both accounts.

Benchmarking (latest data available – December 2012)

Regional (NHS Midlands and East) average for December 70
Black Country average for December 71

Feedback

Sixty four per cent of comments were positive, with food remaining the most requested item for improvement at 13 per cent. A factory visit to view the proposed Steamplicity food system took place at the end of January, with positive feedback from the visiting team (a full board paper on this is on the agenda). A hospital visit to see the system in action is being arranged for early February and will be complemented by patient involvement to make a full assessment.

BBC Inside Out programme feature re Pressure Sores:

The Trust was featured on the BBC Midlands Inside Out programme on 21st January regarding our high level of reporting of grade 3 and 4 pressures sores. The Trust defended the position as in line with good practice and National Patient Safety Agency guidance that a high level of incident reporting is usually indicative of an honest and open culture which enables organisations to learn from incidents and near misses. We also stressed that we are an integrated provider with community services and this makes comparisons with trusts which are solely acute service providers invalid. We also talked about the improvements we had made to the prevention and management of pressures sores.

Capacity Pressures:

The Trust is continuing to face capacity pressures from higher numbers of emergency patients requiring care. We are working with partner organisations in the Clinical Commissioning Groups, West Midlands Ambulance Service and the Local Authority, to implement schemes to reduce pressures on the front door and expedite discharges as quickly as possible. The front door and flow pressures have resulted in a deterioration of the 95% Emergency Department waiting times target.

Francis Report:

The second Francis Report into care at Mid Staffordshire NHS Foundation Trust is being released on 6th February. A verbal update will be provided at the Board meeting for information.

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7th February 2013

TITLE:	**Summary of Key issues from the Clinical Quality, Safety & Patient Experience Committee held on 13th December 2012.**		
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

Reports from Reporting Groups

1. **Patient Safety Group (14th November 2012**) – the following issues were highlighted:
   - **Health & Safety** – 18 safety alerts were received in the period. 2 alerts were outstanding. One was subsequently closed and assurance was received that the requirements of the second alert had been met.
   - **Incident Reporting for Cardiac Arrests/MET Calls –** The group agreed that these would be formally captured and reported via Datix.
   - **Feedback from the Red Incident Assurance and Learning Group** - The report highlighted a fall in the number of incidents awaiting an RCA. Actions to improve the process of completing investigations and the actions arising from these were agreed.
   - **Patient Safety Leadership Walk rounds** - There were 18 Patient Safety Leadership walk rounds since April and Action Plans had identified 79 actions. The group discussed the progress of these and agreed to focus on the wards/areas visited.

2. **Drugs and Therapeutics** (**14th November 2012)** - The following issues were discussed:
   - **Supply of Medicines –** The Group considered the MHRA recommendations on medicine supply based on the basis of product origin and the use of **methylthioninium** as a dye in theatres.
   - **CMU Contract Changes –** Issues around "off-label" use were raised.

3. **Safeguarding Group (15th November 2012)** – the following issues were highlighted:
   - **Training - PFI Partners Safeguarding Adults Compliance** – More slots were being identified for staff groups requiring face to face training. Assurance had been received that 16% of staff would be trained each month. The Committee discussed the various training options available for staff. This would be escalated to the Board.
   - **Department of Health letter re: Jimmy Savile Allegation –** Letter asking Trust's to review practices relating to vulnerable people in relation to: safeguarding; access to patients (including that afforded to volunteers or celebrities); and listening to and acting on patient concerns. Actions to review existing policies and practices were progressing.
   - **Serious Case Review –** The Director of Nursing advised that a serious case review would be presented to the Dudley Safeguarding Children's Board in December.
   - **Guidelines for Under 16's who are Pregnant –** The Group discussed a pathway for young people under 16 years who were pregnant, to minimise the clinical risk associated with ruptured ectopic pregnancy and to deal appropriately with safeguarding concerns. A risk assessment and guidelines would be developed and in future the Trust would test girls over 12 years of age before some procedures. This was a safeguarding concern and reference was made to the "Gillick competency" when deciding whether a child was mature enough to make decisions.

***Note**: Gillick competency and Fraser guidelines refer to a legal case which looked specifically at whether doctors should be able to give contraceptive advice or treatment to under 16-year-olds without parental consent.*

Emergency Department National Survey Results – Published by the Care Quality Commission on 6th December 2012. The Trust had made improvements since the previous (2008) survey and were classified as 'about the same' as other trusts for all questions. Two of the questions had deteriorated, both by a marginal 0.2 and 20 questions showed improved scores. 275 patients responded out of 800 which was much improved from 2008. The Committee reviewed the results and the comparative scores with 2008.

Customer Care - The paper updated progress with customer care work and plans for future work. The Customer Care Ambassadors in the group had developed customer care promises demonstrating the Trust commitment to Care, Respect and Responsibility. The Committee was asked to consider how they wished to progress and agreed that this area should be incorporated into the Patient Experience Strategy.

Patient Experience Strategy – This report outlined the approach for recruitment, induction, appraisal and leadership development. Two additional pieces of work were progressing, Intelligence of Kindness by the Chaplain and Compassion in Practice by the Director of Nursing.

The Committee discussed the Leadership Development Programme, the skills and behaviours, learning outcomes and leaders' toolkit with the focus on the service provided and not the targets or financial position.

Quality Dashboard Report (Month 7) - One of the listed Quality Indicators - Increase in breast feeding initiation rates, was red rated for the reporting period. The Day Case Rate for Surgery for Dupuytren's contracture indicator was shown as an outlier on the NHS Choices Indicator list: The 'Maternity – Smoking in Pregnancy' measure was achieved in October with performance at 14.9% against the 15% target.

The Acute Trust Quality Dashboard confirmed the Trust position for Clinical Effectiveness, Patient Experience and Patient Safety. The SHMI had been updated to 106.8.

Serious Incident (SI) Monitoring Report (November 2012) - 11 new incidents were reported – 2 pressure ulcers and 9 general SI's. There were 24 open general SI's (15 undergoing investigation, 7 awaiting assurance that all actions identified in the RCA had been completed and 2 recommended for closure). There were no breaches in the 2 day reporting from date of identification and completion of RCA's within the agreed time scales. Two areas were highlighted for further review: Radiology Incidents and Diabetic Care EAU. The Committee agreed that assurance was required and requested the attendance of the Clinical Leads for Radiology and Diabetic Care at the next meeting.

Quarterly Aggregated Incident Report Update from August 2012 (CQS/12/46.2) - The Director of Nursing updated the Committee on the issues raised at the August 2012 meeting and questions raised about infection control audits. The Director of Nursing assured the Committee that audits were undertaken on a regular basis and were on the audit plan. The results were currently between 93 and 97%.

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Committee reports were referenced to the risk register**.**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 1 - Respecting & Involving people , Outcome 4 – Care & welfare of people , Outcome 7 – Safeguarding, Outcome 16 – Assessing & monitoring quality of service
	NHSLA	**Y**	**Details:** Risk management arrangements eg 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 13th December 2012 and specifically the Training of PFI Partners Safeguarding Adults Compliance

Enclosure 3

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 31st January 2013**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**
CORPORATE OBJECTIVE: SO 10 Enabling Objective			
SUMMARY OF KEY ISSUES: **The Committee considered standing reports on performance for December 2012 and year end forecasts for 2012-13 financial year.**			
IMPLICATIONS OF PAPER:			
	Risk Register	**Risk Score**	**Details:**

RISKS		**Y**	**Risk to achievement of the overall financial target for the year**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **Monitor has rated Trust at Green for Governance & 3 for Finance at Q2. The Trust remains on quarterly monitoring**
	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 31st January 2013

1. Background

The Finance & Performance Sub Committee of the Board met on 31st January 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 year end performance reports. The Committee noted in particular the following matters:

2. Junior & Middle Grade Trust doctors

Mrs Morrey presented a report setting out a phased programme of recruitment to new training posts. The Committee requested quarterly update reports.

3. Workforce KPIs

The Committee considered a progress report and noted:

- November absence is 4.41%an increase from 4.12% previously and YTD is 4.03% (target 3.5%)
- Turnover is 7.52% a slight increase on previously, 7.33%
- Mandatory Training 67.9% – 3 subjects are over 80% compliant. IG is a problem at 51%
- Appraisals 64.6% (down from 66.4% in December).
- Pre Employment Checks 99%
- Live vacancy rate is 164 posts

The Committee noted the report but requested assurance that where pre employment checks had not been completed for Bank staff , a positive risk assessment had in all cases been completed and recorded.

4. Income & Expenditure Position – December 2012

The Trust made a trading surplus of £356,000 in December due to an agreement with Dudley CCG to refund the contractual 2012-13 readmissions penalty of £2.3m (£1.5 in recognition of current cost pressures. pay and non pay spending trends had reduced slightly in month (seasonal effect). The Committee noted that the underlying Trust I&E position remains poor and is deteriorating each quarter.

The Committee noted that in December EBITDA were 8.2% (Plan 7.4%) and now £2.1m ahead of the period Plan).

The annual I&E forecast had now moved £0.7m surplus.

CIP performance of £9.9m to date was marginally ahead of plan but included £3m non recurrent items.

The Committee had previously requested a monthly analysis of movements in headcount, by Dept, type etc and an analysis of all movement for year to date. This will be incorporated in future reports.

The Committee noted the report, the forecast for outturn of 'on or above plan' but expressed concern at the deteriorating underlying recurrent position.

5. Balance Sheet (Statement of Position)

Mr Walker reported on the Trust's Balance Sheet (Statement of Position) at 31st December 2012, which remains strong;

- £27.6m cash balance (£0.6m below plan).
- 38.2 days liquidity margin.
- Debtor and Creditor days remain broadly on plan.

The Committee noted the report.

6. Capital Programme

Capital spending for April-December was £6.1m, £0.1m behind Plan. The Trust estimates a total annual capital spend of £9.2m against the approved programme of £9m. Key variances are medical equipment £0.2m below plan and IT Programme, £1.1m over plan.

The Committee noted the report.

7. Performance Targets

Mr Shine, Head of Information, reported strong performance for against all measures for the Month and Period to Date.

Key Performance headlines for the month are:

- No never events reported in month
- MRSA and C-Diff cases, are within monthly trajectory
- Other Monitor, CQC and contractual standards and targets have been met for the month
- Diagnostic waits – no breaches in December
- A&E 4 Hours – 95.6% in December – quarter 3 performance 95.06%

The Committee noted the report.

8. Cost Improvement Programme 2012-13

Mr Sullivan presented the report for Q3. The Committee noted an achievement of £9.7m against an annual target of £10.7m. The Trust has £1m to identify and deliver. Of CIP delivered to date, £3.6m 37% is non recurrent. The Committee expressed concern at this level of Non Recurrent CIP.

The Committee noted the report.

9. Monitor Q3 Submission report

The Committee noted Mr Assinder's report on the proposed Q3 Submission, confirming the Trust's classification of:

- Finance: FRR 3.45
- Governance: Green

The Committee further approved Monitor's 3 standard declarations.

10. Financial Plan 2013 to 2018

Mr Assinder presented a five years financial plan which identified a cumulative gap between income and expenditure of £44m.

The Committee considered in detail a range of planning assumptions for 2013-14. At 'first pass' there exists a CIP requirement for 2013-14 of £15.2m (5.9%). This can be reduced by:

- Requiring Directorates to meet 2012-13 CIPs c/fwd
- Removing contingency reserves
- Holding back non pay 'inflation' funding

This would leave a net CIP requirement of £9.1m or 3.6%. To date the Trust has a number of CIP schemes scoped to bridge this position:

- Directorate 2% specific schemes £4.6m
- Transformation schemes £1.3m
- IT contribution £0.3m
- Agency spending £1.2m
- MARS etc £1.9m

The Committee were advised of the significant risk associated with the 2013-14 CIP plans. The Committee committed to a more rigorous approach to monitoring CIP delivery than previously.

11. 2013-14 CIP Plans

Mr Assinder presented the update on 2013-14 CIP proposals. Whilst the Committee noted some impressive 'headline' numbers for CIP proposals, Mr Assinder warned that a great deal of detailed work had now to be undertaken to turn these into 'cashable' benefits. In addition the submitted schemes had to be risk assessed for clinical quality implications.

Mr Cattell reported upon progress on the establishment of the Pharmco Company. The Committee noted a high degree of slippage on previous estimates.

The Committee noted the report.

12. CQIN

Mr Beeken presented a report on progress against CQIN schemes Dementia and Alcohol and Smoking cessation schemes present a significant risk to income achievement.

13. Simulation Centre Business Case

Mr Price presented this case for the establishment of a clinical simulation training facility at RHH.

The Committee supported the case for consideration by the Board.

14. Matters referred to Board of Directors/ Committees

The Board is asked to consider the Simulation Centre Business Case.

PA Assinder
Director of Finance & Information
Secretary to the Board

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th February 2013

TITLE:	Infection Control Report		
AUTHOR:	Denise McMahon – Director of Nursing Dr Liz Rees - Consultant Microbiologist/ Infection Control Doctor	**PRESENTER:**	Denise McMahon 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 is 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 COMMITTEE:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

The Dudley Group NHS
NHS Foundation Trust

Report to: Board of Directors

Report by: Director of Nursing/DIPC & Consultant Microbiologist

Subject: Infection Prevention & Control Report

Summary

Clostridium Difficile – Annual Target 77 (Post 48 hrs) - The Trust has breached the monthly C.Difficile target in the last two months although the annual target is on trajectory. A meeting was held at the beginning of January to discuss periods of increased incidence of C.Difficile on wards C3 and C4. These periods of increased incidences are defined as 2 or more post 48 hour cases identified within a ward area within a 28 day period and are used as an indicator that there may have been breaches in infection control practice in the area leading to these episodes. The meetings discuss cleaning and environmental audit results, the use of personal protective equipment, commode chair audits, antimicrobial prescribing audits and a review of any RCA findings from the individual cases. Further meetings will be arranged to review any outstanding issues.

C.Difficile Cases Post 48 hours – Ward breakdown:

Ward	Totals for 2011/2012	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	As of 29th Jan 2013	Running Total
A1	**1**	0	0	0	1	0	0	0	0	0	0	1
A2	**6**	0	0	3	1	1	1	1	1	2	0	10
A4	**2**	0	0	0	0	0	0	0	0	0	0	0
B1	**0**	0	0	0	0	0	0	0	0	0	0	0
B2	**9**	0	0	1	0	0	0	0	0	0	0	1
B3	**7**	0	2	0	0	0	0	0	0	1	1	4
B4	**8**	0	0	0	0	1	0	0	0	0	1	2
B5	**1**	0	0	0	0	0	0	0	0	0	0	0
B6	**1**	1	1	0	0	0	0	0	0	0	0	2
C1	**19**	1	0	1	0	0	1	0	2	1	0	6
C3	**16**	0	0	0	2	0	0	1	0	1	1	5
C4	**8**	0	0	0	0	0	0	0	1	2	0	3
C5	**6**	0	0	0	0	0	0	1	0	0	0	1
C6	**3**	1	0	0	0	0	0	1	0	0	0	2
C7	**13**	2	1	0	0	0	0	1	1	1	0	6
C8	**7**	0	0	0	0	0	0	1	0	0	1	2
MHDU	**3**	0	0	0	0	0	0	0	0	0	0	0
CCU/PCCU	**1**	0	0	0	0	0	0	0	0	0	0	0
Critical Care	**6**	0	0	0	0	0	0	0	0	0	0	0
EAU	**0**	0	0	0	0	0	0	1	0	0	0	1
SHDU	**0**	0	0	0	0	0	0	0	1	0	0	1
Total	**117**	**5**	**4**	**5**	**4**	**2**	**2**	**7**	**6**	**8**	**4**	**47**

See Appendix 1 – Board Report (2012/13)

MRSA – Annual Target 2 (Post 48 hrs) - There have been no cases in the month of January 2013.

Norovirus - There have been no confirmed cases of norovirus in the Trust. However, we have had occasional bays closed for periods of 24 hrs for assessment of patients with symptoms consistent with norovirus to ensure against spread.

Bordetella pertussis (whooping cough) - The number of cases nationally are reducing. The look back exercise involving the member of community staff has been completed. The result of the case is that it was well managed.

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

(N13) Clostridium difficile infection

Month / Year	> 48 hrs Activity	PCT Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-12	5	7	-28.6%	5	7	-28.6%	9	10
May-12	4	6	-33.3%	9	13	-30.8%	11	12
Jun-12	5	6	-16.7%	14	19	-26.3%	6	8
Jul-12	4	6	-33.3%	18	25	-28.0%	7	9
Aug-12	2	6	-66.7%	20	31	-35.5%	5	7
Sep-12	2	5	-60.0%	22	36	-38.9%	8	9
Oct-12	7	6	16.7%	29	42	-31.0%	16	16
Nov-12	6	6	0.0%	35	48	-27.1%	8	9
Dec-12	8	7	14.3%	43	55	-21.8%	14	14
Jan-13	4	7	-42.9%	47	62	-24.2%	8	9
Feb-13	-	7	-	-	-	-	-	-
Mar-13	-	8	-	-	-	-	-	-
FY 2012-13	47	77	-39.0%				92	103

Monthly number of C-Diff cases

The PCT target for Cdiff is 77 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.
Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours.
The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

(N1) MRSA infections

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-12	-	1	-100.0%	0	1	-100.0%	-
May-12	-	0	0.0%	0	1	-100.0%	1
Jun-12	-	0	0.0%	0	1	-100.0%	-
Jul-12	-	0	0.0%	0	1	-100.0%	-
Aug-12	-	0	0.0%	0	1	-100.0%	-
Sep-12	-	0	0.0%	0	1	-100.0%	-
Oct-12	-	1	-100.0%	0	2	-100.0%	-
Nov-12	1	0	100.0%	1	2	-50.0%	1
Dec-12	-	0	0.0%	1	2	-50.0%	-
Jan-13	-	0	0.0%	1	2	-50.0%	1
Feb-13	-	0	0.0%	1	2	-50.0%	-
Mar-13	-	0	0.0%	1	2	-50.0%	-
FY 2012-13	1	2	-50.0%				3

Monthly number of MRSA cases

As a Foundation Trust the regulator Monitor measures compliance against the contract with our commissioners Dudley PCT. The target in this contract is 2 bacteraemias.

MSSA infections

Monthly number of MSSA cases

Month / Year	Total	Cumulative
Apr-12	4	4
May-12	4	8
Jun-12	4	12
Jul-12	1	13
Aug-12	2	15
Sep-12	5	20
Oct-12	4	24
Nov-12	7	31
Dec-12	5	36
Jan-13	-	36
Feb-13	-	36
Mar-13	-	36
FY 2012-13	36	

E Coli infections

Monthly number of E coli cases

Month / Year	Total	Cumulative
Apr-12	15	15
May-12	13	28
Jun-12	17	45
Jul-12	14	59
Aug-12	23	82
Sep-12	22	104
Oct-12	30	134
Nov-12	20	154
Dec-12	14	168
Jan-13	9	177
Feb-13	-	177
Mar-13	-	177
FY 2012-13	177	

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7th February 2013

TITLE:	**Report of the Chair of Audit Committee**		
AUTHOR:	**Jonathan Fellows**	**PRESENTER**	**Jonathan Fellows**
CORPORATE OBJECTIVE: Quality			
SUMMARY OF KEY ISSUES: The attached report summarises the matters discussed at the Audit Committee meeting held on 15th January 2013.			
IMPLICATIONS OF PAPER:			
RISK	**No**		**Risk Description:**
	Risk Register: No		**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: ***(Please tick or enter Y/N below)***

Decision	Approval	Discussion	Other
	X	X	

RECOMMENDATIONS FOR THE BOARD

The Board are asked to:

- **Note the reports of the internal and external auditors, local counter fraud specialist and clinical audit leads including a review of governance framework review on the agenda for the February Board workshop with each Board member completing the brief questionnaire beforehand**

CORPORATE OBJECTIVES : *(Please select for inclusion on front sheet)*		
SO1.	**Quality**	To exceed all internal quality targets by 2014 and to be recognised as the highest quality service provider in the region by patient groups, staff and other key stakeholders**.**
SO2.	**Innovation**	To have nurtured a proactive learning institution of excellence
SO3.	**Productivity**	To have established clinically and financially effective models of care**.**
SO4.	**Prevention**	Continually working with partners to develop new pathways that enable patients to make more appropriate use of Dudley Group services.
SO5.	**Staff engagement**	To be an organisation with a high commitment culture where everybody exhibits Trust behaviours and seeks to exceed expectations
SO6.	**Patient Experience**	To provide excellent service and care making patients feel involved, valued and informed.

The Dudley Group NHS
NHS Foundation Trust

Report of the Chair of Audit Committee to the Board of Directors
Meeting held on 16th October 2012

EXECUTIVE SUMMARY

- The Trust's Audit Committee met on 16th October 2012. The Committee considered in detail:

  - Progress reports from Internal Audit, External Audit, Local Counter Fraud Specialist (LCFS) and Clinical Audit;
  - A review of the Risk and Assurance Framework Arrangements;
  - The summary of Monitor recommendations to FTs following its reviews of self-certification;

- The Audit Committee also met privately with the Internal Auditors of the Trust. There were no matters that the Internal Auditors wished to bring to the attention of the Committee.

1. PROGRESS REPORTS FROM INTERNAL AUDIT, EXTERNAL AUDIT, LCFS AND CLINICAL AUDIT

- 8 internal audit reports had been issued since the previous Audit Committee meeting held on 16th October 2012. These were:

  - Payroll : **AMBER**/**GREEN**;
  - General Ledger : **GREEN**;
  - Data Quality - % of Diagnostic Waits < 6 weeks : **GREEN**;
  - IT Financial Controls : **GREEN**
  - Charitable Funds : GREEN
  - Treasury Management & Cash Receipting : **GREEN**
  - Debtors & Creditors : **GREEN**
  - Capital Programme & Asset management : **GREEN**

- The Payroll audit found that at present budget holders were not required to confirm the establishment information provided by Management Accounts and that any delays in forwarding information to the Payroll Department risked overpayments to staff.

- Given the consistently high assurance levels achieved on these core financial systems reviews, Internal Audit proposed not to include them in each annual plan. This would free up capacity in the plan to direct to other areas of higher risk.

- 11 recommendations had passed their target dates for implementation. However, a number of these would be addressed by the follow up reviews of Data Quality and Discharge planning.

- The External Audit update report confirmed that the deadline for submission of the Quality Report would be brought forward to align with the Accounts submission deadlines; also that mandatory indicators to be reported on in the Quality Accounts were C Difficile, readmissions within 28 days and incidents resulting in harm or death. The Committee expressed concern that there may not be consistency of reporting across Trusts and asked the External Auditors to raise the issue of clear data definitions when responding to the consultation process.

- The LCFS proactive annual work plan was on track.

- The Clinical Audit progress report recommended a further 24 clinical audits for inclusion on the Annual Plan. To date 83% of the CQC / NHSLA mandatory audits had been completed and all of the audits targeted for completion by the end of the financial year remained on track.

2. REVIEW OF RISK AND ASSURANCE FRAMEWORK ARRANGEMENTS

- The Audit Committee considers the effectiveness of the Risk Register and Board Assurance Framework at least annually. Given the changes to the Committee structure that have taken place in the past year the Audit Committee felt it would be helpful for the full Board to review effectiveness, possibly at a forthcoming Board workshop. A brief questionnaire which would assist in assessing the effectiveness of the current arrangements had been prepared by the Governance Manager.

- **The Board is asked to consider including on the agenda for the Board workshop due to take place in February an assessment of the current Risk and Assurance Framework arrangements and, ahead of that workshop, for each Board member to consider responses to the brief questionnaire attached as an appendix to this report.**

3. MONITOR SELF CERTIFICATION RECOMMENDATIONS

- Monitor had circulated a checklist to Boards on governance issues highlighted in recent independent reviews of Foundation Trusts in serious breach. The list of recommendations would be considered by the Audit Committee, which would advise the Board of any resulting changes to the process or practice of the current Governance Framework that it believed should be considered as a consequence of the Monitor recommendations.

JCF/29TH January 2013

The Dudley Group NHS
NHS Foundation Trust

REVIEWING THE RISK AND ASSURANCE FRAMEWORK ARRANGMENTS **APPENDIX**

Questions for the Board to consider		Response
1	Are you satisfied with the current Risk Management and Assurance Arrangements?	
2	Are there any changes you would like to see? If so, what?	
3	What do you think the Assurance Framework is there to do?	
4	How does it fit with the Board agenda?	
5	Who else / what other groups do you think could use the Assurance Framework?	
6	Are you satisfied with the existing Committee structure and reporting arrangements?	
7	Are there any changes you would like to see? If so what?	
8	Do the existing Terms of Reference for Committees cover all of the areas on which you require Assurance?	

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

on 7 February 2013

TITLE:	**Board Secretary's Report**		
AUTHOR:	**Paul Assinder** **Secretary to the Board**	**PRESENTER**	**Paul Assinder** **Secretary to the Board**
CORPORATE OBJECTIVE: SG03 Good governance			

SUMMARY OF KEY ISSUES:

The Board is asked to note:

- **Appointments to Council Committees as set out in paragraph 2 above (subject to Council approval)**
- **The appointment of Mr Johnson as Lead Governor (subject to Council approval)**

The Board is asked to approve:

- **For the purposes of the 2012 Act the definitions of 'significant transaction' as set out in 3.1 below.**
- **The definition of 'Non NHS Income' as set out in paragraph 4 below.**
- **The appointment of the Director of Operations as the lead director for Emergency Preparedness.**

IMPLICATIONS OF PAPER: (*Please complete risk and compliance details below)*			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Signif transactions/ Council of Governors
	Equality Assured	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	**Approval**	**Discussion**	**Other**
	X		

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the report and consider approvals outlined above.

The Dudley Group NHS
NHS Foundation Trust

Report of the Board Secretary to the Board of Directors (7 February 2013)

1. **Trust Constitution**
   Changes to the Trust's Constitution, approved by the Board and Council of Governors in November have been communicated to Monitor. We are awaiting formal approval from Monitor's Legal Department.

2. **Council of Governor elections to office**
   Elections were recently held for the posts of chairs of Council Committees, under the supervision of Auditors RSM Tenon (see enclosure). Council will be asked to approve the following appointments:

Chair of Governance Committee	Mr Rob Johnson
Chair of Member Engagement Committee	Mr Bill Hazelton
Chair of Strategy Committee	Mr David Stenson

   In addition an election was held for the post of Lead Governor. Council will be asked to approve the appointment of Mr Rob Johnson as Lead Governor.

   All appointments are for 3 years duration (to 31st January 2016).

3. **The Council of Governors' role in Significant Transactions and Structural Changes.**

Under the 2012 Act Governors are tasked with taking certain decisions regarding significant transactions and structural changes proposed for the Foundation Trust by the Directors. More than half of the members of the Council of Governors of the Trust must vote to approve the Trust entering into any significant transaction or structural change. The Trust therefore needs to assist the Governors by providing appropriate information on the proposed decisions.

The Board will recommend to Council the adoption of current Monitor approval regime.

3.1 Significant Transactions & Structural Changes

Significant Transactions

Under the 2012 Act Foundation Trusts can either decide themselves what constitutes a 'significant transaction' and set this definition in its FT constitution or by agreement with the Governors, Trusts may in fact choose not to give a definition but consider each transaction on a piecemeal basis.

It is the view of Directors that a clear definition would create a firm understanding of the approval process transactions need to follow in future. The Board intends to recommend to Council the adoption of the current Monitor regime for the definition and approval of significant transactions.

Monitor's current definition of a significant transaction is one which exceeds any of three tests:

i. **ASSET VALUE**
   Greater than 25% by value of the FTs total assets is classed as significant.
   Calculated as those gross assets subject to the transaction, divided by the gross assets of the FT.

ii. **INCOME VALUE**
   Greater than 25% of FT income is classed as significant. Calculated as the income attributable to the assets or the contract associated with the transaction, divided by the total income of the FT.

iii. **CAPITAL VALUE**
   Greater than 25% increase or reduction to capital value is classed as significant. Calculated as the gross capital of the organisation being acquired or sold, divided by the total capital of the FT following completion.

3.2 The continued role of Monitor and Structural Changes

Under the new Risk Assurance Framework, Monitor will still require details of any planned Investment or transaction worth more than 10% of an organisation's assets, revenue or capital. However this will be considered by Monitor from a governance as well as continuity of service perspective and Monitor will report back to Governors.

For any 'structural change' an FT will still need to make an application to Monitor. However, under the 2012 Act Monitor's role will be limited to ensuring that necessary steps in the process have been followed (such as consultation, referral to Competition authorities etc). The appropriate approval by the Council of Governors will be required in line with the thresholds set for the level of transaction (above). Typical structural changes include merger, acquisition, separation or dissolution.

4. The Council of Governors role in approving plans to increase Non NHS Income

The 2012 Act effectively removes the former cap upon Foundation Trusts generating income from private practice but replaces this with a requirement that each FT generates the majority of its annual income (+50%) from the NHS. The Act places upon FTs the responsibility for agreeing locally definitions of 'Non NHS' income. Whilst superficially this sounds uncontroversial, it does require some debate with auditors regarding definitions (eg the treatment of services to NHS patients funded by local authorities etc). Governors are requested to approve a working definition in the interim such that for the purposes of the 2012 Act 'Non NHS Income' be defined as 'Private Patient Income' (as defined in current Foundation Trust Accounting Guidance). Council will be invited to either ratify this definition or to consider an alternative agreed with the trust's Auditors, at a future meeting.

5. Director responsible for Emergency Preparedness, Response and Resilience

Latest major incident planning guidance requires the Trust to nominate a Board level lead for emergency preparedness.

The Board is recommended to approve the appointment of the Director of Operations in this role.

6. Recommendations

The Board is recommended to:

5.1 Note appointments to Council Committees as set out in paragraph 2 above (subject to Council approval)

5.2 Note the appointment of Mr Johnson as Lead Governor (subject to Council approval)

5.3 For the purposes of the 2012 Act approve the definitions of 'significant transaction' as set out in 3.1 above.

5.4 Approve the definition of 'Non NHS Income' as set out in paragraph 4 above.

5.5 To approve the appointment of the Director of Operations as the lead director for Emergency Preparedness.

PA Assinder
Board Secretary

The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 7th March 2013 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item		By	Time
1.	**Chairmans Welcome and Note of Apologies – D Mcmahon**		J Edwards	9.30
2.	**Declarations of Interest**		J Edwards	9.30
3.	**Announcements**		J Edwards	9.30
4.	**Chief Executives Overview Report**	Enclosure 1	P Clark	9.30
5.	**Quality**			
	5.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 2	D Bland	9.40
	5.2 Quality Accounts Report	Enclosure 3	D Eaves	9.50
6.	**Productivity**			
	6.1 Matters Arising from Finance and Performance Committee by Exception Report	Enclosure 4	D Badger	10.00
7.	**Prevention**			
	7.1 Infection Prevention and Control Exception Report	Enclosure 5	Y O'Connor	10.10
	7.2 Risk and Assurance Committee Exception Report	Enclosure 6	A Becke	10.20
	7.3 Quarterly Safeguarding Report	Enclosure 7	Y O'Connor	10.30
8.	**Corporate and Strategic**			
	8.1 Board Secretary's Report - Establishment of a Clinical Quality and Safety Committee and a Workforce and Patient Experience Committee	Enclosure 8	P Assinder	10.40
	8.2 Revalidation Report	Enclosure 9	P Harrison	10.50
	8.3 Organ Donation Half Yearly Report	Enclosure 10	D Badger	11.00
	8.4 National Institute for Health Research Capability Statement	Enclosure 11	P Harrison	11.10
9.	**Date of Next Board of Directors Meeting** 9.30am 4th April, 2013, Clinical Education Centre		J Edwards	11.20
10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards	11.20

Board of Directors Members Profile.

Paula Clark – Chief Executive

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

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

Paul Assinder – Director of Finance and Information

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

Richard Beeken – Director of Operations and Transformation

Richard is executive lead for the operational delivery in clinical services, estates and facilities and the transformation project. He is responsible for the operational leadership and management of all clinical services and the performance improvement of clinical and business processes. Richard also manages the performance of the Trust's contracts with PFI partners Summit Healthcare.

Denise McMahon – Director of Nursing

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

Paul Harrison – Medical Director

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

Annette Reeves – Associate Director of Human Resources

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

Tessa Norris – Director of Community Services and Integrated Care

Tessa's remit at Board is an in attendance role to provide insight to Community services, integrated care and as lead for Governor Development. Tessa also brings an additional clinical voice to the Board as a Registered Nurse.

John Edwards – Chairman

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

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

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

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

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

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

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

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

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

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

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

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

Richard is also responsible for the following:
Chair of the Charitable Funds Committee
Non Executive Director Lead for Security Management
Member of Finance and Performance
Member of Audit Committee
Assigned to the Governors Governance Committee
Member of the Remuneration Committee
Member of the Nominations Committee

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

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

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

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors 7th March 2013

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

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- Friends and Family Report
- Capacity Pressures
- Nursing Student Times Awards: Shortlisted in Two Categories
- Keogh Review into Mortality Indicator Outliers

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
NHS Foundation Trust

Chief Executive Update – March 2013

Friends and Family Report:

	Apr-12	May 12 overall	June 12 overall	July 12 overall	Aug 12 overall	Sept 12 overall	Oct 12 overall	Nov 12 overall	Dec 12 overall	Jan 13 overall	Feb 13 overall
Date range	Baseline Month	29/04/2012 – 26/05/2012	27/05/2012 – 30/06/2012	01/07/2012 – 28/07/2012	29/07/2012 – 25/08/2012	26/08/2012 – 29/09/2012	30/09/2012 – 27/10/2012	25/10/2012 – 24/11/2012	25/11/2012 – 29/12/2012	30/12/2012 – 26/01/2013	27/01/2013 – 23/02/2013
Organisation NPS - weekly	52	77*	76*	73*	77*	77*	76*	76*	75*	71*	70
% of footfall (inpatient discharges - Min'm 10%)	12%	15%	12%	19%	18%	18%	22%	29%	21%	26%	35%

* CQUIN upper quartile achieved

NPS Score	>= 71
	52** to 70
	< 52
% of footfall	>= 10%
	< 10%
** 52 is DGH baseline set in April	

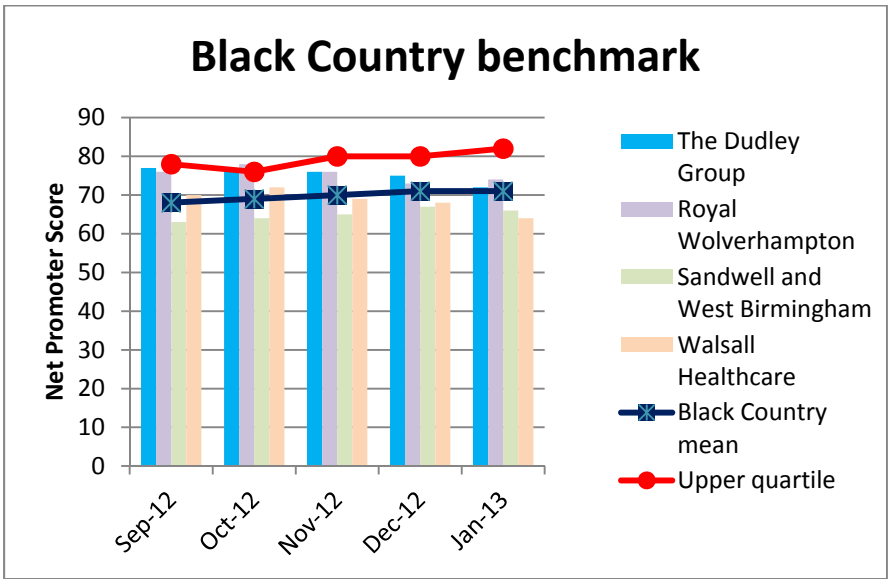
In February the Trust achieved a score of 70 but did not reach our own target to be above 71 for the first time since setting the baseline in April 2012.

This slight drop in results has affected not just us but also others in the Black Country. This could be due to recent NHS media coverage.

We did, however, see a significant rise in feedback during February with 35 per cent of inpatients participating in the Friends and Family Test.

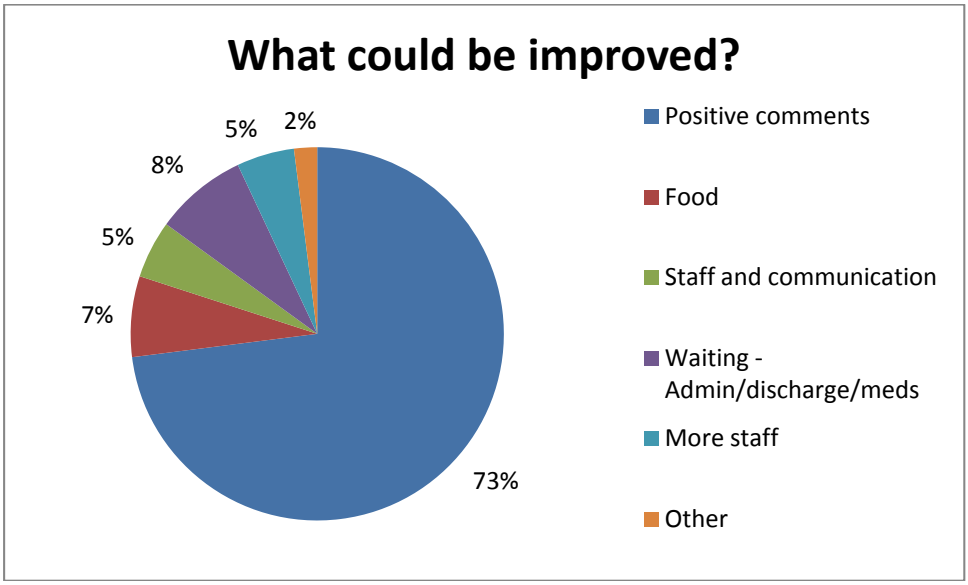
Benchmarking (latest data available – January 2013)

Regional (NHS Midlands and East) average for January	71
Black Country average for January	71
Trust score for January	71



Feedback
Fifty one per cent of respondents to the FFT survey in February and 73% of the comments were positive.

Food slipped into second place of the most requested items for improvement reducing from 13 per cent to seven per cent, with waiting times rising from three per cent to eight per cent.



A pilot of an alternative meal system 'Steamplicity' is taking place on two wards in the hospital during March. A taster session for staff on those wards has already taken place and a further session for Governors, relatives and patient panel members will take place in early April.

Readiness for national roll out of the Friends and Family Test
The Trust will be launching the Friends and Family Test into A&E in March 2013 in readiness for the national roll out of the Friends and Family Test in April 2013.

Capacity Pressures:
The Trust is still under significant pressure from emergency admissions and has once again had to escalate to Level 4. We are not alone and pressures have been seen across the Black Country and into the wider West Midlands. A meeting, led by the Local Area Team Director, is scheduled for 11th March. This is to follow up the output from the Emergency Care Summit held before Christmas and assess what more needs to be done.

Nursing Student Times Awards:
The Trust has been shortlisted in two categories; Mentor of the Year and the Best Education Provider for Post Graduate Nursing Education.

The Dudley Group NHS
NHS Foundation Trust

Keogh Review into Mortality Indicator Outliers:
Following the Francis Report, the Department of Health announced five Trusts it planned to investigate for being outliers for two years on the Summary Hospital-level Mortality Indicators (SHMI).

Sir Bruce Keogh announced a further nine hospitals who will be looked at as part of his review for being outliers for two years on the Hospital Standardised Mortality Indicator (HSMR). The Dudley Group is on this new list.

This team, we are told, will look at such things as:

- Mortality
- NHSLA
- Clinical Audit
- Patient comments
- Safety incidents
- Coding trends
- Missing data
- Staff surveys

A timescale and terms of reference for the DoH review will be announced shortly.

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 7th March 2013

TITLE:	**Summary of Key issues from the Clinical Quality, Safety & Patient Experience Committee held on 10th January 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

Matters arising – Dr Jane Dale (Endocrinology) attended the meeting at the Committee's request to provide assurance on the management of two reported serious incidents. She highlighted her concerns about the management of these and the need to raise staff awareness about the care of patients with diabetes when admitted to the Trust. She also highlighted weaknesses in the current training arrangements and the need to confirm compliance with an NPSA alert relating to the prescribing of insulin. Dr Dale expressed concern that supporting guidelines were out of date.

Reporting Groups – The following reports were received:

1. **Blood Transfusion and Competency Training Update -** 58% of medical staff who are required to complete blood transfusion training have completed this in the last 3 years. There are 165 doctors to be trained. No medical staff required to undertake competency assessments in the administration of blood (largely Anaesthetics and Emergency medical staff) have completed this to date. The Committee agreed the action required to address and prioritise this.

2. **Patient Safety Group** – key issues arising from the meeting held on 12th December 2012:
   - **Falls Report** - A multi disciplinary group had developed a Falls Prevention Bundle to improve the focus on patients falling and potentially decrease the number and severity of patient falls. The Falls Link Worker role was re-launched in January to provide renewed focus on the Falls Prevention Pathway and the Falls Bundle document.
   - **INCIDENTS - Feedback from the Red Incident Assurance and Learning Group** - There was a fall in the number of delayed Root Cause Analyses (RCAs) but a number were outstanding.
   - **Patient Safety Leadership Walk rounds** –21 Patient Safety Walk Rounds have taken place since April 2012. 31 actions have breached agreed completion dates. The group discussed progress and noted that some actions taken locally had not been recorded.
   - **Update from theatres on retained surgical packs** - An update was provided on the use of the WHO surgical checklist. Additional data to increase assurance and enable action to be taken when issues were identified had been discussed with the theatres manager.
   - **Staff Sickness** – Following concerns about staffing levels on a ward due to sickness and vacant posts, the Director of Nursing had met with the Matron to identify immediate actions.

3. **Internal Safeguarding Group -** key issues from the meeting on 13th December 2012:
   - **PFI Partners Safeguarding Compliance** –53% of the PFI Partners had completed the training.
   - **Learning Disability Liaison** - funding for this post had been promised, but not received
   - **Restraint Training** – The Restraint Policy had been agreed. Progress would now focus on high risk areas; staff training would concentrate on 'escalation management' and not patient restraint.

4. **LET Working Group -** key issues from the meeting on 6th December 12:
   - **Quality Assurance Educational Visits -** There had been 3 visits, Radiology and Maxillo-Facial visits had been good and the posts for Junior Doctors had been approved. Actions arising from the Paediatric visit were being progressed by the Head of Medical Education and would be completed before a re-visit in April 2013.
   - **Workforce Issues –** The Deputy Clinical Tutor and Senior Learning and Development Manager were hoping to include the Trusts Leadership training in the SpRs training plan.

NICE Update - 41 pieces of guidance had not been assessed. The guidance had been distributed to identified leads for a baseline assessment and a response. These were not received within the 4 week timescale. Escalation of outstanding NICE Guidance was discussed with all Clinical Directorates to improve reporting systems and was also discussed at the Trust Management Executive meeting in January 2013.

Clinical Audit Findings - Many clinical audits were in progress or in the process of data analysis. Consequently, the number of completed audits with identified clinical audit outcomes remained low at this point in the year.

Friends and Family Survey Results - the following issues were highlighted:

- The Net Promoter Score (NPS) remained constant. Food remained the top recommendation for improvement. Wards had been asked to complete a 'You said, We did' report to highlight how feedback from patients was used to make improvements. Wards were given until the end of January to complete this report and would be asked to update this quarterly based on ongoing feedback.

- **Ward Trends** – Six Wards failed to reach the minimum 10% data collection in December. From April all wards would need to collect 15% footfall. Under new guidelines questions could not be asked at the bedside and patients could not be assisted to complete them. There was also a change in the way that the data was reported and published. The Trust was required to report the data monthly by ward, with up to two specialties listed against each ward. Results would be published on NHS Choices with a Trust-wide score on the main screen and individual ward scores under specialties. This would allow comparison by listing wards as normal, better or worse than others.

Patient Story - The Committee listened to a video of a patient confirming his experiences at Russell's Hall Hospital. The Committee welcomed the positive story and noted the importance of recognising the good work as well as focusing on the negative aspects of care.

NHS Choices - the Trust was doing better than most of the neighbouring Trusts and had received almost three times the number of '**would recommend'** ratings than neighbouring organisations.

Serious Incident (SI) Monitoring Report - 10 new incidents were reported – 3 general SI's and 7 pressure ulcers. There were 28 open general SI's (9 undergoing investigation, 4 awaiting assurance that actions identified in the RCA investigation had been completed, 1 extension requested, 1 waiting review by the Lead Director and 13 recommended for closure). Concerns highlighted from the General SI's were consistent reporting of fractures as a result of a fall and from the pressure ulcer SI's, Wards A2, Stroke and Community. There were no breaches in the 2 day reporting from date of identification and completion of RCAs within the agreed time scales.

Quality Dashboard Report for Month 8 - 4 of the listed Quality Indicators were red rated for the reporting period. Maternity – Increase in breast feeding initiation rates, MRSA – breach, Maternity – Smoking in Pregnancy and TAL Appointment booking within 4 days. One indicator was flagged as an outlier on the NHS Choices Clinical Indicator list. The 'Maternity – Smoking in Pregnancy' measure had risen above the 15% target with performance of 15.7%. The 'TAL Appointment booking within 4 days' fell to its lowest performance level since May, with a final position for November of 56.3%.

Dudley CCG Appreciative Visit on Falls - The Committee received a report and action plan from an Appreciative Visit from the Dudley CCG in October 2012 looking at the care and treatment of patients who had a fall. The Director of Nursing felt that this was a positive visit and was very helpful.

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Committee reports referenced 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 eg 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 10th January 2013

Enclosure 3

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th March 2013

TITLE:	Quality Account Update (Apr-Dec 2012)		
AUTHOR:	Derek Eaves – Interim Deputy Director of Nursing Liz Abbiss – Head of Customer Relations and Communications	**PRESENTER:**	Derek Eaves – Interim Deputy Director of Nursing

CORPORATE OBJECTIVE:

SG01: Quality, Safety and 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.

SG02: Patient Experience – To provide the best possible patient experience.

SUMMARY OF KEY ISSUES:

The attached paper indicates the Trust's position at the end of the third quarter with the five Quality Priority targets and the National Clinical Audits. The paper shows the actions being taken to achieve the five targets.

With regard to the specific targets: for **Patient Experience,** the percentage of patients reporting receiving enough help from staff to eat their meals where this is needed has fallen to just below the 85% target this quarter although the accumulative yearly figure remains on target. There has been an increase in the number of patients stating they have received enough information on reaching the wards but the end of year target has not yet been met. The community based target is based on an annual survey which has not yet completed.

With regards to **Pressure Ulcers** the dramatic decrease in avoidable ulcers reported in the community continues so that target is likely to be met at the end of the year while the hospital numbers have increased slightly from the last quarter so achieving the end of year target may be difficult.

With regards to **Infection Control** the targets are being met so far.

With regards to **Nutrition/Hydration,** there was an increase in the completion of fluid balance charts but there was dip in the figures for MUST. Although we have met one of the targets for Hydration (by September, 70% completion) to achieve 90% in March looks unlikely. The achieving of the MUST target looks more promising.

With regards to the **National Audits and Confidential Enquiries** plans are in place to participate with all of those relevant to the Trust's services.

IMPLICATIONS OF PAPER:

RISKS	**Risk Register**	**Risk Score**	Details:
COMPLIANCE	**CQC**	N	Details:
	NHSLA	N	Details:
	Monitor	Y	Details: Quality Report requirements
	Other	Y	Details: DGNHSFT Quality Account requirements

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
✓		✓	

RECOMMENDATIONS FOR THE BOARD:

To note the position with regards to the targets and with regards to the national clinical audit participation at the end of the third quarter.

THE DUDLEY GROUP NHS FOUNDATION TRUST
QUALITY ACCOUNT UPDATE OCTOBER - DECEMBER 2012

QUALITY PRIORITY 1 ACTION PLAN: Hospital (a) Increase the number of patients who receive enough assistance to eat their meals from 81 per cent to 85 per cent. (b) Increase the number of patients who receive enough information about ward routines from 57 per cent to 65 per cent. **Community** (a) Increase the number of patients who use their Single Assessment Process folder to monitor their care from 75.3 per cent to 80 per cent. (b) Increase the number of patients who would know how to raise a concern about their care and treatment if they wished to do so from 80.8 per cent to 85 per cent.

Planned Actions	Who	By When	Progress at end of December 2012
Hospital			
Consider feasibility of increasing employed nutritional support workers, continue utilizing trained volunteer mealtime assistants, embedding of 15-minutes meal bell alert along with behind the bed boards identifying mealtime assistance requirements	Sheree Randall	March 2013	Trust wide staffing review in progress, with the recommendation (by the Matron for Elderly Care) for the introduction of the nutritional support workers into Ward C3 – Geriatric Medicine. Continue with monthly link nurse meetings for Essence of Care, which reinforces the need to identify patients who require assistance at mealtimes by utilizing the behind the bed boards, red tray system & electronic handover. Hand bell alert introduced on 1st March & compliance is monitored via mealtime audits. Posters to this effect now in place. Trust wide audit of behind the bed boards & use of hand bells in Sept 2012. Trust data is collected via the monthly lead/link nurse nutrition audits. Results currently show 85% compliance with hand bell usage to inform patients and staff of mealtime arrival. The same audit also shows 99% compliance with completion of the behind the bed board. Q3 update- monthly link nurse audits continue. Weekly fluid balance chart audits, by lead nurses, introduced 1st January 2013. Continuing discussion regarding the appointment of Nutritional Support Workers into C3. Awaiting decision re use of nurse call system to provide a more permanent arrangement for pre meal time bell, from Head of Estates.
Introduce bedside folders to inform patients of ward routines	Mandy Green	December 2012	Change in terms from bedside folders supplier means these are no longer a free resource. A new welcome letter/4pp leaflet is being developed for each ward area instead. Q3 update – Bespoke welcome leaflets have been drawn up for each ward. Changes to visiting times at the end of Dec have been incorporated. These have now been distributed to all wards. **COMPLETED**

Planned Actions	Who	By When	Progress at end of December 2012
Community			
Raise awareness with patient (or family/carer) of the use of the Single Assessment Process folder to keep them informed of the care provided and as a means of communication	Sally-Anne Osborne	Oct 12	Questions relating to the use of and awareness of the SAP document included in the 2011/12 patient experience survey. All services/teams using the SAP have discussed with the patients the use of SAP. The SAP multi-agency working group is currently redesigning the document to promote the sharing of information across the agencies and for use when a patient is admitted to acute care. Q1 update – Comms plan drafted for new document Q2 update – the SAP working group continues to meet monthly to progress the revised document. Content of the folders agreed, criteria for folder use agreed, scoping supplier. Communications team from DGNHSFT and DMBC engaged in supporting the project. Folder narrative and patient leaflet being drafted and will be tested using patient/client groups prior to final print. Inclusion of SAP questions in the annual patient experience survey. Q3 update – Folder content drafted for approval prior to review by users. IT teams from the Local Authority and The Trust working together to ensure that the document is compatible. Supplier identified. Patient experience surveys complete for all community services, awaiting results.
Ensure PALS leaflets are available for patients, refresh posters in clinic areas advising patients how to complain if they wish to, PALS advice to be documented as part of assessment	Sally-Anne Osborne	Complete and ongoing	All community services/teams have accessed the Trust's PALs leaflet and posters to raise awareness with patients to enable them to raise concerns when they need to. This has been discussed in team meetings. **COMPLETED**

Hospital

October - December data and commentary

	Baseline for CQUIN from 11/12	**Target 12/13**	Qtr 1 2012/13	Qtr 2 2012/13	Qtr 3 2012/13	Qtr 4 2012/13	2012/13 YTD
Did you get enough help from staff to eat your meals?	81	**85**	82	92	84.5		86.6
When you reached the ward, did you get enough information about ward routines, such as timetables and rules?	57	**65**	41.8	53.9	56.9		51.1

Patients' reporting that they received enough help from staff to eat their meals has dropped into the red during quarter three but remains in the green year to date. This relates to one per cent of the 798 patients surveyed during the quarter answering that they either sometimes or did not receive the help they needed. The breakdown of wards concerned shows individual isolated incidents in the main. For January (as at 28.01.13) the score is back up to 96.4%.

The number of patients reporting that they received enough information about ward routines has increased again during quarter three, but remains in the red as it has not passed the baseline figure set in 2011/12. We would hope to see an improvement in quarter four with the introduction of the new welcome leaflet. (As at 28.01.13 the score for January is 71.8%).

Community

Community data are based on an annual survey not yet completed.

Operational lead: Mandy Green, Communications Manager

QUALITY PRIORITY 2 ACTION PLAN: Reduce avoidable stage three and four hospital acquired pressure ulcers, against activity, so that the number for 2011/12 has been reduced by 50 per cent in 2012/13.

Reduce avoidable stage three and four acquired pressure ulcers that occur on the district nurse caseload through the year, so that the number for the final quarter of 2011/12 has been reduced by 10 per cent at the second quarter of 2012/13 (Jul- Sep) and by 20 per cent at the final quarter of 2012/13 (Jan-Mar).

Planned Actions	**Who**	**By When**	**Progress at end of December 2012**
Continue to embed the reliable reporting system with community nursing teams	L Turley	March 2013	Datix system is in place with progress discussed at bi monthly pressure ulcer group meeting held in the community. COMPLETED
Train community staff to know what stage ulcers are at and treat accordingly Agreed to introduce midlands and East staging tool to benchmark current practice with neighbouring Trusts in the midlands	L Turley TV Team	March 2013 April 2013	All community teams have attended or sent one representative to initial staging updates including use of the skin bundle documents. Mandatory updates ongoing for whole Trust open to community staff Mandatory updates x 4 booked for community teams to be extended to include equipment update and 30 degree tilt Following datix report any possible discrepancies based on the description are communicated to teams for extra assurance Initial mandatory staging session complete TV to complete training sessions and ward walks for all nurses in Trust Visual aids to be distributed
Introduce a revised and improved version of the pressure ulcer prevention and management document	L Turley	Aug 2012	**COMPLETED**
Undertake a check of the use of the new document described above	L Turley	Nov 2012	Once document is launched process to be agreed Dec 2012 Pressure Ulcer prevention document launched. Agreement to audit inclusion of document for all high risk patients in community through NCRS coding. Assurance of correct completion to be audited through NCIs.
Undertake training of social services carers and carers within residential homes	L Turley C Carter	March 2013	**Residential homes** have been offered training and several sessions delivered. Outstanding homes have been identified and Tissue Viability nurses are working with Convatec to assist in delivery of training sessions. **Community Carers.** Sessions have been completed with an agreement from social services that senior carers will cascade the information to those not present. **COMPLETED** **Private Care agencies. COMPLETED**. December 2012: Further training sessions organized throughout the year. DNs to be advised of dates. Private care agencies have refused to complete documents.

			Commissioners aware. Lisa Turley has met with managers who will feedback at their managers meeting. Mop up sessions completed and all residential homes invited. Not all have attended but have been invited again to future sessions.
Improve the reporting of the incidence of pressure ulcers so that it is done electronically across the Trust rather than on paper as at present	TV Team and governance	April 2012	**COMPLETED**. Datix reporting introduced and being used by all community teams. Processes are in place to track the patients journey

October - December Data

Hospital

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

Period	2011/12	Apr- June 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13
No. of stage 3		8	5	6	
No. of Stage 4		11	6	8	
Total	110	19	11	14+	

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

Month	Stage 3	Stage 4	Total
July	1	2	3
Aug	2	2	4
Sept	2	2	4
Oct	4	2	6
Nov	0	3	3
Dec	2	3	5

Community

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

Period	Last quarter of 2011/12	Apr- June 12	Jul-Sep 12	Oct-Dec 12	Jan-Mar 13
No. of stage 3	19	2	1	2	
No. of Stage 4	14	3	3	4	
Total	33*	5	4	6+	

*Please note that this figure has changed from that reported in the Annual Report (when it was 40), as initially reported incidents may be deemed as unavoidable following investigation. +Please note than these figures may change dependant on the outcomes of RCA investigations as to whether reported pressure ulcers are avoidable or unavoidable.

Month	Stage 3	Stage 4	Total
July	0	2	2
August	0	0	0
September	1	1	2
October	2	2	4
November	0	0	0
December	0	2	2

October - December Commentary

With regards to the hospital, the numbers continue to be below the average 27.5 per quarter last year although the provisional number for the last quarter (14) is above the second quarter (11) but below the first quarter (19). In total, therefore there have been 44 in nine months. As the aim is to reduce the previous year's numbers by 50%, this means in the last quarter we should not have more 11 (the target is based on activity and so there may be some slight adjustment to these figures). The community target of a reduction of 10% in the second quarter from the final quarter of 2011/12 has been so well exceeded that, as long as the numbers remain similar for the rest of the year, the final year end target has already been achieved.

A new innovative campaign has been developed with the involvement of the tissue viability team and communications it is aimed that this will help to sustain the importance and profile of pressure ulcer reduction.

Operational Lead: Lisa Turley, Tissue Viability Lead Nurse

QUALITY PRIORITY 3 ACTION PLAN: To reduce our MRSA and Clostridium difficile (C.diff) rates in line with the national and local priorities. MRSA Bacteraemia (blood stream infections) target is no more than 2 post 48 hour cases; C.diff is no more than 77 post 48 hour cases.

Planned Actions	Who	By When	Progress at end of December 2012
Introduce hydrogen peroxide 'fogging' for the environment when patients are discharged to reduce cross contamination	IPCT	1/06/12	**COMPLETED** Went live on 1st June 2012. All wards aware of process for ordering "fogging" for rooms where patients have had infections. Also being used for routine cleaning of medical equipment. Information launched on the HUB
Improve training support for anti-microbial (drugs that destroy disease-carrying micro-organisms) prescribing	Dr Rees/ Antimicrobial pharmacist	October 2012	**COMPLETED** Video available on the HUB Training was at 80% compliance
Review the details of the local cleaning contract in light of new national directives	IPCT/ Matrons	March 2013	Working group meeting regularly to review the policy in line with new national guidance. Risk assessment for ward areas completed
Agree competencies for the nursing element of cleaning the environment	Matrons/ Lead nurses/ Interserve	December 2012	Competencies developed and agreed. Pilot started on Maternity, ED and Cardiac Catheter lab. Roll out programme for other areas being developed
Agree and report competencies of contracted cleaning staff	Interserve	March 2013	Discussion with Interserve to get copies of their training records and competency information
Improve information gathering including feedback and changes in practice regarding anti-microbial prescribing, bringing more senior medical input into the root cause analysis process	RCA review panel	September 2012	**COMPLETED** RCA panel meets fortnightly and reviews RCAs. Themes presented at Infection Control Committee.
Ensure more reliable investigations of individual infection cases with feedback and action plans to prevent or reduce it happening again	RCA review panel	September 2012	As above
Introduce the new testing algorithm introduced by the Department of Health	IPCT/ Microbiology	April 2012	**COMPLETED** and on the HUB
Clarify the reporting regime as outlined by Department of Health guidelines	IPCT/ Microbiology	April 2012	**COMPLETED**
The National Patient Safety Agency (NPSA) infection prevention project to be expanded and taken into the surgical and high dependency areas	IPCT/ ITU consultants	March 2013	In progress
Review usage of protein pump inhibitors medication used for patients with stomach problems	IPCT/ Dr Rees/ GI cons.	January 2013	Completed. Policy on HUB strengthened.
Monitor and record the time it takes to place patients into side rooms once an infection has been identified	IPCT	March 2013	Ongoing as part of the Saving Lives High Impact Interventions

October - December Data

Clostridium difficile infection

Monthly number of C-Diff cases

Month / Year	> 48 hrs Activity	PCT Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-12	5	7	-28.6%	5	7	-28.6%	9	10
May-12	4	6	-33.3%	9	13	-30.8%	11	12
Jun-12	5	6	-16.7%	14	19	-26.3%	6	8
Jul-12	4	6	-33.3%	18	25	-28.0%	7	9
Aug-12	2	6	-66.7%	20	31	-35.5%	5	7
Sep-12	2	5	-60.0%	22	36	-38.9%	8	9
Oct-12	7	6	16.7%	29	42	-31.0%	16	16
Nov-12	6	6	0.0%	35	48	-27.1%	8	9
Dec-12	8	7	14.3%	43	55	-21.8%	14	14
Jan-13	-	7	-	-	-	-	-	-
Feb-13	-	7	-	-	-	-	-	-
Mar-13	-	8	-	-	-	-	-	-
FY 2012-13	43	77	-44.2%				84	94

(N1) MRSA infections

Monthly number of MRSA cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-12	-	1	-100.0%	0	1	-100.0%	-
May-12	-	0	0.0%	0	1	-100.0%	1
Jun-12	-	0	0.0%	0	1	-100.0%	-
Jul-12	-	0	0.0%	0	1	-100.0%	-
Aug-12	-	0	0.0%	0	1	-100.0%	-
Sep-12	-	0	0.0%	0	1	-100.0%	-
Oct-12	-	1	-100.0%	0	2	-100.0%	-
Nov-12	1	0	100.0%	1	2	-50.0%	1
Dec-12	-	0	0.0%	1	2	-50.0%	-
Jan-13	-	0	0.0%	1	2	-50.0%	-
Feb-13	-	0	0.0%	1	2	-50.0%	-
Mar-13	-	0	0.0%	1	2	-50.0%	-
FY 2012-13	1	2	-50.0%				2

October - December Commentary

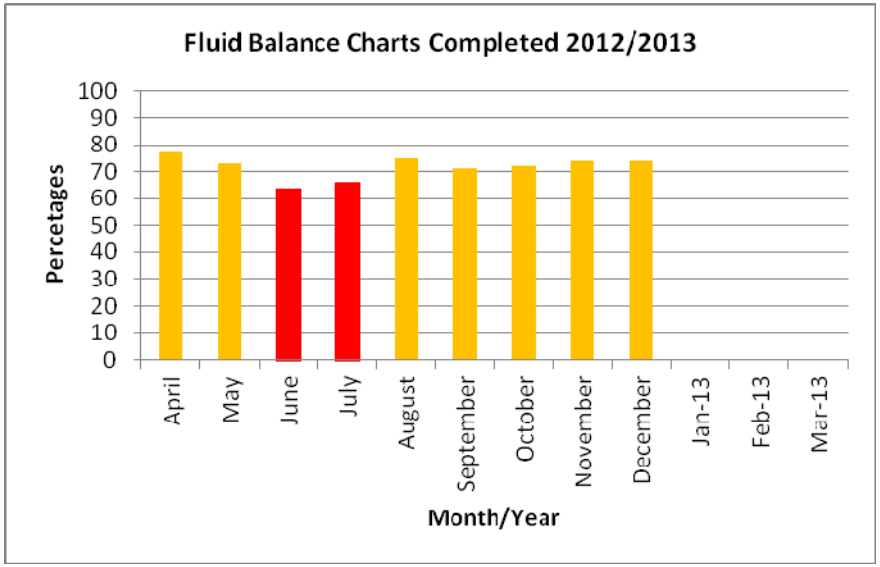
- The Clostridium difficile numbers, whilst remaining below the annual trajectory, has in Oct and Dec been above the monthly trajectory (1 case in each month).
- Hydrogen Peroxide service has been running now for 8 months and we have completed over 200 decontaminations of rooms where patients have been identified with an infection.
- The Trust has recorded one post 48 hour MRSA Bacteraemia in November 2012. A table top review of the case was undertaken and it was identified that on a number of occasions MRSA results had not been reviewed when the patient had attended Outpatient appointments leading to no treatment being given. Outpatients Department Lead Nurse has reviewed the actions identified in the RCA and implemented a system to ensure results are checked.
- RCA panel meets monthly to review themes from reviews of patients with Cdifficile.

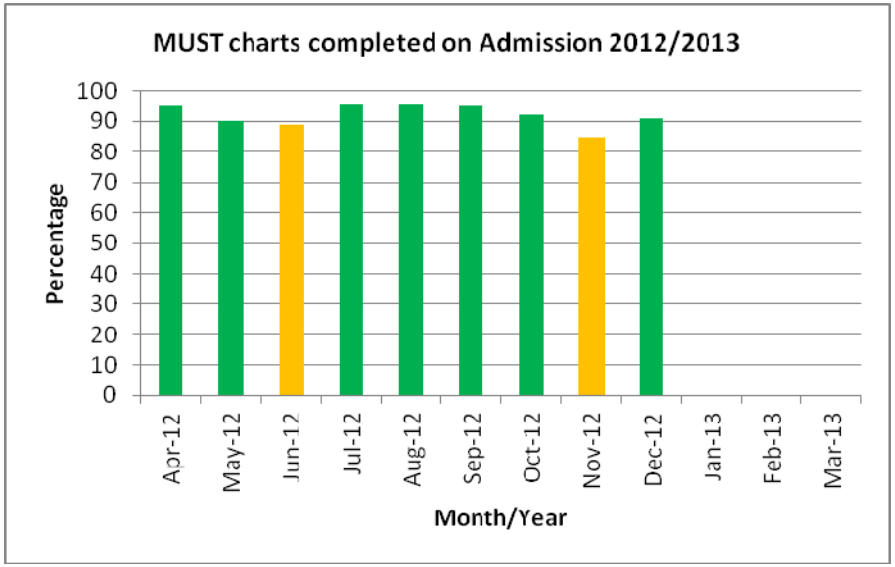
Operational lead: Dawn Westmoreland, Consultant Nurse, Infection Prevention and Control

QUALITY PRIORITIES 4 AND 5 ACTION PLAN: Nutrition Increase the number of patients who have a risk assessment regarding their nutritional status within 24 hours of admission. By September 2012 at least 90 per cent of patients will have the risk assessment completed and this will continue for the rest of the year. **Hydration** Increase the number of patients who have fluid balance charts fully completed. By September 2012 at least 70 per cent of patients will have a fluid balance chart fully completed and this will rise to at least 90 per cent by the end of the year (March 2013).

Planned Actions	Who	By When	Progress at end of December 2012
Nutrition steering group to review indicators quarterly and drive changes from any required action points	K Broadhouse	June 2012 then quarterly	**COMPLETED**. Reports go to the QDPT Nutrition and are discussed qtly.
Continue audit of MUST and education to be delivered in targeted areas	Ann Marsh	Dec 2012	New education package underdevelopment by dietetics dept. To target EAU to improve compliance with assessment.
Essence of Care Link nurses re enlisted	K Broadhouse	June 2012 then monthly monitoring	**COMPLETED**. Has now established core group members. Meetings undertaken bi monthly.
Fluid balance charts redesigned and to be introduced	K Broadhouse	Apr 2012	**COMPLETED**. New design utilized in all ward areas only exceptions critical care units, now embedded within the trust.
New fluid balance charts to include new lunch time evaluation requiring trained nurse signature	K Broadhouse	Apr 2012	**COMPLETED**
Education package for fluid balance developed to be delivered in all ward areas	Ann Flavell	Apr 2012	**COMPLETED** Education package and SOP developed and rolled out trust wide, delivered by link nurses.
Competency document for fluid balance developed for all staff to sign	K Broadhouse	Dec 2012	All ward areas to provide list of staff members who have received training and have signed competency sheet. 50% compliance by end of April 2012. Matron Randall has data of all wards and compliance. Lists are being returned from ward areas of all staff trained to undertake fluid balance monitoring and competency statement signature lists collated.
New fluid balance criterion to be included in the Nursing Care Indicator (NCI) audit	K Broadhouse	June 2012	**COMPLETED** New audit tool developed and went live on 1st June 2012.

April - December Data





April - December Commentary

The completion of the fluid balance charts has recovered slightly from a fall noted in June and July. The last 3 months data show we are scoring consistently above the 70% threshold; the average score for this criterion is currently 71% for this year. The lead nurses have commenced weekly audits to ensure fluid balance charts are completed as demanded. The completion of the MUST assessment on admission to trust did fall in November however, the score has recovered slightly in December to above 90% the average score for the year remains 93%.

Operational Leads: Dr S. Cooper, Consultant Gastroenterologist, Sheree Randall, Matron, Karen Broadhouse, Quality Project Lead

Participation in national clinical audits and confidential enquiries

For 2012-13, 41 national clinical audits and 4 confidential enquiries cover NHS services that the Trust provides. The Trust is participating in 41 (100%) of national clinical audits and 4 (100%) of national confidential enquiries which it is eligible to participate in.

There are 9 national audits which the Trust is not eligible to participate in as the services are not undertaken within the organisation.

All national audits and confidential enquiries are progressing as planned, and are being tracked via Performance Accelerator.

The national clinical audits and confidential enquiries that the Trust is eligible to participate in, and actually participating in during 2012-13, are listed below in table 1.

Table 1. National clinical audits that the Trust is eligible to participate in during 2012-13

AUDIT PROJECT TITLE	CATEGORY	TRUST PARTICIPATION	STATUS
ICNARC Case Mix Programme Database	Acute care	Yes	In progress
National Joint Registry	Acute care	Yes	In progress
CEM Renal Colic Audit 2012	Acute care	Yes	Complete
Trauma Audit & Research Network Audit (TARN)	Acute care	Yes	In progress
BTS Emergency Use of Oxygen Audit	Acute care	Yes	Complete
BTS Community Acquired Pneumonia Audit	Acute care	Yes	In progress
BTS Adult NIV Audit	Acute care	Yes	Start date 01-02-2013
NHS Blood & Transplant Potential Donor Audit	Blood & Transplant	Yes	In progress
National comparative audit of blood transfusion - Audit of the use of Anti-D	Blood & Transplant	Yes	Delayed nationally until Spring 2013
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	Blood & Transplant	No	Not required *
National Lung Cancer Audit (LUCADA)	Cancer	Yes	In progress
National Bowel Cancer audit Programme (NBOCAP)	Cancer	Yes	In progress
Head & Neck Cancer Audit (DAHNO)	Cancer	Yes	In progress
National Oesophago-gastric Cancer Audit	Cancer	Yes	In progress
ICNARC National Cardiac Arrest Audit	Heart	Yes	In progress
VSSGBI National Vascular Database	Heart	Yes	In progress
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Heart	Yes	In progress
National Heart Failure Audit	Heart	Yes	In progress
Heart Rhythm Management (pacing / devices)	Heart	Yes	In progress
Adult cardiac surgery audit (ACS)	Heart	No	Not required *
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Heart	No	Not required *

AUDIT PROJECT TITLE	CATEGORY	TRUST PARTICIPATION	STATUS
Coronary angioplasty	Heart	No	Not required *
Pulmonary hypertension (Pulmonary Hypertension Audit)	Heart	No	Not required *
RCPCH National Paediatric Diabetes Audit (NPDA)	Long term conditions	Yes	Complete
National Diabetes Inpatient Audit (NaDIA) 2011	Long term conditions	Yes	Complete
UK Inflammatory Bowel Disease Audit - biologics	Long term conditions	Yes	In progress
National Pain Audit	Long term conditions	Yes	In progress
Renal Registry Renal Replacement Therapy Audit	Long term conditions	Yes	In progress
BTS Adult Asthma Audit	Long term conditions	Yes	Complete
BTS Bronchiectasis Audit	Long term conditions	Yes	In progress
National Review of Asthma Deaths (NRAD)	Long term conditions	Yes	In progress
Renal Transplantation (NHSBT UK Transplant Registry)	Long term conditions	No	Not required *
National audit of psychological therapies (NAPT)	Mental Health	No	Not required *
Prescribing in mental health services (POMH)	Mental Health	No	Not required *
Suicide and homicide in mental health (NCISH)	Mental Health	No	Not required *
National Carotid Interventions Audit	Older people	Yes	In progress
National Hip Fracture Database	Older people	Yes	In progress
National Parkinson's Audit 2012	Older people	Yes	In progress
National Dementia Audit (NAD) 2012	Older people	Yes	Complete
CEM Fractured NOF Audit 2012	Older people	Yes	Complete
Sentinel Stroke National Audit Programme (SSNAP)	Older people	Yes	Organisational audit complete
(PROMS) Hernia / Varicose veins / Hip replacement / Knee replacement	Other	Yes	In progress
(PICAnet) Paediatric intensive care	Women's & Children's health	Yes	In progress
(MBRRACE-UK) Perinatal Mortality	Women's & Children's health	Yes	In progress
(NNAP) Neonatal intensive and special care	Women's & Children's health	Yes	In progress
BTS Paediatric Pneumonia Audit	Women's & Children's health	Yes	In progress
BTS Paediatric Asthma Audit	Women's & Children's health	Yes	In progress

AUDIT PROJECT TITLE	CATEGORY	TRUST PARTICIPATION	STATUS
RCPCH National Childhood Epilepsy 12 Audit	Women's & Children's health	Yes	To commence Spring 2013
RCPCH Child Health (CHR-UK)	Women's & Children's health	Yes	In progress
CEM Fever in Children Audit 2012	Women's & Children's health	Yes	Complete
* **Denotes that the Trust does not undertake service**			

National confidential enquiries that the Trust is eligible to participate in during 2012-13

NAME OF ENQUIRY		TRUST PARTICIPATION	STATUS
Alcohol Related Liver Disease Study	NCEPOD	Yes	Complete
***Bariatric Surgery Study**	NCEPOD	Yes	Complete- Organisational data only
Subarachnoid Haemorrhage Study	NCEPOD	Yes	In progress
Time to Intervene	NCEPOD	Yes	Complete
Tracheostomy related complications	NCEPOD		To commence Feb 2013
Death following lower limb amputation	NCEPOD		To commence Spring 2013

***The Trust does not perform Bariatric Surgery but has participated in the study of patients who have been admitted as an emergency following Bariatric surgery elsewhere.

In addition to the national audits for Quality Accounts the Trust has chosen to participate in additional 4 audits as listed below in Table 2.

AUDIT PROJECT TITLE	SPECIALTY	TRUST PARTICIPATION	STATUS
National Audit Project (NAP5) Accidental Awareness during General Anaesthesia	Anaesthetics	Yes	In progress
National Obstetric Anaesthetic Database (NOAD)	Anaesthetics	Yes	In progress
National Insulin Pump Audit	Diabetes & Endocrinology	Yes	In progress
Audit of Blood Sampling and Labelling	Haematology	Yes	Complete

Table 2

Contributors to the report: M Green, D Westmoreland, C Carter, L Turley, K Obrenovic, L Medhurst, K Broadhouse
Report compiled by: D. Eaves

Enclosure 4

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 28th February 2013**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**
CORPORATE OBJECTIVE: SO 10 Enabling Objective			
SUMMARY OF KEY ISSUES: **The Committee considered standing reports on performance for January 2013 and forecasts for 2012-13 financial year.**			
IMPLICATIONS OF PAPER:			
	Risk Register	**Risk Score**	**Details:**

RISKS		**Y**	**Risk to achievement of the overall financial target for the year**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **Monitor has rated Trust at Green for Governance & 3 for Finance at Q1. The Trust remains on quarterly monitoring**
	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 28th February 2013

1. Background

The Finance & Performance Sub Committee of the Board met on 28th February 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 year end performance reports. The Committee noted in particular the following matters:

- IT related CIP schemes were on track to deliver benefits in 2013-14 onwards
- Workforce related issues:
  - December absence was 4.6%
  - YTD absence was 4.1% both increasing and above target
  - Turnover is constant at 7.62%
  - Mandatory training compliance has increased to 69.7%
  - Appraisal rates have reduced to 61.8%
- Financial matters:
  - January trading deficit was £118,000
  - YTD surplus is £2.1m but forecast outturn is £666,000
  - Full year CIP of £10.1m achieved but 39% is non recurrent
  - Balance Sheet remains strong with liquidity at 38.3 days
  - Capital spend £7.8m forecast outturn is £9.1m
- Performance against waiting and associated targets
  - Performance against all key indicators remains strong
  - A&E performance is strongest in the SHA but remains under significant pressure
  - Diagnostic waits are again an issue with 133 breaches in January (126 cardiology) The Committee considered a rectification plan
- Procurement progress report was noted for quarter 3.

2. Matters referred to Board of Directors

No specific matters were referred to the Board

PA Assinder
Director of Finance & Information
Secretary to the Board

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th March 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 Trust currently stands at 49 post 48 hr cases (not locked down) which falls within trajectory. The Trust has not breached the monthly C.difficile target since November 2012 and the annual target is on trajectory.

C.Difficile Cases Post 48 hours – Ward breakdown:

Ward	Totals for 11/12	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2013	As of 27th Feb 2013	Running Total
A1	**1**	0	0	0	1	0	0	0	0	0	0	0	1
A2	**6**	0	0	3	1	1	1	1	1	2	0	0	10
A4	**2**	0	0	0	0	0	0	0	0	0	0	0	0
B1	**0**	0	0	0	0	0	0	0	0	0	0	0	0
B2	**9**	0	0	1	0	0	0	0	0	0	0	0	1
B3	**7**	0	2	0	0	0	0	0	0	1	1	0	4
B4	**8**	0	0	0	0	1	0	0	0	0	2	0	3
B5	**1**	0	0	0	0	0	0	0	0	0	0	0	0
B6	**1**	1	1	0	0	0	0	0	0	0	0	0	2
C1	**19**	1	0	1	0	0	1	0	2	1	0	0	6
C3	**16**	0	0	0	2	0	0	1	0	1	2	0	6
C4	**8**	0	0	0	0	0	0	0	1	2	0	0	3
C5	**6**	0	0	0	0	0	0	1	0	0	0	0	1
C6	**3**	1	0	0	0	0	0	1	0	0	0	0	2
C7	**13**	2	1	0	0	0	0	1	1	1	0	0	6
C8	**7**	0	0	0	0	0	0	1	0	0	1	0	2
MHDU	**3**	0	0	0	0	0	0	0	0	0	0	0	0
CCU/PCCU	**1**	0	0	0	0	0	0	0	0	0	0	0	0
Critical Care	**6**	0	0	0	0	0	0	0	0	0	0	0	0
EAU	**0**	0	0	0	0	0	0	1	0	0	0	0	1
SHDU	**0**	0	0	0	0	0	0	0	1	0	0	0	1
Total	**117**	**5**	**4**	**5**	**4**	**2**	**2**	**7**	**6**	**8**	**6**	**0**	**49**

See Appendix 1 – Board Report (2012/13)

MRSA – Annual Target 2 (Post 48 hrs) - There have been no cases in the last month.

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

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

(N13) Clostridium difficile infection

Monthly number of C-Diff cases

Month / Year	> 48 hrs Activity	PCT Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-12	5	7	-28.6%	5	7	-28.6%	9	10
May-12	4	6	-33.3%	9	13	-30.8%	11	12
Jun-12	5	6	-16.7%	14	19	-26.3%	6	8
Jul-12	4	6	-33.3%	18	25	-28.0%	7	9
Aug-12	2	6	-66.7%	20	31	-35.5%	5	7
Sep-12	2	5	-60.0%	22	36	-38.9%	8	9
Oct-12	7	6	16.7%	29	42	-31.0%	16	16
Nov-12	6	6	0.0%	35	48	-27.1%	8	9
Dec-12	8	7	14.3%	43	55	-21.8%	14	14
Jan-13	6	7	-14.3%	49	62	-21.0%	10	11
Feb-13	-	7	-	-	-	-	-	-
Mar-13	-	8	-	-	-	-	-	-
FY 2012-13	49	77	-36.4%				94	105

The PCT target for Cdiff is 77 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.

Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours.

The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

(N1) MRSA infections

Monthly number of MRSA cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-12	-	1	-100.0%	0	1	-100.0%	-
May-12	-	0	0.0%	0	1	-100.0%	1
Jun-12	-	0	0.0%	0	1	-100.0%	-
Jul-12	-	0	0.0%	0	1	-100.0%	-
Aug-12	-	0	0.0%	0	1	-100.0%	-
Sep-12	-	0	0.0%	0	1	-100.0%	-
Oct-12	-	1	-100.0%	0	2	-100.0%	-
Nov-12	1	0	100.0%	1	2	-50.0%	1
Dec-12	-	0	0.0%	1	2	-50.0%	-
Jan-13	-	0	0.0%	1	2	-50.0%	1
Feb-13	-	0	0.0%	1	2	-50.0%	-
Mar-13	-	0	0.0%	1	2	-50.0%	-
FY 2012-13	1	2	-50.0%				3

As a Foundation Trust the regulator Monitor measures compliance against the contract with our commissioners Dudley PCT. The target in this contract is 2 bacteraemias.

Monthly number of MSSA cases

MSSA infections		
Month / Year	**Total**	**Cumulative**
Apr-12	4	4
May-12	4	8
Jun-12	4	12
Jul-12	1	13
Aug-12	2	15
Sep-12	5	20
Oct-12	4	24
Nov-12	7	31
Dec-12	5	36
Jan-13	6	42
Feb-13	3	45
Mar-13	-	45
FY 2012-13	45	

Monthly number of E coli cases

E Coli infections		
Month / Year	**Total**	**Cumulative**
Apr-12	15	15
May-12	13	28
Jun-12	17	45
Jul-12	14	59
Aug-12	23	82
Sep-12	22	104
Oct-12	30	134
Nov-12	20	154
Dec-12	14	168
Jan-13	18	186
Feb-13	12	198
Mar-13	-	198
FY 2012-13	198	

The Dudley Gro
NHS Foundation Trust

Enclosure 6

Paper for submission to the Board on 6th March 2013

TITLE:	**Summary of key issues from the Risk & Assurance Committee Meeting held on 22nd January 2013**		
AUTHOR:	**Julie Cotterill** **Governance Manager**	**PRESENTER**	**Ann Becke (NED)** **Risk & Assurance Committee Chair**
CORPORATE OBJECTIVES: All. The risk registers considered at the Committee are referenced to each of the Trusts strategic objectives.			

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 and ensuring that systems are aligned to maximise the benefit and organisational learning from the risk management arrangements. A number of specialist risk teams report quarterly to the Committee.

SUMMARY OF KEY ISSUES from the meeting held on 22nd January 2013:

The Committee reviewed the progress against actions arising from the meeting held on 16th October 2012 and 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.

Ambulatory Risk Register – Top 5 Risks - Dr Stewart (Clinical Director) and Ms Benson (General Manager) for the Ambulatory Directorate 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.

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. It does not require new structures but does need to be understood and integrated into existing procedures.

Corporate Risk Register - there were 33 corporate risks of which 17 scored 15 or above. The Committee discussed the following:

- COR045 - Diabetes Management (Score 16) – risk clarification required.
- COR26 – Safe Staffing (Score 20) – Inclusion of medical staffing to be discussed
- COR029 – Unavoidable Pressure Ulcers (Community) (Score 15) - Recent assurance confirmed that good progress had been made.
- COR013 – Relationship with Stakeholders (Score 16) - actions required updating.

Operations Directorate Risk Register - there is a rota for Directorates to present their top 5 risks to the Committee. Discussions from the summary of risks presented focussed on the Point of Care Testing (POCT) system. The Committee queried the appropriateness of the score and the gaps in assurance which highlighted the lack of resources to implement and manage a fit for purpose system for all POCT processes.

Nursing Directorate Risk Register - the directorate had 14 risks on the register of which 3 scored 15 or above.

- G008 – Lack of Training for Safeguarding Children (Score 15) - the PFI Partners safeguarding training compliance was now at 68%.
- HS008 – Care management of the Bariatric Patient (Score 12) - There was a rising trend in terms of incidents relating to bariatric services. This would be reviewed for the next meeting.
- HRW002 – Inadequate Nurse Staffing Levels (Score 16) - this area was being reviewed and work was in progress to consider patient mix and skill set required.

Finance, Information and IT Directorate Risk Report - there were 9 risks on the register of which 1 scored over 20. Some risks had been downgraded.

- F009 – Losing significant income from delays in ED coding (Score 20) - Current actions discussed.
- OP012 – Trust Overspend (Score 12) - lack of recorded "assurance" noted. Update for next meeting.
- IT006 – Recruitment and Retention of Accredited Clinical Coders (ACC) (Score 15)

Human Resources Risk Register - three risks had been closed and three new risks had been added to the register:

- IC007 – Natural Rubber Latex Exposure (Score 10)
- WO11 – Inability to Demonstrate Equality and Diversity (Score 9)
- WO12 – Junior Doctors Monitoring (Score 9)

Two further risks had been carried forward:

- HRW008 – Increased length of time to recruit staff (Score 6)
- HRG007 – Inability to prove the review of CRB checks (Score 4)

Community Services and Integrated Care (CSIC) Risk Register - there were 56 risks on the register of which 14 scored 15 and above. The Register had recently incorporated the registers from Pharmacy and Health Records. Risks were reviewed monthly and the progress against action plans assessed.

- PO12 – Administering Injectable Medicines (Score 20) - Risk mitigated to 15. Further mitigating actions for this risk were linked to electronic prescribing.
- P014 – Medication Timings not adhered to (Score 20) - This risk was mitigated to an 8 and would be reviewed again in June 2013.
- P016 – Water ingress into Pharmacy Aseptic Unit (Score 20) - recommended for closure.
- MR003 – Clinic Cancellation/Reduction Resulting in Rescheduling (Score 20) - related to the Transformation project for Outpatients and the roll out of partial booking and remained unchanged.
- CS008 – Ineffective use of Waiting Areas (Corbett & Guest) (Score 20) - due for review and update in February 2013.

NHSLA Risk Management Standards (Trust) - The Trust was assessed against the NHSLA Risk Management standards level 1 in November 2012 and achieved full compliance. The report 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 assessor commented on the high standard of submitted evidence and examples of good practice. An action plan had been developed to address the recommendations made.

NHSLA Risk Management Survey 2012 - The NHSLA was changing its approach to the assessment of risk management arrangements and had invited risk managers to respond to a survey on their overall satisfaction with the current system, standards and assessment and the future design of these. They were expected to start pilot assessments against proposed standards in 2013 /14

Compliance with NPSA Safety Alerts - there were two outstanding NPSA Safety Alerts:

- **Rapid Response Report RRR001** – Harm from flushing of naso-gastric tubes before confirmation of placement'. This was closed on 12th December 2012
- **Safer Spinal (intrathecal), Epidural and Regional Devices Part B – NPSA/004B 2009 NPSA/2011/PSA001** - Part B remains active with a closure date of 1st April 2013.

CQC Quality Risk Profile Exceptions Report - The Quality Risk Profile collated information about care providers and estimated the risk of non compliance against each of the 16 essential standards. This report summarised information received from the CQC comparing the previous risk estimate and latest risk estimate. The majority of the dials were showing low yellow.

Policy Group Recommendations - 17 policies/guidelines had been drafted/revised and had been reviewed by the Policy Group and were **ratified** by the Committee.

Single Equality Scheme - the Committee formally **accepted** the Single Equality Scheme and Terms of Reference (with minor changes).

Response to the Local Supervising Authority Midwifery Officer (LSAMO) Annual Report 2011/2012 - the 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.

Directorate Risk Management Team Reports – the Committee received the reports from the following: Health & Safety Group, Community Services and Integrated Care (CSIC) Report and Women's and Children's Report

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 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
COMPLIANCE and/or LEGAL REQUIREMENTS (continued)	**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 - To note the key issues arising from the Risk & Assurance Committee meetings held on 22nd January 2013

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th March 2013

TITLE:	Internal Safeguarding Board		
AUTHOR:	Pam Smith Matron Lead Safeguarding Children and Adults	**PRESENTER:**	Yvonne O'Connor Deputy Director of Nursing

CORPORATE OBJECTIVE:
SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.
SGO2: Patient Experience - To provide the best possible patient experience.
SGO4: Clinical Partnerships - To develop and strengthen strategic clinical partnerships to maintain and protect our key services.

SUMMARY OF KEY ISSUES:

1. **CQC/OFSTED ASSESSMENT -** The Trust's action plan shows no red actions, 14 amber actions and 11 green actions. Work is ongoing and it is anticipated that all amber actions will be converted to green within the next two months. The action plan is monitored at the Clinical Commissioning Group Health Safeguarding Forum and the Trust's Internal Safeguarding Board.

2. **CQC/OFSTED THEMATIC INSPECTION FOR MENTAL HEALTH AND SUBSTANCE MISUSE -** The Maternity Department is working will all agencies and the Clinical Commissioning Group to review the feedback from the thematic inspection for mental health and substance misuse by Care Quality Commission/Ofsted to develop an action plan.

3. **SECTION 11 AUDIT -** The Trust has been identified to present the action plan developed following the Section 11 audit completed in 2011 at the Dudley Safeguarding Children Board.

4. **LEARNING DISABILITY LIAISION -** An action plan is being developed to address the key findings identified in the Winterbourne View review and as a result of incidents occurring within the Trust. This includes:
   - Improving staff attendance at Mental Capacity Training
   - Raising awareness of best interests meetings and the role of the Independent Mental Capacity Advocate.

   A process to monitor the number of patients with Learning Disabilities Trust wide is also being developed.
   The Clinical Commissioning Group have agreed to develop a CQUIN target for Learning Disabilities for 2013/14 which will provide funding for a band 7 Learning Disabilities Liaison role. This post is the process of being recruited to.

5. **TRAINING –** All staff within the Trust have now received the annual safeguarding staff leaflet. Signature lists to demonstrate that staff have signed on receipt of the leaflet are being completed. Compliance is being monitored at the Internal Safeguarding

Board.

6. **RESTRAINT POLICY AND RESTRAINT TRAINING -** A final draft of the Restraint Policy developed by the Adult Safeguarding Lead has been agreed with key professionals; including Private Finance partners was agreed on the 10th December 2012. The policy is due to be submitted to the Trust's Policy Group for ratification on 8th March 2013.

7. **CRIMINAL RECORDS BUREAU POLICY -** The Trust's Criminal Records Bureau Policy has been reviewed, updated to reflect the changes to the Disclosure and Barring Service and ratified. Work is in progress to identify staff in high risk areas to check current CRB status and to identify monitoring on a 3 yearly basis.

8. **DEPARTMENT OF HEALTH LETTER RE: JIMMY SAVILE ALLEGATION (Gateway Ref. 18350) –** A review of safeguarding practices in light of the Savile allegations has been undertaken Trust wide and an action plan has been developed to provide evidence of assurance that robust safeguarding practices and procedures are in place within the Trust has been developed.

9. **DEPRIVATION OF LIBERTY SAFEGUARDS AUTHORISATION -** The Trust is working collaboratively with the local authority Head of Safeguarding to implement the changes to the Deprivation of Liberty Safeguards process.

10. **SAFEGUARDING ADULTS – MULTI AGENCY POLICY AND PROCEDURES –** Multi agency policies and procedures for the West Midlands have been launched. The Trust is working with the Dudley Safeguarding Adults Board to implement these and work is progressing to agree a formal process for making a referral to Social Services.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:**
	Risk Register: CS011 score 6 NEW Score 12		**Risk Score:** Lack of Safeguarding Children Intermediate Training Lack of Learning Disabilities Role Trust wide
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Compliance with Care Quality standards Outcome 7
	NHSLA	**Y**	**Details:** CNST Maternity standards
	Monitor	**Y**	**Details:** Ability to maintain at least level 1 NHSLA
	Equality Assured	**Y**	**Details:** Better Health outcome Improved Patient access and Experience
	Other	**N**	**Details:** Safeguarding

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
		Y	

RECOMMENDATIONS FOR THE BOARD

To note the key issues arising from the quarterly Safeguarding report to Board February 2013 and identify any actions for follow up.

The Dudley Group NHS
NHS Foundation Trust

SAFEGUARDING REPORT TO TRUST BOARD

FEBRUARY 2013

1. CQC/OFSTED ASSESSMENT

The Trust is working with collaboratively with other health partners to implement an action plan following the Care Quality Commission/Ofsted inspection in November 2011. The report was reviewed at the Internal Safeguarding Board on 15th November 2012. The action plan shows no red actions, 14 amber actions and 11 green actions. Work is ongoing and it is anticipated that all amber actions will be converted to green within the next two months. The action plan is monitored at the Clinical Commissioning Group Health Safeguarding Forum and was reviewed on 17th December 2012. Evidence of assurance to demonstrate completion of the actions has been identified at a meeting between the Matron Lead for Safeguarding and the Clinical Commissioning Group's Designated Nurse for Safeguarding on 28th January 2013. The Matron Lead for Safeguarding is in the process of collating this.

2. CQC/OFSTED THEMATIC INSPECTION FOR MENTAL HEALTH AND SUBSTANCE MISUSE

The Maternity Department is working will all agencies and the Clinical Commissioning Group to review the feedback from the thematic inspection for mental health and substance misuse by Care Quality Commission/Ofsted to develop an action plan. Maternity has shared policies and procedures and are attending further meetings with key professionals from other agencies.

3. SECTION 11 AUDIT

The Trust has been identified to present the action plan developed following the Section 11 audit completed in 2011 at the Dudley Safeguarding Children Board. The action plan was reviewed at the Internal Safeguarding Board on 15th November 2012. The Named Nurse for Safeguarding is reviewing compliance against the action plan.

4. LEARNING DISABILITY LIAISION

The Strategic Health Authority completed a Learning Disabilities review within the Trust on 9th October 2012. The reviewers reviewed the Trust's Learning Disabilities action plan; this is reviewed monthly at the Internal Safeguarding Board and was identified by reviewer's as a positive approach to improving services for Learning Disabilities within the Trust. The reviewer's supported the Trust's work with the Clinical Commissioning Group to secure funding for a Learning Disabilities Liaison Role. An action plan is being developed to address the key findings identified in the Winterbourne View review and as a result of incidents occurring within the Trust. This includes:

- Improving staff attendance at Mental Capacity Training
- Raising awareness of best interests meetings and the role of the Independent Mental Capacity Advocate.

A process to monitor the number of patients with Learning Disabilities Trust wide is also being developed.

The Clinical Commissioning Group have agreed to develop a CQUIN target for Learning Disabilities for 2013/14 which will provide funding for a band 7 Learning Disabilities Liaison role. This post is the process of being recruited to.

5. TRAINING

All staff within the Trust have now received the annual safeguarding staff leaflet. Signature lists to demonstrate that staff have signed on receipt of the leaflet are being completed. These are being sent to the Named Nurses for Safeguarding. Compliance is being monitored at the Internal Safeguarding Board meeting monthly so that actions to improve compliance levels can be identified.

(i) Safeguarding Children compliance

80.4% comprising E learning and joint sessions. Training within Surgery & Anaesthetics remains difficult; options for improving compliance are being explored by the Named Nurse for Safeguarding Children and Theatre Manager to put on some bespoke training sessions for theatre staff.

(ii) Safeguarding Adults compliance

72.5%.Training within Theatre remains difficult. The Named Nurse for Safeguarding Adults is liaising with the Theatre Manager to put on some bespoke training sessions for theatre staff.

(iii) Private Finance Initiative partners Safeguarding compliance

A training programme for Private Finance Initiative partners has recently been introduced. 16% of staff have attended face to face training to date. More training slots are being identified for staff groups who need to attend face to face training.

Some staff can access E learning training. Training figures for this have been requested. Compliance is being monitored at the Internal Safeguarding Board.

(iv) Mental Health compliance

37% of staff have completed training. Training dates have been set for 2013 and Matrons, Medical Service Heads; Lead Nurses/Managers are targeting staff to attend training.

A bespoke session for Mental Capacity Act training has been delivered to Consultants at the Grand Round.

6. RESTRAINT POLICY AND RESTRAINT TRAINING

A final draft of the Restraint Policy developed by the Adult Safeguarding Lead has been agreed with key professionals; including Private Finance partners was agreed on the 10th December 2012. The policy is due to be submitted to the Trust's Policy Group for ratification on 8th March 2013. A further meeting to discuss the training programme for staff is being scheduled and high risk areas will be targeted for training.

7. CRIMINAL RECORDS BUREAU POLICY

The Trust's Criminal Records Bureau Policy has been reviewed, updated to reflect the changes to the Disclosure and Barring Service and ratified. The Matron Lead for

Safeguarding Children and Adults and the Named Nurse for Safeguarding Children are working in consultation with HR Workforce and work is in progress to identify staff in high risk areas to check current CRB status and to identify monitoring on a 3 yearly basis. This is being monitored at the Internal Safeguarding Board.

8. GUDELINES FOR UNDER 16's WHO ARE PREGNANT

Discussions have taken place with the Emergency Department and at the Trust Children's Services Group meeting to identify a pathway for young people under 16 years who are pregnant to minimise the clinical risk associated with ruptured ectopic pregnancy and to deal appropriately with the safeguarding concerns. A risk assessment and guidelines are being developed.

9. REFERRAL TO TREATMENT ACCESS POLICY

The Referral to Treatment Access Policy has been updated to include the process identified to ensure that the safeguarding responsibilities for children and young people who Did Not Attend hospital appointments are considered and information is shared with other agencies i.e. GP's/Health Visitor/School Health Advisor/Social Care. No feedback is currently received from other agencies when Did Not Attends are reported.

10. COMMON ASSESSMENT FRAMEWORK POLICY

Progress with the implementation of the Common Assessment Framework policy is monitored at the Internal Safeguarding Board. Common Assessment Framework meetings are being undertaken by other agencies without checking if key professionals within the Trust are able to attend.

11. DEPARTMENT OF HEALTH LETTER RE: JIMMY SAVILE ALLEGATION (Gateway Ref. 18350)

The letter from Sir David Nicholson KCB CBE, National Health Service Chief Executive requesting Trust boards to examine its safeguarding practices in light of the Savile allegations was reviewed at the Internal Safeguarding Board on 15th November 2012. It was agreed that a risk assessment would be completed by the Matron Lead for Safeguarding

Children and Adults and the Named Nurse for Safeguarding Children. This will be included on the corporate risk register.

The following Trust policies and practices were identified to be reviewed:

- **Safeguarding Policy** – this is currently being reviewed and is in the process of being sent to the Policy group for ratification.

- **CRB Policy** – this has been recently ratified and work is ongoing to identify staff in high risk areas to check CRB status on appointment and every three years. All areas where children and young people under 16 years have been identified in the high risk category.

- **Volunteers Policy** – this needs to be reviewed to include a section on supervision for Volunteers working with children and young people.

- **Wishing Well – Make a wish service** – The service is run by a Hospital Volunteer and grants wishes to children who have been admitted to the children's ward. The Volunteer meets with children/young people and their parents/carers following their discharge from hospital to grant their wish. A review of the service has been completed and guidelines are being developed.

A policy for access to patients for celebrities and volunteers visiting the Trust is also in the process of being developed to ensure that appropriate supervision is provided on all visits to ward and department areas where patients, children or vulnerable adults are involved.

An action plan to provide evidence of assurance that robust safeguarding practices and procedures are in place within the Trust has been developed and this is being monitored at the Internal Safeguarding Board.

12. DEPRIVATION OF LIBERTY SAFEGUARDS AUTHORISATION

The Trust is working collaboratively with the local authority Head of Safeguarding to implement the changes to the Deprivation of Liberty Safeguards process. The Deputy Nursing Director has been identified as the Trust's single point of contact for the Local Authority to liaise with.

13. SAFEGUARDING ADULTS – MULTI AGENCY POLICY AND PROCEDURES

Multi agency policies and procedures for the West Midlands have been launched. The Trust is working with the Dudley Safeguarding Adults Board to implement these and work is progressing to agree a formal process for making a referral to Social Services.

Pam Smith
Matron Lead Safeguarding Children and Adults
28th February 2013

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

PAPER FOR SUBMISSION TO THE BOARD OF DIRECTORS ON 7th MARCH 2013

TITLE:	**Board Secretary's Report**		
AUTHOR:	**Paul Assinder** **Board Secretary**	**PRESENTER**	**Paul Assinder** **Board Secretary**

CORPORATE OBJECTIVE: (*Please select from the list on the reverse of sheet)*

Good governance

SUMMARY OF KEY ISSUES: *(please identify key issues arising from report or minutes)*

The report updates the Board on progress towards:

- **Monitor approval of changes to the Trust's Constitution**
- **Monitor issueing of an Operator Licence for 2013-14**
- **Creation of a Workforce and Patient Safety Committee**

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

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

ACTION REQUIRED OF COMMITTEE:

Decision	**Approval**	**Discussion**	**Other**
	X		

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the report and consider recommendations.

The Dudley Group NHS
NHS Foundation Trust

REPORT TO BOARD OF DIRECTORS 7th MARCH 2013

1. **Trust revised constitution**

Directors will recall that the Board and Council of Governors approved changes to the Trust Constitution, following Royal assent of the 2012 Health & Social Care Act. The Trust is in discussion with Monitor regarding such changes and the Regulator's approval is expected to be confirmed in the near future.

2. Monitor provider licence 2013-14

The Regulator has confirmed that it is its intention to automatically issue operator licences for foundation trusts currently operating within the terms of their authorisation. The Trust is therefore currently liaising with Monitor regarding the details of the new licence, which it is expected, will be issued in the next 3 weeks.

3. **Establishment of a new Board Committee – the Workforce and Patient Experience Committee**

In 2012, the Board established a new Committee, the Clinical Quality, Safety and Patient Experience Committee (CQSPE) and resolved to review its effectiveness after six months operation. The view of Committee members and the Executive Team is that the terms of reference of this Committee are unwieldy and too broad to allow proper scrutiny. In particular, the priority placed upon clinical quality issues by the Committee is such that the important area of patient experience doesn't get an adequate airing. Similarly, it is apparent that the fragmentation of workforce and organisation development subjects between the CQSPE and Finance and Performance Committees has hampered a holistic discussion of workforce planning and human resources related issues.

The Board is therefore requested to consider the following steps:

a. The removal of workforce and OD related matters and patient experience from the terms of reference of the current CQSPE
b. Renaming the remainder Committee as 'The Clinical Quality and Safety Committee'
c. Establishing a new Committee, 'The Workforce and Patient Experience Committee'
d. The changes to take effect from 1st April 2013

If the Board is minded to approve the above, revised terms of reference will be presented to its meeting on 4th April.

4. **Recommendation**

The Board is asked to:

a. **Note the report in 1 above**

b. **Approve changes to its committees set out in paragraph 2 above.**

Paul Assinder
Secretary to the Board
February 2013

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th March 2013

TITLE:	**Revalidation Update Report**		
AUTHOR:	**Dr D Perks, Assistant Medical Director for Revalidation/Dr P Harrison, Medical Director and Responsible Officer**	**PRESENTER**	**Dr Paul Harrison, Medical Director and Responsible Officer**
CORPORATE OBJECTIVE: **SG05: Staff commitment**			

SUMMARY OF KEY ISSUES:

Revalidation for medical staff commences in December 2012 under the auspices of the General Medical Council (GMC). Revalidation is required by all doctors in order to be given a liscence to practice which is then valid for five years. In order to be revalidated doctors will have had to have five satisfactory annual Strengthened Appraisals (initial revalidation will require less than this). This brief paper outlines some of the background to revalidation, gives a brief update on the Trust's preparedness and highlights some potential issues.

- The Trust currently has an appraisal rate of approximately 68% at 22nd February, which needs to reach 100% by the end of March 2013
- Significant efforts are being made to ensure appraisals are completed on time
- New electronic appraisal and assessment systems are now in use and are facilitating the appraisal process.

IMPLICATIONS OF PAPER:

RISK	**No**		**Risk Description:**
	Risk Register: No		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** **Outcome 12: requirements relating to workers** **Outcome 13: staffing** **Outcome 14: supporting workers**
	NHSLA	**Yes**	**Details:** **1.9: professional clinical requirements**
	Monitor	**Yes**	**Details: good governance**
	Equality Assured	**Yes**	**Details: better health outcomes for all**
	Other: GMC	**Yes**	**Details: 'Good Medical Practice'**

ACTION REQUIRED OF COMMITTEE:			
Decision	**Approval**	**Discussion**	**Other**
			Yes, for noting

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To note the content of the report and potential impacts.

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 Dudley Group NHS
NHS Foundation Trust

REPORT OF THE MEDICAL DIRECTOR TO THE BOARD OF DIRECTORS

7TH March 2013

REVALIDATION UPDATE REPORT

Summary and Background

Revalidation for medical staff commenced in December 2012 under the auspices of the General Medical Council (GMC). This paper gives a brief update on the Trust's preparedness and highlights some potential issues.

For revalidation purposes, the Trust is deemed to be the Designated Body for all medical staff who hold permanent, fixed term or long term locum posts (this excludes doctors in training). For short term locum doctors, the Trust will be required to produce a report for their appraisal records. In the opening round of revalidation, the cycles are shortened and initially for doctors revalidating this year and next they must have had at least one strengthened appraisal. In the first year (up to end March 2013) only the Responsible Officer (RO) - the Trust Medical Director - needs to revalidate. Next year (2013/14), 20% of the Trust doctors need revalidating and a further 40% in each of the two subsequent years.

The role of the RO is set out in the The Medical Profession (Responsible Officers) Regulations 2010. The regulations give senior doctors in certain organisations (designated bodies) functions for specified doctors that will ensure doctors are appraised annually and where there are concerns about a doctor's fitness to practice they are investigated and referred to the GMC. In England, where the concerns are below the level where referral to the GMC is considered necessary ROs will investigate, identify the cause and take the appropriate action to bring the doctor back on track**.**

A strengthened appraisal is undertaken against the GMC four domains and 12 attributes described within the document 'Good Medical Practice', with further input from the Academy of Medical Royal Colleges and individual Royal Colleges. It must contain input from the doctor on the areas of Continual Professional Development (CPD), Audit of own/team practice, complaints/compliments, significant events and colleague/patient feedback (a minimum of one 360 degree appraisal is needed in each revalidation cycle). A doctor must now show reflection against all aspects of the above to achieve a satisfactory appraisal. They must be appraised against all aspects of their work: Clinical/Management/Academic /Private Practice/Voluntary. This will be carried out by their designated body.

Trust's Progress and Actions

Update on actions since last report:

i) Appointed Mr N Whear as member of Dudley Medical Appraisal Group.

ii) Remediation policy in place.

iii) A total of ten appraisal training sessions for appraisers and appraisees undertaken by Assistant Medical Director.

iv) New electronic 360 degree assessment tool now in use (linked to Trust Electronic Appraisal System)

v) Successful bid for funding from SHA for additional training (£6500). Being used to run two Strengthened Appraisal courses using external support to develop new cohort of appraisers (as per previous report December 2012).

vi) Two Appraisal Courses for Staff Grade and Associate Specialist (SAS) doctors. Nationwide this group are recognised as having least engagement and understanding of appraisal/revalidation.

Ongoing Issues

The Trust currently has an appraisal rate of approximately 68% since April 2012, which needs to reach 100% by the end of March 2013. This has improved since the report in December and this issue is being actively pursued by the Medical Director (Responsible Officer), the Assistant Medical Director and Mr Whear. SAS and other non-consultant grade doctors are slower at engaging.

Time pressures for appraisal remain a concern, again as per previous report to Board in December 2012.

Minor issues with electronic appraisal software – these are being addressed.

Reconciling the Trusts staff records with the GMC Conect database and our electronic appraisal system remains an ongoing problem

Recommendations/Actions:

The Board is asked to note the content of this report and, in particular the on going issues.

Enclosure 10

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 7th March 2013

TITLE:	**Organ Donation Half Yearly Report.**		
AUTHOR:	**David Badger**	**PRESENTER**	**David Badger**
CORPORATE OBJECTIVE:			
SUMMARY OF KEY ISSUES: **This report presents a mid- year review of progress with the Dudley Group NHS Foundation Trust Annual Organ Donation Plan 2012-13.** **The report also highlights specific priority actions for the Trust Board to consider.**			

IMPLICATIONS OF PAPER: ***(Please complete risk and compliance details below)***			
RISK			**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**		**Details:**
	NHSLA		**Details:**
	Monitor		**Details:**
	Equality Assured		**Details:**
	Other		**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
	√	√	

RECOMMENDATIONS FOR THE BOARD

It is recommended that the Trust Board:

i. **Notes progress with the delivery of the Dudley Group Foundation Trust Annual Organ Donation Plan.**
ii. **Reaffirms commitment to the promotion of organ donation and membership of the Organ Donation register in every practical way possible.**
iii. **Supports the establishment on site of a physical piece of art as a memorial/celebration of Organ Donation in a way that recognises individual donors as well as generating interest and discussion of organ donation generally.**
iv. **Supports the National proposal for recognition for families of donors as set out in Section 4 of the report.**

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

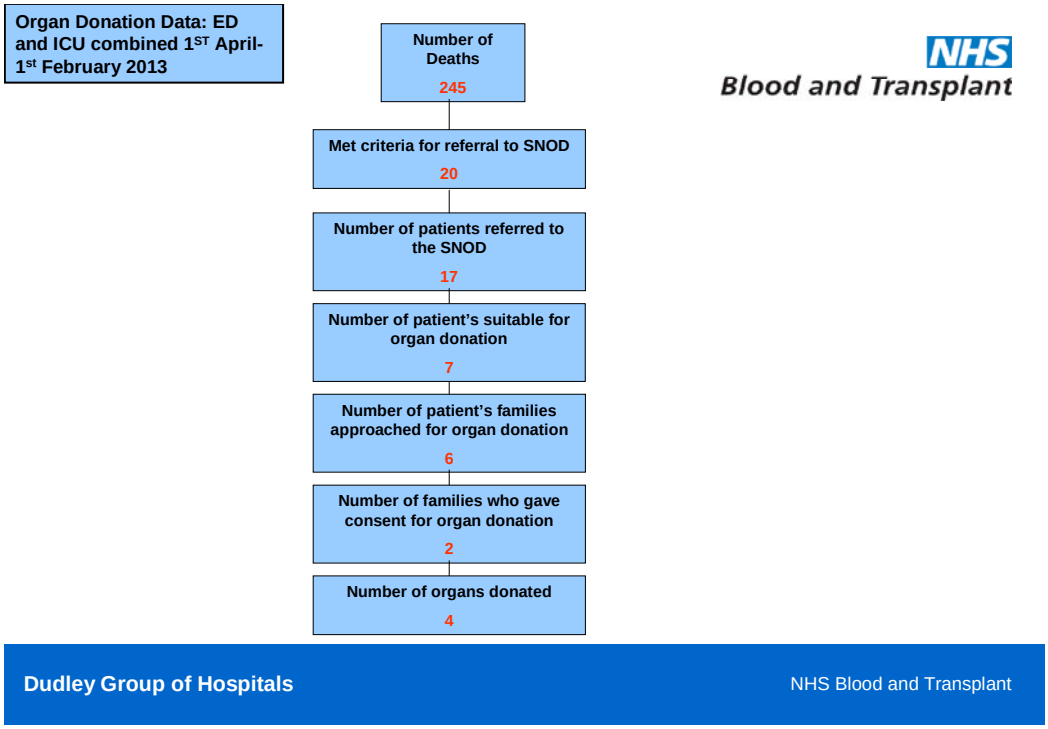
The Dudley Group NHS
NHS Foundation Trust

PAPER FOR SUBMISSION TO TRUST BOARD

Title:	**Organ Donation Committee Report**
Summary:	This is the second report from the Organ Donation Committee to the trust board outlining the Trust's organ donation data, and progress with Dudley Group NHS Foundation Trust Annual Organ Donation Plan 2012-13. Section 1 – Organ Donation Data Section 2- CQC data Section 3 - Issues arising from data and actions planned Section 4 - Donor recognition project Appendix 1- National Context and progress Appendix 2- Section 5 – Progress with 2012-13 Annual Organ Donation Plan
Action required of Trust Board	The trust board is asked to: (a) Support action plans to address Organ Donation data (b) Support actions planned as part of 2012-13 Annual Organ Donation Plan and Donor recognition project (b) Support NICE guideline principles
Corporate objective ref:	Quality strategy
CQC Essential Standards	Outcome 1, 4, 6.
Author:	Dr Julian Sonksen: Clinical Lead Organ Donation Dr Rajan Paw: Clinical lead Organ Donation Miss Rebecca Timmins: Specialist Nurse Organ Donation
Lead Director:	Mr David Badger
Date of Paper:	7th March 2013
For Trust Board meeting on:	7th March 2013

Section 1: Organ Donation Data

Below is all organ donation activity for ICU and ED combined from 1st April 2012 to 1st February 2013.



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

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

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

- **Neurological Death Testing (NDT);** The trust is currently achieving a 100% NDT rate. The national average is currently 75%.
- **Referral to the Specialist Nurse- Organ Donation (SN-OD) for consideration for Donation after Brain Death (DBD) donation**; the trust is currently achieving 100% referral to the SN-OD for DBD donation. The national average is 91%.
- **Approach to the family for consent for DBD donation**; NICE CG 135 recommendations (1.1.12 and 1.1.14) suggest that the initial approach to those close to the patient to discuss organ donation should include the Multi Disciplinary Team (MDT) and should include the Medical and Nursing staff caring for the patient, the SN-OD, and local faith representatives where appropriate.

There were 2 occasions where it was appropriate to approach the family for organ donation and on both occasions the families were approached for organ donation. The approach rate is therefore 100%. The national average is 92%.

- **Obtaining consent for DBD donation;** Consent was obtained for organ donation on 1 out 2 of occasions. The consent rate for DBD Donation is therefore 50%. The national average is 69%.

  The initial approach and discussion for organ donation on the first occasion involved the Consultant and Nurse caring for the patient, and the SN-OD. Consent was obtained for organ donation.

  The initial approach and discussion for organ donation on the second occasion involved an ICU Specialist Registrar. The Consultant and Nurse caring for the patient and the SN-OD later discussed organ donation with the family and consent was not obtained on this occasion. NICE CG 135 recommends that the approach for donation should be planned with the MDT (1.1.18) and be done once the family understands that death has occurred (1.1.20). The approach by the ICU Spr occurred before Brain Stem Death had been established.

- **Number of Organ's donated from DBD donors;** 4 organs were donated from 1 DBD Donor at the Trust. The national average organs donated from a DBD donor is 4.0.

- **Referral to the SN-OD for consideration for Donation after Cardiac Death (DCD) donation**; the referral rate to the SN-OD for DCD donation is 83%. The national average is 62%. There were 2 patients from ED that were not identified as potential organ donors or referred from the ED Department.

- **Approach to the family for DCD donation;** There were 4 out of 4 approaches to the family for DCD donation. The approach rate in the trust is therefore 100%. The national average is 57%. If the 2 patient's from ED that which were not identified or referred to the SNOD as potential organ donors, if they were identified, we could have approached the families of these patient's for organ donation.

- **Consent for DCD donation;** Out of the 4 approaches to the family for DCD donation, consent was given on 1 occasion. The SNOD and Clinical were jointly involved in the approach to the family for organ donation on this accession as per NICE CG 135 recommendations.

  The consent rate in the trust for DCD donation is 25%. The national average is 52%.

- **Number of Organs donated from DCD donors;** There has been 0 organs donated from DCD Donor's at the Trust so far this year. This is because the one occasion where consent was given for DCD donation, the patient passed away over a longer period of time which meant that DCD donation could not be possible. The time from withdrawing medical treatment to the time of death cannot be predicted in patients and therefore likelihood of donating by DCD donation is also unpredictable. The families wishing to agree to DCD donation are fully supported by the SNOD and ICU staff and are prepared during the consenting process by the SNOD that in some cases DCD does not take place, but the offer and willingness to donate is as important as the donation itself.

Section 2 – CQC Data

The below CQC data demonstrates the performance of both the ED and ICU departments combined. The data shown demonstrates the Trust's performance from the 1st April 2012 to 10TH February 2013

N1; No of deaths where the diagnosis of ND was suspected and patient met criteria for ND Testing and had ND tests performed	Target set 80%	Achieving 100%
N2; Number of cases where ND testing was planned and the SNOD was informed	Target set 90%	Achieving 100%
N3; Number of cases where there was a decision to WOT in a patient with a catastrophic Neuro Injury and the SNOD was informed before WOT	Target set 50%	Achieving 40%
N4; Number of cases where ND was confirmed or a decision to WOT as per N3, and an approach was made to the family for organ donation	Target set 65%	Achieving 75%
N5; Number of times that donation activity if formally considered by committee and progress with Annual Organ Donation Plan	At least quarterly	Achieving Mitigating circumstances for meeting Annual Organ Donation Plan

Actions planned to improve organ donation data

- **Improve DBD and DCD consent rate:**
- DBD and DCD guidelines have been updated and awaiting key stakeholder agreement and ratification. These will guide staff on best practice on approaching families for organ donation in timely manner. This is also in line with NICE CG135 recommendations.
- 2013-14 Annual Organ Donation Plan to incorporate annual training for staff in ICU/ED incorporating key messages on factors that increase identification and consent rates.
- Organ Donation Committee to continue to promote organ donation. We know nationally that if a patient is on the Organ Donor Register or discussed organ donation with their family, the consent rate is 92% versus 53% if they had not made their donation wishes known.
- **Improve identification and referral of potential organ donors in ED Department:**
- Carry out actions planned as per Root Cause Analysis for 2 missed referrals (NEW17878/17876).
- Continue to monitor.

Actions planned to meet CQC target

- Meet N3 standard by 31st March 2013: Actions carried out as per Root Cause Analysis for patient not referred to the SNOD from ICU which has contributed to us under performing to this target (NEW91411).
- Continue to monitor.

Section 4: Donor recognition project

Recommendation 12 of the Organ Donation Taskforce was to publically and personally recognize individual organ donors and the gift given to others.

Personal Support

Donor families are supported by the SN-OD personally and receive home visit's as required. Information about the recipient's that they have helped following the donation, and how the donation has impacted upon their life post transplant, are provided to the donor family by the SNOD. Further correspondence and exchange of letters is also possible via the SNOD as the donor family and recipient's wish.

Public Support

There are only a few public displays of donor recognition in Hospitals' in the U.K. (Queens Medical Centre (QMC) in Nottingham, Royal Derby, Royal Cornwall, Royal Berkshire, Dorset) and there is no public display of donor recognition work in the West Midlands. There is work in progress to obtain a national recognition program.

The unveiling of "The Circle of Life", which cost £9000 for the sculpture and was installed free of charge by Interserve, at Queens Medical Centre in Nottingham was undertaken by H.R.H The Duchess of Gloucester. This event received good media coverage with BBC and local media.

National work

A proposed UK Donor Recognition Program is currently in quite advanced discussions. Following discussions with the Royal Household it was identified that Lord Lieutenants could provide broad support nationally for this proposal. Lord Lieutenants are knights or members of the Order of St John which has ancient links with healthcare. The proposal aims to deliver a program for donor families so that

Soon after donation, each willing family is sent a message of recognition, ideally from a member of a Royal Household.

During national Transplant Week, local ceremonies are hosted by the respective Lord-Lieutenants, where a recognition award from the Order of St John, is given to willing families.

Events such as St James's Palace reception are used to create a platform of national recognition or form a part of an annual donation recognition program.

Promotion of Organ Donation

The sculpture or statue that is finally attained for this project will recognize the generous act of donation that is given, but also promote organ donation and registration on to the organ donor register, and will encourage people visiting the hospital to talk to their families about their end of life wishes.

The benefit's locally for our patient's at DGOH are that there are currently 70 patients in the Trust awaiting a kidney transplant and undertaking Haemodialysis. There are 5 patients awaiting a kidney and pancreas transplant.

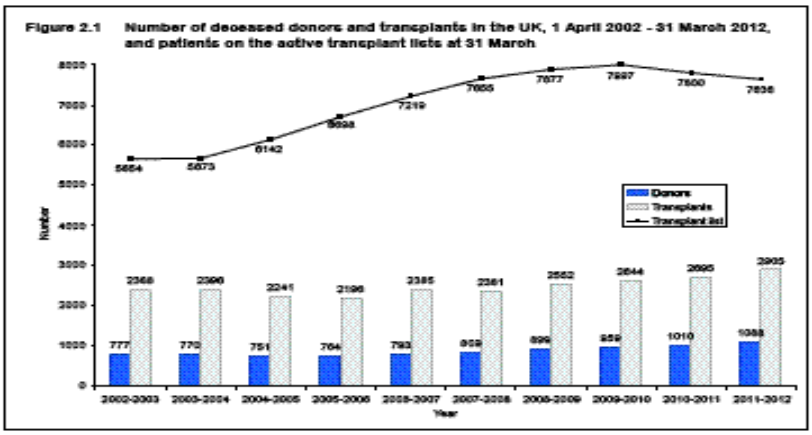
The cost benefit of kidney transplantation compared to dialysis over a period of ten years (the median transplant survival time) is £241,000 or £24,100 per year for each year. The quality of life saved is unquantifiable. We therefore hope that DGOH Charities Committee and NHSBT consider the cost of the donor recognition project against the cost saved to the NHS, should more people talk about organ donation and make their donation wishes known. We know that if a family knows that their loved one wants to donate that they will support this wish and consent for organ donation is higher (92% versus 53%).

Our actions to date have been

- Present to and ask support from DGOH Charities Committee to assist in the funding with this project (28th February 2013).
- Discussions with Interserve to take place regarding support for the installation of the memorial.
- Application to NHSBT for funding before 31st March 2013
- Meetings with Steve Field, Dudley Borough artist regarding material and costing. Ideas include a 2 tier competition to local artists arranged by Steve Field. Artists will be asked to submit ideas for the project and from this we will identify a few key artists to provide further drawings. These drawings will be held as an exhibition at the hospital and we will invite staff and governors to view the artists work and give feedback as to their work. The final decision on the artwork/sculpture will rest with the Organ Donation Committee and Trust Board.
- Research Trust's who have implemented Donor Recognition projects.

Appendix 1: National context and progress

On the 31st March 2013 NHS Blood and Transplant (NHSBT) will have arrived to the 5 year timeline given by the Department of Health and Organ Donation Taskforce in delivering the key objectives which if implemented, it was suggested would increase organ donation rates by 50% over 5 years. The below figure demonstrates the decreasing trend of patient's awaiting a transplant and the increasing trend of deceased organ donors and number of transplants.



The objectives set for the next 5 years for NHSBT is also set below. To achieve these objectives will require the commitment and cooperation of NHS Trusts nationally, and leadership from Organ Donation Committee's and key stakeholders.

Strategic Targets – Organ Donation and Transplantation	2011-12 Plan	2011-12 Actual	2012-13 Plan	2013-14 Plan	2014-15 Plan	2015-16 Plan	2016-17 Plan
Number of Deceased Organ Donors	1,095	1,095	1,214	1,252	1,273	1,289	1,298
Cumulative percentage increase in deceased organ donation (from a 2007-08 baseline of 809 donors)	35%	34%	50%	55%	57%	59%	60%
Number of people registered on the Organ Donor Register (ODR)	18.9m	18.8m	19.8m	20.8m	21.8m	22.8m	23.8m
Number of Living Organ Donors	1,050	1,050	1,081	1,112	1,143	1,174	1,205
Number of Organ Transplants	4,108	<4,108	4,230	4,348	4,407	4,454	4,480

Appendix 2: Progress with 2012-13 Annual Organ Donation Plan

Action Plan	Status	Outstanding Actions
Action Plan 1 Achieve 100 % Neurological Death Testing rate in ICU and ED combined.	Achieving	DBD policy to be agreed and ratified
Action Plan 2 Referral to the SN-OD of 100% of cases where Neurological Death is confirmed Referral to the SNOD 100% of cases where the patient has a neurological injury and meets the local trigger for consideration for donation after cardiac death donation (CQUIN target 50%). Referral to the SNOD 75% of cases where the patient meets the local criteria for referral for consideration for Donation after Cardiac Death donation (non neurological injury).	Achieving Achieving 40 % Achieving 83%	Discuss RCA's regarding patients not referred to SNOD from ED with ICU Consultant's at QPDT on 5th March. Annual training project for trust staff to be rolled over to 2013-14 annual objectives DCD policy to be agreed and ratified
Action Plan 3 Checking of the Organ Donor Register on ICU and ward areas	Actions completed	
Action Plan 4 The SNOD is present for the initial donation conversation to the family regarding Organ Donation in over 65% of occasions where Neurological Death has been confirmed by testing, or the patient met the local criteria for consideration for Donation after Cardiac	Achieving 100% where ND confirmed Achieving 50 % for Donation after Cardiac Death	Ratification of reviewed DCD and DBD Guideline with NICE recommendations included.
Action Plan 5 Trust is compliant with NICE recommendations CG135	Actions outstanding	Annual training project for trust staff to be rolled over to 2013-14 annual objectives

		Ratification of reviewed DCD and DBD Guideline with NICE recommendations included.
Action Plan 6 Donor Optimization	Actions outstanding	Continue to use Midlands Organ Donation Services Care Pathway Await national Care Bundle
Action Plan 7 Promote Organ Donation and Number of People on the Organ Donor Register	Actions outstanding	Organ donor recognition project

Enclosure 11

The Dudley Group
NHS Foundation Trust

Paper for submission to Board of Directors on 7th March 2013

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

CORPORATE OBJECTIVE: The standard operating procedure may refer to any of the Trust's objectives.

SUMMARY OF KEY ISSUES:

For the past two years Dudley Research & Development Directorate has chosen to publish information about its research infrastructure and capabilities under the auspices of the National Institute for Health Research (NIHR) with the intention of promoting the Trust to commercial companies.

North Wing's Clinical Research Unit has excellent laboratory facilities that could attract commercial and academic studies; the pharmacy has robust procedures for running clinical trials; more specialties are becoming research active.

The NIHR requires Trust Boards to approve a statement of the organisation's research facilities and expertise on an annual basis. This is then uploaded onto the NIHR website for viewing.
The Research & Development Directorate has reviewed and updated the information in the document and requests Trust Board endorsement before 29/03/2013, the deadline set by NIHR.

IMPLICATIONS OF PAPER:

RISKS	**Risk Register** **N**	**Risk Score**	**Details:**
COMPLIANCE	**CQC**	**Y**	**Details:** Outcome 2 – consent.
	NHSLA	**Y**	**Details:** Link to reporting of incidents.
	Monitor	**Y**	**Details:** Quality accounts.
	Other	**Y**	**Details:** At present this document is not mandatory; completion does attract a small payment. There is discussion that perhaps all research-active Trusts should complete this document.

The Dudley Group NHS
NHS Foundation Trust

ACTION REQUIRED OF BOARD: *(Please tick below)*			
Decision	**Approval**	**Discussion**	**Other**
	X		
RECOMMENDATIONS FOR THE BOARD: To approve the updated R&D Operational Capability Statement, for submission to the NIHR.			

CORPORATE OBJECTIVES : *(Please select for inclusion on front sheet)*		
SO1.	**Quality**	To exceed all internal quality targets by 2014 and to be recognised as the highest quality service provider in the region by patient groups, staff and other key stakeholders**.**
SO2.	**Innovation**	To have nurtured a proactive learning institution of excellence
SO3.	**Productivity**	To have established clinically and financially effective models of care**.**
SO4.	**Prevention**	Continually working with partners to develop new pathways that enable patients to make more appropriate use of Dudley Group services.
SO5.	**Staff engagement**	To be an organisation with a high commitment culture where everybody exhibits Trust behaviours and seeks to exceed expectations
SO6.	**Patient Experience**	To provide excellent service and care making patients feel involved, valued and informed.

NIHR Guideline B01
R&D Operational Capability Statement

Version History

Version number	Valid from	Valid to	Date approved	Approved by	Updated by
RDOCS 001	18/02/2011	17/02/2012	03/03/2011	Trust Board	
RDOCS 002	30/05/2012	29/05/2013	07/06/2012	Trust Board	J Griffiths
RDOCS 003	08/03/2013	07/03/2014		Trust Board	M Marriott

Contents

Organisation R&D Management Arrangements

Information on key contacts

Organisation Details	
Name of Organisation	The Dudley Group NHS Foundation Trust
R&D Lead / Director (with responsibility for reporting on R&D to the Organisation Board)	Prof George Kitas via Dr Paul Harrison, Medical Director
R&D Office details:	
Name:	Margaret Marriott
Address:	Clinical Research Unit, North Wing, 1st Floor, Russells Hall Hospital, DY1 2HQ
Contact Number:	01384 321024 or 01384 456111 X3309
Contact Email:	margaret.marriott@dgh.nhs.uk or research.RHH@dgh.nhs.uk
Other relevant information:	
Key Contact Details e.g. Research Governance Lead, NHS Permissions Signatory contact details	
Contact 1:	
Role:	Research and Development Facilitator - Governance & Operations (oversees research throughout DGH)
Name:	Margaret Marriott
Contact Number:	01384 321024
Contact Email:	margaret.marriott@dgh.nhs.uk
Contact 2:	
Role:	Research and Development Facilitator - Portfolio & Financial Development (oversees research throughout DGH)
Name:	Rebecca Storey
Contact Number:	01384 456111 ext 3733
Contact Email:	rebecca.storey@nhs.net
Contact 3:	
Role:	Research Support Officer (Cancer & Cardiology)
Name:	Post vacant
Contact Number:	
Contact Email:	Research.RHH@dgh.nhs.uk
Contact 4:	
Role:	Research Support Officer (Rheumatology & Gastro Intestinal Research)
Name:	Kirsty Baron
Contact Number:	01384 456111 ext 3734
Contact Email:	Research.RHH@dgh.nhs.uk
Contact 5:	
Role:	Research Support Officer (Muskuloskeletal & Academic Secretary to Rheumatology Department)
Name:	Ben Watkins
Contact Number:	01384 456111 ext 1890
Contact Email:	Ben.Watkins@dgh.nhs.uk

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Information on staffing of the R&D Office

R&D Team		
R&D Office Roles (e.g. Governance, Contracts, etc)	Whole Time Equivalent	Comments indicate if shared/joint/week days in office etc
Research and Development Facilitator (G&O)	1	Research governance advice, contracts, study set-up, overview of all research taking place in the trust
Research and Development Facilitator (P&FD)	1	Maximising recruitment opportunities, audit & monitoring strategy, external funding opportunities in the Trust
Research Support Officers	2.4	Assistance with study set up, research governance, administration, finance, study approvals, amendments and correspondence with healthcare professiona
		Research support officers also act as data manager for studies when required

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Information on reporting structure in organisation (include information on any relevant committees, for example, a Clinical Research Board / Research Committee / Steering Committee.)

Reporting Structures
All proposed research activity is reviewed by the Protocol Review Sub-Committee locally. Review may take the form of site specific assessment on behalf of the Trust, proportionate peer review of locally designed studies, review of educational projects. Twice monthly agendas are prepared by R&D office staff. Quarterly lists of reviewed studies are provided to the Risk Committee. The Risk Committee also receives notification of any serious adverse events occurring to Trust patients enrolled in clinical trials. The committee also receives a list of serious adverse events occurring nationally to patients enrolled in clinical trials sponsored by the Trust.

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Information on Research Networks supporting/working with the Organisation.
Information on how the Organisation works with the Comprehensive Local Research Network (CLRN), Primary Care Research Network (PCRN), Topic Specific Clinical Research Networks (TCRN).

Research Networks	
Research Network (name/location)	Role/relationship of the Research Network eg host Organisation
Greater Midlands Cancer Research Network	GMCRN provides funds for some cancer research nurses, data manager and secretarial support. Also provides Good Clinical Practice training courses
Birmingham and Black Country CLRN	BBC CLRN provides funding for the research governance & management (RM&G) of DH-recognised portfolio studies and funding for research infrastructure in DGH.
	Peer support and advice for R&D officers; Good Clinical Practice training are provided by the CLRN. News of developments is disseminated to R&D offices by CLRN.
	DGH uses the CLRN pool of trained research nurses made available by BBC CLRN to help out in areas with no local research infrastructure in DGH.
West Midlands Stroke Network	The Network works with the Stroke Unit and R&D office to provide research staff to undertake stroke related clinical trials in the Trust.
REACH	Starting to be involved in the Reproductive and Child Health Network run from Birmingham Women's Hospital. Two studies currently open.
Medicines for Children Research Network	Starting to be involved in the Medicines for Children Research Network, run from Birmingham Children's Hospital. BCH staff support DGH recruitment.
UHB Gastroenterology Unit	Provides research staff to identify and invite patients to take part in specialised studies running at University Hospitals Birmingham. Currently no staff in place.
UHB/ University of Birmingham Diabetes studies	Collaboration about to commence. UHB/UoB staff to visit DGH Diabetes Centre to recruit to NIHR studies.

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Information on collaborations and partnerships for research activity (e.g. Biomedical Research Centre/Unit, Other NHS Organisations, Higher Education Institutes, Industry)

Current Collaborations / Partnerships				
Organisation Name	Details of Collaboration / Partnership (eg	Contact Name	Email address	Contact Number
University of Birmingham (SportEx)	MSc, PhD studentships, academic collaboration	Prof Joan Duda and others	j.l.duda@bham.ac.uk	
University of Wolverhampton	PhD and MSc studentships; academic collaboration	Prof Yiannis Koutedakis	y.koutedakis@pe.uth.gr	
Action Heart	Hosting of research	Russell Tipson	info@actionheart.com	
University of Aston	PhD studentships, academic collaboration	Prof Helen Griffiths and Prof Amtul Carmichael	h.r.griffiths@aston.ac.uk; amtul.carmichael@dgh.nhs.uk	

University of Manchester	PhD and MSc studentships; academic collaboration	Prof Deborah Symmons	deborah.symmons@manchester.ac.uk	
University of Birmingham	Medical Research Council/ Arthritis Research UK Centre for musculoskeletal ageing	Prof Janet Lord	J.M.Lord@bham.ac.uk	
University of Birmingham	Translational Research Partnership for Joint and musculoskeletal diseases	Dr Claire Potter	c.potter@bham.ac.uk	
Birmingham City University	PhD studentships; academic collaboration	Prof Jon Raphael	jon.raphael@bcu.ac.uk	
University of Newcastle (Institute of Cellular Medicine)	Sjogren's Registry	Dr Wan-Fai Ng	wan-fai.ng@ncl.ac.uk	
University of Athens Medical School	Rheumatoid Arthritis	Prof P Sfikakis		
University of Nijmegen, The Netherlands	Rheumatoid Arthritis	Prof Piet van Riel	petrusvriel@gmail.com	
University of Oslo, Norway	Rheumatoid Arthritis	Prof Torre Kvien; Dr Anne Grete Semb	a-semb@diakonsyk.no	
The Mayo Clinic, USA	Rheumatoid Arthritis	Prof Sherine Gabriel	sherine.gabriel@mayo.edu	

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Organisation Study Capabilities

Information on the types of studies that can be supported by the Organisation to the relevant regulatory standards

Types of Studies Organisation has capabilities in (please tick applicable)							
	CTIMPs (indicate Phases)	Clinical Trial of a Medical Device	Other Clinical Studies	Human Tissue: Tissue Samples Studies	Study Administering Questionnaires	Qualitative Study	OTHER
As Sponsoring Organisation	Phase 4 study		X	X	X	X	
As Participating Organisation	Phases 2, 3 & 4	X	X	X	X	X	
As Participant Identification Centre	X	X	X	X	X	X	
PhD studentships in rheumatology/ pain management			X	X	X	X	

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Which licences does the organisation hold which may be relevant to research?

Organisation Licences			
Licence Name Example: Human Tissue Authority Licence	Licence Details	Licence Start Date (if applicable)	Licence End Date (if applicable)
Clinical Pathology Accreditation	Immunology - 1207; Cellular Pathology - 1203	Accredited	
Clinical Pathology Accreditation	Clinical Biochemistry - 1205 ; Haematology - 1204	Conditional approval	
Human Tissue Authority Licence	Procurement of tissue, distribution and testing of donors for autologous peripheral blood stem cells for transplant	ongoing	

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Organisation Services

Information on key clinical services contacts and facilities/equipment which may be used in studies for supporting R&D governance decisions across the organisation.

Clinical Service Departments					
Service Department	Specialist facilities that may be provided (eg number/type of scanners)	Contact Name within Service Department	Contact email	Contact number	Details of any internal agreement templates and other comments
Cardiology		Anne Drewnicki	anne.drewnicki@dgh.nhs.uk	X3401	
Action Heart Gym	Fully equipped and staffed cardiac rehabilitation gym	Russell Tipson	info@actionheart.com	X1470	regularly used for exercise studies
Clinical Biochemistry	Fully equipped and staffed fully functional Clinical Biochemistry laboratory	Dr David Vallance	David.Vallance@dgh.nhs.uk	X2080	
Clinical Biochemistry	High Pressure Liquid Chromatography	Dr David Vallance	david.vallance@dgh.nhs.uk	X2081	
Clinical Research Unit - Research Lab	Beckman Coulter Flow Cytometer	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	Ultra Centrifuge (Beckman Coulter) x 1	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	Light Cycler 480 (Roche) real time PCR	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	Spectrophotometer	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	Western Blotting - specific protein analysis	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Molecular Lab	Fujifilm Quick Gene 480: DNA/RNA	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	-80C Freezers x 3	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Molecular Lab	-20C Freezer x 1	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	Light Cycler 2.1 (Roche) real time PCR	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	Refrigerated centrifuge x 1	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	Micro centrifuge x 1	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	Standard centrifuge x 1	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Research Lab	Microscope Axioskop 40 (Zeiss)	Jackie Smith	jacqueline.smith@dgh.nhs.uk	X3707	
Clinical Research Unit - Exercise Physiology Lab	Pulse wave analysis	Aamer Sandoo	Aamer.Sandoo@dgh.nhs.uk	X3717	
Clinical Research Unit - Vascular Physiology Lab	Mobile Ultrasound x 1	Aamer Sandoo	Aamer.Sandoo@dgh.nhs.uk	X3717	
Clinical Research Unit - Vascular Physiology Lab	Laser doppler x 1	Aamer Sandoo	Aamer.Sandoo@dgh.nhs.uk	X3717	
Clinical Research Unit - Exercise Physiology Lab	Exercise bike x 1	George Metsios	g.metsios@wlv.ac.uk	X3717/3719	
Clinical Research Unit - Exercise Physiology Lab	Body composition analysis (whole body) x	George Metsios	g.metsios@wlv.ac.uk	X3717/3719	
Clinical Research Unit - Exercise Physiology Lab	Body composition analysis (abdomen) x 1	George Metsios	g.metsios@wlv.ac.uk	X3717/3719	
Clinical Research Unit - Exercise Physiology Lab	Treadmill x 1	George Metsios	g.metsios@wlv.ac.uk	X3717/3719	
Clinical Research Unit - Exercise Physiology Lab	Haemodynamic monitor x 1	George Metsios	g.metsios@wlv.ac.uk	X3717/3719	
Clinical Research Unit - Exercise Physiology Lab	Gas analysis system - Metalyzer x 1	George Metsios	g.metsios@wlv.ac.uk	X3717/3719	
Clinical Research Unit - Vascular Physiology Lab	Ultrasound facility	Rainer Klocke	rainer.klocke@dgh.nhs.uk	X5807	
Histopathology		Steph Gawthorpe	Stephanie.Gawthorpe@dgh.nhs.uk	X2033	
Haematology	Platelet aggregometer x 1	Sue Rides	susan.rides@dgh.nhs.uk	X2091	
Clinical Biochemistry	High Pressure Liquid Chromatography	David Vallance	david.vallance@dgh.nhs.uk	X2081	
Microbiology		Alan Jackson	alan.jackson@dgh.nhs.uk	X2472	
Radiology - CT	CT scanners x 2; 1 x 128 multi-slice; 1 x 64 multi-slice	Tim Usher	tim.usher@dgh.nhs.uk	X2043	
Radiology - MRI	Philips Intera 1.5T MRI scanner (software a	Tim Wicker	tim.wicker@dgh.nhs.uk	X1269	
Radiology - MRI	Siemens Verio 3T scanner	Tim Wicker	tim.wicker@dgh.nhs.uk	X1269	
Radiology - plain film	Siemens Multix /Fuji CR XG5000 x1	Judy Veness	judy.veness@dgh.nhs.uk	X2341	
Radiology - DXA	GE Lunar, bone densitometry (DXA scanner), Corbett Hospital	Jane South	jane.south@dgh.nhs.uk	X4609	
Pharmacy	Aseptic services	Manesh Patel	manesh.patel@dgh.nhs.uk	X3311	
Pharmacy	Cytotoxic Isolators x 3	Manesh Patel	manesh.patel@dgh.nhs.uk	X3311	
Pharmacy	Monoclonal Antibody Isolator x 1	Manesh Patel	manesh.patel@dgh.nhs.uk	X3311	
Pharmacy	Very limited shelf space for ambient storage; fridge storage available	Manesh Patel	manesh.patel@dgh.nhs.uk	X3311	
Pharmacy	Dispensary	Hayley Pearson	hayley.pearson@dgh.nhs.uk	blp 8000	
Medical Physics	for studies involving ionising radiation	Mark Rawson	Mark.Rawson@nhs.net	01902 307999	New Cross Hospital, Wolverhampton
Radiotherapy	Delivery of radiotherapy treatment (at New Cross Hospital, Wolverhampton)	Steve Jackson	Stephen.Jackson1@nhs.net	01902 695221	New Cross Hospital, Wolverhampton
Georgina Day Case Unit	Delivery of chemotherapy	Allison Field	allison.field@dgh.nhs.k	X2442	
Rheumatology Day Case Unit	Delivery of rheumatology drug infusions	Shirley O'Hare	shirley.o'hare@dgh.nhs.uk	X3708	

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Information on key management contacts for supporting R&D governance decisions across the organisation.

Management Support e.g. Finance, Legal Services, Archiving					
Department	Specialist services that may be provided	Contact Name within Service Department	Contact email	Contact number	Details of any internal agreement templates and other comments
Archiving		Margaret Marriott	margaret.marriott@dgh.nhs.uk	01384 321024	
Contracts		Margaret Marriott	margaret.marriott@dgh.nhs.uk	01384 321024	
Data management support	Currently available for cancer studies	Karen Kanyi	karen.kanyi@dgh.nhs.uk	01384 456111 ext 2513	
Data management support	Currently available for rheumatology	Margaret Marriott	margaret.marriott@dgh.nhs.uk	01384 321024	
Finance	Salary costings;	Lisa Bradley	lisa.bradley@dgh.nhs.uk	X1034	
Information Technology	Compatibility of websites for e-crf data capture; data transfer issues	Richard Rooke	richard.rooke@dgh.nhs.uk	01384 456111 ext 3291	
Legal: via Finance & Information Dept	Opinion re contract clauses; insurance	Alison Fisher	alison.fisher@dgh.nhs.uk	01384 456111 X1039	
HR	Advice regarding honorary contracts, letters of access	Andrea Homer	Andrea.Homer@dgh.nhs.uk	01384 456111 X3253	
Statistical support	Power calculations and design advice	Peter Nightingale	Peter.Nightingale@uhb.nhs.uk	0121 371 2174	

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Organisation R&D Interests

Information on the areas of research interest to the Organisation

Organisation R&D Areas of Interest				
Area of Interest	Details	Contact Name	Contact Email	Contact Number
Rheumatology	Rheumatoid arthritis, clinical drug trials	Dr Karen Douglas	karen.douglas@dgh.nhs.uk	01384 244754
Rheumatology	Rheumatoid arthritis, cardiovascular disease and exercise	Prof George Kitas	kitas@dgh.nhs.uk	01384 244842
Colorectal and upper GI cancer	Drug trials	Prof David Ferry	profdavidferry@gmail.com	01384 244239
Breast cancer treatment	Breast cancer and exercise	Prof Amtul Carmichael	amtul.carmichael@dgh.nhs.uk	01384 244015
Breast cancer treatment	Drug trials and radiotherapy trials	Dr Rozenn Allerton	rozenn.allerton@nhs.net	01384 244219
Prostate cancer treatment	Drug trials and radiotherapy trials	Dr Pek Koh	on leave until July 2013	
Colorectal and Breast cancer	Endothelial markers in cancer	Mr Paul Stonelake	paul.stonelake@dgh.nhs.uk	01384 244013
Lung cancer	Drug trials	Dr Simon Grumett	simon.grumett@nhs.net	01384 244242
Haematology	Lymphoma	Dr Jeff Neilson	jeff.neilson@dgh.nhs.uk	01384 456111 x2478
Haematology	Myeloma	Dr Craig Taylor	craig.taylor@dgh.nhs.uk	01384 244219
Haematology	Myeloproliferative diseases	Dr Steve Jenkins	stephen.jenkins@dgh.nhs.uk	01384 244158
Haematology	Acute & chronic leukaemias	Dr Savio Fernandes	savio.fernandes@dgh.nhs.uk	01384 244581
Cardiology	Drugs and devices	Dr Craig Barr	cs.barr@dgh.nhs.uk	01384 244084
Respiratory Medicine	Chronic Obstructive Pulmonary Disease	Dr Philip Brammer	philip.brammer@dgh.nhs.uk	01384 244568
Gastroenterology	NIHR portfolio studies	Dr Neil Fisher (as HoD)	neil.fisher@dgh.nhs.uk	01384 244147
Dermatology	NIHR Portfolio studies, drug studies	Dr Effie Ladoyanni	Effie.Ladoyanni@dgh.nhs.uk	01384 244708
Chemical Pathology (cholesterol; weight management)	NIHR portfolio studies	Dr Mourad Labib	mourad.labib@dgh.nhs.uk	01384 244078
Diabetes & Endocrinology	NIHR Portfolio studies	Dr Terence Pang	Terence.Pang@dgh.nhs.uk	01384 456111 ext 2018

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Information on Local / National Specialty group membership within the Organisation which has been shared with the CLRN

Specialty Group Membership (Local and National)					
National / Local	Specialty Group	Specialty Area (if only specific areas within	Contact Name	Contact Email	Contact Number
National and local	Musculoskeletal		*Prof G Kitas*	kitas@dgh.nhs.uk	*01384 244842*
Local	Inflammation and Immunity		*Dr K Douglas*	karen.douglas@dgh.nhs.uk	*01384 244803*

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Organisation R&D Planning and Investments

Planned Investment			
Area of Investment (e.g. Facilities, Training, Recruitment, Equipment etc.)	Description of Planned Investment	Value of Investment	Indicative dates
R&D Facilitator (Portfolio & Financial Development)	New staff member on a two year fixed term contract	£45,000	01/03/2013 - 28/02/2015

Add lines in the table as required by selecting and then copying **a whole Excel row which is a part of** the table (note: select and copy the row **not** cells in the row).
Then select a **row** in the table and 'insert copied cells'. (Please do not select and copy individual cells or groups of cells as this does not preserve formatting.)

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Organisation R&D Standard Operating Procedures Register

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

RP09 - GMCRN	Working File Set up	The process and uses of a working file set up in addition to the Investigator Site file.	10/07/2008 (adopted by the Trust 08/06/2009)	10/07/2011
TR01 - GMCRN	Performing and Documenting Training for Research Staff	Outlines the process in place to ensure that Trust staff involved in research are appropriately trained and their experience and training is fully documented	10/07/2008 (adopted by the Trust 08/06/2009)	10/07/2011
TR02 - GMCRN	Minumum Training Recommendations	Highlights the recommended training for Trust staff engaged in research related activities	10/07/2008 (adopted by the Trust 08/06/2009)	10/07/2011
PH01 - GMCRN	Chemotherapy Trials Prescriptions - Version 2	Describes the procedure for completing, prescribing and signing trial prescriptions acuratley within clinical trials	12/08/2011 (GMCRN SOP adopted by the Trust)	12/08/2012
Pharmacy SOP CT01	Clinical trial training manual for Assistant Technical Officers	To guide pharmacy ATOs in preparation and dispensing for clinical trials	02/01/2012	01/01/2014
Pharmacy SOP CT02	Clinical Trials training pack for Assistant Technical Officers	To guide pharmacy ATOs in preparation and dispensing for clinical trials	01/05/2012	30/04/2014
Pharmacy SOP CT03	Clinical trials re-accreditation for Assistant Technical Officers	Re-accreditation for ATOs	07/07/2012	06/07/2014
Pharmacy SOP CT04	Clinical trial training manual for Pharmacists and Technicians	To guide pharmacists and technicians in preparation and dispensing for clinical trials	22/07/2011	21/07/2013
Pharmacy SOP CT05	Clinical trials training pack for pharmacists	To guide pharmacists in preparation and dispensing for clinical trials	09/07/2011	08/07/2013
Pharmacy SOP CT06	Clinical trials re-accreditation for Pharmacists	Re-accreditation for pharmacists	09/07/2011	08/07/2013
Pharmacy SOP CT07	Clinical Trials training pack for pharmacy technicians	To guide pharmacy technicians in preparation and dispensing for clinical trials	23/06/2011	22/06/2013
Pharmacy SOP CT08	Clinical trials re-accreditation for Pharmacy Technicians	Re-accreditation for pharmacy technicians	23/06/2011	22/06/2013
Pharmacy SOP CT09	Procedure for the recording of clinical trials staff training	Procedure for the recording of clinical trials staff training	15/02/2012	14/02/2014
Pharmacy SOP CT10	Information Governance in Clinical Trials	Information Governance - what data to send	01/02/2012	30/01/2014
Pharmacy SOP CT11	Procedure for collection of Investigational Medicinal Products (IMPs) after dispensing	Collection of IMP from pharmacy	08/02/2012	07/02/2014
Pharmacy SOP CT12	Procedure for recalling Investigational Medicinal Products (IMPs) in a clinical trial	Recalling IMP	26/01/2012	25/01/2014
Pharmacy SOP CT13	Procedure for receipt of a clinical trials protocol	Receiving a protocol	21/09/2011	20/09/2013
Pharmacy SOP CT14	Procedure for assessing a new clinical trial within pharmacy	Assessing new trial	10/09/2011	09/09/2013
Pharmacy SOP CT15	Procedure for the risk assessment and risk management of clinical trials	Risk assessment and risk management	22/12/2011	21/12/2013
Pharmacy SOP CT16	Procedure for settng up a Trust research & development (R&D) approved clinical	Set up for R&D approved clinical trial	01/09/2011	31/08/2013
Pharmacy SOP CT17	Procedure for assigning charges for a new clinical trial	Assigning charges	08/02/2014	07/02/2014
Pharmacy SOP CT18	Procedure for preparation for a clinical trial site initiation visit	Site Initiation Visit preparation	06/09/2011	05/09/2013
Pharmacy SOP CT19	Procedure for the allocation and use of PIN numbers for clinical trials	Relabelling of IMPs	09/08/2011	08/08/2013
Pharmacy SOP CT20	Procedure for the 'Greenlight' Process - authorisation to proceeed for a new Clinical Trial	Pharmacy greenlight process	01/09/2011	31/08/2013

Pharmacy SOP CT21	Procedure for the prescribing of IMP on an in-patien chart.	In-patient prescribing of IMP	21/09/2011	20/09/2013
Pharmacy SOP CT22	Procedure for receiving Investigatinal Medicinal Products (IMPs)	Receiving IMPs	02/07/2012	01/07/2014
Pharmacy SOP CT23	Procedure for labelling of investigational medicinal products (IMPs) for a clnical trial	Labelling of IMPs	23/12/2011	22/12/2013
Pharmacy SOP CT24	Clinical trial prescription dispensing procedure	Dispensing procedure	24/12/2011	23/12/2013
Pharmacy SOP CT25	Procedure for final checking of investigational medicinal prodcucts (IMPs)	Final checking of IMPs	06/09/2011	05/09/2013
Pharmacy SOP CT26	Procedure for the dispensing of investigational medicinal products (IMPs) out of hours	Out of hours dispensing	13/12/2011	12/12/2013
Pharmacy SOP CT27	Procedure for closing down a clinical trial	Closing down of a trial	03/12/2011	02/12/2013
Pharmacy SOP CT28	Procedure for the temperature monitoring of clnical trials materials	Temperature monitoring	30/07/2011	29/07/2013
Pharmacy SOP CT29	Procedure for the safe management of an investigational medicinal product (IMP) spill	Safe management of IMP spill	04/08/2011	03/08/2013
Pharmacy SOP CT30	Procedure for relabelling of investigational medicinal products (IMPs)	Relabelling of IMPs	30/12/2011	29/12/2013
Pharmacy SOP CT31	Procedure for the destruction of investigational medicinal products (IMPs)	Destruction of IMPs	27/07/2013	26/07/2013
Pharmacy SOP CT32	Procedure for 'Code Breaking' within a Clinical Trial	Also known as unblinding of a study where it is not known what drug patient has been allocated in randomisation.	06/09/2011	05/09/2013
Pharmacy SOP CT33	Procedure for the quarantining of investigational medicinal products (IMPs)	Quarantining of IMPs	23/12/2011	22/12/2013
Pharmacy SOP CT34	Procedure for Receiving Patients Unwanted Investigational Medicinal Products (IMPs)	How to deal with patients unwanted IMPs	22/12/2011 - pharmacy	21/12/2013
Pharmacy SOP CT35	Repoting and Documenting Errors and Near Misses in Clinical Trials	Documenting errors and near misses	01/09/2011 - pharmacy	31/08/2013
Pharmacy SOP CT36	Outpatient Charges for Clinical Trials Prescriptions	Outpatient Prescription Charges	30/12/2011	29/12/2013
Pharmacy SOP CT37	Procedure for the Accountability of Clinical Trial Drugs within Pharmacy	Accountability of IMPs	24/01/2012	23/01/2014
Pharmacy SOP CT38	Procedure for the ordering of Investigational Medicinal Products (IMPs)	Ordering IMPs	20/09/2010	19/09/2012
Pharmacy SOP CT39	Procedure for Investigational Medicinal Products (IMPs) Stock Control	IMP stock control	10/03/2012	09/03/2014
Pharmacy SOP CT40	Procedure for the Use of File Notes in Pharmacy for Clinical Trials	File notes	Under review	
Pharmacy SOP CT41	Procedure for Archiving Clinical Trial Documentation/ Pharmacy Files	Archiving documentation/pharmacy files	Under review	
Pharmacy SOP CT42	Procedure for Version and Document Control for Clinical Trials	Version and document control	20/09/2010	19/09/2012

Pharmacy SOP CT43	Procedure for Professionally Checking a Clinical Trial Prescription	Professionally checking prescription	Under review	
Pharmacy SOP CT44	Procedure for receipt of clinical trial prescription into pharmacy	Receipt of clinical trial prescription	29/12/2011	28/12/2013
Pharmacy SOP CT45	Procedure for the notification of an admission of a clinical trial participant to a ward in DGNHSFT	Admission of clinical trial participant to a ward	Under review	
Pharmacy SOP CT46	Procedure for the use of IMP as patient's own drugs for in patient use	Use of IMP as patient's own drugs for in patient use	Under review	
Appendix 1	Clinical Trial Drug Destruction Certificate		09/08/2011	08/08/2013
Appendix 2	Clinical Trial Drug Recall Record		29/01/2012	25/01/2014
Appendix 3	Clinical Trial Collection Record Form		Under review	
Appendix 4	Good Clinical Practice Handout		07/07/2012	06/07/2014
Appendix 5	Clinicla Trials Presentation		01/04/2011	31/03/2013
Appendix 6	Good Clinical Practice Handout for ATOs		07/07/2012	06/07/2014
Appendix 7	Clinical Trial Set up Checklist		06/12/2011	05/12/2013
Appendix 8	Pharmacy Greenlight Authorisation Form		01/04/2011	31/08/2013
Appendix 9	Unblind Request Checklist		06/09/2011	05/09/2013
RD1	Raising an invoice	Trust procedure for requesting an invoice	18/02/2013	15/05/2014
RD2	Site specific assessment	Trust procedure for approving studies where the Trust is a participating organisation	18/02/2013	15/05/2014
RD3	Peer review before ethics	Trust procedure for approving studies where the Trust is a sponsoring organisation	18/02/2013	15/05/2014
RD4	Finance costing template	Trust procedure for using the NIHR approved costing template	18/02/2013	15/05/2014
RD5	Pharmacy approvals process - NHS Permissions	Process RD Office/ Pharmacy follows to ensure the correct processes are followed to allow for NHS Permissions	18/02/2013	18/02/2014
RD6	Training for staff administering CTIMPS	Georgina Unit	18/02/2013	18/02/2014
RD7	Dealing with radiological exposures in research	The process the R&D Office uses when setting up a study involving ionising radiation or radioactive materials	19/02/2013	19/02/2014
RD8	Amendments SOP	Process the R&D office uses when handling amendments	18/02/2013	18/02/2014
PF1	Set up and control finance	The process the R&D office uses when setting up and controlling study finance procedures	18/02/2013	18/02/2014
PF2	Oversee organisation and study finance	The process the R&D offices uses when overseeing study wide financial arrangements	18/02/2013	18/02/2014
RD90	Auditing	The process the R&D Office follows when auditing a study - participating and study-wide	18/02/2013	18/02/2014
RD91	Archiving and document destruction SOP	The process the R&D Office uses when archiving a study - both participating and study-wide	18/02/2013	18/02/2014
Policy	Procedure for prescribing, safe handling and administration of cytotoxic	Trust policy for administrating chemotherapy	01/11/2008	01/10/2010
Policy	Systematic anti cancer programme education and training: A multi-disciplinary	Trust education and training programme for cytotoxics which can be applied to the use of investigational medicinal products	New Trust training manual as of Feb 2011	
Policy	Policy on indemnity whilst undertaking research activities	Trust policy on indemnity whilst undertaking research	01/08/2011	01/06/2012

Policy	Policy for taking and documenting	Trust policy for taking informed consent	01/11/2009	01/11/2012
Policy	Managing Intellectual Property Policy	Trust policy for managing IP	01/12/2010	01/12/2013
Policy	Research Governance Policy	Trust policy for adhering to the Research Governance Framework	01/11/2011	01/11/2014
Policy	Policy to address research misconduct &	Trust policy to address misconduct and fraud	01/12/2010	01/11/2012
Policy	Policy for recognition of research	Trust policy for research passports	07/04/2010	41370
Procedure	Procedure for reporting serious adverse	Trust procedure for reportings SAEs and SUSARs	under review	
Policy	Policy for undertaking research involving	Trust policy for studies involving adults lacking capacity	01/08/2011	01/06/2014

Additional SOPs relating to activties carried out within the aseptic pharmacy unit are also available and these outline all activities which are carried out by the unit and may therefore be relevant to clinical trials. They are all available in

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Information on the processes used for managing Research Passports

Indicate what processes are used for managing Research Passports

Research passports are checked in the manner described on NIHR website. Issued letters of access are recorded on a networked database accessible only to R&D Directorate staff. The database includes date of issue of the letter of access, date of CV, and whether the individual has recently undergone GCP training, and when. A Trust policy is in place.

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Information on the agreed Escalation Process to be used when R&D governance issues cannot be resolved through normal processes

Escalation Process

Issues are reported on a quarterly basis to the Risk and Assurance Committee. The committee may request detailed reporting, including root cause analysis, or reporting to a regulatory body. It could refer specific issues to the Clinical Quality, Safety ad Patient Experience Committee. The Trust also has a policy for dealing with Research Misconduct and Fraud.

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Planned and Actual Studies Register

The Organisation should maintain or have access to a current list of planned and actual studies which its staff lead or collaborate in.

Comments
A web based database (Reda), supported by an in-house Access database (newprojects) stored on the RandD network drive listing all projects is maintained by R&D staff. The R&D Office also maintains a spreadsheet that lists planned, recruiting, and closed (in follow-up) studies.

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Other Information

For example, where can information be found about the publications and other outcomes of research which key staff led or collaborated in?

Other Information (relevant to the capability of the Organisation)
The Research & Development Directorate holds lists of publications produced by Trust employees. The Deputy Clinical Librarian undertakes a quarterly search of online databases for new publications and produces a consolidated list for each calendar year in February/March of the following year.

The Dudley Group of Hospitals NHS
NHS Trust

TRUST BOARD AGENDA
Thursday 25 September 2008 at 11.00am
Clinical Education Centre

	Item		By
1.	**Chairman's Welcome and Note of Apologies –** **D. Mcmahon**		A Edwards
2.	**Declarations of Interest**		A Edwards
3.	**Announcements**		A Edwards
4.	**Minutes of Previous meeting:** • Thursday 31 July 2008 Public Board Meeting	Enclosure 1	A Edwards
5.	**Action Sheet – Progress Report by Exception**	Enclosure 2	A Edwards
6.	**Other Matters Arising**		
7.	**Chief Executive's Report**	Verbal	P Farenden
8.	**Strategic Issues** • Report on Shadow Council of Governors	Verbal	A Edwards
9.	**Operational Performance** • Corporate Performance Report Period to 31 August 2008	Verbal Report	P Assinder
10.	**Reports for Approval** • Research and Development Report	Enclosure 3	P Harrison
11.	**Information Items to be Noted** • To be Advised		
12.	**Any Other Business** • Limited to urgent business notified to the Chair/ Corporate Secretary in advance of the meeting		A Edwards
13.	**Date of Next Trust Board Meeting** • AGM – 29th September, 2008 at 6.30pm, Village Hotel • 30th October, 2008 at 11.00am in the CEC		
14.	**Meeting Closes**		

The Dudley Group of Hospitals NHS
NHS Trust

Minutes of the Public Trust Board meeting held at 11.00 a.m. on Thursday, 31st July 2008, in the Clinical Education Centre

Present:

Alfred Edwards, Chairman
Ann Becke, Non Executive Director
Denise McMahon, Director of Nursing
Paul Brennan, Operations Director
Kathryn Williets, Non Executive Director
David Wilton, Associate Non Executive Director
Roger Callender, Associate Medical Director
Paul Harrison, Medical Director
Jonathan Fellows, Associate Non Executive Director
Janine Clarke, Director of Human Resources
Paul Assinder, Director of Finance and Information
David Badger, Non Executive Director

In Attendance:

Jackie Meechan, PA

08/81 Chairman's Welcome and Note of Apologies

Apologies were received from Paul Farenden, Chief Executive.

08/82 Declarations of Interest

There were no Declarations of Interest.

08/83 Announcements

David Badger and Alf Edwards had attended a Conference on the proposed NHS Constitution. They informed the Board that a public consultation programme is to be completed by 17th October, 2008. This would be led by Dudley PCT and involve Dudley Health Economy Communications teams. Details of the Constitution are on the NHS website.

08/84 Minutes of the Previous Meeting – 26th June 2008 – Trust Board Meeting

The minutes of the 26th June 2008, Trust Board meeting, given as Enclosure 1, were approved as a correct record and signed by the Chairman.

08/85 Action Sheet – 29th May, 2008 – Progress Report by Exception

The Board reviewed the Action Sheet. There was one Item No. 08/37.1 to carryover for the Board meeting on 30th October 2008.

08/86 Matters Arising

None to report.

08/87 Chief Executive's Report

As the Chief Executive was absent, the Chairman informed the Board that Cynthia Bowers, Chief Executive for the SHA had been appointed to the post of Chief Executive Designate to the new national body, the Care Quality Commission. Peter Shanahan will take up the position of Interim Chief Executive at the SHA.

08/88 Strategic Issues

08/88.1 A discussion had taken place at the Finance & Performance Committee on 31 July 2008 following which it was agreed that a workshop would be set up for Board members to discuss capacity planning issues and hospital led reconfiguration. Alf Edwards confirmed he would send out further details.

08.88.2 Janine Clarke, Director of HR informed the Board she would bring the Workforce Strategy to the September meeting.

08/89 Operational Performance

Paul Assinder, Director of Finance & Information distributed Item 9 from the Finance & Performance Committee detailing the Trust Performance for the 3 months Period to 30 June 2008.

08/90 Reports for Approval

No reports for approval.

08/91 Information Items to be noted

The Board noted the Integrated Governance minutes for the May, June and July meetings had previously been circulated to Board members.

08/92 Any Other Business

08/92.1 Paul Brennan, Operations Director informed the Board that together with Paul Assinder, Director of Finance & Information he had been negotiating with Summit to improve the performance of IT. Matters were still being concluded, but it was hoped to expand on the PFI deal for the future and a figure of approximately £250,000 per annum was required to cover the uplift. The sign off for this was hoping to be in early August. The Board agreed the Audit Chair together with Paul Brennan and two Non Executive Directors, Ann Becke and Jonathan Fellows were to be involved in finance issues.

08/92.2 Paul Brennan, Operations Director informed the Board that work has been progressing to install a hyperbaric chamber at Russells Hall Hospital. It is planned to move the Child Assessment Unit offsite and install the chamber where the Unit is situated.

The Board was informed there will be no cost to install the chamber and it will be run by a combination of external and Trust staff. It will be one of only three in the country. A full proposal will be submitted to the Investment Committee in November, 2008.

08/92.3 Paul Brennan, Operations Director informed the Board good progress was being made to implement a second MRI scanner in the X-ray Dept. At the moment there were issues surrounding installation of the second scanner and Mr Brennan is looking at ways to overcome this.

08/92.4 Alf Edwards, Chairman informed the Board following comments from a number of members of the Shadow Council of Governors and subsequent discussions at the last Board meeting, a small group had been convened to make recommendations regarding Governor/Director communications. Notes of the meeting had been circulated for comment and a paper would be presented to the September Board meeting.

08/93 Date of Next Meeting

The next Board meeting will be held at 11.00am on Thursday, 25th September, 2008 in the Clinical Education Centre.

Signed as a correct record: …… Chairman

Date: ……

The Dudley Group of Hospitals NHS
NHS Trust

Action Sheet
Minutes of the Trust Board
Held on 31 July 2008

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
08/88.1	Strategic Issues	A discussion had taken place at the F&P Committee on 31st July 2008 following which it was agreed that a workshop would be set up for Board members to discuss capacity planning issues and hospital led reconfiguration. Alf Edwards confirmed he would send out further details.	C	25/9/08	
08/88.2	Strategic Issues	Director of HR informed the Board she would bring the Workforce Strategy to the September meeting.	DHR	25/9/08	
08/92.4	Any Other Business – Shadow Council of Governors	Paper to be presented to the September Board meeting	C	25/9/08	
08/37.1	Research and Development	Prof. G Kitas to be invited to the October Board meeting to report on clinical trials	MD	30/10/08	
08/92.2	Any Other Business – Hyperbaric Chamber	A full proposal will be submitted to the Investment Committee in November, 2008	OD	Nov 08	

Communication with the Council of Governors

Notes of the Meeting held on Friday 25 July – 10:00 am
CEO's office 'C' Block

Present:
Liz Abbiss, Paul Assinder, Janine Clarke, David Wilton, Alf Edwards (Chair)

The key points made at the session were as follows;-

As a basic principle, engagement should exist between the "Council of Governors" (CoG) and the "Board of Directors" as corporate bodies – not on an individual or group basis.

- The role, function and responsibilities of the Governor need to be re-presented to the Council.
- The 3 different groups of Governors, elected public, elected staff and appointed, may merit different types/levels of communication.
- The Trust should define the "added value" expected from the Council of Governors.
- It is critical to ensure that Board time and commitment is protected and that engagement with the CoG is properly and effectively managed.
- A quarterly report from the Board to the CoG should be given – appropriate content relating to performance to be determined.
- A quarterly report from the CoG to the Board relating to membership issues should be given.
- DW suggested that Governor resources should be "managed" by developing and effective "to do" list.
  Ideas were;-
  - Membership development & communication
  - Quarterly report to Board of Directors
  - Strategy workshop
  - Service areas where efficiency might be improved – to aid the challenging Trust cost reduction targets.
  - Areas where any available Trust capital resource might be directed.
- All membership issues/proposals to be supported by quantified actual levels of support.

For action

• Share Notes of discussion with Denise McMahon	ARE
• Produce Board paper	ARE
• Review Job Description for FT Manager	PA/DM
• Review Terms of Ref. for Nomination/Remuneration Committee	ARE

A R Edwards
26 July 2008

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board**
Report by: **The Medical Director**
Subject: **Research & Development**
Date: **25 September 2008**

Summary

The Clinical Research Unit facilities continue to impress visitors to the Trust. The Comprehensive Local Research Network (CLRN) recently commissioned an article and photographs of the Unit to be included in a newsletter disseminated to 18 local NHS Trusts. The conversion of a clinical preparation room to additional laboratory space to accommodate genotyping equipment is planned.
Blocks to recruitment to UK Clinical Research Network (UKCRN) recognised oncology studies remains a concern. One 0.6 WTE research nurse commenced in May 2008 and interviews took place in early September for a pharmacist and pharmacy technician. Georgina Day Case Unit capacity is still an issue. An additional FT research nurse, once in post, will spend 0.4 WTE administering chemotherapy in an effort to resolve this problem.
Two TRACE RA (rheumatology) sub-studies will attract UKCRN funding support; a £30,000 grant has been secured from Wyeth to produce a commissioned audit report.

(a) Funding: The new funding mechanism via BBC CLRN commenced on 01/04/2008. Allocations were confirmed in early September. Including DH transitional funding, the Trust has received £322,181 for 2008/09. Future funding is dependent on successful recruitment to eligible UKCRN studies.

(b) Activity: There are currently >130 active studies and approximately 55 research active professionals. Recruitment to cancer studies is slightly below target – 38 against a target of 46 randomisations in 5 months, a picture repeated in other local Trusts. Target is 111 randomisations during 2008/09. TRACE RA, the rheumatology study co-sponsored by the Trust, continues to recruit steadily (107 randomisations to date in Dudley since June 2007) and 48 centres open to recruitment nationwide.
Recruitment to 4 commercial studies opening to recruitment during 2008 has been disappointing, but new studies are being set up to replace these. However, one study has recruited extremely well.
MHRA inspectors visited the Trust in May to monitor a commercial study. The sponsors were extremely pleased with the findings: no major shortcomings.
More than 40 papers authored by Trust staff have been published in peer-reviewed scientific journals during the 2007-08 financial year.

(c) Education and Training: 10 members of staff will complete the 3-day research and audit methodology course during September 2008 and for the first time will be facilitated entirely by Trust staff. Online Good Clinical Practice training continues to be available. The Trust also hosted a 3-hour GCP training update session in July 2008, open to all researchers within the Trust and Greater Midlands Cancer Research Network.

(d) Research Governance Implementation: A total of 15 projects were assessed by the protocol review sub-committee from 04/03/2008 to 03/09/2008; all were approved.
Reported Serious Adverse Events: 4 relating to the TRACE RA study locally and nationally; 9 relating to other (oncology) studies.
A new policy to cover all types of research on incapacitated patients has been produced and the research indemnity policy has been revised.

(e) Issues: The single most important objective is to sustain and improve recruitment levels by maximising recruitment opportunities and opening new UKCRN recognised studies, particularly in oncology. This is currently slow because of the administrative burden, the time needed to complete pre-printed prescriptions for safety reasons, and familiarisation of Day Case staff with new chemotherapy regimes.

Recommendations

It is recommended that the Board acknowledges this report and asks that it continue to be kept informed of Research & Development issues on a six monthly basis.

The Dudley Group of Hospitals NHS
NHS Trust

Public Trust Board Agenda
Thursday 27th September 2007

	Item	Time	By
1.0	**Chairman's welcome and note of apologies**	1 min	A Edwards
2.0	**Declarations of Interest**		
3.0	**Announcements**		
4.0	**Minutes of the previous meeting: -** o 14th June 2007 Public Trust Board Meeting o 2nd July 2007 Trust Board Session - Action Planning for Foundation Trust Status o 19th July 2007 Extraordinary Board Meeting – Action Planning for Foundation Trust Status	2 mins Enc 1 Enc 2 Enc 3	A Edwards
5.0	**Action Sheet – Progress Report by Exception**	2 mins Enc 4	A Edwards
6.0	**Matters Arising**	10 mins	A Edwards
7.0	**Chief Executive's Report**	10 mins	P Farenden
8.0 8.1 8.2	**Strategic Issues** **Foundation Trust Issues (Appendix 2 to follow)** **New Board Agenda – Strategy** **Discussion on proposed indicators/dataset for strategic reporting and review**	30 mins Enc 5 App1 App2 Enc 6	Papers from L Williams, presented by P Farenden
9.0	**Operational Performance:** Exception reports to highlight concerns in the following areas, with information presented graphically: o Finance o Efficiency o Patients' experiences o Clinical quality o Access and targets	15 mins Enc 7	P Assinder
10.0	**Regular Scheduled Reports for Approval:** o Human Resources o Disposal of Guest Hospital site to English Partnerships [provisional]	15 mins Enc 8 Enc 9 To follow	J Clarke P Brennan
11.0	**Information Items to be noted** o Audit Committee Annual Report 06/07 o Charitable Working Funds Committee Minutes o Research and Development o Clinical Audit Report * o Integrated Governance Report * * These reports are available on the Trust web site at www.dgoh.nhs.uk	1 min Enc 10 Enc 11 Enc 12	P Assinder P Assinder P Harrison A Close A Close
12.0	**Any Other Business:** o Limited to urgent business notified to the Chair/Trust Secretary in advance of the meeting		

13.0	Date of Next Trust Board PUBLIC Meeting: **Thursday 20th December 2007 at 11.00 am in the Clinical Education Centre.**		

ENCLOSURE 1

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

PUBLIC TRUST BOARD MEETING

MINUTES OF THE MEETING HELD ON THURSDAY 14th June 2007 at 9.00 am AT DUDLEY CLINICAL EDUCATION CENTRE, RUSSELLS HALL HOSPITAL

Present:	**Mr A Edwards (in the Chair)**	**Mr P Brennan**
	Mrs H Boszko	**Mr P Harrison**
	Mr D Badger	**Mr D Ashfield**
	Mr P Assinder	**Mr L Williams**
	Mrs A Close	**Mrs K Williets**
	Mr P Farenden	

Action

Also in Attendance : Clare Craddock
Express & Star Reporter

131/07 **APOLOGIES FOR ABSENCE**
Apologies were noted for Mrs Janine Clarke, Mrs Ann Becke and Mr Roger Callender.

132/07 **DECLARATIONS OF INTEREST**
There were no declarations of interest.

133/07 **ANNOUNCEMENTS**
No Announcements.

134/07 **MINUTES OF THE MEETING HELD on 10th May 2007**
The minutes of the meeting dated 10th May 2007, were noted with amendments to the Audit Committee Section. The following points are to be added to the minutes;-

The Audit Chair, David Ashfield reported that a number of issues had arisen at the Audit Committee which were to be brought to the attention of the Board: -

134.1 Deployment of Clinical Services – because of items raised by internal audit, it had been agreed at the Finance and Performance Committee meeting, that a plan of action from the Director of Operations be brought to the Finance & Performance and Audit Committees as soon as possible.

134.2 The Audit Committee had noted issues regarding the Pharmacy stocks; in particular the security issues had been raised in two successive audits. A plan of action had been requested.

134.3 The Audit Committee had concerns over timeliness of progress of the action plans in response to Audit recommendations. The responsible Managers were to be challenged to respond to this point, and a report had been requested to come back to the Audit Committee.

135/07 **CHIEF EXECUTIVE REPORT**
The Chief Executive highlighted the following issues of interests: -

135.1 New Strategy Framework – Investing for Health
It was reported that the new Strategy Framework – 'Investing for Health' would be officially launched on 25th June - going public in November this year. It will not only include financial issues but also how to improve the health of the population.

135.2 Annual Health Care Commission Ratings 2006/2007
Inspections started in June with random/selected visits. The Publication is due out October 18th 2007.

135.3 Single Sex Wards
Following on from the statement published by the SHA, which commented that Russells Hall Hospital did not operate a fully single sex ward system, the Chief Executive reported on a conversation he recently had with Cynthia Bowers, Chief Executive of the SHA,, who apologised for the incorrect statement and confirmed that Russells Hall Hospital should not have been added to the list. A statement from Cynthia Bowers was issued as a formal apology to the Trust.

135.4 Capacity Management – West Midlands Ambulance Service

It was reported that WMAS no longer wished to host the Capacity Management Team. Paul Brennan was presently engaged in discussions with WMAS as to the implications of this and to report back at next Board.

135.5 LDP

The LDP was signed off Nationally by the NHS Chief Executive, and the process was now complete.

135.6 Cancer Network Board

Paul Farenden announced that he had been appointed Vice Chair of the Cancer Network Board for future meetings.

135.7 Prime Minister's Visit

It was reported that the Prime Minster's visit had been considered a great success by the staff The Chief Executive expressed the Trust's gratitude to all the staff involved in organising the visit.

MATTERS ARISING FROM THE MINUTES

136/07

REPORTS FOR RECOMMENDATION/APPROVAL

137/07 **APPROVAL OF 2006/2007 ANNUAL ACCOUNTS & STATEMENT OF INTERNAL CONTROL**

Following detailed debate on the draft accounts at Finance and Performance Committee, the Finance Director updated the Board on the annual accounts and statement of internal control approval. The auditors had completed the work on the accounts and a clearance meeting had been held. The Trust Board approved the accounts for 2006/2007.

9.25 am Chairman Alf Edwards temporarily left the meeting and handed over to Vice Chair Kathryn Willets to continue in his absence.

REPORTS RECEIVED BY THE BOARD FOR INFORMATION

138/07

DIRECTOR OF HUMAN RESOURCES REPORT

The Board noted the report of the Director of Human Resources for information.

139/07

FINANCE & PERFORMANCE COMMITTEE & REPORT

The minutes of the meeting held on 8th May 2007, were noted and agreed by the Board as a correct record.

140/07

THE DIRECTOR OF FINANCE REPORT

The Director of Finance & Information presented his report to the Board. Mr Assinder reported that the figures showed a mixed start to the new financial year with some early slippage against plans to increase elective workload in out patients, day cases and in patient elective areas to achieve 18 week waiting targets. However this was mainly the result of a lack of detailed scheduling information in the first month of the year and he expected the early shortfalls to be smoothed out once the Operations Directorate produces detailed workload plans.

There was concern about a significant breach of outpatient waits caused by the paucity of information available to scheduling staff during the period of PAS implementation. This problem had been rectified and lost appointments were expected to be reinstated by end of June. The Operations Director was to provide a full report to the Trust Board on the PAS Project in order that lessons may be learned for the future. It was also agreed that this item would be discussed on the Finance & Performance agenda at the July meeting.

At the end of Month One, the Trust recorded an I&E surplus of £1,126,000, which represented a slight underachievement of the period plan. The position needed to be treated with a degree of caution given the early point in the year. This position is £0.6m behind plan for the period, made up of an under-recovery of £0.4m against income, and £0.2m overspends against budgets, offset by lower than planned depreciation. The Finance Director stressed that whilst the income was behind plan, the comments on the fragility of early phasing of additional 18 weeks activity targets should be borne in mind, with also, significant reserves that have not yet been released into the position.

The report was noted and acknowledged by the Board.

141/07

AUDIT COMMITTEE REPORT

The Audit Committee Chair Mr David Ashfield gave a report on the meeting of the Audit Committee held on 13th June 2007 as follows: -

a) Procurement and receipt material services – A report had been received from the Head of Procurement, confirming that all the outstanding items agreed on the management action plan had been actioned.

b) Pharmacy Stocks and Stores – It was reported that action plans were in place to address the issues raised in this audit report. Due to the operational nature of the issues raised, a full action report was to be brought to the June Finance and Performance meeting.

c) The Annual Internal Audit Report had indicated a 'substantial' assurance rating on the audits carried out in 2006/2007. Mr Ashfield commented that this was an excellent result for the Trust.

d) It was reported that Mr Miah on behalf of Pricewaterhouse Coopers the external auditors had signed off the Accounts with an unqualified opinion. Mr Ashfield commented that the reports from internal audit and external audit reflected the excellent financial performance by the Trust in 2006/2007, and that the Trust staff should be congratulated.

142/07

UPDATE ON FT APPLICATION

The Corporate Development Director updated the Board on the current situation on the FT Application, following on from the Monitor Board to Board meeting in London earlier this month.

143/07 **ANY OTHER BUSINESS**

144/07 **CONSULTANT INTERVIEW PROCESS**

Non Executive Director David Badger reported on recent issues concerning the interviewing process for Consultants. The Board were updated on a recent incident that needed to be noted and actioned. The interviewing process was to be updated by Paul Brennan and David Badger and brought back to the board for approval in July. In the meantime the Board agreed that the Operations Director and the Medical Director could decide to proceed with an interview with only one candidate if there were exceptional circumstances such as a nationally recognised shortage.

There being no other business the Public Trust Board meeting closed.

145/07 **DATE OF NEXT MEETING PUBLIC MEETING**

Next Meeting: To Be Advised.

ENCLOSURE 2

The Dudley Group of Hospitals NHS
NHS Trust

NOTES OF TRUST BOARD SESSION, MONDAY 2ND JULY 2007

ACTION PLANNING FOR FOUNDATION TRUST STATUS

Present:

Alfred Edwards	Paul Farenden
David Ashfield	Paul Assinder
Ann Becke	Paul Brennan
Hilary Boszko	Janine Clarke
Kathryn Williets	Ann Close
Les Williams	Paul Harrison

1. Apologies

David Badger

2. Introduction

2.1 Purpose of Session

The Chairman explained the purpose of the session in the context of the last two weeks which had been difficult. The Trust Board was unused to being considered as a failure and it had been difficult to adjust. The approach developed and the case put to Monitor had been signed up to corporately. The purpose of this session therefore was to move forward positively and constructively, to identify what we now need to focus on and to develop plans to put this work in place. In addition we would need to ensure that we provided effective processes for checking progress against this work plan.

The issues identified to Monitor in the request for self deferral were listed on the agenda circulated by Les Williams prior to the meeting. This also covered issues from the Ernst and Young Due Diligence report and the issue of Information and IT, from a discussion amongst Executive Directors.

It was important to learn from the assessment and Board to Board processes. It would be important to take account of the changing perspective and challenges from Monitor and to ensure that when we re-enter the assessment process, we are confident of succeeding.

2.2 Update from Monitor Board

Paul Farenden reported on the content of his telephone conversation with Stephen Hay on Friday 29th June 2007, after the Monitor Board meeting. He indicated that:

- The Trust's request to self defer had been agreed.
- Monitor felt we may need longer than the timeframe we had suggested. This would be for the Trust to determine, but Monitor's view was that this may be between 9 and 12 months.
- Monitor had confidence that the Trust would respond to the financial issues raised and go back with an appropriate robust financial case.

- More time was needed to develop the strength of the challenge from Non Executives. Some 'refreshment' may be required. Monitor suggested that the Trust undertakes an assessment process for the Non Executives which would lead to development or some replacement on the Board.

To ensure absolute clarity about these issues and Monitor's requirements, Paul had suggested that he and the Chairman meet with Stephen Hay and Bill Moyes and this had been welcomed and agreed for Monday 9th July at Monitor's offices.

Ann Becke queried how we would measure that what we are doing is appropriate and that we have improved, to ensure we are successful next time. It was felt that this was indicated in the nature of the issues we had identified to Monitor that we felt we had to address. Ann felt that external validation would be required and noted that this was mentioned in several areas identified on the agenda.

Hilary Boszko was unsure how Monitor had made their assessment of the level of challenge offered by the Non Executives, as there had been minimal contact with the Assessment Team. Paul Farenden suggested that Monitor's view was based on the content of the IBP and that this had not been challenged by Non Executives, in combination with the poor performance at the Board to Board meeting. Hilary also felt that we needed to change fundamentally how we recorded Board activity and discussion.

3. Indicative Timetable

The Indicative Timetable given on the agenda was now inappropriate, given the comments from Monitor.

It was agreed that the timeframe for seeking re-assessment would be determined by the actions we needed to address and undertake. This needed a careful judgement. Although the tendency would be to return to the process as early as possible, we had to be certain that we had completed all the action necessary and that we had the detailed evidence available to support our case. If we returned too early, evidence would not be available to an appropriate level to ensure success. Paul Assinder indicated a concern about the financial case being adversely affected by the change in the NHS financial regime and environment and that this would worsen the more time that passed.

It was clarified that the Enterprise Programme was expected to begin implementation from 1st September 2007, so that the Trust would be able to increase its catchment population or reduce its cost base from 1st April 2008. This may be sufficient to give Monitor confidence but it would be necessary to provide evidence of robust plans for cost reductions in 2008/09 (and future years) and agreements from GPs to move activity to us (this would be required for LDP planning for 2008/09).

The Trust Board agreed to aim for an authorisation date of 1st February 2008.

This would require a Board to Board meeting in January 2008, preceded by the Assessment Team working with us from November 2007. This timetable would necessitate us declaring ourselves ready for re-assessment by October 2007. Les Williams indicated that at this stage, it remained unclear as to the nature of the re-assessment process. This timeframe was correct if a full re-assessment and due diligence process were to be undertaken, but this may need adjustment after the meeting next week with Monitor.

4. Agreed Issues to Address and Action Planning

4.1 From Monitor

These were confirmed as:

- **Further development, evaluation and inclusion of Enterprise programme**
  - Changed models of care and implementation from 1st September 2007
  - Identified impact on CIP delivery for 2008/09
  - Linkage to Capacity Plan
  - External validation (analysis of other FTs' practices)

- **Improvement of CIP planning, control and reporting**
  - Robust process for generating ideas for CIP
  - Appropriate challenge from NEDs
  - Effective controls and reporting
  - External validation (analysis of other FTs' practices)

- **Revision of base case financial model**
  - Review of income and activity growth projections (esp. from 2009/10 onwards)
  - Definition of stepped cost increases
  - Delivery of increased CIP
  - Review of contribution rate from additional work undertaken
  - Development of single transparent plan
  - Capacity plan linked to activity and financial model to assure of proper planning for activity changes – bed occupancy and use of facilities
  - External testing of our assumptions (benchmarking)

- **Development of more comprehensive Assurance Framework**
  - Board to review structure of Assurance Framework using new external facilitation
  - More detailed plans for current and future years to close gaps in control and in assurance

- **Strengthen NED scrutiny and challenge**
  - Introduce current corporate finance and governance skills
  - Review how NEDs provide scrutiny and challenge in Board and committees
  - Provide development programme for NEDs to improve skills in challenge and scrutiny

- **Other Issues**
  - Increase public FT members
  - Changed board composition

The Board agreed to establish workstreams for each area of concern that would drive forward the issues and develop the Trust's approach for review and scrutiny at the full Board, before incorporation into the Trust's re-submission for assessment.

- **Further development, evaluation and inclusion of Enterprise programme**
- **Improvement of CIP planning, control and reporting**
- **Revision of base case financial model**

As these were inextricably interlinked, they were debated together.

It was confirmed that all Board members had been invited to attend the 12th and 13th July Away Days on Enterprise. Paul Brennan indicated that there were three possible outcomes from the Enterprise Programme:

- Increase efficiency and release capacity
- Secure agreements with GPs in Sandwell and Wyre Forest to transfer work to us
- Additional patients coming to us

In time for the re-assessment, it was possible to deliver the first two of these, but not the third. The plan therefore had to be predicated heavily on securing the capacity release and removing costs. It would be a further step then to grow activity, but the Trust's financial case could not be predicated on this basis. Monitor appeared to be more comfortable with the ability of NHS Trusts to secure cost reductions than to achieve activity growth. Hilary Boszko indicated that it may be possible to evidence potential for activity growth by surveying GPs as to their propensity to re-direct referrals to this Trust.

Paul Assinder and Les Williams commented on the concern of Monitor about activity growth assumptions, particularly around A&E attendances, direct access services and elective growth from 2008/09 onwards. Paul indicated that the Long Term Financial Model would need to be adjusted to take account of Monitor's views and using the standards and parameters that Monitor employed, such as 6% EBITDA, 30% contribution rate, CIP of at least 2.5%, or £5m per year.

The financial case would have to be clear and unequivocal and the debate around the assumptions used and included, and the outcomes from the further reiteration of the modelling, would need to be evidenced in detail.

Paul Assinder felt that obtaining Monitor's assessor case would be helpful as a further test of our assumptions and the outcomes of the revised base case.

David Ashfield indicated that this would need to be tested at the level of each service, so that we would review the profitability of each service line. Where this was not working in delivering profit, it would indicate areas for revisiting.

In re-presenting the case, the Board felt that it should be presented in a succinct format, which was readable and clear, identifying only the fundamental issues. Hilary Boszko was of the view that as these skills were not available in the Trust, it would be necessary to obtain them from management consultants.

The Board agreed to review the assumptions used for the base case financial model, the outcomes planned and delivered by the Enterprise programme, and CIP planning and delivery, to identify the evidence supporting these, to ensure external validation of the robustness of the assumptions made, and to challenge the assumptions and the outcomes through the Board.

This work would need to be completed by early September to allow judgements to be made on securing increased contracts for more activity in 2008/09 LDPs or to enact triggers to achieve cost reductions. It was also agreed that the approach on CIP would be to identify the capacity release to be delivered by Enterprise as a cost reduction, to remove the costs and then to reinvest these savings to secure activity growth as new activity. This would concentrate on the planned and delivered outcomes and not on the delivery vehicle of the Enterprise Programme.

- **Development of more comprehensive Assurance Framework**

Ann Close reported that the Integrated Governance Committee had received a paper last week on strengthening the Assurance Framework. Following a discussion with Paul Assinder earlier, Ann indicated that this would require a review of the Trust's business objectives and importantly the identification of risks which were consequent upon them.

The Board agreed that it would undertake this work itself and then seek external validation on the process and outcomes as part of achieving appropriate assurance.

The Board agreed that each of the workstreams would identify risks relating to the issues, plans to mitigate or remove those risks and any potential gaps in control and gaps in assurance, leading to further plans to close these gaps.

The Board agreed to the inclusion of external validation reports on the top risks into the reports made to Board meetings, so that it becomes an explicit part of the expected process.

- **Strengthen NED scrutiny and challenge**

Further discussion on this issue would take place after the outcome of the meeting with Monitor on Monday 9th July was known.

- **Other Issues**

Les Williams reported on the progress made to date with The Campaign Company on recruiting 400 additional FT public members in one week, targeted at the areas of Tipton, Rowley Regis and Wyre Forest. He undertook to circulate the specification for this service to Board members.

The Board agreed that a regular report on membership should be made to the Finance and Performance Committee.

It was noted that growth in membership would be an annual requirement from Monitor and Les would assess how this could be achieved for future years in the light of experience of using this external company. This would lead to a recurrent funding requirement.

Les would research the number of FT members at the time of authorisation of recently authorised FTs.

The Board agreed to seek clarification from Monitor on the issue of whether or not this significant increase in public membership numbers had any impact on the validity of the elections already undertaken in February/March 2007, particularly if the Trust was not authorised for a further 9 to 12 months.

The issue of Board composition would be discussed after the meeting with Monitor on Monday 9th July.

4.2 From Ernst and Young Stage 2 Due Diligence report

The agenda identified the Summary of Key Findings from the Ernst and Young report.

The Board noted that the leads for each of these and timeframes for reporting on completion to the Board had been agreed at the Board meeting on 14th June 2007, and these were re-confirmed.

These are given at Appendix 1.

There were two further issues which had been raised in the final report, which were not included in Appendix 1:

- **The Trust should review its process for managing large change projects**

The Board agreed that Janine Clarke would review the Service Improvement System change methodology as the basis for this, and ensure Non Executive involvement at an appropriate stage and effective reporting mechanisms.

- **Ensure the draft IT Disaster Recovery, Business Continuity Plans and Internal Major Incident Plan were ratified by the Board as soon as possible**

The Board agreed that the Major Incident Plan, for external major emergencies, would be presented to the next Trust Board by Paul Brennan for information.

The Board agreed that the completion of the IT Disaster Recovery, Business Continuity Plans and Internal Major Incident Plans would be overseen by the Integrated Governance Committee, which would need to advise on timeframes for completion and presentation to the Trust Board for debate and agreement.

- **IT and Information**

Although not picked up in detail by either Monitor or Ernst and Young, the Board felt that IT and Information were issues for debate to ensure more focus on strategy, monitoring progress and linkage to achieving operational and strategic goals. There was a lack of clarity about the Trust's IT Strategy and Ann Becke expressed considerable concern over the issue of remote access to Trust systems. This was indicative of an inability to complete projects to agreed timeframes. It was noted that there were many IT projects being undertaken which lacked focus and prioritisation and this would need to be resolved. Ann Becke offered to identify an expert on health IT to provide external assurance for the Board.

The Board agreed that there was a need to identify and pursue only those IT projects which were core to delivering the Trust's strategy and business objectives.

This needed to include a review of the organisational arrangements for managing IT and the relationships with Siemens Healthcare Systems and Connecting for Health.

5. Next Steps – Way Forward

The Board agreed that the Executive Directors would develop a plan on how to address each of the following issues, and return with this for debate with the full Board on Thursday 19th July 2007 from 11am to 2pm:

- Activity levels and assumptions
- Capacity release and capacity planning
- CIP planning and delivery
- Increasing market share
- Presentation of the Trust's proposals to Monitor
- Information and IT

All of these would take into account:

- Monitor's targets, parameters and expectations
- Risks to be identified and responded to
- Controls to be put in place
- Evidence to be provided or sought
- Identification of from where and how assurance can be provided to the Board

The plan would indicate how these issues will be assessed and addressed, who will lead and to what timescales.

The Board agreed that a Non Executive Director should be assigned to each workstream.

6. Any Other Business

6.1 Timing of Finance and Performance Committee and Trust Board

The Chairman raised this issue in the light of the changed dates for the Finance and Performance Committee, consequent upon the need to sign off the monthly reports to Monitor, within authority delegated by the Board, from when the Trust is authorised. He suggested that the date of the Trust Board itself should be moved to the last week of the month as well, to follow the Finance and Performance Committee, so that the Board could deal with issues within the month following month end, rather than having to wait for five or six weeks after month end. It may be feasible to follow on from the Finance and Performance Committee with the Board meeting. This would require detailed timetabling.

The Board agreed that Les Williams would develop a proposal for discussion to address dates and agenda structure.

Page	Section	Recommendation	Lead	Agreed Action	Date	Report to
47	High Level Controls	Cash Flow & Ratio reporting	DoF	1)Include monitor ratios & 3 year cash forecast		
				in monthly report to F&P Committee	Jul-07	F&P Committee
50	Risk Management	Assess benefits of Level 3 NHSLA	DoF	2) Cost benefit analysis to F&P Committee	Jul-07	F&P Committee
			DoN	3) Prepare Action Plan with DoOp	Sep	Trust Board
51	Risk Management	Strong arrangements for CIPs	DoF	4) Agree CIPs reporting arrangements (exceptions)	Jun	F&P Committee
			CE	5) Cex to review CIP development arrangements	Jul	Trust Board
54	Mgt Reportg Framework	Develop CSU Flas Reporting	DoF	6) Agree prog for CSU sign off of bespoke reports	Jul	F&P Committee
			DoOp	7) report to Audit Committee on effectiveness	Oct	Audit Com
57	Finan Controls	Cash & Ratio reporting	DoF	as (1) above		
58	Finan Controls	Ref Costs to inform CIP alloc	DoOp	8) Report to F&P on ref costs/tariff in Enterprise	Sep	F&P Committee
61	Audit Arrangements	LCFS guidance on whistleblowing	ACChair	9) Chair of Audit to review role of LCFS in		
				whistle blowing policy & recommend		
				plans to improve profile.	Sep	Audit Com
65	IT Arrangements	DR, Bus Contin & Major Incident				
		Plans to be agreed & ratified.	DoOp	10) Status Report to Trust Board	Jul	Trust Board
				11) TB consideration of DR Plan	Sep	Trust Board
				12) TB consideration of Business Continuity Plan	Sep	Trust Board
				13) TB consideration of Maj Incident Plan	Sep	Trust Board
66	IT Arrangements	Communicate IT vision to Siemens	DoOp	14) strategic Away days with Siemens	Jul	F&P Committee
				15) Agree Actions from Away Day & act	Tba	F&P Committee

The Dudley Group of Hospitals NHS
NHS Trust

ENCLOSURE 3

NOTES OF EXTRAORDINARY BOARD MEETING
THURSDAY 19TH JULY 2007

ACTION PLANNING FOR FOUNDATION TRUST STATUS

Present:

Alfred Edwards, Chairman
David Ashfield, Non Executive Director
David Badger, Non Executive Director
Hilary Boszko, Non Executive Director
Paul Farenden, Chief Executive
Paul Assinder, Director of Finance and Information
Paul Brennan, Operations Director
Janine Clarke, Director of Human Resources
Ann Close, Nursing Director
Les Williams, Director of Corporate Development

In attendance:

Tracy Simmons, PA to Chair and Chief Executive

Apologies:

Ann Becke, Non Executive Director
Kathryn Williets, Non Executive Director
Dr Paul Harrison – Medical Director

Minutes of an Extraordinary Board meeting to discuss Action Planning for Foundation Trust status, held at 10am on Thursday 19th July 2007

07/07 Announcements

07/07.1 Special Audit Committee Meeting

David Badger, Non Executive Director (NED), asked that the Board minutes record that he had requested a Special Audit Committee meeting to discuss the final Due Diligence Report from Ernst & Young. In his view, there were serious differences between the levels of assurance given by both the External and Internal Auditors and the opinion given in Ernst & Young's Due Diligence Report, in which they were not able to give a clean audit opinion on the Trust's Financial Reporting Procedures. This meeting will take place on Monday 30th July 2007.

The Board noted the request and the date of the Special Audit Committee meeting. (A1)

07/07.2 Support to Trust Board and Committees

Les Williams, Director of Corporate Development (DCD), updated the Board on revised arrangements to support the minuting of the Board and its Committees. From Wednesday 18th July, Tracy Simmons, PA to the Chair and Chief Executive, had agreed to undertake an expanded role in providing committee support. To assist in this, it may be helpful to record all meetings. Board members were asked if there were any objections for all Board and Committee meetings being taped. Hilary Boszko, NED, raised the issue of security and it was agreed that once the Chairman had signed the minutes as approved by the Board, the tapes would be wiped clean.

The Board approved the request for recording equipment to be used in all Board meetings and Committee meetings. (A2)

07/07.3 Circulation of Board and Committee Minutes

Hilary Boszko also proposed that minutes of the Board and its Committees should be circulated in draft format within a working week of the meeting being held.

The Board agreed that minutes of Board and Committee meetings would be circulated in draft within a working week of the meeting being held. (A3)

07/08 Minutes of the Extraordinary Board Meeting on Action Planning for Foundation Trust Status held on 2nd July 2007.

Les Williams, DCD, asked the Board to approve the minutes of this meeting which had been previously circulated.

Under 'Other Issues' (para 4, page 5), it was agreed to amend the statement, 'the Board agreed to receive a regular report on membership at the Finance and Performance Committee and the Trust Board' to remove the reference to a report to the Trust Board as this would be unnecessary duplication..

Paul Brennan, Operations Director (OD), queried the action (para 4, page 6, in the bullet point: 'Ensure the draft IT Disaster Recovery, Business Continuity Plans and Internal Major Incident Plan were ratified by the Board as soon as possible'
This read 'The Board agreed that the Major Incident Plan, for external major emergencies, would be presented to the next Trust Board by Paul Brennan for debate and agreement'. Paul Brennan reported that the Major Incident Plan was already in place and that therefore the report should go to the Board for information only, not debate and approval. The Board agreed this.

The Board agreed that these amendments should be made to the minutes, which were then agreed as a correct record. (A3)

07/08.1 Purpose of Session

Alfred Edwards, Chairman, explained that the purpose of this meeting was to agree the detailed plans for the workstreams established by the meeting held on 2nd July 2007. The Executive Team had developed detailed plans and had added several planning areas, to ensure a comprehensive approach. A proforma had been developed which allowed for brevity and consistency in plans and their monitoring at Board and Committee level.
.
The proformas for each work stream, most of which had been previously circulated, for discussion and approval, were:

- Strategy/Business Objectives, Activity Levels and Assumptions, Capacity Release, Capacity Planning, CIP Planning and Delivery, Increasing Market Share
- Presentation of Proposals
- Information and Information Technology
- Membership Numbers
- Managing Large Change Projects (tabled)
- Major Internal Incident Plan, Disaster Recovery/Business Continuity Plans including IT
- Strengthening Assurance Framework
- Compliance with National Core Standards and Targets
- Effective NED Challenge (tabled)

07/09 Discussion and Approval of Workstream Plans to Achieve Authorisation

The Board discussed issues of principle concerning the pursuit of authorisation.

07/09.1 Overall Strategy

The comments made by Monitor on the Trust's application had been discussed in detail prior to this meeting and the importance of a single, clear cohesive plan was reiterated by Board members. This meant that the emphasis on setting the strategy needed to be placed on cost reduction and efficiency leading to capacity release. It would only be possible to plan to use released capacity if there were signed agreements with GPs or PCTs for the transfer of appropriate levels of activity to this Trust.

The Board agreed to base its overall strategy and financial planning on delivering cost reductions and capacity release. (A4)

07/09.2 Date for Re-submission of Application

Board members noted that Monitor would require two to three months' notice of the Trust's readiness for re-assessment and for the process leading to authorisation to be completed. Several dates were discussed, trying to balance the need to achieve authorisation as soon as possible with the need to ensure that the application was fully successful when re-assessment was requested. It was felt that there was value in ensuring the Trust was fully ready for authorisation before returning to Monitor.

The Board agreed to work to be ready to request re-assessment by Monitor by the autumn of 2007, leading to potential authorisation in early 2008 (A5)

07/09.3 Non Executive and Executive Director Leads

Each workstream had been allocated a suggested lead Non Executive Director. David Ashfield, NED, queried the basis on which these had been proposed. Les Williams, DCD, indicated that it was hoped that the NEDs would provide effective challenge throughout the development and implementation of the plans. The allocation had been made based on known current involvement or lead responsibilities and then to ensure that all NEDs were involved in at least one workstream. David Ashfield indicated his wish to provide challenge to the CIP elements of the workstream. It was suggested that Executive Director leads should also be assigned.

The Board agreed that the NEDs should be assigned to workstreams as proposed, with David Ashfield providing challenge to the CIP element of the workstream, and that an Executive Director would be identified to each workstream (A6)

The Board agreed that Janine Clarke, Director of Human Resources, (DHR), would organise a development session for NEDs to consider and develop skills in effective challenge and scrutiny. (A7)

07/09.4 Relationship of Workstreams with Enterprise Programme

Given the detailed planning work currently being undertaken following the Enterprise Programme away days in the previous week, Paul Brennan, OD, suggested that it was essential to align this activity with the workstream plans.

The Board agreed that Executive Directors would align these two planning activities and raise any problems or issues with Board members by Friday 27th July, 2007 (A8)

07/09.5 Format of Workstreams/Plans

Les Williams, DCD, explained the format of the Workstream Plans, as a means of bringing together all the elements required, including a clear statement of Monitor's expectations and requirements. This had been taken from the letter from Monitor agreeing our self-deferral, their feedback to the Chair and Chief Executive and Ernst & Young's final letter.

The Board agreed that Non Executive Directors would notify Les Williams of any proposed additions to the sections of the workstream plans on Monitor's targets, parameters, expectations, by Wednesday, 25th July 2007 (A9)

Ann Close, Nursing Director (ND), indicated that further work needed to be done to reflect the risks properly.

The Board agreed that Ann Close, ND, and Paul Assinder, Director of Finance and Information (DFI), would meet with lead Executive and Non Executive Directors for each workstream to complete the Risk sections. (A10)

07/09.6 Discussion of Individual Workstream Plans

The Board discussed the individual workstreams and made the following comments or amendments:

a) Strategy/Business Objectives, Activity Levels and Assumptions, Capacity Release, Capacity Planning, CIP Planning and Delivery, Increasing Market Share

The combination of these separate elements of work was felt to be sensible, although the scale of work in the timeframes suggested was felt to be challenging.

Amendments were:

- **Monitor's targets, parameters, expectations – Strategy/Business Objectives**
  Amend to reflect 'achievement of at least 6% EBITDA per year in base case', 'In downside case, achieve surplus each year' and 'achieve balanced working capital position each year'

- **Monitor's targets, parameters, expectations – Activity Levels and Assumptions**
  Amend third bullet point to read 'Reduced forecasts for elective and outpatient activity growth'.

- **Proposed Workplan: Action**
  Under the heading 'Quality', amend to read: 'Identify targets for infection rates, mortality rates, re-admission rates, patient satisfaction results, patient safety indicators'.

  Under the heading 'CIP Planning and Delivery', amend third bullet point to read 'Initial proposals, challenge and firm plans for 2008/09 and 2009/10 (£5m per year)'.

  Under the heading 'Mitigation Plans', ensure that dates are reconciled with dates in Workstream Plan 'Strengthening Assurance Framework'.

With these amendments, the Board approved the workstream plan (A11)

b) Presentation of Proposals

Amendments were:

- **Proposed Workplan: Action**
  Amend fourth bullet point to begin 'Revise sections not dependent on LTFM…'

  Amend sixth bullet point to remove reference to 'from management consultancy', and to reflect this in the section 'Controls in place or required', second bullet point.

With these amendments, the Board approved the workstream plan (A12)

c) Information and Information Technology

The Board approved the workstream plan (A13)

d) Membership Numbers

Given the higher profile on membership numbers than anticipated, the amendment was:

- **Proposed Workplan: Action**

Add bullet point to read: 'Maintain observation of changes in political emphasis'.

With this amendment, the Board approved the workstream plan (A14)

e) Managing Large Change Projects

Janine Clarke, DHR, tabled this workstream plan and a supporting paper 'Managing Large Scale Change Initiatives'. This recognised the need for the Trust Board to have a recognised and consistent change management methodology through which all significant changes within the Trust should be managed.

The Board noted that other than Programme Enterprise, there was no consistent, organisational wide approach to change in the Trust. It was therefore recommended that this be addressed as below:

- All large scale change should be approved and monitored by one group, to ensure that projects are aligned and that effort and resource is focussed on those changes that are likely to have the greatest positive impact on organisational performance.
- The three options for this managing group were:
  - Finance and Performance Committee
  - Integrated Governance Committee
  - A specialist change management board.

This group would take decisions on project investment and monitor progress on a bi-monthly basis. It is also recommended that a quarterly report on change projects was presented and discussed at full Trust Board.

The Board noted the paper and agreed to let Janine Clarke have any suggested amendments by 31st July 2007. (A15)

The Board approved the workstream plan, subject to any amendments to be suggested to Janine Clarke as soon as possible. (A16)

f) Major Internal Incident Plan, Disaster Recovery, Business Continuity Plans including IT

The Board approved the workstream plan (A17)

g) Strengthening Assurance Framework

The Board approved the workstream plan (A18)

h) Compliance with National Core Standards and Targets

- **Proposed Workplan: Action**

Add bullet point to read: 'Assess impact of bed occupancy levels on incidence of HCAI.'

With this amendment, the Board approved the workstream plan (A19)

i) Effective Non Executive Director Challenge

This was an essential workstream which needed to be implemented effectively and quickly.

- **Proposed Workplan: Action**

Add bullet point to read: 'Agree brief for evaluation programme and select three external agencies to tender'.

Amend third bullet point to include: 'To include consideration of involvement of shadow Council of Governors'.

With these amendments, the Board approved the workstream plan (A20)

07/ 10 OTHER ISSUES

07/10.1 Proposed Dates for Finance and Performance Committee and Trust Board Meetings

David Badger, NED, raised his concerns about the suggestion of both the Finance and Performance and Trust Board Meetings being held on the same day. Both meetings tended to be long and this would cause a problem and be unsuitable for many Board members to stay to the end of both meetings.

Les Williams, DCD, requested a view from the Board about preferences for structuring the two meetings, as he was working on the earlier suggestion that both meetings should be held on the same day. Hilary Boszko, NED, suggested the Board should test the new structure and review after a period of time.

The Board agreed to look at holding the Finance and Performance Committee and Trust Board on the same day, through the proposal being prepared by Les Williams, DCD. (A21)

07/10.2 Publicising Reasons for Delay in the Foundation Trust Application

Comments were made from the Board regarding the lack of information for the reasons for the delay in the Foundation Trust Application to staff and public members. Les Williams, DCD, commented that he was drafting a letter to staff and public members explaining the reasons for the delay.

The Board agreed that a letter should be sent to all staff and public members explaining in more detail the reasons for the delay in the Foundation Trust application. (A22)

07/11 Any Other Business

07/11.1 Sale of Guest Hospital Site

Paul Brennan, OD, advised the Board that the sale of the Guest Hospital was progressing and that the financial and market advice he had received was that the proposed sale to English Partnerships for a sum of £6m represented value for money. He asked the Board therefore to agree the sale on this basis.

The Board agreed to proceed with the unconditional sale of the Guest Hospital site to English Partnerships for a sum of £6m. (A23)

07/12 Date of Next Trust Board Meeting

The next Trust Board meeting will be held on Thursday 27th September 2007, in the Trust Headquarters, Clinical Education Centre, 2nd Floor, C Block, Russells Hall Hospital.

PLEASE NOTE: THE NEXT TRUST BOARD MEETING WILL BE A PUBLIC BOARD MEETING.

Approved by Trust Board: [date]

Signed by Chairman: [signature]

Published on Trust website (where relevant): PUBLIC MINUTES WILL BE PUBLISHED.

ENCLOSURE 4

ACTION & APPROVAL SHEET
From Minutes of the Extraordinary Meeting held on Thursday 19th July 2007.

The Dudley Group of Hospitals NHS
NHS Trust

Minute	Item No.	Subject:	Action:	Responsible	Due Date	Actioned YES/NO
A1	07/07.1	Special Audit Committee Meeting	The Board noted the request and the date of the Special Audit committee meeting.	DA		YES
A2	07/0732	Support to Trust Board and Committees	The Board approved the request for recording equipment to be used in all Board meetings and Committee meetings.	LW/TS		YES
A3	07/07.3	Circulation of Board and Committee Minutes	The Board agreed that minutes of Board and Committee meetings would be circulated in draft within a working week of the meeting being held.	LW/TS		YES
A4	07/08	Minutes of the Extraordinary Board Meeting on Action Planning for Foundation Trust Status held on 2nd July 2007	The Board agreed that these amendments should be made to the minutes, which were then agreed as a correct record.	LW		YES
A6	07/09.2	Date for Re-submission of Application	The Board agreed to work to be ready to request re-assessment by Monitor by the autumn of 2007, leading to potential authorisation in early 2008.	LW		YES. Now amended by paper to F&P Committee
A7	07/09.3	Non Executive and Executive Director Leads	The Board agreed that the NEDs should be assigned to workstreams as proposed, with David Ashfield providing challenge to the CIP element of the workstream, and that an Executive Director would be identified to each workstream.	LW		YES
A8	07/09.3	Non Executive and Executive Director Leads	The Board agreed that Janine Clarke, Director of Human Resources, (DHR), would organise a development session for NEDs to consider and develop skills in effective challenge and scrutiny.	JC		IN PROGRESS
A9	07/09.4	Relationship of Workstreams with Enterprise Programme	The Board agreed that Executive Directors would align these two planning activities and raise any problems or issues with Board members by Friday 27th July 2007.	PB/LW	27/07/07	YES
A10	07/09.5	Format of Workstreams/Plans	The Board agreed that Non Executive Directors would notify Les Williams of any proposed additions to the sections of the workstream plans on Monitor's targets, parameters, and expectations, by Wednesday, 25th July 2007.	LW/ Non Execs	25/07/07	YES
A11	07/09.5	Format of Workstreams/Plans	The Board agreed that Ann Close, ND, and Paul Assinder, Director of Finance and Information (DFI), would meet with lead Executive and Non Executive Diretors for each workstream to complete the Risk sections.	AC/PA		IN PROGRESS

A16	07/09.6 e)	Managing Large Change Projects	The Board noted the paper and agreed to let Janine Clarke have any suggested amendments by 31st July 200.	JC/Board	31/07/07	YES
A17	07/09.6 e)	Managing Large Change Projects	The Board approved the workstream plan, subject to any amendments to be suggested to Janine Clarke as soon as possible.	JC/Board	ASAP	YES
A22	07/10.1	Other Issues Proposed Dates for Finance and Performance Committee and Trust Board Meetings	The Board agreed to look at holding the Finance and Performance committee and Trust Board on the same day, through the proposal being prepared by Les Williams, DCD.	LW		YES
A23	07/10. 2	Publicising Reasons for Delay in the Foundation Trust Application.	The Board agreed that a letter should be sent to all staff and public members explaining in more detail the reasons for the delay in the Foundation Trust application.	LW		YES
A24	07/11.1	Sale of Guest Hospital Site	The Board agreed to proceed with the unconditional sale of the Guest Hospital site to English Partnerships for a sum of £6m.	PB		YES

ENCLOSURE 5

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Trust Board, Thursday, 27th September, 2007**

Report of: **Director of Corporate Development**

Subject: **Foundation Trust Status Issues**

1. Summary

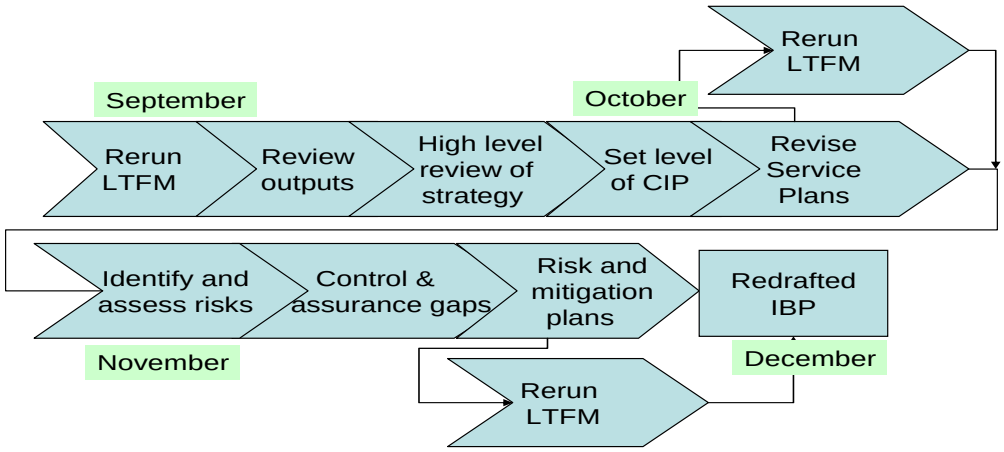
This report requests Board approval of the proposed overall timetable for returning to Monitor for further consideration of our application for Foundation Trust status, as recommended by the Finance and Performance Committee.

In light of this amended timetable, the Foundation Trust Workstream Plans, agreed by the Extraordinary Board session on 19th July 2007, have been updated and are attached at Appendix 1 for approval.

In addition, an analysis of Performance Benchmarks has been produced by Paul Brennan relating to Foundation Trust status. These need to be debated and agreed by the Board to influence how we approach the development of our strategy, the IBP and LTFM. This is attached at Appendix 2.

2. Proposed Overall Timetable

At its meeting on 28th August, 2007, the Finance and Performance Committee considered a report from me which identified the stages of work needing to be undertaken and the implications for the date at which we return to Monitor for further consideration of our application. This was summarised as shown in the graphic below:



It was agreed to recommend to the Trust Board that this overall timetable should be agreed and that the previously agreed Workstream Plans should be updated to reflect this timescale.

3. Performance Benchmark

Appendix 2 gives details of issues which are known to be of concen and interest to Monitor, and identifies the Trust's current position in relation to each of these. It is important in planning the inputs to our strategy development and the LTFM that we agree our position on several of these items.

4. Recommendations

The Trust Board is recommended to:

- Approve the Finance and Performance Committee's recommendation that the Integrated Business Plan and Long Term Financial Model should be re-submitted to Monitor by the end of December 2007, leading to potential authorisation as an NHS Foundation Trust in early 2008

- Approve the updated Workstream Plans as given in Appendix 1.

- Agree its view relating to issues listed in Appendix 2.

Les Williams
Director of Corporate Development

2007-09-06- ft time board sept - lnw

ENCLOSURE 5 APPENDIX 1

FOUNDATION TRUST PROJECT – WORKSTREAMS TO ACHIEVE AUTHORISATION

Workstream Title:	**Strategy/Business Objectives, Activity Levels and Assumptions, Capacity Release, Capacity Planning, CIP Planning and Delivery, Increasing Market Share**
Non Exec Director	David Badger

Monitor's targets, parameters, expectations:	**Evidence required:**
Strategy/Business Objectives • Single, cohesive, transparent plan • Achieve 6% EBITDA at least per year in base case • In downside case, achieve surplus each year • Achieve balanced working capital position each year • Income and pay cost inflation to be in line with benchmarked levels • Deterioration of debtor days from removal of beneficial payment arrangement with PCT • Assumption that planned land and residential sales are delayed • Improved Board Finance report • Achievement of risk rating of 3	• Revised LTFM and financial plan which achieves all these standards • Assumptions grounded in evidence which is detailed and demonstrable • Effective reporting to F and P Committee and Board • Scrutiny and challenge evident from Non Executives • Revised downside case which is viable and sustainable across period • Risk rating of 3 based on assumptions above
Activity Levels and Assumptions • Realistic activity assumptions agreed with PCTs • Risk of demand management reducing income • Reduced forecasts of elective and OP activity growth • Risk of competition from Mercury (diagnostics)	• Agreed, signed off assumptions, with no surprises • Analysis of competition, incl. Mercury, feeding through to LTFM and downside case
Capacity Release • Will not accept projected capacity release without evidence	• Detailed plans enacted or in place to achieve release
Capacity Planning • Contribution rate of no more than 30% • Analysis of step cost changes	• Impact of this rate in model, or evidential basis, externally benchmarked, for different rate
CIP Planning and Delivery • Effective reporting to F and P and Board • At least £5m per year (2.5% in tariff)	• Comprehensive, robust reporting • Evidence of effective NED challenge • Detailed plans enacted or in place to achieve CIP • Plans implemented in 2007/08, detailed agreed plans for 2008/09 and 2009/10 of at least £5m per year (2.5% in tariff), commitment to £5m per year for 2010/11 and 2011/12
Increasing Market Share • Will not accept argument for growth without evidence	• Signed agreements with GPs/PCTs to move activity

Proposed Workplan:			
Action:	**Lead:**	**By:**	**Outcome Measures:**
Strategy and Business Objectives			
• Obtain Monitor Assessor Case for use as benchmark	LW/PA	End July	• Assessor Case available
• Run LTFM regularly to drive strategy development	PA	End Sept onwards	• LTFM outputs available
• Develop further strategy and business objectives, using targets to define them:	Execs	End Oct	• Schedule of agreed targets for each strategic objective and item listed
Quality			
• Identify targets for infection rates, mortality rates, re-admission rates, patient satisfaction results, patient safety indicators	PA/AC		
Productivity			
• measures being developed for Enterprise	PB		
• identify step cost change points	PA		
• capacity release targets	PB		
• model capacity analysis for IP, DC, OPs, diagnostics	PA		
• cash releasing CIP delivery (at least 2.5%)	PB		
• external benchmarking/validation (CHKS, Dr Foster)	PA		• External report
Profitability			
• targets developed through Service Line Reporting	PA/GK		
• contribution rate of more than 30%	PA		
• external benchmarking/validation (CHKS, Dr Foster)	PA		• External report
Process			
• Board session on current/external benchmarks for above	LW	27th Sept	• Session held and documented
• Develop delivery plans	Execs	2nd Nov	• Plans provided
• Identify risks, action plans, sources of assurance and gaps in control/assurance	Board	Mid Nov	• Plans agreed and risk assessed
•			
Activity Levels and Assumptions			• Signed statements of support from PCTs
• Reassess and validate activity assumptions and levels with PCTs	PA	End Sept	
• Review assumptions for direct access/diagnostics (Mercury), private hospitals (Capio) and impact on capacity	PA	End Sept	• Detailed analysis and impact statement
• Update demographic analyses	LW	End Oct	• Revised profile for IBP
• Update competitor analysis, to include PCT/PBC spending power	LW/PA	End Oct	• Updated analysis for IBP
• Explore potential use of SHA reserve for PCT schemes in community and risk assess	PA	End Sept	• Statement of detail of approach and risk assessment
• Pursue agreements with GP practices to switch – Great Bridge, Tipton, Worcs St.	LW/PB	End Dec	• Signed agreements to switch activity
• Check other FTs assumptions	LW/PA	End Oct	• Statement of assumptions made for comparison/validation
• Ask SHA FD to review assumptions	PA	End Nov	
Capacity Release			
• Agree plan to reduce/close capacity (part of Enterprise business case)	PB	2nd Nov	• Business case to Board and agreed
Capacity Planning			• Capacity model linked to LTFM
• Identify step cost change points	PB	2nd Nov	
• Capacity release targets	PA		
• Model capacity analysis for IP, DC, OPs, diag	PA		

Proposed Workplan:			
Action:	**Lead:**	**By:**	
CIP Planning and Delivery • Arrangements in place to deliver 2007/08 CIP	PB	End Aug	• Plan confirmed at F and P Committee and Board
• Evidence of delivery in year to targets	PB	End Sept	• Evidence of delivery to date and forecast
• Initial proposals, challenge and firm plans for 2008/09 and 2009/10 (£5m per year)	PB	End Nov	• Plans agreed at F and P and Board
• Commitment to £5m per year for 2010/11 and 2011/12	AE/PF	End Sept	• Commitment discussed and agreed at F and P and Board
• Effective NED challenge	AE	Ongoing	• Documented in F and P Committee and Board
Increasing Market Share • Concentrate on market share, not catchment population			
• Identify increased levels of market share by specialty and Clinical Unit within context of current marketing strategy	PH/PB/ LW	End Oct	• Targets established

• Set targets to achieve:
  • Maintaining activity/income at risk
  • Restoring activity/income lost
  • Winning new activity/income
		End Oct	• Targets established

• Secure agreements with GP practices as soon as possible – Tipton, Great Bridge		End Dec	• Signed agreements identifying referral switch, evaluated and risk assessed
Mitigation Plans • Develop mitigation plans for downside scenario – short, medium and long term actions	Execs	Mid Nov	• Plans identified
• Model impact of mitigation plans in terms of cost, activity, income, and quality	PA	End Nov	
• Risk assess, discuss and agree at Board	Board	Mid Nov	• Model outputs available
• Develop plans for gaps in control/assurance	Board	Mid Nov	• Risk assessments agreed
• External review of mitigation plans	PA	End Nov	• Plans for gaps agreed • External report

Risks Identified:	Controls in place or required:
• Risk of failure to deliver action plans to time	• Regular monitoring through F and P Commmittee • NED involvement/scrutiny and challenge at appropriate points
• Failure to manage complexity and inter-relationships appropriately	• Mechanism through Exec Team • Reports to F and P Committee

Sources of Assurance for Board:	Evidence of assurance from:
• Use of external benchmarking data • Engagement of external organisations/individuals to check assumptions and outputs/outcomes	• CHKS, Dr Foster • External auditors, SHA FD, FTs

Milestones:	Date:	Notes:
Content agreed by Board:	19.7	Updated for new timeframe 11.9
Report back to Committee:		
Minuted Challenge:		
Final Board sign off:		
Evidence collated:		

Ready for Monitor:		

FOUNDATION TRUST PROJECT – WORKSTREAMS TO ACHIEVE AUTHORISATION

Workstream Title:	**Presentation of Proposals**
Non Exec Director:	Hilary Boszko

Monitor's targets, parameters, expectations:	**Evidence required:**

• Transparent, single plan
• Presented as IBP, focussing on issues where they require assurance:
  • Issues from work of Ernst and Young
  • Challenge from Non Executive Directors
  • Financial viability and sustainability
• Trust to contact three months before date of authorisation, with request for assessment
• Assessment will require resubmission of IBP and financial model
• Further due diligence process will be required
	• New IBP, written in succinct format, readable and clear
	• Updated Long Term Financial Model

Proposed Workplan:

Action:	**Lead:**	**By:**	**Outcome Measures:**
• Undertake detailed workstreams as planned and agreed on 19th July 2007	All	19th July	Agreed content and timeframe for workstreams
• Clarify likely format for IBP and LTFM for authorisation on 1st February 2008	LW	End July	Stated and known format and content changes
• Ensure IBP is drafted based on outcome of LTFM	LW/PA	End Nov	IBP based on LTFM
• Revise sections not dependent on LTFM and workstreams where possible (Section 2 Profile, Section 4 Market Assessment, Section 8 Leadership and Workforce, Section 9 Governance Arrangements) as prototypes for revised presentation	LW and others as req'd	End Oct	Revised sections to F and P Committee in October
• Review style and presentation at Finance and Performance Committee	LW	Sept	Style and presentation agreed at F and P Committee
• Obtain external review for style and presentation	LW	End Oct	External report, changes agreed
• Apply lessons to these and remaining sections (Section 3 Strategy, Section 5 Service Development Plans, Section 6 Finance, Section 7 Risks)	LW (3) PB (5) PA (6) AC (7)	Nov	Revised Sections available
• Present IBP for approval	LW	20th Dec	IBP agreed by Board
• Submit to Monitor	LW	Jan 2008	Submission made

Risks Identified:	**Controls in place or required:**
• Failure to meet Monitor's expectations, including use of incorrect format • Lack of external validation • Lack of time to complete redrafting, including failure to receive contributing workstreams/ sections on time	• Explicit checks to be put in place – from Monitor and management consultants • External review to be engaged • Agreed strict timetables to be followed

Sources of Assurance for Board:	**Evidence of assurance from:**
• Lack of criticism on style from Monitor in recent process • External management consultancy view to be obtained • Repeated and early opportunities for debate and agreement at F and P Committee	• Monitor's feedback • Report available • F and P meetings

Milestones:	**Date:**	**Notes:**
Content agreed by Board:	19.7	Updated for changes for timeframe 7.9.07
Report back to Committee:		
Minuted Challenge:		
Final Board sign off:		
Evidence collated:		
Ready for Monitor:		

FOUNDATION TRUST PROJECT – WORKSTREAMS TO ACHIEVE AUTHORISATION

Workstream Title:	**Information and Information Technology**
Non Exec Director:	Ann Becke

Monitor's targets, parameters, expectations:	**Evidence required:**
Not stated but agreed by Board as an essential area for inclusion in key actions	The Trust has a coherent information and IT strategy that supports the delivery of its business objectives and operational performance of the Trust

Proposed Workplan:

Action:	**Lead:**	**By:**	**Outcome Measures:**
Establish a work stream within the enterprise framework for information and IT that will	D. Ops/FD	End July 2007	Confirm project director and manager
• Align the information and information technology functions in the Trust	D Ops/FD	Sep-07	Coherent IT and information strategy that demonstrates
• Develop a coherent information and IT strategy that supports the delivery of the Trust's business objectives	TBC	Nov-07	links to achievement of trust's priority business objectives.
• Identify a cohesive management and accountability framework for the delivery of information and IT projects		Oct-07	Integrated Information and IT functions
• Identify skills and resources needed to deliver the information and IT strategy and any gaps		Dec -07	Effective management and accountability framework for delivery of information and IT projects
• Prioritise IT implementation plan against key clinical operational performance needs		Nov -07	IT systems enhance clinical performance and integrated /shared clinical documentation

Risks Identified:	**Controls in place or required:**
• Ineffective communication between Siemens and the Trust • Trust and Siemens business objectives no aligned • Lack Capacity and capability within the trust. • Lack of consistent and interested clinical and management input. • Failure by the Trust to drive the agenda • Scepticism for information and IT solutions based on history	• Clearly articulated business objectives • Clear lines of communication and accountability within the trust and between the Trust and • Siemens regarding IT and information. • Clear priorities for information and IT solutions identified. • Identification of essential resources required to deliver the strategy and gaps in current provision. • Clear plan that identifies what will be achieved and by when

Sources of Assurance for Board:	**Evidence of assurance from:**
Information and IT strategy presented to Board External validation of strategy	Strategy IT implementation checklist

Milestones:	**Date:**	**Notes:**
Content agreed by Board:		
Report back to Committee:		
Minuted Challenge:		
Final Board sign off:		
Evidence collated:		
Ready for Monitor:		

FOUNDATION TRUST PROJECT – WORKSTREAMS TO ACHIEVE AUTHORISATION

Workstream Title:	**Membership Numbers**
Non Exec Director:	David Ashfield

Monitor's targets, parameters, expectations:	**Evidence required:**
• Significant increase in total number required from 2,050 in coming months • Expected that representative membership will be developed • Will need to reflect population spread and demographics - age, BME communities, young people	• Public FT members' register up to date, showing significant increase • Membership constituency report showing demographics compared to census data

Proposed Workplan:

Action:	**Lead:**	**By:**	**Outcome Measures:**
• Maintain existing in house membership recruitment – leaflets in OPD letters	LW	Ongoing	Maintained level of recruitment
• Appoint Membership Officer post and recurrent admin support	LW	MO – end August	Mem Officer and support in post
• Ask appointing organisations to Council of Governors to circulate leaflets to all members/staff	LW	End July	Increased membership from these organisations
• Employ recruit company specialists to target 5,000 extra members by mid September	LW	In place	7,250 total members by mid Sept
• Ask all Governors to recruit members	LW	End July	10 leaflets to each Governor
• Pursue agreed plan for contacting appropriate groups in Wyre Forest and Tipton and Rowley Regis	LW	Early Oct	Continued growth from these areas over period
• Develop plan to maintain annual growth in members, based on experience to mid September	LW	October	Agreed plan at Board October
• Maintain observation of changes in political emphasis	LW	Ongoing	Awareness of potentiall changed requirements

Risks Identified:	**Controls in place or required:**
• Failure to achieve target numbers overall in time • Failure to achieve representative membership • Failure to appoint to Membership Officer • Failure to provide adequate admin support	• Agreed contract with penalties and weekly reviews • Specific targets set in contract for area, BME and young people • Interviews set for late July • Need to appoint 0.5 wte Band 2 as soon as possible

Sources of Assurance for Board:	**Evidence of assurance from:**
• Agreed to provide to F and P Committee and then on to Board monthly report showing progress of recruitment and from which source	• Reports made
• Public FT members' register – held by Membership Officer until authorised	• Access to Members' Register

Milestones:	**Date:**	**Notes:**
Content agreed by Board:	19.7	Updated for revised timeframe 7.9.07
Report back to Committee:		
Minuted Challenge:		
Final Board sign off:		
Evidence collated:		
Ready for Monitor:		

FOUNDATION TRUST PROJECT – WORKSTREAMS TO ACHIEVE AUTHORISATION

Workstream Title:	**Compliance with National Core Standards and Targets**
Non Exec Director:	Kathryn Williets

Monitor's targets, parameters, expectations:	**Evidence required:**
Compliance with all the national core standards and targets is a fundamental requirement under the authorisation of an NHS Foundation Trust. MRSA performance is significantly above trajectory. Given the critical importance of this target and the fact that the Trust is unlikely to rectify its breach until 2008/09 the Trust should continue to implement the infection control plans to reduce the monthly run rate of incidences as a matter of urgency. Performance against the MRSA target will be re-considered when the Trust re-activates its application.	MRSA bacteraemia rates are 1 or < 1 per month. From July 2007 All remaining core standards and targets are met

Proposed Work plan:

Action:	**Lead:**	**By:**	**Outcome Measures:**
• Implementation of infection control annual programme and action plan is continued.	AC	Continuous	Progress reports against actions by target date and exceptions reported.
• Progress reports and numbers of MRSA bacteraemias reported against trajectory monthly.	AC	Monthly	Number of MRSA bacteraemias (pre and post 48 hours)
• CEO Directors of Nursing, Medical and operations ensure action is taken where there is non compliance with infection control policies and practices	PF/AC PH/ PB	Continuous	RCAs, audits, incidents, observations show compliance with policies and practices
• Report exceptions in Hygiene code quarterly to Integrated Governance and Board	AC	Aug IG Sept Board (the Quarterly)	Compliance with requirements of Hygiene code
• Provide weekly reports to MRSA improvement Team and Seek further advice and support as necessary.	PF/AC	As necessary	Breaches are reported with mitigating action where required
• Directors with responsibility for HCC core standards and targets to report breaches and potential breaches monthly to Integrated Governance and Trust Board	All	Monthly	Mid year assessment shows on target for compliance in all core standards with the exception of Infection Control
• Action to mitigate breaches to be taken	All	As required	
• Mid year self assessment against core standards to be taken.	All	Oct	Exceptions and mitigating action reported monthly
• Monthly performance reports on targets to be reported to Finance and Performance committee with corrective action being taken.	PA	Monthly	

Risks Identified:	**Controls in place or required:**
• Failure to keep to 1 MRSA or < 1 MRSA bacteraemia per month • Failure of PCT and HPU to manage community infection within the community • Failure to identify breaches or potential breaches in HCC Standards and targets	• Close monitoring of infection control by CEO/Nursing Director and Medical Director. • Clear lines of accountability for infection prevention and control throughout the operations directorate. • Monthly reporting by MSH and Matrons to chief Exec • Full time clinical champions for 6 months in 7 high risk areas to ensure high standards of clinical practice • Introduce weekly saving lives audits with action plans • Written expectations of standards of infection

	prevention and control required disseminated through Operation directorate with consequences of non compliance made clear • MRSA management pathway agreed across health economy. • Directors with responsibility for each core standard • Mechanism in place for reporting breaches or potential breaches and midyear assessment of HCC standards through Integrated Governance is in place • Monthly reports of performance made to F & P committee

Sources of Assurance for Board:	**Evidence of assurance from:**
Reports from Nursing Director, Operations Director and Finance Director External reports from HPU on infection rates	

Milestones:	**Date:**	**Notes:**
Content agreed by Board:		
Report back to Committee:		
Minuted Challenge:		
Final Board sign off:		
Evidence collated:		
Ready for Monitor:		

FOUNDATION TRUST PROJECT – WORKSTREAMS TO ACHIEVE AUTHORISATION

Workstream Title:	**Strengthening Assurance Framework**
Non Exec Director:	Kathryn Williets

Monitor's targets, parameters, expectations:	**Evidence required:**
Results of the work of the independent accounting firm:- From an overall governance perspective we are not satisfied with the design of the Assurance Framework. Ernst Young Report indicates… The Board needs to complete its work on strengthening the design of its Assurance Framework so that it can easily identify the gaps in control and the gaps in assurance	The Trust Board minutes and papers agreeing a strengthened Assurance Framework that identifies gaps in controls and gaps in assurance. Quarterly update reports of full risk register quarterly to board

Proposed Workplan:

Action:	**Lead:**	**By:**	**Outcome Measures:**
Trust Board			
• Re-design risk assessment proforma to include gaps in control and assurance and link sources of assurance to each risk	AC	Aug -07	External review of assurance framework is that it is fit for purpose and enables the Board to identify gaps in assurance and gaps in controls.
• To review risks following revision and confirmation of Board strategic business objectives.	AC	Nov-07	
• Assign director as lead for each risk	PF	Nov-07	
• To review and update corporate risks quarterly to ensure the risk register is dynamic.	All	Sept Dec Mar Jun	
• To clearly identify any gaps in assurance and agree plans for rectifying these.	All	Sept	
• To use the new Trust risk assessment forms as the basis for the register of risks and ensure o Existing controls are stated o Gaps in control identified o Mitigating action plans with timescales and responsibilities are provided o Sources and gaps in assurance are highlighted o Risk score and residual risk score given and risks reassessed as mitigating action is completed	All	Sept Sept	
• Highlight progress (exceptions) using traffic light system with mitigating action monthly and report to IG Committee monthly	All	Sept -07	
• Report full risk register and Assurance framework to the trust board quarterly	AC	Sep Dec Mar June	
• Obtain external review of this process once changes are in operation.	AC/PA	Dec-07	

Risks Identified:	**Controls in place or required:**
Major risks are not identified. Failure to identify lack of control Failure to make progress with mitigating action Failure to identify sources of assurance in some areas External view of process does not comply with Monitors independent accounting firm's view	All board members participate in risk identification process Focus on high level risks related to business objectives Director assigned to each risk Monthly reports on exceptions to Integrated Governance Committee External review of process

Sources of Assurance for Board:	**Evidence of assurance from:**
Quarterly Board reports on full risk register Internal audit of assurance framework External review of assurance framework	Reports made

Milestones:	**Date:**	**Notes:**
Content agreed by Board:		
Report back to Committee:		
Minuted Challenge:		

Final Board sign off:		
Evidence collated:		
Ready for Monitor:		

FOUNDATION TRUST PROJECT – WORKSTREAMS TO ACHIEVE AUTHORISATION

Workstream Title:	**Major Internal Incident Plan, Disaster Recovery, Business Continuity Plans including IT**
Non Exec Director:	Ann Becke

Monitor's targets, parameters, expectations:	**Evidence required:**
Results from the work of the independent accounting firm Ernst Young LLP includes the requirement for the Trust to complete the Major Internal Incident Plan as soon as possible. This plan to include Disaster recovery Business Continuity For the Trusts services and for IT	Trust Board approval of the Major Internal Incident Plan Evidence of Testing of the Plan

Proposed Workplan:

Action:	**Lead:**	**By:**	**Outcome Measures:**
Complete and have in place the following omissions from the Major Internal Incident Plan.			
• Obtain Emergency supplies (budget and space for storage required)	PB	End Sep	List of emergency supplies are available in specified location. Mechanism for replacement is agreed in plan
• Include bomb alert or incendiary attack actions and contingency	JC/Sec Manager	End Sep	Plan is in included in the overall plan
• Identification of 'core (essential) clinical services' and develop individualised disaster recovery plans and business continuity plans. (Identified as theatre, ITU, radiology, pathology, pharmacy, ED, Neonatal unit)	PB	End Nov	Individualised plans for disaster recovery and business continuity are in place in the overall plan.
• Develop IT disaster recovery and business continuity plan	PB/JP/ GM	End Oct	IT disaster recovery and business continuity plan are completed and incorporated into the overall plan.
• Agree mechanisms for testing plan and carry out test	PB/AC	End Jan	Report of test considered by IG and Trust Board

Risks Identified:	**Controls in place or required:**
• Failure to identify all key clinical areas. • Failure of personnel to deliver actions.	Directors given overall lead for each action

Sources of Assurance for Board:	**Evidence of assurance from:**
External scrutiny and testing of plan	Report

Milestones:	**Date:**	**Notes:**
Content agreed by Board:		
Report back to Committee:		
Minuted Challenge:		
Final Board sign off:		
Evidence collated:		
Ready for Monitor:		

FOUNDATION TRUST PROJECT – WORKSTREAMS TO ACHIEVE AUTHORISATION

Workstream Title:	**Effective Non Executive Director Challenge**
Non Exec Director:	Alfred Edwards

Monitor's targets, parameters, expectations:	**Evidence required:**
• NEDs need to demonstrate appropriate level of challenge to Exec Team • Challenge to be on important strategic, financial and service issues • Introduction of current corporate finance and governance skills • Focus on future risks • Evaluation of existing NEDs • Development programme to enhance skills in scrutiny and challenge • Replacement of at least two NEDs	• Documented evidence of challenge at Board and in Committees • Records of challenges at workshops/seminars • Outcome of evaluation process leading to changed NED membership of Board • Development programme implemented • Person specification for additional skills • Successful recruitment of new NEDs with appropriate skills • CVs and profiles of new NEDs available • Improved performance at Monitor Board to Board

Proposed Workplan:

Action:	**Lead:**	**By:**	**Outcome Measures:**
• Agree brief for evaluation programme and select three external agencies to tender	PF/JC	End July	Brief
• Conduct interviews for existing NEDs	AE/PF	End Aug	Chairs report
• Support individual development requirements via appraisal	AE/JC	End Oct	Individual development programme for each NED

• Recruitment of two NEDs with appropriate skills:
  • Corporate finance
  • Corporate governance
To include consideration of involvement of shadow Council of Governors
	AE/JC/ External agency	Nov	New NEDs recruited

• Evidence of contribution made by new NEDs	AE	Jan 08	Documented evidence available
• Conduct assessment centre for Board for future development	JC	Nov	Assessment centre held
• Changed arrangements for Board and Committee support	LW	End Aug	Consistent style and content of support and minutes
• Provide mock Board to Board events with external observation	LW	Oct	Minutes and observation of performance
• External review of board working arrangements, especially challenge and scrutiny	LW	Mid Oct	External report

Risks Identified:	**Controls in place or required:**
• Failure to recruit new NEDs within timeframe • Failure to recruit right skills/background • Failure to achieve NED development in time	• Prioritise Corporate Finance skills • Buy in short term skills • Use head hunting techniques • Greater time commitment from NEDs in short period

Sources of Assurance for Board:	**Evidence of assurance from:**
• Regular reports to Board from AE and JC • Externally run evaluation process • Mock Board to Board events • Independent review of Board working • Improved recording of challenge in Board, Committees, workshops	• Reports provided • External report • Minutes, external reports • External report • Minutes

Milestones:	**Date:**	**Notes:**
Content agreed by Board:	19.7	Amended with JC 23.8
Report back to Committee:		
Minuted Challenge:		
Final Board sign off:		
Evidence collated:		
Ready for Monitor:		

FOUNDATION TRUST PROJECT – WORKSTREAMS TO ACHIEVE AUTHORISATION

Work stream Title:	**Managing Large Change Projects**
Non Exec Director:	David Badger

Monitor's targets, parameters, expectations:	**Evidence required:**
That all large scale change initiatives: - are assessed as to business risk & benefits - are effectively managed - Have appropriate governance arrangements put in place & are monitored effectively. That Non Executive Directors are aware of, and in the case of strategic change programmes, involved in the development of the strategy, and are able to monitor and challenge the progress and performance of the change programme.	- Documented risk/benefit analysis - Project leadership structures, clear lines of accountability in place & change agreed change management methodology adopted. - Regular reporting of progress & outcomes. - NEDs level of awareness & active monitoring & challenge evidence of debate and challenge documented.

Proposed Workplan:

Action:	**Lead:**	**By:**	**Outcome Measures:**
• Develop change management methodology & governance arrangements	JC	July 2007	Change Management approach agreed.
• Existing change projects reviewed as to methodology.	PB/All Directors	September 2007	Review completed and reported to committee.
• All change projects adopt reporting arrangements	All Directors	November 2007	List of all change projects complied & Reports provided.
• Management development programme & leadership Development programmes designed and implemented	JC	Commencing April 08 and ongoing	Improved management & leadership of change programmes, leading to successful delivery of project outcomes.
• Develop new performance Management system, to include change management contribution	JC	August 2007	Individual/team contribution to change programmes assessed & addressed.

Risks Identified:	**Controls in place or required:**
Failure to follow agreed methodology	Performance management System. Reporting arrangements to committee.
Failure to invest time & resources to ensure change successful	Process for agreeing resources incorporated into change methodology and reported at start. Prioritisation of programmes agreed by one committee/group to ensure prioritisation and focus of effort.
Failure to appoint appropriately skilled programmes leaders & managers	Leaders apportioned against identified knowledge/skills requirements. Access to Management Development & leadership development programmes/support. Individuals' contribution assessed against new Performance Management system.

Sources of Assurance for Board:	**Evidence of assurance from:**
Adoption of evidence based change management methodology. Reports on progress/performance of individual change programmes. Use of external 'experts' as required. Trust performance effectiveness, in core capabilities (including change management) assessed and reported.	Janine Clarke Lead Director External Experts. Director of HR.

Milestones:	**Date:**	**Notes:**
Content agreed by Board:	19.7	
Report back to Committee:		
Minuted Challenge:		
Final Board sign off:		
Evidence collated:		
Ready for Monitor:		

ENCLOSURE 5 (APPENDIX 2) TO FOLLOW

ENCLOSURE 6

The Dudley Group of Hospitals NHS
NHS Trust

Report to: **Trust Board, Thursday, 27th September, 2007**

Report of: **Director of Corporate Development**

Subject: **New Board Agenda - Strategy**

1. Summary

The Board meeting is now operating in a different way, reflecting the requirement of operating as an NHS Foundation Trust as part of its continuing preparations towards FT status.

A new arrangement for running the Finance and Performance Committee and the Trust Board on the same morning has been introduced for this month's meetings as the start of a three month pilot.

In addition, a new format of Board agenda has been introduced, which responds to 'The Intelligent Board' report and seeks to ensure that the Trust spends the appropriate amount of time on strategic issues, while ensuring there is effective scrutiny of operational performance.

This paper asks the Board to agree the dataset for strategic reporting and review so that effective decisions can be made each month.

2. Business Requirement

As an NHS Foundation Trust, Board members should be spending a greater proportion of their time on developing strategy and reviewing progress against the strategy being implemented by Executive Directors. While scrutiny of operational performance is important, it is critical that the Board adds value to the Trust through properly and effectively exercising their strategic role. It is the Board's responsibility to ensure that the Trust continues to develop in the right direction, performing effectively and being sensitive to the market in which it operates, identifying potential opportunities for development and risks and threats from competitors.

The regularity of a monthly review of the current position and attention to information forecasts of year end and future positions will reinforce the strategic role being played by the Board.

This approach marks a further stage in the progression of the Board from managing an NHS Trust to being effective in the FT environment. This is a new area for the Trust Board and it is anticipated that the development of the datasets required will take several months until they are fully effective.

3. Principles

To undertake its role in Strategy, the Board needs to receive information which is:

- Structured around an explicit set of strategic goals

- Indicative of trends in performance for finance and business development
- Based on current and forecast performance, anticipating future issues
- Looking externally rather than internally

As with all information for management, the information presented should be simple to understand, making use of graphics as well as commentary, timely and direct the Board towards consideration of significant issues, risks and exceptions. Statistical Process Control will be used to identify if any data point in a trend analysis is an outlier or the result of normal variation.

This approach will ensure that the Trust Board is able to make relevant and constructive decisions, based on effective early warning of potential problems and will contribute to the further development of all Directors' understanding of the performance of the organisation. This will require a different form of scrutiny, thinking and debate to that appropriate for Board committees, such as Finance and Performance.

A clear distinction between strategic and operational performance is essential. It may be useful to consider the distinction defined as:

- Finance and Performance Committee – considers year to date performance and performance forecast to end of the current year
- Trust Board – considers implications of year end forecast position for future years.

In this Trust, this is assisted by the fact that the Finance and Performance Committee will consider the detail of the Trust's current year performance on a monthly basis, immediately prior to the Trust Board meeting being held. Recent discussions have concluded the data set to be presented to the Finance and Performance Committee and the September meeting will receive the latest developed set, including forecast outturn and traffic lighting of risk issues. This data set has taken account of the recommendations in 'The Intelligent Board' and the suggestions from the Ernst and Young Due Diligence report to include ratio analyses and longer term cash flow forecasting.

It should be anticipated therefore that the majority of the Trust Board will be spent on strategic issues and that the Board meeting can operate effectively within the two hours allotted for it each month.

4. Proposed Minimum Data Sets

The Board needs to agree the information it wishes to receive regularly to ensure it operates effectively in formulating and reviewing progress against strategy and the market within which it operates. In general terms, this needs to cover our market and business development issues, and anticipating the needs of patients in the communities we serve.

Given below are the recommendations made in 'The Intelligent Board', along with some suggestions for consideration for inclusion, based on our local needs. These take account of the need to pursue both our particular strategic objectives and to ensure that the Board has a regular and continuing opportunity to review the market and environment in which it works.

The timeframes identified relate to the business cycle previously agreed by the Board, with the period October to March each year being especially pertinent to framing the following year's plan.

Market and Business Development				
Indicator	**Source**	**Style and Frequency**	**Purpose**	**Timeframe**
Referral rates and activity performed by specialty for DGoH and competitor Trusts	Dr Foster HMM /HES download, manipulated locally	Trend analysis (line graph) for 06/07 and 07/08 to date, with forecast outturn Monthly	Identify levels of activity by specialty compared to competitors – to identify specialties for more detailed analysis to HRG/Procedure level and variations from previous patterns over time	October Board meeting
Market share by area by specialty for DGoH and competitor Trusts' latest position	Dr Foster HMM /HES download, manipulated locally	Pie chart for current and forecast outturn position Monthly	Identify extent of penetration of whole volume of market for specialty, with particular reference to Wyre Forest and Sandwell - to identify specialties for further development/examination and level of risk involved	October Board meeting
Analysis of selected GP practices/clusters in Dudley, Wyre Forest, Sandwell and other areas	Dr Foster HMM/HES download	Report on specified GP practices/clusters of interest, as target practices for increasing referrals	Identify effectiveness of marketing for specific purposes by rolling programme of reviews every three months: 1. Dudley 2. Wyre Forest and Sandwell 3. Others	Monthly
Take up of services by local population/neighbourhood	Mapping package using HMM/HES download	Map backed up by trend analysis Quarterly	Identify extent of take up of particular services by residents of each area – to identify potential for further gain or loss to competitors	To be agreed
Health Needs of local populations	PCT DPH reports	Brief report summarising key trends Annually	Identify potential changes in demand for services based on demographic changes	December each year
Views of Governors/FT members on service development	Feedback from Council of Governors	Report from strategy debates with Council of Governors December and June	Identify issues from FT members for consideration in developing business areas	January and July each year
Analysis of Competitors	Annual Plans Annual Reports Local intelligence	Report on significant competitors Annual	Identify changes in financial viability and portfolio of services of competitors	October each year
Analysis of Commissioners	Annual LDPs Annual Reports	Report on significant commissioners	Identify threats and opportunities based on expressed intentions to change what services are commissioned	May and October each year

Finance: Key Trends and Forecasts				
Indicator	**Source**	**Style and Frequency**	**Purpose**	**Timeframe**
Forecast Outturn for Income and Expenditure against budget and Financial Risk Rating	Financial systems	Forecast financial position at year end Monthly	Identify expected end of year position and any issues to be addressed	In place to F and P
Impact on modelled Income and Expenditure and Financial Risk Rating for future years	Monitor's model	Model outputs Monthly	Identify impact of expected year end position on future years for Income, Expenditure and Financial Risk Rating	To be agreed
Projected activity and income changes by specialty and Financial Risk Rating	SLR reporting	Projected profit/loss by specialty Monthly	Identify early warning of issues in individual specialties	To be agreed
Cash flow forecasts	Financial systems	Cash flow forecasts for 6 months, 12 months and 24 months horizons Monthly	Identify issues with managing cash and levels of borrowing for two years ahead	To be agreed

Locally Defined Strategic Objectives				
Indicator	**Source**	**Style and Frequency**	**Purpose**	**Timeframe**
Quality: measures to be agreed	Various Trust systems	Trend analysis of performance, by exception Monthly	Identify potential variances to allow decision on appropriate action	October Board meeting
Productivity: measures to be agreed	Various Trust systems	Trend analysis of performance, by exception Monthly	Identify potential variances to allow decision on appropriate action	October Board meeting
Profitability: measures to be agreed	Various Trust systems	Trend analysis of performance, by exception Monthly	Identify potential variances to allow decision on appropriate action	October Board meeting

Key External Developments				
Indicator	**Source**	**Style and Frequency**	**Purpose**	**Timeframe**
Policy changes	National publications and guidance	Narrative report Annually as minimum Usually as issues arise	Identify any changes in policy at national or SHA level which impact on delivery or relevance of strategy	January each year and ad hoc
Technology changes	Horizon scanning exercise	Narrative report Annually as minimum As issues arise	Identify potential changes in how health care is delivered (equipment, pharmacological and interventional changes) to allow decision on impact and relationship to strategy	January each year and ad hoc
Environmental changes	Various	Narrative report Annually as minimum As issues arise	Identify any changes in environment which impact on delivery or relevance of strategy	January each year and ad hoc

5. Recommendation

The Trust Board is recommended to approve the dataset above as a minimum and to identify any additional indicators they wish to see developed to enable effective Board decisions on strategy.

Les Williams
Director of Corporate Development

2007-09-03 – strategy new board agenda - lnw

ENCLOSURE 7

The Dudley Group of Hospitals NHS
NHS Trust

REPORT OF THE DIRECTOR OF FINANCE AND INFORMATION TO THE TRUST BOARD – 27 SEPTEMBER 2007

TRUST PERFORMANCES APRIL TO AUGUST 2007

This report highlights key exceptions and variances and should be read in conjunction with the more detailed reports presented to the Finance and Performance Committee for the same period.

1. EXECUTIVE SUMMARY

Financial performance YTD and forecast remains very strong. CIP performance is satisfactory to date, but with moderate risk in future months. Some access issues and outpatient and MRSA waiting breaches are apparent.

FINANCE			ACCESS AND TARGETS		
	YTD	Forecast		YTD	Forecast
Cash			Activity v Plan		
I & E			Health Commission		
Margin			18 Weeks		
Debtors					
			CORPORATE STRAGEGY		
EFFICIENCY			**CUSTOMER FOCUS**		
	YTD	Forecast		YTD	Forecast
CIP			MRSA		
SLR Project			C. Diff		
Workforce Efficiency			Referrals		
Length of Stay			Market Share		
Day Surgery Rate			Complaints & Claims		
			Patient Waits		

2. FINANCIAL PERFORMANCE (APRIL TO AUGUST)

Performance to date in all area exceeds plan and is forecast to do so at year end.

	YTD	Forecast
Clinical Income - Surplus over Plan (£000)	388	1,500
EBITDA (£000)	9,007	15,400
EBITDA Margin (%)	10.38%	7.50%
Surplus (£000)	6,116	9,200
Normalised Surplus (£000)	1,900	3,480
Cash Balance (£000)	28,000	25,000
Liquidity Days	17.7	5.0
NHS Debtor Days	4.9	3.5

KEY POINTS:

i) Performance exceeds period plan by £0.4m EBITDA and £1.0m I & E Surplus

ii) Income £0.5m above plan, expenditure is £0.2m below plan, depreciation is £0.2m below plan and interest is £0.4m above plan.

iii) Forecast EBITDA £15.4m is £3.6m above annual plan due to improved trading and released reserves.

iv) Balance sheet is stronger than plan due to EBITDA gains, sale of Corbett land and capital slippage.

KEY FINANCIAL RISKS:

(1) CIP Slippage - the contribution from new schemes is significant - £1.5m
(2) PCT Affordability/Disputes - overtrading will put pressure on PCTs Commissioning resources - £2.0m risk

3. EFFICIENCY

3.1 CIP PROGRAMME

Schemes Commenced to 31 August 2007	£m	Status
18 Weeks Funds Surplus	1.6	
Coding Depth/Development	0.6	
Drugs Prescribing	0.2	
Clinical Units Procurement	0.2	
Corporate Directorates	0.3	

- Although coding savings are being achieved overall, the composition of savings remains off-plan.

Schemes Commencing in Future	£m	Status
Nurse Pool (Sept 07)	0.9	
Pathology Review (Sept 07)	0.1	
Medical Secretaries (Sept 07)	0.5	
Flexible Theatres (Sept 07)	0.2	
Clinical Units - Other (Oct 07)	0.3	

- Nurse pool working protocols still being finished
- Medical Secretaries transcribe system awaited

Schemes Commencing in 2008/09
Schemes flowing from the Enterprise Workstreams are covered in a separate report to the Trust Board

3.2 **WORKFORCE RELATED EFFICIENCY INDICATORS**

	Month 4	Month 5	YTD
Average pay per WTE (£)	2,903	2,945	3,185
IP/DC Spells per WTE	2.56	2.63	2.90
Clinical Unit income per WTE (£)	5,503	5,673	5,529
Total WTE worked	2,978	2,935	2,935*

* Average YTD

KEY POINTS:

i) Elective inpatient/day case productivity was below average in July and August.

ii) However, emergency and OP activity boosted Unit income levels.

3.3 **SERVICE LEVEL PERFORMANCE**

The Service Level Reporting (SLR) Project is progressing according to plan.

	Deadline	Status
2006/07 Ref Costs to Service Level	Sept 07	
Information on 2006/07 to CSU's	Oct 07	
SLR YTD model agreed	Nov 07	
YTD SLR Reports	Q4 07/08	
Patient Costing Project	2008/09	

The project to allocate and apportion 2006/07 reference costs and HRG income has been completed and a Service Line Profitability Report has been prepared for the September 2007 Finance and Performance Committee.

Agreement of baseline positions with clinical colleagues to 2007/08 budgets has now commenced.

Ardentia LTD are developing the Trusts patient level costing analysis for presentation to the Trust Enterprise Working Group in October.

3.4 **CLINICAL EFFICIENCY INDICATORS**

3.4.1 **LENGTH OF STAY**

No update this month.

3.4.2 **DAY SURGERY RATES**

No update this month.

KEY EFFICIENCY RISKS
(1) A significant proportion of 2007/08 CIP Projects are scheduled to commence in future months and the risk of slippage is assessed as £1.5m for the year.
(2) Future years CIP proposals and based upon the success of the Enterprise Workstreams and Clinical Change Programmes.

4. ACCESS AND TARGET PERFORMANCE

3.1 ACTIVITY V PLAN

	YTD	Forecast
A & E		
Critical Care		
Day Cases		
IP Elective		
IP Non Elective		
Out Patients		

KEY POINTS:

i) IP Electives significantly (>20%) below plan for Rheumatology, Gynaecology and Plastics.

ii) OP Follow ups below plan (>10%) for General Surgery and T & O.

iii) Still PAS related recording problems in Outpatients Department, being addressed by Health Records.

iv) Clinical income is £0.4m above Plan for period.

3.2 PERFORMANCE AGAINST HEALTHCARE COMMISSION TARGETS

For period to 31 August 2007, all targets were being met with the exception of the following:

3.2.1 11 WEEKS OUTPATIENT MAXIMUM WAITING TIME

At 31 August the Trust reported 2 breaches in the following areas:

Pain Management 1
Rheumatology 1

3.2.2 CONTINUED IMPROVEMENT IN MRSA EPISODES

	Target YTD	Actual YTD	
MRSA Reported Infections	5	15	

	Target 2007/08	Forecast 2007/08	
MRSA Reported Infections	12	36	

5. CUSTOMER FOCUS

5.1 WAITING TIMES

	YTD	Forecast
Outpatients 11 Weeks Max		
IP Elective 20 Weeks Max		
A & E 4 Hour Max		
MRI Diagnostics 13 Weeks		
CT Diagnostics 13 Weeks		
Other Diagnostics 13 Weeks		
Cancer 31 Day Wait		
Cancer 62 Days Wait		
18 Weeks		

KEY POINTS

i) Some breaches in maximum referral to OP Wait continue. 2 in total, 1 in Pain Management and 1 in Rheumatology.

5.2 INFECTION CONTROL

	YTD	Forecast
MRSA Bacteraemias		
C Difficile		

i) MRSA Infections to date 15 (plan YTD 5). Target for year is 12 - so significant breach.

5.3 PATIENT SURVEYS

No update in September. The Picker Institute 2006 survey was presented to the Board in December 2006. The Trust scores were significantly more favourable than pears in 4 of 58 categories (including quite and cleanliness factors) and worst in 14 of 58 (including Information provision, admission delays and food).

5.4 REFERRALS AND MARKET SHARE ANALYSIS

No update information this month - awaiting Dr Foster analysis.

KEY PATIENT EXPERIENCE RISKS

(1) MRSA bacteraemias are not falling at desired level.

(2) Electronic communication with GP Practices (eg discharge summary etc) is still unavailable.

6. OTHERS MATTERS

6.1 CHARITABLE LEGACIES

I am pleased to report the kind legacy of £20,000 (£10,000 Leukaemia Unit and £10,000 to the Childrens Department at RHH) from the estate of Mrs Dorothy Davenport.

6.2 APPROVAL OF WRITE OFF OF BAD DEBTS APRIL TO SEPTEMBER 2007

i) The Board is asked to note the write off under delegated authority of 25 cases with individual values of £500 or less and a combined value of £3,637.20

ii) The Board is asked to approve the write off of 4 cases exceeding £500 value as follows:

	£
Overseas Visitor Mr Tilla Khan	955.76
Overseas Visitor Mr Ghista Vasile	1,086.48
Overseas Visitor Ms Angela Petrosian	3,238.67
Overseas Visitor Ms Samara Azeem	1,586.73
Total	**6,867.64**

These patients have each been pursued unsuccessfully for some months and legal advice is that all such debts are practically irrecoverable.

iii) The Board is asked to note the recovery of a debt in respect of Mr C Santiago (private patient) for £803.05, previously written off.

7. RECOMMENDATION

The Board is asked to note the report and to approve the debt write off in paragraph 6.2(ii).

Paul Assinder
Director of Finance and Information
20 September 2007

APPENDIX 1

SUMMARISED FINANCIAL POSITION AT 31 AUGUST 2007

1. **INCOME AND EXPENDITURE**	**YTD £m**	**Forecast £m**
Clinical Income	81.1	195.1
Other Income	5.6	10.8
Total Income	86.7	205.9
Pay	46.7	113.5
Drugs	5.1	12.2
PFI	13.6	32.6
Other	12.3	32.2
Total Expenditure	77.7	190.5
EBITDA	9.0	15.3
Net I & E Surplus	6.1	9.2

2. **BALANCE SHEET**	**31/8/07 £m**
Fixed Assets	77.8
Stocks	3.5
Debtors	5.6
Cash	23.2
Creditors	(15.2)
Net Current Assets	17.1
Long Term Debtors/Creditors	23.4
	118.3

	£m
Public Dividend Capital	17.2
Revaluations/I & E Reserves/Donated	101.1
	118.3

ENCLOSURE 8

The Dudley Group of Hospitals NHS
NHS Trust

REPORT TO: Trust Board Report September 2007

REPORT OF: **Director of Human Resources & Organisational Development.**

1. Summary

This report sets out a brief summary of key workforce issues. It is for information only.

2. Modernising Medical Careers and MTAS

Members will be aware of recent medical coverage of the issues regarding the appointment of Junior Doctors in August 2007.

The Trust has responded and managed these issues effectively with no adverse impact on services.

3. Consultant Appointments

A performance mentoring and management process has been developed for newly appointed consultant medical staff. This incorporates a revised recruitment process, a mentoring and support scheme and performance measurement scheme that tracks competence, productivity, behaviour and time to contribution.

This process has been implemented from August 2007, for new consultants. The key features from this are being reviewed for possible extension to other staff groups as part of the new performance management system.

4. Health and Safety

The Health and Safety committee met on 3 August 2007, and the following key points should be noted:-

- The Directorate audit reports to Health and Safety committee process has now been agreed, with implementation commencing immediately.
- Discussions are taking place with Birmingham Medical School on Health and Safety and Manual Handling training for medical undergraduates and in the mean time our Manual Handling Advisor is looking to provide some training for medical students at the Trust.
- There are currently a number of training places still available for conflict resolution. The Trust is required to train all front line staff by March 2008. A campaign to address this is being implemented.
- The Annual Trust Health and Safety week is being held week commencing 29 October 2007. Each day of the week will be themed to an area of Health and Safety pertinent to the Trust:
  - Day 1 Musculoskeletal Disorders
  - Day 2 Hazard Spotting
  - Day 3 Patient Safety and Occupational Health
  - Day 4 Security
  - Day 5 COSHH

Janine Clarke
Director of Human Resources & Organisational Development

ENCLOSURE 9 TO FOLLOW

ENCLOSURE 10

Dudley Group of Hospitals NHS Trust

Annual Report of the Audit Committee for the Financial Year 2006/07

1. Introduction

The purpose of this report is for the Audit Committee to account to the Trust Board on its activities during the year 2006/07. In practice this covers the period up to the approval of the Trust's Annual Report and Accounts in June 2007.

The Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes.

In order to discharge this function the Audit Committee prepares an annual report for the Board and Accounting Officer and expresses a considered opinion based upon the evidence placed before it.

2. Audit Committee's Opinion for 2006-07

Members of the Board should recognise that assurance given can never be absolute. The highest level of assurance that can be provided to the Board is a reasonable assurance that there are no major weaknesses in the Trust's risk management, control and governance processes.

The opinion of the Committee, based on the evidence placed before it during the year, is that the Trust's risk management, control and governance processes are adequate and effective and may be relied upon by the Board.

3. Terms of Reference and Membership

The Audit Committee is constituted as a sub-committee of the Trust Board and consisted of three Non-Executive Directors, namely David Badger, Kathryn Willietts and David Ashfield, Chair of the Committee. It is recommended that the Chair of the committee is a suitably (CCAB) qualified accountant and as a Fellow of the Institute of Chartered Management Accountants, David Ashfield fulfiled this requirement.

Other individuals are required to attend all Audit Committee meetings. These include the Trust Director of Finance & Information, senior representatives of the External Auditors of the Trust, PricewaterhouseCoopers and senior representatives of the Internal Auditors of the Trust, Deloittes & Co. Other people may be invited from time to time from the

Trust or from external organisations and the Trust Director responsible for Corporate Governance, the Director of Nursing, attends one meeting during the year.

The major function of the Audit Committee is :-

1) To ensure that the Trust has an adequate and efficient system of internal control, risk management and corporate governance. The committee therefore ensures the installation, development and maintenance of the appropriate systems of control.
2) To review all matters concerning the Internal Audit service and in particular to review the Internal Audit Strategy, plan its implementation and review all Internal Audit reports, and recommend to the Board of Directors the appointment of the Internal Auditors.

3) To review the External Auditor's Strategy, Plan and review all External Audit reports.
4) To consider any other topics it is deemed advisable to review on behalf of the Board of Directors.

The following table records members in attendance (or tendering apologies at each meeting during the 2006-07 cycle.

Date of Meeting	Mr. Ashfield	Mr. Badger	Mrs Williets	Mr. Assinder	PwC	Deloittes
10th May 2006	yes	yes	yes	yes	yes	yes
4th July 2006	yes	No	yes	yes	yes	yes
18th October 2006	yes	yes	yes	yes	yes	yes
16th January 2007	yes	yes	yes	yes	yes	yes
17th April 2007	yes	yes	yes	yes	yes	yes
13th June 2007	yes	yes	yes	yes	yes	yes

As can be seen, the Committee enjoyed virtually full attendance throughout the year.

At the commencement of the year, the Committee undertook a Self Assessment Exercise as commended by the DoH/Audit Commission's 'NHS Audit Committee Handbook'. The resulting recommended actions flowing from this (these included; Audit Committee Chair's Ex Officio membership of the Integrated Governance Committee; a specific audit of assurance coverage between the Audit, F&P and IG Committees; the publication of an Audit Committee Work Programme; and Training Needs Assessment) were all actioned satisfactorily during the year.

The Trust's Local counter Fraud Specialist, Lorna Barry of Deloittes (Raj Kaur during Lorna's maternity leave) made regular written and personal reports to the Committee.

The Committee is able to draw on the independent advice of the Trust's auditors and any other officers or outside agencies it considers necessary. We have met the auditors in private on two occasions in order to ensure that they have the freedom to raise any issues of concern. We have no matters to report as a result of these meetings.

1. Internal Audit

Internal Audit services are provided by Deloittes. The Committee has received progress reports from the internal auditors throughout the year and a final report in June 2007 providing the Head of Internal Audit Opinion.

The overall opinion was that **significant assurance** can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

The Committee actively monitors the implementation of management actions in response to internal audit recommendations and holds directors and managers to account for this. During 2006-07 we have considered 14 detailed internal audit reports by Deloittes. We are pleased to record that 12 of these (86%) received an overall assurance rating of 'full or significant'. We consider this an excellent result.

We have been concerned about the timescale for implementing improvements in the respect of two audits in Pharmacy and in Stores and Procurement. Both of these matters have subsequently been resolved to our satisfaction.

We have agreed a programme of internal audit work for 2007/08 which takes into account the principal risks faced by the Trust. We will continue to monitor the implementation of actions to improve controls.

5. Counter Fraud Services

The Local Counter Fraud Specialist (LCFS) is provided by Deloittes. The LCFS has provided a number of progress reports during the year and an annual report in June 2007. The Annual Report showed that arrangements in place for the year have complied with the Secretary of State Directions on counter fraud.
There have been no significant new matters leading to legal action, although in two cases findings were referred to Human Resources for internal action.
We have agreed a programme of work for 2007/08 which takes into account the risk experience of the Trust and risks identified nationally.

6. External audit

The external audit for the year has been provided by PricewaterhouseCoopers (PwC). The main reports from External audit have concerned the financial position, the Auditors Local Assessment (ALE) and the Annual Accounts.
An unqualified opinion was given on the accounts and on the Trust's Use of Resources. The Trust's reported[01] 2006-07 ALE score was 3 overall and in all categories (band 0

(poor) to 4 (excellent)) placing it in the top group of performers in the Healthcare Commission's Annual Assessment with a rating of 'Good'.

We have agreed the audit plan for 2007/08 with PwC.

7. Joint Working

The Committee wishes to put on record its appreciation of the considerable efforts PWC and Deloittes have made to coordinate their work and efforts through regular planning and assessment meetings. Such meetings are minuted and monitored by the Committee.

8. Financial performance

Whilst financial performance is not our direct responsibility, we nevertheless have a significant interest in ensuring that the systems of risk management and internal control will provide assurance to the Board in respect of the reported financial position.
We were satisfied that the fundamental financial accounting systems are robust (receiving significant assurances and relatively few identified gaps in control). We were pleased to note that external audit found the quality of the year-end accounting processes and working papers of a consistently high standard and recorded their appreciation at the Audit Committee meeting in June. Notably, the bottom-line financial position reported to the Board, a surplus of £5m, was once again unchanged as a result of their audit work.

9. Conclusion

In summary the Audit Committee is able to report that it has continued to review the key controls and processes within the Trust to ensure corporate and financial governance and has been given adequate assurance that they are operating effectively. This has been supported by the reports of the Internal and External Auditors received by the Committee during the year.
This coupled with the reporting of a significant surplus for the year and a healthy balance sheet leads the Committee to believe that the Trust is in an excellent position to achieve its stated objectives.

The Committee would like to thank the employees of the Trust who have made this possible and also to those who have contributed to the work of the Audit Committee.

10. Recommendation

The Board is requested to receive this report

Chair of Audit Committee
August 2007

ENCLOSURE 11 TO FOLLOW

ENCLOSURE 12

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board (Public)**

Report by: **The Medical Director**

Subject: **Research & Development**

Date: **September 2007**

Research & Development Annual Report

The report was circulated prior to the meeting for the Board's consideration.
The Board is asked to approve the report.

THE DUDLEY GROUP OF HOSPITALS NHS TRUST

Report to: **The Trust Board**

Report by: **The Medical Director**

Subject: **Research & Development**

Date: **September 2007**

Summary

Highlights of the year were the completion of the Clinical Research Unit (CRU) and R&D Directorate's move to North Wing; two prestigious awards (research fellow salary and administrative support) from the Arthritis Research Campaign; opening to recruitment of the first Dudley co-sponsored national multicentre randomized controlled trial (TRACE RA), examining the role of statins in rheumatology patients.

Obstacles to success include limited research nurse and service capacity, limiting the opening of new oncology studies. It has not been possible to complete the training plan for in-house Good Clinical Practice, due to time spent on the development of CRU, but staff are able to access an online training package, paid for by the R&D Directorate.

It was again not possible to audit 10% of research studies within the 2006/07 timeframe but this was completed by June 2007.

Funding: DH interim funding for 2007/08 continues at 80% of 2006/07 levels. R&D staff continue to prepare funding bids for locally designed research programmes.

Activity: There are currently >150 active studies and >70 research active professionals. Recruitment to oncology treatment studies has diminished due to service capacity and research nurse follow-up issues.

Rheumatology and cardiology continue to enrol patients in a variety of studies. MSc student projects continue to increase in number.

Staff are now in post to manage and recruit to the TRACE RA study and funding.

Rheumatology continues to produce a substantial number of publications; surgery and biochemistry also productive.

Education and Training: 27 members of staff completed the 3-day research and audit methodology course during 2006/07. A new in-house course has been developed for 2007/08.

Research Governance Implementation: A total of 46 projects were assessed by the protocol review sub-committee from 04/09/2006 to 17/08/2007; 43 were approved.

Changes in legislation necessitate revision of the research consent policy to cover studies that recruit participants who temporarily lack capacity to consent.

A written agreement with the co-sponsors of the TRACE RA study is in place; agreements with individual NHS Trusts continue to be signed off; all queries raised have been resolved to date.

Challenges:

DH interim funding will taper to 25% in 2008/09 and more funding is expected to be generated through the Comprehensive Local Research Network (CLRN). In addition, good recruitment to TRACE RA and multicentre cancer studies should assist funding levels, coupled with increased commercial trial activity.

Recruitment to oncology trials has been slower, due to falling number of open studies, difficulties in opening new studies, and the accrual of follow-up work resulting from previous successful recruitment.

It has not proved possible to complete the training plan for in-house Good Clinical Practice, due to the large amount of time devoted to selecting, ordering and liaising with other departments to equip the Clinical Research Unit.

The Board is asked to consider the new format and advise of any changes required, and approve the report.