The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 1 June, 2017 at 9.30am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – P Bytheway**		J Ord	To Note	9.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	9.30
3.	**Announcements**		J Ord	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 4 May 2017	Enclosure 1	J Ord	To Approve	9.30
	4.2 Action Sheet 4 May 2017	Enclosure 2	J Ord	To Action	9.35
5.	**Staff Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 4	D Wulff	To note assurances & discuss any actions	10.00
	7.2 Audit Committee Exception Report, including Audit Committee Chair's annual report	Enclosure 5	R Miner	To note assurances & discuss any actions	10.10
	7.3 Research and Development Report	Enclosure 6	J Neilson	To discuss	10.20
	7.4 Freedom to Speak Up Guardian's Report	Enclosure 7	S Jordan	To discuss	10.30
	7.5 Guardian of Safe Working Report	Enclosure 8	B Elahi	To discuss	10.40
	7.6 Annual Operating Plan	Enclosure 9	L Peaty	To approve	10.50
	7.7 Chief Nurse Report	Enclosure 10	S Jordan	To note assurances & discuss any actions	11.00

	7.8 Nurse/Midwife Staffing Report	Enclosure 11	S Jordan	To note assurances & discuss any actions	11.10
	7.9 Organ Donation Presentation	Enclosure 12	J Sonksen/R Paw/R Evans	To Note	11.20
8.	**Finance and Performance**				
	8.1 Cost Improvement Programme and Transformation Overview Report	Enclosure 13	A Gaston	To note assurances & discuss any actions	11.30
	8.2 Finance and Performance Committee Exception report	Enclosure 14	J Fellows	To note assurances & discuss any actions	11.40
9.	**Any other Business**		J Ord		11.50
10.	**Date of Next Board of Directors Meeting** 9.30am 6 July 2017 Clinical Education Centre		J Ord		11.50
11.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		11.50

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 4th May, 2017 at 9:30am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Julian Atkins, Non Executive Director
Doug Wulff, Non Executive Director
Jonathan Fellows, Non Executive Director
Diane Wake, Chief Executive
Paul Bytheway, Chief Operating Officer
Paul Harrison, Medical Director
Siobhan Jordan, Interim Chief Nurse

In Attendance:

Helen Forrester, EA
Glen Palethorpe, Director of Governance/Board Secretary
Andrew McMenemy, Director of HR
Liz Abbiss, Head of Communications and Patient Experience
Mark Stanton, Chief Information Officer
Anne Baines, Director of Strategy and Performance
Dr Mark Hopkin, Associate Non Executive Director
Chris Walker, Deputy Finance Director
Lisa Peaty, Deputy Director of Strategy and Performance (Item 17/052.3)
Amanda Gaston, Head of Service Improvement (Item 17/053.1)
Paul Stonelake, Responsible Officer (Item 17/052.8)
AHP Member Representatives (Item 17/050)

17/045 Note of Apologies and Welcome
9.34am

Ann Becke, Non Executive Director, Paul Taylor, Director of Finance and Information and Matt Banks, Operational Medical Director had sent apologies.

The Chairman welcomed Siobhan Jordan, Interim Chief Nurse, to her first Board meeting.

17/046 Declarations of Interest
9.35am

The Medical Director's standing declaration was noted and it was confirmed that this did not conflict with any items on the agenda requiring any decision.

Dr Mark Hopkin confirmed that he was a GP and Clinical Lead at the CCG and it was confirmed that this did not conflict with any items on the agenda requiring a decision.

There were no other declarations of interest.

17/047 Announcements
9.35am

The Chairman confirmed that this was Anne Baines last meeting as Director of Strategy and Performance, and passed on thanks and well wishes from the Board.

The Board noted that Terry Whalley, former BCA Programme Director, leaves his role at the end of May. The Board noted his departure.

17/048 Minutes of the previous Board meeting held on 6th April, 2017 (Enclosure 1)
9.37am

The minutes on page 7, item 17/041.5, Charitable Funds Committee Report should read "There was £2.4m available in total with £230k in the General fund." and "It was positive to note that the Charity had spent more than it had received as the fund balances needed to be reduced."

With these amendments the minutes of the previous meeting agreed by the Board as a true and correct record of the meetings discussion and could be signed by the Chairman.

17/049 Action Sheet, 6th April, 2017 (Enclosure 2)
9.38am

17/049.1 Urgent Care Centre Build

The Deputy Director of Finance confirmed that the Urgent Care Centre project team was meeting the following week and will work with designers to look at options for accelerating the build.

All items on the action sheet were either complete or for a future meeting.

17/050 Patient Story
9.40am

Liz Abbiss, Head of Communications and Patient Experience, presented the patient story and welcomed the members of Allied Health Professional (AHP) staff present in the meeting. The video was of a patient who had suffered a stroke and received treatment from several of the Trust's and Wolverhampton's services.

The Chief Operating Officer confirmed that the Trust has been working with AHPs to take forward their agenda.

The Director of Strategy and Performance asked about the patients move to West Park, Wolverhampton and whether there could be an integrated pathway. The Board noted that commissioners do not provide funding support for patients under 65 years locally to continue with rehabilitation assistance.

Liz confirmed that staff stories will now be shown at Board on a quarterly basis, in addition to continuing with patient stories.

Mr Atkins, Non Executive Director, asked if the level of support that had been provided was normal. The Board noted that this was the normal pathway for Stroke patients.

The Chairman asked about step down facilities within the community. The Director of Strategy and Performance stated that she was sure that this would become an MCP pathway. The Chief Executive confirmed that this was a national issue and not particular to Dudley.

The Chairman and Board noted the story and asked that all AHP colleagues were thanked for their work in supporting this patient and working effectively within multi-disciplinary teams.

17/051 Chief Executive's Overview Report (Enclosure 3)
9.58am

The Chief Executive presented her Overview Report, given as Enclosure 3, including the following highlights:

- **Department of Health Funding for the Emergency Department:** The Department of Health had announced that the Trust is to receive £1m A&E funding.

- **Directors Blog:** Directors across the Trust were blogging about the news in their areas, as another way to communicate with staff and the public about key issues.

- **Dying Matters Awareness Week:** The Trust is taking part in Dying Matters awareness week (8th to 14th May). One of the aims of the week is to highlight the importance of and raise awareness of engaging in individualised planning for patients who are dying.

- **Educators Shortlisted for Student Nursing Times Awards:** Three members of staff from the Trust have received national recognition from the Student Nursing Times Awards by making the shortlist in the category of Educator of the Year. The students did not win but the Trust will reapply next year and will benefit from accessing the expertise of the successful entry.

- **Thanking our Caring Profession:** International Day of the Midwife is on 5th May and International Nurses Day is 12th May. The Trust will be celebrating all of its caring professionals across all areas of the organisation.

- **Friends and Family:** The detailed report had been presented at the Finance and Performance Committee.

- **Visits and Events:** The Board noted the meetings and events during the previous month.

The Chief Executive confirmed that she will be making some changes to future reports.

The Board noted that the Trust was attending the CHKS awards the following week and the HSJ awards in two weeks time for day case theatre and interventional radiology.

The Chairman and Board noted the report.

17/052 Patient Safety and Quality

17/052.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
10.01am

Dr Wulff, Committee Chair, presented the Clinical Quality, Safety and Patient Experience Committee Exception Report, given as Enclosure 4.

The Board noted the following key areas from the Committee meeting:

- Issues around the patient safety alert for Naso Gastric Tube placements had been brought to Board's attention the previous month and the potential for not meeting the alert deadline had been identified. The Board was pleased to note that the Trust had met the deadline and the risk recorded the previous month had been mitigated and the suggested change to the original risk as there remains a risk of continued compliance. The Board noted that the wording will change and the risk will remain on the Risk Register.

- The Committee received a report from Radiology regarding the risk associated with the reporting of plain x-ray films. An update will be provided at the next meeting.

- The Board noted the assurances received and decisions made by the Committee and noted the actions taken regarding the NPSA alert and programme of monitoring to ensure the Trust remains compliant.

The Chairman and Board noted the report, assurances received, decisions made and noted the NG tube alert.

17/052.2 Quarterly Safeguarding Report (Enclosure 5)
10.06am

The Chief Nurse presented the Quarterly Safeguarding Report, given as Enclosure 5.

The Board noted the following key issues:

- Inspections had taken place and actions identified. Plans were in place for actions not yet delivered.

- The focus was on ensuring that all staff are appropriately trained to the right level.

Dr Wulff, Non Executive Director confirmed that safeguarding is examined by the Clinical Quality, Safety, Patient Experience Committee, for the assurance of the Board.

The Chairman and Board noted the report.

17/052.3 Operational Plan 2016/17 Quarter Four Report (Enclosure 6)
10.09am

The Director of Strategy and Performance, presented the Operational Plan 2016/17 Quarter Four Report, given as Enclosure 6. The Board noted the following key areas:

- The Board noted the final quarters report and year end position.
- There was disappointment at the number of deliverables that had not been met at year end.
- The Trust will use the same process for next year on reporting achievements and identifying risks.

Mr Miner, Non Executive Director, asked about the direction of travel and whether the Trust had flat lined in its efforts to achieve the delivery ask. The Director of Strategy and Performance agreed there had been a struggle to stay on track and the Executive team will work through how it can improve its approach, responses, mitigations and pace of change. Mr Miner agreed that the Trust needs to work at pace so that both change and operational delivery goals can be met.

The Chief Executive stated that there needs to be more ambition, pace and focus.

Dr Hopkin asked if the problem was the lack of actions around issues rather than just noting the position. The Chief Executive agreed and confirmed that there will be more focus on making improvements and taking action in a timely way.

The Chief Nurse had been discussing the issue with nurses and had not met any push back on making changes to the way of working.

The Chairman stated that some very good performance had been delivered and there were some improving trends. It was important to recognise there were many good practices and a solid foundation to build from.

The Chairman asked if there were any further risks that may need picking up like cancer, CQUINS and access to 7 day services.

The Director of Governance/Board Secretary confirmed that these were already on the Corporate Risk Register.

The Chief Executive commented that focus on the CQUIN indicators was not emphasised because of the block contract in place in 2016/17 but this will be different for the coming year and new processes are being put in place to ensure we deliver well.

The Chairman and Board noted the report and the subsequent actions arising.

17/052.3 Complaints and Claims Report (Enclosure 7)
10.20am

The Director of Governance/Board Secretary, presented the Complaints and Claims Report, given as Enclosure 7. The Board noted the following key issues:

- The Board noted the Annual report.
- The Trust continues to send acknowledgement responses within 3 days.
- There had been a significant increase on last year for full responses within 40 days.
- More resolution meetings were being held to assess the underlying issues complainants wanted resolved.
- A summary of the annual figures was outlined on page 1 of the report.
- The number of complaints in year had reduced. All complaints are used as an opportunity to learn and findings are disseminated to appropriate teams.
- Until and including quarter 3 the numbers relating to dissatisfied complaints had included all complaints where further questions had been submitted. This had now been rectified.
- Complaints about communication had similar numbers to the previous year. The Trust had launched its “In Your Shoes” campaign and it was expected once fully embedded across the organisation complaints of this nature could reduce.
- Complaints as a % of the total patient activity in the Trust remain at 0.03% over the year and 8% of the activity for compliments.
- The Trust continues to work with NHS Resolution (formerly NHSLA) and the recommended approaches in responding to complaints and claims.

Mr Fellows, Non Executive Director, asked if there was any potential for NHS Resolution premiums to reduce. The Director of Governance/Board Secretary confirmed that there is potential for this but premiums are set for a 3-5 year period so the Trust needs to sustain improvement. The Chief Executive confirmed that she is giving this some focus, as it links to the overall Quality Strategy.

Dr Wulff, Non Executive Director, asked if there was any indication that certain areas were generating more claims. The Board noted that the Trust had reinvigorated the learning group and taking feedback to divisions but there were no specific areas attracting more claims.

Mr Miner, Non Executive Director, asked if issues were around engagement rather than clinical care. The Director of Governance/Board Secretary agreed that many of the complaints and claims issues were around communication.

The Medical Director confirmed that there is good evidence that dealing with complaints promptly and effectively de-escalates the complaint.

The Chairman noted that the Trust is engaged in reducing NHS Resolution premiums and work is being undertaken to track any areas of concern. The Chairman asked if the Trust provided the equivalent of customer service training. The Director of Human Resources confirmed that it did.

The Chief Executive asked that future reports would also contain correlation with incidents and examples of learning. She was disappointed to read the narrative on the Rule 28 report which suggested some actions had been delayed.

The Chairman and Board noted the report and the actions underway.

Future reports to contain correlation with incidents and examples of learning.

17/052.4 End of Life and Palliative Care Strategy Group Report (Enclosure 8) 10.39am

Dr Wulff, Committee Chair, presented the End of Life and Palliative Care Strategy Group Report, given as Enclosure 8. The Board noted the following key issues:

- The last meeting looked at the activities of reporting groups.
- Launch of the economy wide end of life and palliative care strategy. The strategy on a page was attached to the report. The strategy will be launched this calendar year.

The Chairman asked why it was taking so long to launch the strategy. The Board noted that there had been some differences around understanding the reporting mechanisms for the Committee and these had now been clarified. There had also been some changes to national guidance and this needed to be incorporated in the Strategy. The Board noted that although the strategy had not been launched formally it was actually working in practice. The Chairman asked for further discussions outside of the Board in this respect. The Board noted that the Chairmanship of the group had not yet been finalised. The Chief Executive confirmed that she was involved in End of Life Care nationally and would be content to Chair the group. The Chief Nurse confirmed that she was fully committed to good End of Life care and would also be content to be involved. The Chairman asked that the Executive Team agree representation and confirm arrangements.

The Chairman and Board noted the report and the ongoing work on End of Life Care in Dudley.

Executive Team to agree Chairmanship of the group and confirm arrangements.

17/052.5 Staff Survey Report (Enclosure 9)
10.43am

The Director of Human Resources presented the Staff Survey Report, given as Enclosure 9. The Board noted the following key issues:

- Focus groups had met and the majority of feedback received showed appreciation of engagement.
- The Trust will take forward the focus group and other feedback received.
- Greater engagement had resulted following the Chief Executive briefings.
- Directors were now producing blogs on a variety of issues which were available on the intranet.
- The Trust needs to develop consistent, regular engagement activity.
- There will be a focus on health and well being for staff.
- Improved appraisal rates should have a positive impact on the next staff survey including opportunities for learning and development.
- Pulse surveys were being introduced to gauge in year improvement.
- More focus groups will be held later in the year, and before the next staff survey to check progress.

Mr Fellows, Non Executive Director, asked how the Trust can retain staff and whether the negative coverage in the press had an impact on morale. Liz Abbiss confirmed that her team had discussed how they could counteract negative coverage and ensure good work and achievement was more widely recognised.

The Director of Human Resources confirmed that marketing and branding would be a focus for his Directorate going forward. There was also ongoing work in this regard with NHS Employers.

The Chief Operating Officer raised the “breakfast with the boss” sessions and stated that the Trust had received some excellent feedback from staff attending. The Director of Human Resources confirmed that there were similar themes arising from the breakfast with the boss sessions and the focus groups.

The Chairman asked to see broad themes around how the organisation can make improvements that would be impactful.

The Chairman and Board noted the report and approved the plan asking that the comments and suggested actions be progressed.

17/052.6 Annual Certifications Report (Enclosure 10)
10.54am

The Director of Governance/Board Secretary presented the Annual Certifications report, given as Enclosure 10.

The Chairman and Board noted the report and approved the self certification as compliant for each element within the required annual declarations.

17/052.7 Workforce and Staff Engagement Committee Exception Report (Enclosure 11)
10.57am

Mr Atkins, Committee Chair, presented the Workforce and Staff Engagement Committee Exception Report given as Enclosure 11.

The Board noted the following key issues:

- The Committee received an update on the workforce business plan which made a proposal for the Trust to go smoke free from 1st January, 2018. A report will be provided to the June Board.
- An outline of the learning and development strategy will be developed and include costings.
- Apprenticeships had just missed the annual target of 100 apprenticeships, with 97 achieved.
- The Committee was presented with the new workforce KPIs which were favourably received
- Staff friend and family results had seen an improvement in Q4 of 2016/17.

The Director of Strategy and Performance confirmed that work was being undertaken to encourage service improvement opportunities through NVQs. It was noted such training could be funded through the new apprenticeship levy.

The Chairman and Board noted the report.

17/052.8 Medical Revalidation Report (Enclosure 12)
11.12am

Mr Stonelake, Responsible Officer, presented the Medical Revalidation Report given as Enclosure 12.

The Board noted the following key issues:

- Successfully separated the role of the Medical Director from Responsible Officer and Mr Stonelake had taken on the latter role.

- Some issues in supporting the function had been experienced because of a change in personnel.

- The Trust had appointed a Medical Revalidation Support Officer who was currently being trained.

- There had been some confusion in the Trust around where the responsibility lies for monitoring numbers of medical appraisals completed. Directorate managers had assumed some responsibility for this, including reporting to the HR team. It had now been agreed that there will be one team responsible for maintaining data and distributing it. The appraisal revalidation team will take this responsibility. The medical appraisal requirements and the need to report this externally will continue to ensure all doctors employed by the Trust are fit to practice.

- The Trust had achieved 90% of appraisals completed which is around the national average.

The Chief Operating Officer agreed that there needs to be clear understanding around the medical appraisal reporting process.

Mr Fellows, Non Executive Director, asked who sets the objectives. Mr Stonelake confirmed that this is the line manager and is within job planning.

Dr Hopkin, Associate Non Executive Director, stated that the quality of the appraiser is important. It was noted that training is available for appraisers.

Mr Miner, Non Executive Director, asked for assurance that the process identified medics who have leadership potential. Mr Stonelake confirmed that these will be identified during the appraisal process and will feed into the wider Trust management processes.

The Chairman noted that medical appraisals will be managed by the medical revalidation team but there will be close alignment with the HR department so that numbers could be incorporated into the overall system.

The Chairman and Board noted the report and the annual operational return of revalidation numbers.

17/053 Finance and Performance

17/053.1 Cost Improvement Programme and Transformation Overview Report (Enclosure 13)
11.01am

The Head of Service Improvement presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 13.

The Board noted the following key highlights:

- The Trust finished with the £1.8m anticipated shortfall against its CIP target for 2016/17.

- For 2017/18 projects are in early stages and milestones were not yet agreed. Some schemes though were already delivering in month 1 to the amount of £1.3m of the £12m target.

- 42 schemes had been identified and only 3% were non recurrent although this will change during the year.

- Anticipated savings were set out showing pay and non pay and income opportunities.

- 35% of schemes have PIDs developed.

- Lessons learned from 2016/17 were identified. Mitigation plans will be developed for the coming year using this knowledge.

- Recognised need to encourage all Divisions to achieve above and beyond targets and to identify some alternative projects.

The Director of Strategy and Performance stated that the Trust had lost some pace on in-year delivery in 2016/17. Changes were being put in place which will help the Trust in monitoring progress “run-rate”.

The Chief Executive stated that future reports will include monthly profiles of projected savings.

The Chairman and Board noted the report.

17/053.2 Finance and Performance Committee Exception Report (Enclosure 14) 11.32am

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 14.

The Board noted the following key issues:

- The Trust received the full £10.5m STF funding.
- The Trust had been allocated a further £1.4m additional STF funds as a result of exceeding the 2016/17 control total.
- Performance in March saw A&E, Diagnostics and VTE met and significant advances in appraisals and mandatory training numbers. There remain significant challenges in the year ahead.
- £12.5m CIP will only be achieved in 2017/18 if agency spending can be reduced and the number of inpatient beds reduced by improving delayed transfers of care. There is a risk to the CCG meeting the cost of overperformance due to the increasing demand for hospital services.
- Failure to achieve the control total in 2017/18 is also a risk as £8.5m STF money will not be realised.
- Items referred to the Board for further discussion included the hybrid mail business case. This will be submitted to the Board once all the requested detail is available.
- The membership of the Finance and Performance Committee will be widened to allow more focus on divisional performance on a regular basis.

The Chief Information Officer confirmed that the two outstanding points on the hybrid mail business case were now met and will be available for discussion at a convened Board meeting on 11th May, 2017.

The Chairman and Board noted the report and the developments outlined.

Hybrid Mail business case to be received at a Board meeting on 11th May, 2017.

17/054 Any Other Business
11.37am

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

17/055 Date of Next Meeting
11.37am

The next Board meeting will be held on Thursday, 1st June, 2017, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 4 May 2017

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/053.2	Finance and Performance Committee	Hybrid Mail business case to be received at the Board Workshop.	MS	11/5/17	Approved
17/042.2	Finance and Performance Committee Exception Report	The Director of Finance and Information to check if timescales for the build could be reduced.	PT	1/6/17	Project Team to meet to discuss escalating the project.
16/118.5 & 17/027.1	Research and Development	The Medical Director to produce a Research and Development gap analysis.	JN	1/6/17	On Agenda
17/030.7	Freedom to Speak Up Guardian Report	Further update to the Board in 3 months time.	CLM	1/6/17	On Agenda
17/030.8	Guardian of Safe Working Report	Further update to the Board in 3 months time.	BE	1/6/17	On Agenda
17/052.4	End of Life and Palliative Care Strategy Group Report	Executive Team to agree Chairmanship of the Group and report back.	ET/DW	1/6/17	Siobhan Jordan to Chair.
17/041.7	Corporate Risk Register and Assurance Report	The Executive Team to consider the inclusion of the new Apprenticeship levy on the Risk Register.	ET	6/7/17	
17/052.3	Complaints and Claims Report	Future reports to contain correlation with incidents and examples of learning.	GP	7/9/17	

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 1 June 2017

TITLE:	**23 May 2017 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe – Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES
SO 1 – Deliver a great patient experience
SO 2 – Safe and caring services

SUMMARY OF KEY ISSUES:
The attached provides a summary of the assurances received at this meeting, the decisions taken, the tracking of actions for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

The Committee requests the Board to note the assurances received at the meeting and the decisions made by the Committee.

The Committee requests that the Board endorse the requests to the Trust Executive to maintain the focus on learning and improvement from quality and safety reviews, concerns, complaints and incidents.

The Committee requests that the Board support the request for the following issues to be risk assessed by the respective Divisions - out of date Standard Operating Procedures, inability to scan patient name bands, incomplete blood transfusion training and the prevention of pressure damage.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	23 May 2017	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- The outcomes of the weekly audits on compliance with the National Patient Safety Agency Alert in respect of Naso Gastric Tube placements were received by the Committee. Insufficient assurance was provided from the audits to change the frequency to quarterly. Data from Nerve Center identified insertions but not recording the review of placements. Agreed that the audit be expanded to include care plans and that action be taken by the Chief Nurse and Chief Operating Officer to review the audit results for weekends.
- Executive Management assurance was provided on the performance in respect of key quality indicators.
- There are currently 3 policies under review that have exceeded their planned review date. The lead executive directors are aware of these instances. The Committee reiterated its stance that the review of Polices should be a priority.
- A further update to that provided at the last Committee on the work of the Mortality Surveillance Group was provided. This update reconfirmed that work is underway to update the Trust policy and supporting procedures for the case review of all deaths and that will be considered by the Mortality Surveillance Group ahead of being report to this Committee.
- An Executive Management update was provided in respect of the work of the Quality and Safety Group. The Committee asked the Group chair, the Chief Nurse, to present at the next meeting a more detailed update on the issues being discussed by the Group, not least on progress with the falls action plan, blood transfusion training and safeguarding champion recruitment.
- An Executive Management update was provided in respect of the work of the Internal Safeguarding Group. Assurance was provided in respect of progress with associated actions flowing from the last CQC Safeguarding Children Inspection Plan.
- The Committee was updated on action being taken by the Trust in respect of the risk of un-reported plain film x-rays. The Committee was informed of the action plan in place including external support with reporting of unreported films. The Committee asked that further information be brought back to the August meeting.

- Executive Management assurance was provided in respect of the Trust focus on learning and improvement which was demonstrated within the aggregated learning report. This report had already been shared with the Governors to inform them of improvements and learning applied from past incidents, concerns or complaints. The Committee requested that the Executive Team push the Divisions to focus on learning and improvement and asked that examples are cascaded across the Trust.
- The Committee received a report on the operation of the Evergreen Unit. The Committee asked for a number of areas to be looked at in more detail including the admission criteria, discharge processes and quality of care audit processes. The Committee asked for the outcome of this work to be presented to the Committee in July.
- The Committee received Executive Management assurance on the continuing work within Maternity. The Committee noted the plan to continue to bring update reports to the Committee on a monthly cycle throughout the year.
- The Committee received an update on the outcome of an external review into an adverse event during a research study. The Committee noted the action plan developed in respect of this review and assurances that processes are now in place to prevent a recurrence of this type of adverse event.

Decisions Made/Items Approved

- The Committee approved 4 policies.
- The Committee supported the closure of 23 Root Cause Analyses (RCA) action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.
- The Committee approved the submission of the report supporting the CQUIN in respect of reducing neonatal admission be sent to the Commissioners.

Actions to come back to Committee (items the Committee is keeping an eye on)

- The continued reporting of the outcomes of the audits in respect of the NPSA alert regarding Naso Gastric Tube Placement.
- The Committee as part of its discussion on the performance report asked that a separate report on maternity performance be brought back to the Committee.
- The Committee to receive reports directly from the respective Divisions on the actions taken as a result of the internal quality and safety reviews.
- The outcome of the action plan for plain film x-rays reporting be brought back to the meeting in August.
- The Committee requested a further report in July on the Evergreen Unit.

Items referred to the Board for decision or action
The Committee requests the Board to note the assurances received at the meeting and the decisions made by the Committee. The Committee requests that the Board endorse the requests to the Trust Executive to maintain the focus on learning and improvement from quality and safety reviews, concerns, complaints and incidents. The Committee requests that the Board support the request for the following issues to be risk assessed by the respective Divisions - out of date Standard Operating Procedures, inability to scan patient name bands, incomplete blood transfusion training and the prevention of pressure damage.

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 6 April 2017

TITLE:	**16 May 2017 Audit Committee Summary Report to the Board including the Audit Committee Annual Report**		
AUTHOR:	Richard Miner – Committee Chair	**PRESENTER**	Richard Miner – Committee Chair

CORPORATE OBJECTIVES

ALL

SUMMARY OF KEY ISSUES:

The attached provides a summary of the assurances received at this meeting, the decisions taken, the tracking of actions for subsequent meetings of this Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

To note the assurances received via the Committee, the decisions taken in accordance with the Committee's terms of reference and action any items referred to the Board.

To receive the Audit Committee annual report and endorse the actions to be taken by the Committee during the forthcoming year with regards to monitoring of management actions in respect of the data quality internal audits.

Audit Committee highlights report to Board

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**16/5/2017**	**Richard Miner**	**yes**	**no**
			x	

Declarations of Interest Made

None

Assurances Received

- The (ISA 260) report from PwC (the external auditors) on their audit work on the Trust's accounts for the 2016/17, including use of resources (value for money) showing an unmodified (clean) opinion.
- The ISA 260 report from PwC on the Charitable Funds.
- The limited (in scope) assurance provided by PwC in respect of the Quality Account and Report.
- The Head of Internal Audit Opinion (HoIA) for 2016/17 – an adequate and effective framework for risk management, governance and internal control notwithstanding some "further enhancements" that could be applied. This report is the same as last year, the second highest level of confidence, and the enhancements were set out in my previous report. The Opinion supports the contents within the Trust's Annual Governance Statement.
- The LCFS Annual Report for 2016/17 including the self-review tool which reflected an overall amber rating (this is fairly normal).
- The Trust's Annual Clinical Audit Report for 2016/17.

Decisions Made / Items Approved

The Committee:

- Approved the signing of the Letter of Representation on the Trust's annual accounts for 2016/17.
- Using the delegated powers given by the Board at its meeting on 11 May, approved the Trust's Annual Accounts for 2016/17.
- Approved the draft Annual Reporting noting a number of modifications and changes necessary and that will receive final approval at the Finance and Performance ("F&P") Committee on 25 May.
- Approved the signing of the Letter of Representation on the Quality Accounts.
- Approved the draft Quality Account and Report for 2016/17subject to its final completion (and if necessary, final endorsement at the F&P Committee on 25 May).
- Approved the signing of the Letter of Representation on the Charitable Funds for 2016/17.
- Approved the Charitable Funds Accounts and Annual Report for 2016/17.
- Approved the LCFS Annual Report for 2016/17.
- Approved the Audit Committee's Annual Report subject to some minor changes necessary on completion of some audit work and which has now been done.
- Noted the losses report for Quarter 4 and for 2016/17.

Actions to come back to Committee / Group (Items Committee / Group

Audit Committee highlights report to Board

keeping an eye on)

- Data quality follow-up work due to previous “red” opinions (VTE and TIA data quality).
- Monitoring of management actions and timescales identified in the HoIA opinion.

Items referred to the Board / Parent Committee for decision or action

- That the Limited (in scope) Assurance Report provided by PwC on the Quality Accounts contained:
  - A qualified (except for) opinion on the A&E 4 hour wait indicator. The data provided was insufficient to demonstrate compliance with the national priority indicator.
  - A disclaimed opinion on the 18 week RTT indicator. In a number of cases during a limited period, the patients “clock” commenced with date of appointment rather than date of referral. This had been reported to commissioners and NHSI.
- The Audit Committee’s Annual Report (attached to this document).
- The losses report for 2016/17

The Dudley Group NHS
NHS Foundation Trust

ANNUAL REPORT OF THE AUDIT COMMITTEE FOR THE YEAR 2016/17

1. Introduction

The Audit Committee is established to provide assurance to the Board that there is an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives and that this system is established and maintained.

The purpose of this report is for the Audit Committee to account to the Trust Board of Directors on its activities relating to the financial year 2016/17. In practice this covers the period up to the approval and sign off of the Trust's Annual Report and Accounts, which is due to take place on 16 May 2017. The Board gives delegated powers to the Audit Committee to approve these documents.

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

The Committee's responsibilities are set out in detail below.

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

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

2. Audit Committee's Responsibilities

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

a) To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical, that supports the achievement of the organisation's objectives;

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

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

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

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

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

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

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

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

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

3. Audit Committee Membership

The Audit Committee is constituted as a sub-committee of the Trust Board with approved terms of reference that are aligned with the *Audit Committee Handbook 2014* published by the HFMA and Department of Health. The required quorum for meetings is two Non-Executive Directors.

It is recommended that the Chair of the committee is a suitably (CCAB) qualified accountant. Richard Miner is an Associate of the Institute of Chartered Accountants in England and Wales and a Fellow of the Association of Chartered Certified Accountants.

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

The table below records attendance at each meeting, including the last meeting of the 2015/16 cycle; the 2016/17 cycle of 5 meeting of the year was held on 16 May 2017:

Date of Meeting	Audit Chair	Other NEDs	Finance Director	External Auditors	Internal Auditors	LCFS
24 May 2016	Yes	2	Yes	Yes	Yes	Yes
8 September 2016	Yes	2	No*	Yes	Yes	Yes
15 November 2016	Yes	2	Yes	Yes	Yes	Yes
24 January 2017	Yes	2	No*	Yes	Yes	Yes
21 March 2017	Yes	2	Yes	Yes	Yes	Yes

* The Deputy Director of Finance – Financial Reporting was present on each occasion.

Other individuals from the Trust are invited to attend meetings including the Chief Executive, Chief Nurse and the Director for Governance.

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

The Terms of Reference for the Audit Committee are reviewed annually and the most recent update was approved at the November meeting and presented to the Board at its December 2016 meeting. Whilst all Non-Executive Directors can attend meetings of the Audit Committee should they wish to do so, two specific Non- Executive Directors have been appointed to serve on the Audit Committee, in addition to the Chair of the Committee in order to provide the Committee with sufficient balance and experience.

4. Internal Audit

Internal Audit services for the 2016/17 year were provided by RSM. Internal Audit supports the work of the Audit Committee in two key areas:

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

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

As is normal, a risk- based approach was taken to establish the internal audit plan for 2016/17. This took account of the strategic and operational risks relating to quality and safety issues; service delivery standards and targets; workforce; finance and business, as identified by both management and the Committee, as well as the need to review key financial systems to ensure that External Audit could continue to place reliance on the work of Internal Audit.

The Committee noted, once again, that the risk from cyber crime is continuing to have a growing impact on the shape of the assurance the Committee is seeking. The Committee received a specific from the Director of IT on the Trust's approach to combatting Cyber Crime.

Internal Audit has undertaken a number of advisory assignments as well as risk assurance assignments for which it issues a range of opinions between green (substantial assurance) and red (no assurance). Red reports were issued in the following areas:

- Data quality on Venous Thromboembolism Evaluation (VTE) and stroke suspected Transient Ischaemic Attacks (TIA) key performance indicators.
- IT Data Security Review
- IT Disaster Recovery

All issued reports have their agreed action tracked and followed up, with Internal Audit providing a report on the progress made by management in implementing the agreed actions.

Other areas reviewed were in most cases rated as providing substantial assurance or reviewed in an advisory capacity:

- IT Projects (EPR) - advisory
- CIP Monitoring – substantial assurance
- General Ledger – substantial assurance
- Safer staffing reporting – partial assurance
- Management Action Follow Up (Data Security) – reasonable assurance
- Payroll Process – reasonable assurance
- Payroll Right to Work in the UK – partial assurance
- Cash and Treasury Management – substantial assurance
- Income and Debtors – substantial assurance
- Quality and Safety Review outputs and reporting – reasonable assurance
- Divisional Governance, risk and performance management – advisory
- Information Governance Toolkit Assessment – advisory

As a result of this work, the proposed opinion from the Head of Internal Audit is that:

"The organisation has an adequate and effective framework for risk management,

governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

The reference to further enhancements to the framework relates particularly to VTE, stroke suspected TIA, the incomplete Emergency Planning work and Safer Staffing Reporting.

Internal Audit also concluded based on their work that there were no significant internal control weaknesses that required reporting within the Trust's Annual Governance Statement.

The further enhancements relate to those framework areas (above) which provided only partial assurance but given Internal Audit is directed towards those more challenging or "uncomfortable" areas, this should not come as a complete surprise.

5. Clinical Governance

The core business of every NHS organisation is healthcare and consequently it is appropriate and necessary for the Audit Committee to consider the clinical objectives and risks in the Assurance Framework and report to the Trust Board on the controls and assurances relating to these. The Director of Governance reports to the Audit Committee on the progress of the Clinical Audit Plan and the Chief Nurse is also available to attend the Audit Committee as necessary.

A total of 71 clinical audits have been commenced in respect of 2016/17 with all but 2 audits either complete or in progress at the year end.

The Trust participated in 35 National Clinical Audits linked to the Department of Health Quality Account list.

The Audit Committee also received quarterly reports from the Research and Development Directorate.

6. Counter Fraud Services

The Local Counter Fraud Services (LCFS) have continued to provide a combination of fraud awareness newsletters and training, hold meetings with key managers and engage in active investigations. The essence of their work is preventative. Highest risks have been identified in the following areas:

- Consultant job plans (a national issue)
- Secondary employment/working when off sick
- Cyber crime

The LCFS concluded based on their work that there were no significant fraud risks that required reporting within the Trust's Annual Governance Statement.

7. External Audit

This will be the second year that PriceWaterhouseCoopers (PwC) has acted as external auditor. Ali Breadon took over from Richard Bacon as Engagement Lead though Matthew Elmer continues as Engagement Senior Manager and the change has been seamless.

The following audit risks were identified:

- Risk of management override controls
- Risk of fraud in revenue and expenditure recognition
- Valuation of land and buildings

Other areas that have been considered include:

- Going concern
- The Trust Quality Report, which is reported on separately
- The accounts of the Charitable Funds Committee and those of Dudley Clinical Services Limited, both of which are consolidated into the Trust's annual financial statements.

The audit of the Financial Statements requires the setting of a materiality level in order to assess the impact of any adjustments that might be necessary.

The audit is planned on the basis that the Trust has an effective financial control environment and this is subsequently tested along with application of various substantive analytical procedures. They also take into account the work of the internal auditors.

The Trust is required to demonstrate its Economy, Efficiency and Effectiveness in its Use of Resources which it has done in 2016/17 and the Trust is now clear of its Enforcement Notice which had previously affected the Audit Report. PwC have issue an unmodified (clean) audit opinion. This also reflects the fact that PwC has been able to satisfy itself as to the going concern of the Trust as well as to the truth and fairness of the financial statements.

As far as the Quality Account is concerned, this is a "limited assurance" style of report but 2016/17 highlights a qualified (except for) opinion in respect of A&E 4 hour waits due to data inconsistencies and a disclaimer of opinion on the 18 week RTT measure. In the case of RTT, this was due to inconsistencies in starting times for the patient "clock" during a limited period. It had been reported to commissioners and NHSI.

8. Review of Audit Committee Effectiveness

During the year the Committee carried out a (self) review of its effectiveness and reported positively.

9. Conclusion and Audit Committee Opinion 2016/17

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

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

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

The Audit Committee reviewed the Trust's Annual Governance Statement and confirms, based on the information it has received, the statement is a balanced view of the Trust's systems of risk management, governance and internal control.

Richard Miner ACA FCCA
Chair of Audit Committee
May 2017

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board on 8June 2017

TITLE:	**Research & Development 6-monthly Report**		
AUTHOR:	**Claire Phillips, R&D Manager; Margaret Marriott, R&D Facilitator**	**PRESENTER**	**Jeff Neilson, Director of R&D**

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

SUMMARY OF KEY ISSUES:

- Research Nurse coverage of studies
- NIHR study portfolio balance
- Support Department Capacity Issues
- Research Data Archiving

IMPLICATIONS OF PAPER:

RISKS	**Y**		• **Risk Descriptions**: • As recruitment target for NIHR portfolio studies are not met, CRN research income has reduced. • Lack of clinical support department capacity is affecting our ability to take on new research. • Identification of suitable archiving space • Finding funding for research data archiving when income is diminishing
	Risk Register:		To register as departmental risks
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, effective, caring, responsive, well led
	Monitor	**Y**	**Details:** R&D activity included in the Annual Report
	Other	**Y**	**Details:** Recruitment activity is monitored by CRN:WM, NIHR, DH

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE COMMITTEE:
The Committee is requested to note the key issues arising and identify any further actions required.

Research & Development Report

Strategic Direction
We aim to increase the number of patients taking part in research and embed research into the core business of the Trust, integrating with clinical care. We now have a balanced portfolio of commercial/ non-commercial studies, and continue to redress the balance towards academic observational studies.
Study Portfolio Mix: Three home grown Band 2 studies have achieved NIHR adoption and will recruit during 2017/18 Two of these are collaborations with the School of Sport and Exercise, University of Birmingham. Another Band 2 study is conducted with the University of Wolverhampton. We work to increase our academic partnerships and hold joint quarterly meetings between clinical and academic staff. We now have three recruiting commercial Haematology projects, and continue to conduct commercial research in other specialties, particularly Rheumatology, Cardiology, Dermatology and Diabetes. We will investigate the possibility of increasing DH Research Capacity Funding which relates to increased recruitment to NIHR portfolio AND number of local Chief Investigators recognised as NIHR Senior Investigators. We can only encourage consultants to become involved in research; recognition of principal investigator status within consultant job planning will be more tangible encouragement for them to integrate research into standard medical care.

Benefits of research
The Pathfinder study has identified a second Dudley patient who can be referred for a new treatment for Pompe disease, a rare (1 in 50,000 live births) multisystem genetic disorder. A recent paper in the gastroenterology journal GUT (http://dx.doi.org/10.1136/gutjnl-2015-311308) has shown that integrating research into the care patients with colorectal cancer improved post-operative mortality by 1.5% and 5-year survival by 3.8%. This effect applied to all hospitals with high rates of research (≥16%) regardless of size and whether they were academic centres. At the time the study was conducted (2001-2008), we were a high recruiter into colorectal cancer studies. There is no reason to believe that this effect is confined to colorectal cancer.

Accolades for the Clinical Research Unit Laboratory
2017 has brought with it a flurry of awards relating to the work of the R&D Biomedical Scientist team, headed by Jackie Smith. In March 2017 Jackie was runner-up in the Unsung Clinical Hero category of the Committed to Excellence Awards and in April also accepted a Clinical Research Network prize for the laboratory's support for clinical research. More recently -04/05/2017 - the laboratory passed its re-accreditation inspection for Good Clinical Laboratory Practice, the only unit of its kind in the West Midlands area.

Diabetes Research
We fully met our recruitment and retention target for the REACH commercial study, looking at use of a new insulin for patients with Type 2 diabetes. For the DUAL VIII study, Dudley was the third best UK recruiting site, also comparing types of insulin control.

Black Country Alliance
With our neighbour, SWBH, we are exploring the possibility of increasing the opportunities for Dudley participants to take part in new research studies as a dedicated Faecal Incontinence and Constipation Healthcare (FINCH) service is developed at Russells Hall Hospital.

100,000 genomes project
R&D biomedical scientists continue to assist with blood collection for patients and relatives with rare diseases; many of the accompanied children display challenging behaviours and it is thus a fairly time-consuming non-research activity. Due to the Trust shortage of histopathologists, the Chief Research Biomedical Scientist has now agreed to prepare colorectal tumour tissue for the 100,000 genomes project. We are uncertain whether this level of activity will be sustainable in the long term, since this project was envisioned as the implementation of genomic medicine rather than pure research.

National developments and performance management

High level objectives
Trusts are expected to recruit to commercial and academic clinical trials within 70 days of receiving an initial Health Research Authority assessment letter and full set of documents from the Sponsor. Metrics indicate that Dudley's performance is now more in line with the majority of local acute Trusts where capacity issues and financial constraints are affecting study initiation and ability to recruit to time and target.

The EDGE database is continuing to provide useful business intelligence for R&D. The next significant development stage, led by Research Support Officer John Walters, will be implementation of a finance system that captures all research visit payments due and will provide a more accurate means of income projection. The exercise will require a significant level of buy-in from all research teams but will assist greatly with R&D decision-making.

Capacity for research support departments
R&D is no longer able to initiate studies that require CT or MRI scans that are additional to the DGH clinical pathway due to capacity within Radiology. Stroke research has been affected by this most recently. Many malignant haematological studies have undergone significant protocol amendments recently which have placed higher demands on the aseptic unit research pharmacist. It has therefore been taking longer to open any new studies requiring aseptic unit input.

Finance and Staffing
While Clinical Research Network (CRN) core funding based on the Activity Based Funding model is indeed reduced by £40K for 17/18, the Trust was also successful with two strategic funding bids. One bid is for a WTE research nurse to work on DGH's fledgling paediatric and reproductive health portfolios for one year, mentored by specialist CRN staff. The second bid builds on the successful study recruitment by the R&D biomedical scientists, providing for a full time Band 3 scientific support officer until 31/03/2018.
The reduction in funding requires us to look at ways of increasing research nurse and data manager capacity, probably by changing to generic rather than specialty working amongst the teams. This situation is currently further exacerbated by long term sickness and resignations by experienced team members who already normally cover a number of specialties.

Electronic Patient Record/IT/Archiving
R&D is in communication with the IT Governance Manager regarding a range of issues concerning data safety and access to CRN Business Intelligence information. Acquiring external secure space for long term clinical data storage is now a priority task.

Education/Professional Development/Promotion
Dudley-based half-day refresher courses in Good Clinical Practice for research purposes continue to be led by Margaret Marriott. Members of the R&D admin team have attended the EDGE international conference and the NHS R&D Forum annual conference.
On 22/05/2017 R&D staff ran a stall at the Main Entrance, Russells Hall Hospital, to promote International Clinical Trials Day. A more regular R&D newsletter is planned for the Trust.

Recruitment by Specialty compared with Targets

Recruitment data as provided by CRN Coordinating Centre on 01/05/2017

Current financial year only. Recruitment counted to end of last month

The Dudley Group NHS Foundation Trust only

Specialty	Target		Recruits	*Variance*
	Full year	Pro rata		
Ageing	1	1		*-1*
Anaesthesia, perioperative medicine and pain management	70	70	263	*193*
Cancer	200	200	139	*-61*
Cardiovascular disease	200	200	208	*8*
Children	50	50	24	*-26*
Critical care	3	3	39	*36*
Dementias and neurodegeneration	1	1		*-1*
Dermatology	100	100	26	*-74*
Diabetes	50	50	45	*-5*
Gastroenterology	25	25	57	*32*
Haematology	50	50	52	*2*
Health services and delivery research	1	1	70	*69*
Hepatology	1	1	31	*30*
Infectious Diseases and Microbiology	1	1		*-1*
Injuries and emergencies	1	1		*-1*
Metabolic and endocrine disorders	300	300	426	*126*
Musculoskeletal disorders	500	500	162	*-338*
Neurological disorders	10	10		*-10*
Ophthalmology	1	1		*-1*
Renal disorders	40	40	10	*-30*
Reproductive health and childbirth	40	40		*-40*
Respiratory disorders	20	20	16	*-4*
Stroke	20	20	4	*-16*
Surgery	4	4	12	*8*
xx Additional aspirational target xx	311	311		*-311*
	2000	**2000**	**1584**	***-416***

	R&D Department Gap Analysis May 2017						
	Area of Performance						
No.	**Current State**	**Future State**	**Gap (Y/N)**	**Gap Description**	**Factors Responsible**	**Recommendation/Action**	**Challenges**
1	Patient Recruitment Actual 2016/17 = 1584 (79% of recruitment target)	Patient Recruitment CRN Target 2016/2017 = 2000	YES	Did not meet the CRN patient recruitment target, with a shortfall of 416 pts.	Staff sickness 2.4 WTE; therefore capacity is lower to recruit patients to studies; Strict inclusion /exclusion criteria for some studies Small patient recruitment targets for some studies (due to number of sites participating) Limited management structure to drive recruitment and monitor targets	0.4 WTE returned to work 06.04.17: 2 due review June & July 2017 for action plan. R&D Manager and Deputy R&D Director now in post, to drive recruitment and monitor throughout the year to achieve targets. Assess studies for participation on a basis whereby a balanced portfolio of studies is achieved with realistic recruitment targets	1 x WTE Research Nurse leaving Trust end May 2017; 0.6WTE Senior Research Nurse leaving June 2017, 1.0 WTE Senior Research Nurse retiring Mar 2018. EPR system to provide efficiencies in patient identification and tracking? Radiology, Pharmacy and labs have sufficient capacity to support research growth. Adequate clinical research space to support more patients being recruited to studies.

No.	Current State	Future State	Gap (Y/N)	Gap Description	Factors Responsible	Recommendation/Action	Challenges
2	Number of specialities conducting research = 16	All specialities to have some research participation	YES	Research to be encouraged in all specialities.	Time/capacity No incentives to participate in research Processes not clear	Reproductive Health and Paediatrics are being targeted to increase research Include research within consultant job planning Clinical Leads to champion research & innovation within their areas Student Nurse placements - exploring whether R&D can be included in their placement, as an introduction to R&D R&D activity and process/contacts to be included in Trust Staff induction (also links to increased promotion of R&D).	Time and capacity constraints Trust acceptance of R&D being included in induction programme Clinicians, nurses, AHP's not interested in research Funding of consultant SPA time for involvement in research

No.	Current State	Future State	Gap (Y/N)	Gap Description	Factors Responsible	Recommendation/Action	Challenges
3	Current CRN funding for R&D is decreasing; current Research Capacity Funding (RCF) is the minimum amount	Increase research funding through increased patient recruitment Increase Research Capacity Funding through increased 'home grown' research	YES	Funding has decreased	patient recruitment has fallen 2016/17 CRN funding reduced by 40k	Increase 'home-grown' research projects to enable RCF funding to increase. Review other funding streams (research grants; Charity Funding; build collaborations with other universities/Trusts & BCA/charities, to increase research and funding Explore other alternative research roles/pay bands to replace current/future vacancies Review current capacity within the delivery teams to identify where we are able to use what we have to cross cover another speciality where possible, to keep within our financial budget	Time to implement Staff posts/bands to be reviewed when staff leave Ensure quality of research remains high Capacity to cover other studies as staff leave Scope for growth is limited, (with current staffing) to increase number of studies and patients.

No.	Current State	Future State	Gap (Y/N)	Gap Description	Factors Responsible	Recommendation/Action	Challenges
4	R&D Quality Assurance - some Policies and SOPs in place. No current auditing/monitoring of academic studies	Full spectrum of Policies/SOPs that compliment Trust SOPs for local R&D implementation, as required. Audit/monitoring programme implemented to ensure quality of studies delivered in line with GCP and Research Governance Framework	YES	No current internal audits/monitoring of academic studies taking place. Some policies in place to ensure quality systems and standardised processes across the department	Previously unable to implement audit/monitoring programme due to staff shortages and capacity.	Internal audit/monitoring programme of academic studies to begin July 2017. Training for some staff may be required, but can be accessed via CRN training programme. SOPs to be developed further and implemented across the department, to ensure quality systems and standardised processes.	Time and capacity
5	Patient & Public Involvement(PPI) in R&D	Increase research Ambassadors to 2 or more. Actively contribute to protocol review/design; patient groups and promotion of R&D. To establish a patient focus group whereby patients representatives are involved in research from the beginning (protocol design) to the end (study findings).	YES	Currently we have 1 patient Ambassador that attends R&D occasionally, plus national and local meetings as required.	Little awareness nationally, in previous years, that patients should be involved in research design, whereas now it greatly recognised that this is beneficial for both study sponsors and patients to be involved.	Invite patient Ambassador to join Protocol review panel to assess new study protocols. " Speciality Leads are currently exploring whether any further Research Ambassadors could be identified and invited to join a PPI Focus Group for R&D.	PPI is required for any funding awards/grant applications etc to be successful patients willing to take on the role of Research Ambassador?

No.	Current State	Future State	Gap (Y/N)	Gap Description	Factors Responsible	Recommendation/Action	Challenges
6	R&D Space - shortage of consulting rooms and exercise lab to house all exercise equipment. Current Rheumatology OPD areas are used for research visits. No additional space within the Trust/Centrafile for archiving of study documents	Research exercise lab space required and small office area to enable the growth of commercial, academic and 'home grown' research studies. External archive storage facility used for all study data to be archived securely according to GCP requirements	YES	Unable to run all exercise lab clinics due to lack of space for equipment and temperature monitoring controls. No facility to send study data for archive.	Office space required for R&D admin staff Centrafile cannot take any additional data for storage	Continue talks with Medical Directorate to possible conversion of existing space. Review costs for external archive facility (Trust arrangements for future archive?)	Cost for room conversion Alternative location for shared kitchen area. Cost for external archiving (commercial studies are funded but academic studies are not)
7	R&D Promotion within Trust and externally	All staff aware of R&D Dept, location and what/where to go for information. Departments actively referring patients for research. R&D features in all Trust reports.	YES	Some staff are not aware of R&D or its location. Minimal promotion currently around R&D; website requires update.	Time & capacity to undertake	International Clinical Trials Day - display in Main Reception area 22.05.17, RHH; adverts for this event on The Hub. Twitter account set up (via Comms) to promote what R&D are involved in; R&D Newsletter to be sent out regularly to all Department leads Support from the Trust Board to embed research into the Trust core business	Funding to put on awareness days/workshops Ways in which the Trust Board can support the promotion of R&D.

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on the 1st June 2017

TITLE:	Freedom to Speak Up Guardian Role Update		
AUTHOR:	Carol Love-Mecrow Deputy Chief Nurse/Freedom to Speak Up Guardian	**PRESENTER:**	Siobhan Jordan Interim Chief Nurse

CORPORATE OBJECTIVE:
SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

This paper gives the background to the role and latest developments nationally and regionally. It summarises the number and types of concerns raised at the Trust over the year. These are:

Number of concerns raised	21
Raised anonymously	1
Raised confidentially	18
Related to possible lapses in care	7
Related to bullying or a bullying culture	10
Required investigation	7
Concerns closed	12
Feedback received	7

Finally, it covers the imminent changes in personnel who will be undertaking the role in the future.

IMPLICATIONS OF PAPER:

RISK	**Y**		
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	Details: EFFECTIVE Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence CARING Staff involve and that people with compassion, kindness, dignity and respect
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD:
To receive and note the latest situation with Freedom to Speak Up Guardian issues.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Freedom to Speak up Guardian progress

Introduction

The appointment of the Trust's first Freedom to Speak up Guardian [FSUG] occurred in May 2016 in response to the recommendations in Sir Robert Francis's Freedom to Speak Up review in February 2015. The last 12 months has seen the raising concerns agenda gain prominence, with the majority of Trusts in the United Kingdom having appointed one or more Freedom to Speak up Guardians in their organisations.

Role Development

Training for new guardians continues and the numbers of workshops have increased to ensure that all FSUGs, new to post are appropriately trained and receive support and guidance in this important role. Following feedback from existing guardians changes have been made to the training making it more bespoke to the FSUG role.

Regional Guardian Activity

The West Midlands regional group continues to meet quarterly and share good practice. These regional meetings enable the FSUGs to discuss the challenges of the role and promote a consistent approach to handling concerns across our region. However, the inconsistency in the approach of some Trusts on the appointment of their guardians continues; this often results in concerns raised by guardians on their ability to fulfil the role effectively whilst trying to maintain a substantive post elsewhere, which is often already full time.

Recording of issues

The recording of issues raised continues as per the recent National Guardian Office [NGO] guidance. This information may periodically be requested by the National Guardian Office. We have recently set up a raising concerns inbox where staff can email directly to the FSUG. Details of this will be publicised on the HUB shortly.

Case Reviews

The National Guardian, Dr Henrietta Hughes, has recently announced that from the 12th June 2017 the National Guardian Office will officially commence its case review process to look at cases referred to it where it appears that there is evidence that an

NHS Trust has not appropriately responded to a concern raised by its staff. This process will run for a 12 month trial period, after which it will be reviewed and any necessary changes and improvements made.

The main purpose of a case review is to look into how a speaking up case was handled and to make recommendations where this did not meet with good practice. The central focus will be learning not apportioning blame and case reviews will not look into the merits of the original concern. As the FSUG I do not currently feel that we have any cases that merit a review.

Activity May 2016 - May 2017

Number of concerns raised	21
Raised anonymously	1
Raised confidentially	18
Related to possible lapses in care	7
Related to bullying or a bullying culture	10
Required investigation	7
Concerns closed	12
Feedback received	7

Themes

In the last 12 months the issue of bullying and harassment continues to feature heavily in a number of the concerns. All guardians continue to record these issues to pick up areas that may have a *bullying* culture as this is seen as a deterrent for staff wishing to raise concerns about other issues. Notably, issues regarding possible lapses in patient care remain unchanged from the last report.

Issues/Reflections

The last 12 months as the Guardian have been extremely rewarding albeit a little stressful at times. Staff have been responsive to the role and appreciative of the opportunity to be able to raise concerns safely. Senior staff and managers appear to have become more aware of the speak up agenda and often remind staff that there are other avenues for their concerns if they are reluctant to raise issues at department level.

Future plans

My recent appointment to the post of Deputy Chief Nurse, means, that quite reluctantly, I will be stepping down from my role as the Trust FSUG. The last 12 months have been extremely rewarding and educational. I will be handing the role over in the next few weeks to *2* new Guardians, Marie Banner, Lead Nurse – CCU/PCCU (and Acting Deputy Matron) and Derek Eaves, Professional Lead for Quality, who will be officially announced shortly. I shall initially be supporting the new guardians. Training on the national programme has been arranged for them in June.

I'd like to take this opportunity to thank the Board for entrusting me with this role and I hope to continue to support the speak up agenda in my new post.

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on the 1st June 2017

TITLE:	**Guardian of safe working report**		
AUTHOR:	**Mr Babar Elahi – Guardian of safe Working Hours**	**PRESENTER**	**Mr Babar Elahi – guardian of safe Working Hours**

CORPORATE OBJECTIVES:

SO2: Safe and Caring Services
SO4: Be the place people choose to work
SO5: Make the best use of what we have

The report covers the following elements:

- Guardians quarterly report with on going challenges
- Progress to date

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: Implementation of revised JD contact may adversely impact on rotas**
	Risk Register: Y COR102		**Risk Score: 16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links to safe, caring and well led domains**
	Monitor	**N**	**Details:**
	Other	**Y**	**Details: national requirement for effective guardian role**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the actions taken by the Trust and its appointed guardian of safe working.

The Dudley Group NHS
NHS Foundation Trust

Board of Directors

Guardian of Safe Working Report
June 2017

Purpose

To give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:-

- Exception reports
- Fines
- Vacancies (data provided by Medical Work Force Department)
- Locum bookings (data provided by Finance Department)
- Challenges

Background and Links to Previous Papers

In October 2016, a new contract was introduced for JDT with a new schedule of 2016 TCS. As part of the new 2016 TCS the post of Guardian of Safe Working Hours (GSW) was introduced.

The role of the GSW is to:

- Ensure the confidence of doctors that their concerns will be addressed
- Require improvements in working hours and work schedules for JDTs
- Provide Boards with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response
- Ensure the fair distribution of any financial penalty income, to the benefit of JDTs.

This is the second quarterly GSW report and covers the period of 12th Feb 2017 to 19th May 2017. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

As of April, 2017, 61 junior doctors in the Trust transferred onto the new contract. By the end of 2017 all junior doctors will be on the new contract. The table below shows the number of junior doctors posts which converted to the new contract. The picture will change over the coming year until all the junior doctors have transitioned onto the new contract.

Site	No of posts which converted in December 2016	No of posts which converted in February 2017	No of posts which converted in April 2017
RHH	27	4	30

Challenges

Engagement

Engagement with the junior doctor workforce still remains a challenge. The Guardian is following his strategy to engage junior doctors, which involves.

- Introduction to Guardian and his role by attending Junior Doctor Induction Day.
- Attending junior doctor forum arranged by Postgraduate Clinical Tutor
- Attending junior doctors operational forum
- Creating a dedicated Guardian email in the trust
- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors

The Guardian has found engagement with the Educational Supervisors (ES) and Clinical Supervisors (CS) to be more challenging. There are supervisors who are not responding to exception reports submitted by junior doctors in the time allocated. Chasing these supervisors utilizes undue resources and time. The Guardian has tried to engage with supervisors by making a power point presentation, highlighting the implications of new junior doctors contract for supervisors at the trust annual consultant conference.

Software System

As indicated in the first guardian report, the Allocate does not 'speak' to payroll and as a result all requests for additional payment for hours worked have to be administered manually. Both supervisors and juniors have provided poor feedback on its usage. We are trying to establish better understanding of the system.

Data Collection for Board Report

The Guardian quarterly board report requires data, which has to be provided by guardian office, medical workforce and finance. The Guardian has held meeting with HR and Finance department to streamline this in an orderly manner. It has been agreed that data for board report will be provided at least a month in advance to the guardian office for it to be presented to the board in time.

Process of overtime payments to JDT

The trust is yet to approve an exception reporting policy with JLNC. Delay in this has resulted in JDT not being remunerated for any extra payment as agreed on exception reporting by their supervisors. As a result a process does not exist from approval of payment to it actually being paid.

Non-Compliant Surgical FY1 Rota

The surgical FY1 JDT rota was non-compliant with the TCS 2016 since December 2016. Upon investigation it became clear that the rota and work schedule prepared by medical workforce was changed by the department. There are some suggestions to deal with this in August 2017. In the meantime, this is an issue which requires addressing for current JDT.

Junior Doctors Forum

The Guardian junior doctor forum remains a success with good engagement by juniors. We have been able to address their on going issues. This forum has been attended by Medical Director, which was very well received by the juniors. The success of this forum is attributed towards advertisement of the forum on the hub and attendance by senior medical and non medical members of the forum.

Exception Reports and Fines.

From 13th Feb to 15th May 2017, we have received 21 exception reports by 7 doctors:

- None resulted in guardian fines
- 2 were raised as immediate safety concern. They were investigated and dealt with in time.
- 6 exception reports have resulted in over payment
- 2 have resulted in time in lieu
- 5 have been addressed requiring further information
- 8 are still pending.
- 1 exception report was made as educational rest of 20 were due to hours.

Exception Reports by Department – From 13th February – 15th May 2017 total = 21

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
None	3	1	2	Medicine
None	18	8	10	Surgery/Urology

Exception Reports by Grade - All FY1s

All FY1	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
	7	4	3	7

Response Time

Within 48 hours	Within 7 days	Longer than 7 days	Still open
7	4	3	7

There are still concerns by Junior doctors and supervisors on functionality of Allocate software for exception reports. There are some exception reports which have been resolved by supervisors but they are unable to close the same on the software. Medical workforce is working on producing the trust exception reporting policy.

The Medical Director and Chief Operating Officer are supporting the Guardian to raise the awareness of clinical directors, directorate managers and educational supervisors of their responsibilities within the new contract, in particular that payment for additional hours worked should be the exception rather than the rule.

High level data

Number of doctors/dentists in training (total): **199**

Number of doctors/dentists in training on 2016 TCS (total): **61**

Admin support provided to Guardian: How many hours are allocated to Medical Workforce for Guardian? **NIL**

Hours Monitoring Exercise for doctors on 2002 TCS only

No monitoring exercises have taken place in the last 6 months. ED and GIM are being monitored this month.

Hours monitoring exercises (for doctors on 2002 TCS only)					
Specialty	Grade	Rostered hours	Monitored hours	Banding	WTR compliant (Y/N)
Rheumatology	ST3+	45.25	46.5	1B	Y
Dermatology	ST3+	42.5	41	1B	Y
Neurosurgery	ST3+	47.75	n/a*	1A	Y**

Vacancies (Data provided by Medical Workforce Manager)

Vacancies by month

Specialty	Grade	Feb	March	April	Total gaps (average)	Number of shifts uncovered
Diabetes	CMT	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Diabetes	ACCS	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
EAU	CMT	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
EAU	Trust SHO	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
EAU	Trust SHO	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
EAU	ST Higher	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Renal	FY1			X	Unable to comment	Unable to comment – Full Time Vacancy
Renal	ST Higher	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Stroke	GP Trainee	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Stroke	ST Higher	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Geriatrics	ST Higher	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Geriatrics	GP Trainee	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Geriatrics	GP Trainee	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Geriatrics	CMT	X	X	X	Unable to comment	Unable to comment – Full

						Time Vacancy
ED	ST Higher	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
ED	ST Higher	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
ED	Trust SPR	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
ED	Trust SPR	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
ED	Trust SPR	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
ED	ACCS	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
ED	Trust SHO	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
ED	Trust SHO	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
ED	Trust SHO	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Respiratory	GP Trainee	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Respiratory	GP Trainee	X	X	X	Unable to comment	Unable to comment – Full Time Vacancy
Haematology	FY1	X	X		Unable to comment	Unable to comment – Full Time Vacancy
Haematology	FY1	X	X		Unable to comment	Unable to comment – Full Time Vacancy

Locum Bookings – Bank (Data provided by Finance)

Locum Spend (Bank) by department/grade				
	Jan-17	Feb-17	Mar-17	TOTAL Q4
AMU				
FY1	£9,569	£2,470	£1,817	**£13,856**
FY2	£3,371	£16,571	£7,703	**£27,645**
GP ST	£3,527	-£925	£825	**£3,427**
SHO	£31,519	£8,852	£57,011	**£97,381**
Spec Reg	£2,991	£5,810	-£1,025	**£7,776**
ST (Higher)	£14,614	-£2,449	£12,007	**£24,172**
ST (Lower)	£3,346	£4,732	£0	**£8,078**
Anaesthetics				
Spec Reg	£1,519	-£1,519	£675	**£675**
ST (Higher)	£285	£1,537	£107	**£1,929**
ST (Lower)	£3,263	£1,759	£7,121	**£12,143**
Cardiology				
Spec Reg	£2,016	-£13	£0	**£2,003**
ST (Higher)	£0	£1,384	£0	**£1,384**
Chemical Pathology				
FY2	£1,045	-£13	£0	**£1,032**
ED				
FY2	£1,060	-£751	£0	**£309**
SHO	£3,140	-£602	£12,469	**£15,007**

Spec Reg	£6,866	-£7,010	£7,950	**£7,806**
ST (Higher)	£2,990	-£238	£0	**£2,752**
ST (Lower)	£1,153	£425	£0	**£1,577**
Endocrinology				
SHO	£0	£1,053	£1,082	**£2,135**
ENT				
GP ST	£0	£1,356	-£678	**£678**
Spec Reg	-£36	£0	£2,638	**£2,602**
ST (Higher)	£1,102	£757	£334	**£2,193**
ST (Lower)	£0	£339	-£4	**£335**
Gastroenterology				
Spec Reg	-£964	£2,935	£5,122	**£7,093**
ST (Higher)	£3,822	£1,554	£2,096	**£7,472**
General Surgery				
FY1	-£15	£814	£780	**£1,579**
SHO	£2,427	£1,709	-£1,604	**£2,532**
Spec Reg	£13,477	£7,494	-£1,859	**£19,112**
ST (Higher)	£0	£0	£10,916	**£10,916**
Max Facial				
SHO	£1,413	-£12	£3,108	**£4,508**
ST (Lower)	£4,746	-£73	£6,141	**£10,814**
Obstetrics				
SHO	£5,471	-£1,237	-£2,237	**£1,996**
Spec Reg	£2,576	£6,301	£6,247	**£15,125**
ST (Higher)	£0	£542	-£5	**£538**
ST (Lower)	£1,966	£438	-£5	**£2,399**
Older People				
FY1	£1,477	-£3	£0	**£1,475**
FY2	£1,278	£565	£678	**£2,521**
GP ST	£3,288	-£1,626	£4,000	**£5,661**
SHO	£6,114	-£129	£7,344	**£13,329**
ST (Higher)	£1,980	£0	£2,543	**£4,522**
Paediatrics				
FY1	£0	£0	£407	**£407**
FY2	£141	-£2	£0	**£139**
GP ST	£0	£0	£1,389	**£1,389**
SHO	-£718	£3,531	£1,932	**£4,746**
ST (Lower)	£226	£0	-£26	**£200**
Psychiatry				
FY2	£0	£202	£346	**£548**
Radiology				
ST (Higher)	£0	£1,643	£1,888	**£3,532**
Renal				
ST (Higher)	£508	£4,808	£0	**£5,316**
Rheumatology				
Spec Reg	£848	-£14	£848	**£1,681**
ST (Higher)	£0	£0	£424	**£424**
Stroke				
FY2	-£7	£4,661	-£24	**£4,630**

SHO	£2,549	£5,243	£1,189	**£8,981**
Spec Reg	£0	£48,653	£19,107	**£67,760**
T&O				
FY2	£4,194	-£10	£3,772	**£7,956**
ST (Higher)	£2,034	-£79	£0	**£1,955**
ST (Lower)	£565	£4,005	-£19	**£4,551**
Vascular				
FY2	£982	£0	£0	**£982**
TOTAL	**£153,718**	**£125,439**	**£184,528**	**£463,685**

Locum Bookings – Agency (Data provided by Finance)

Locum Spend (Agency) by department/grade				
	Jan-17	Feb-17	Mar-17	TOTAL Q4
AMU				
SHO	£42,891	£34,225	£30,883	**£108,000**
Spec Reg	£9,383	£8,750	£15,324	**£33,457**
ED				
SHO	£97,301	£106,046	£151,682	**£355,029**
Spec Reg	£22,807	£81,751	£59,255	**£163,812**
General Surgery				
Spec Reg	£0	£13,739	£5,438	**£19,177**
Older People				
SHO	£0	£12,767	£13,390	**£26,156**
Spec Reg	£7,191	£10,350	£9,154	**£26,695**
Paediatrics				
SHO	£0	-£1,558	£2,535	**£977**
Spec Reg	£1,080	£0	£2,169	**£3,249**
Plastic Surgery				
Spec Reg	£8,913	-£9,996	£1,805	**£722**
Stroke				
Spec Reg	£9,780	£8,520	£12,090	**£30,390**
Urology				
Spec Reg	£0	£0	£9,504	**£9,504**
TOTAL	**£199,345**	**£264,594**	**£313,228**	**£777,167**

Regional Guardian of Safe working Conference at Russells Hall Hospital

On 19th May 2017, Dudley Group NHS Foundation Trust hosted the Regional Guardian of Safe working Conference. It was chaired by Mr Babar Elahi. It was an opportunity for this trust to show leadership in promoting the role of guardians across NHS.

Next Steps

1. To encourage wider junior doctor engagement by the Guardian.
2. To ensure the trust is prepared for complete transition of all JDT to new contract in August 2017.
3. To encourage supervisors to understand their responsibilities under TCS 2016.
4. To use the Trust HUB to promote the role of Guardian in the Trust.

The Dudley Group NHS
NHS Foundation Trust

1. Conclusion

1. The GSW is able to give assurance to the Board that the majority of specialty rotas of the current 61 JDTs (2016 TCS) are compliant with Working Time Regulations.

2. There are no concerns to report in relation to the number of number of exception reports.

2. Recommendation

The Board are asked to read and note this first report from the Guardian of Safe Working

Author	**Babar Elahi** **Guardian of Safe Working**
Executive Lead	**Chief Executive**
Date	**24th May 2017**

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 1st June 2017

TITLE:	**Trust Annual Plan Objectives 2017-18**		
AUTHOR:	**Anne Baines**	**PRESENTER**	**Lisa Peaty Deputy Director of Strategy and Business Planning**

CORPORATE OBJECTIVE: All Strategic Objectives

SUMMARY OF KEY ISSUES:

This paper presents the detailed measures and timescales for delivery of the Annual Plan in 2017/18. The detail has been developed by the Executive Team through debate and review of the Annual Plan submitted to NHS Improvement in December 2017 and subsequent changes arising from the publication of the *5 Year Forward View – Next Steps* document. The document reflects the actions in place to deliver the Trust Vision, Values and Strategic Objectives.

Our vision: Trusted to provide safe, caring and effective services because people matter	
Our Values: Care, Respect and Responsibility	
Our Six Strategic Objectives:	
Deliver a great patient experience	**Be the place people choose to work**
Deliver safe and caring services	**Make the best use of what we have**
Drive service improvement, innovation & transformation	**Deliver a viable future**

The document has been shared with Governors through the Strategy Committee.
A summary Plan on a Page and a Communication Plan for dissemination throughout the Trust is in development.

The plan outlines the metrics to be used to measure progress and these will form the basis for quarterly updates to the Board of Directors

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**Y**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	x	x	

RECOMMENDATIONS FOR THE BOARD

Board of Directors is asked to approve the Trust Annual Plan Objectives

The Dudley Group NHS
NHS Foundation Trust

Operational Plan 2017/18

Our vision: Trusted to provide safe, caring and effective services because people matter	
Our Values: Care, Respect and Responsibility	
Our Six Strategic Objectives:	
Deliver a great patient experience	**Be the place people choose to work**
Deliver safe and caring services	**Make the best use of what we have**
Drive service improvement, innovation & transformation	**Deliver a viable future**

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
Strategic aim one: deliver a great patient experience				
➢ **Improve engagement and involve patients, carers and the public in their care and the work of the Trust**	✓ Implement approaches that engage and involve patients, carers and the public in their care / service developments and provide opportunities for feedback ✓ Improve the FFT response rate trust-wide ✓ Further develop mechanisms to implement learning from feedback ✓ Increase the use of Listening into Action (LIA) with Patient Groups	✓ *Percentage positive monthly FFT/patient survey scores equal to or better than the national average for all areas (Inpatients, Outpatients, Maternity, Emergency Department and Community).* ✓ *An agreed 6 month trajectory of improvement until the monthly FFT response rate is equal to national average* ✓ *Annual National Patient Survey results equal to or better than the national average* ✓ *Undertake LIA with patients groups for example dementia, learning disability and end of life*	March 2018	Chief Nurse
➢ **Maintain high performance in national operational performance standards:** • **Urgent care** • **Patient flow** • **Delayed**	✓ Rebuild and reconfigure the UCC to provide more effective front door streaming ✓ Deliver best practice models for discharge ✓ Work in partnership with Dudley and Walsall Mental Health (MCP) to improve 24 hour access to mental health services in A&E	✓ *95% emergency access standard met* ✓ *Best practice models for discharge delivered* ✓ *Additional Mental Health Crisis team support available*	March 2018	Chief Operating Officer
	✓ Deliver the Dudley Health Economy Delayed Transfers of Care Improvement Plan (High Impact Change Model)	✓ *Reduce Delayed Transfers of Care from March 2017 baseline*		

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
transfers of care • **Imaging** • **Cancer** • **Referral to treatment time**	✓ Develop and implement a demand and capacity plan to deliver definitive cancer diagnosis within 28 days ✓ Assess the potential impact of Rapid Diagnostic Centres on the Trust's activity in conjunction with neighbouring trusts.	✓ *Maximum 62day wait for first treatment from: i) urgent GP referral for suspected cancer ii NHS cancer screening service referral* ✓ *National Cancer Dashboard in place* ✓ *STP plans in place*		
	✓ Implement imaging hub at The Guest Outpatients Centre to increase capacity	✓ *Six week wait for diagnostic procedures (99%)*		
	✓ Meet the 18 weeks referral to treatment standard across all specialties	✓ *RTT – 92% of incomplete pathways*		
➢ **Redesign a number of integrated pathways and services as a partner in the MCP**	✓ Further develop the redesign of community nursing services to deliver MCP aims ✓ Implement community based consultant services in elderly care, respiratory, diabetes and paediatrics ✓ Work closely with primary care to optimise the outcomes of the MCP	✓ *TBC* ✓ *Clinics in place* ✓ *Regular discussion in place with practices and localities*	March 2018	Medical Director/Chief Operating officer
Strategic aim two: deliver safe and caring services				
✓ **Deliver the Trust's Quality Strategy Priorities**	✓ Implement the priorities within the Trust's Quality Strategy • Pressure ulcers • Infection control • Nutrition and hydration • Medication management	✓ *Targets outlined in the Trust's Quality Strategy achieved.* *Reduce the number of omitted medication errors by 50%*	March 2018	Chief Nurse
	✓ Improve delivery in incident management	✓ *Decrease in potential under-reporting of patient safety incidents* ✓ *All Serious incidents, including Never Events, closed within 60 days* ✓ *Identify all invasive procedures requiring NatSSIPS and provide assurance of compliance with the standards with the use of LocSSIP*		Director of Governance
	✓ Review the use of National Early Warning Scores to identify deteriorating patients and minimising impact	✓ *Best practice (aligned with partner specialist provider) National Early Warning Systems (NEWS) in place including Paediatric Early Warning Systems (PEWS), Modified Obstetric Early Warning System (MOEWS)*	March 2018	Chief Nurse
✓	✓ Deliver the action plan on the reduction in patient falls within the Trust	✓ *Reduce the number of avoidable falls that result in harm in our inpatient services by a third*		
✓ **Deliver agreed CQUIN requirements**	✓ Develop and deliver all CQUIN schemes	✓ *CQUIN schemes are delivered to expected levels*	March 2018	Chief Operating Officer

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
✓ **Maintain good mortality performance**	✓ Continue to develop arrangements for learning from the death of patients in our care, including publication of data	✓ *SHMI/HSMR within expected range* ✓ *100% of hospital deaths have a multidisciplinary review*	March 2018	Medical Director
✓ **Deliver Safe staffing levels**	✓ Ensure all clinical areas are safely staffed, including all ward and community teams ✓ Review of Allocate Rostering System ✓ Implementation of Job Plans for Clinical Nurse Specialists (CNS) ✓ Implementation of Job Planning for all Consultant posts	✓ *50% Reduction in use of bank and agency staff* ✓ *Substantive staffing in place to cover agreed establishment requirements in both the community and hospital areas. (% measure to be agreed following the staffing review)* ✓ *Extended acuity tools in place* ✓ *Job Plans in place for consultants and CNS* ✓ *Monthly trajectory toward the full year target of £5.7m cap on bank and agency spend is met*	March 2018	Chief Nurse Medical Director Director of HR
✓ **Deliver improvements in maternity care**	✓ Develop and implement the Maternity Transformation Programme (Better Births) ✓ Deliver enhanced maternity dashboard and KPIs to deliver best practice	✓ *Reduction in neonatal deaths, maternal deaths and babies with brain injuries that occur soon or after birth by 20% by March 2020* ✓ *Progress towards key maternity KPIs*	March 2018	Chief Nurse
Strategic aim three: drive service improvement, innovation and transformation				
➢ **Deliver effective medical research activities**	✓ Develop and implement plans to achieve the West Midlands CRN Higher Level Objectives (HLO 1-3)	✓ *West Midlands CRN Higher Level Objectives (HLO 1-3) achieved*	March 2018	Medical Director
➢ **Increase access to 7 day services**	✓ Implement plans to deliver key standards ✓ Actively contribute to appropriate clinical networks to deliver seven day services for emergency vascular surgery, stroke, major trauma, heart attacks and paediatric intensive care	✓ *Improve the position from the audit completed in April 2016 for:* • *Inpatients seen by a consultant within 14 hours* • *Diagnostic services available 7 days a week* • *Interventional services available 7 days a week* • *On-going review of patients by consultants* ✓ *Trauma network peer review recommendations implemented*	March 2018	Chief Operating Officer
➢ **Transform and re-organise services to drive efficiency and improve key services**	✓ Deliver phase two of Outpatients Transformation	✓ *Referral and clinical management processes reviewed and new processes implemented* ✓ *Records management processes reviewed and new processes implemented*	March 2018	Chief Operating Officer
	✓ Implement theatres transformation plans ✓ Develop and implement plans for the hybrid theatre ✓ Address performance challenges in ophthalmology	✓ *Recruitment and retention strategy for theatre staff in place* ✓ *Theatre scheduling undertaken using EPR* ✓ *Phase two of theatre reconfiguration complete* ✓ *Hybrid Theatre business case written and approved* ✓ *Reduced waiting time for ophthalmology*		
	✓ Implement the GIRFT recommendations for relevant specialities	✓ *Hip prosthesis rationalised* ✓ *ENT day case rates improved* ✓ *Consultant physician input to vascular surgery in place* *(Metric for Ophthalmology to be added following GIRFT review in June 2017)*		

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
	✓ Develop and deliver improved pathways for MSK, Respiratory and Neurology in line with the RightCare initiative to reduce unwarranted variation	✓ *Improved pathways developed* ✓ *Improved pathways agreed and implemented*		
	✓ Improvements in service performance delivered for Renal	✓ *Improvement in efficiency (metrics to be approved once plan approved).*		
	✓ Implement the Hospital Pharmacy Transformation Plan (HPTP)	✓ *Increase clinical pharmacy time by 80%* ✓ *Increase pharmacy prescribers to 70%* ✓ *Implement e-chemo prescribing system (October 2017)*		
	✓ Implement improvements to hospital discharge process	✓ *Reduce number of patients with length of stay of 2 weeks or longer*		
Strategic aim four: be the place people choose to work				
➢ **Enhance colleague engagement**	✓ Develop a programme to enhance colleague engagement ✓ Embed the Staff Survey as a tool to help managers share best practice and make improvements to staff engagement	✓ *Staff Survey embedded* ✓ *Improvement in the national Staff Survey engagement score to 48% response rate* ✓ *Extend staff Friend and Family Test update* ✓ *Staff story presented at Board*	March 2018	Director of HR Chief Nurse
➢ **Maximise workforce capacity and capability, undertaking workforce redesign where appropriate**	✓ Create an employee development programme underpinned by an employee training needs analysis ✓ Create an Organisational Development Programme t ✓ Enhance mechanisms to identify potential to support succession planning opportunities ✓ Improve performance against recruitment key performance indicators (KPIs) ✓ Boost staff retention through structured support ✓ Introduce new nursing roles	✓ *Mandatory training target of 90% met be end of year* ✓ *Appraisal target of 90% met by end of year* ✓ *Information Governance training target of 95% met by end of the year* ✓ *Employee development programme in place* ✓ *Organisational development programme in place* ✓ *Leadership Forum commenced* ✓ *New roles in place i.e. Nursing Associate, clinical apprentice and nursing volunteers* ✓ *Development programmes introduced* ✓ *Recruitment and retention KPIs delivered* ✓ *Review non-medical education recruitment strategy – Year 2*	March 2018	
➢ **Maximise employee-well being**	✓ Improve workforce performance in sickness, mandatory training, appraisal ✓ Implement a smoke free site	✓ *Sickness absence target 3.5% met by end of year.* ✓ *Achieve 5% improvement in each of the 3 health & well-being staff survey questions* ✓ *staff well-being events are held at least four times a year focusing on physical and mental health* ✓ *Site smoke free by January 2018*		
Strategic aim five: make the best use of what we have				
➢ **Implement the Digital Trust Programme**	✓ Implement the core foundation systems for the Digital Trust	✓ *Each phase of the Digital Trust plan delivered in line with project plan*	March 2018	Chief Information Officer
	✓ Deliver a Proof of Concept Shared Record between GP's and DGFT	✓ *Proof of Concept Shared Record developed*	Sept 2017	

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
➢ **Match capacity to demand**	✓ Implement an operational demand/capacity management tool	✓ *Operational demand/capacity management tool implemented*	March 2018	Chief Operating Officer
➢ **Deliver the agreed financial plan**	✓ Set budgets that will achieve a £2.5 m surplus and monitor progress. ✓ Deliver CIP of £12.5m and a financial control target of £2.45m surplus ✓ Identify and target specific areas of efficiency as identified through the Model Hospital Portal	✓ *Budgets set that achieve a £2.5m surplus* ✓ *£12.5m CIP and a £2.45m surplus control total achieved* ✓ *Targets identified are delivered*	March 2018	Director of Finance Director of Strategy & Business Planning
✓ **Develop a Clinical Strategy which ensures a sustainable clinical organisation**	✓ Engage clinical workforce in the development of the strategy ✓ Reflect the impact of external initiatives within the strategy (i.e. STP, BCA, MCP)	✓ *Refreshed Clinical Strategy in place*	June 2017	Medical Director and Chief Nurse
Strategic aim six: deliver a viable future				
➢ **Play an active part in the STP arrangements in the Black Country and West Birmingham**	✓ Implement the Sustainability and Transformation Plan	✓ *STP implemented*	March 2018	Chief Executive
✓ **Play a part in the implementation of the Black Country Alliance initiatives.**	✓ BCA procurement Aspirations of the BCA procurement work stream including the Nationally Contracted Products Programme.	✓ *Savings identified achieved* ✓ *BCA procurement work stream implemented*	March 2018	Chief Executive
	✓ Work in partnership to develop a model for delivery of Black Country Pathology Services	✓ *Implement the Black Country Pathology Review*		
	✓ Develop opportunities for pharmacy benefits across Black Country Trusts	✓ *Deliver identified pharmacy benefits*		
	✓ Maximise back office opportunities	✓ *Back office opportunities identified and delivered*		
✓ **Work proactively with BCHCare FT to become the provider of MCP services**	✓ Develop and submit a joint bid in conjunction with BCHCare Foundation Trust ✓ Support and engage staff in the change process ✓ Develop and implement revised care pathways	✓ *Bid developed and submitted* ✓ *Bid successful* ✓ *Communications plan in place for staff* ✓ *Revised care pathways scoped*	March 2018	Chief Executive
✓ **Develop the Trust's market share in the Wyre Forest**	✓ Identify and exploit opportunities for increasing the Trust's market share in the Wyre Forest.	✓ *Establish clinics at Bewdley Medical Centre* ✓ *Expand clinics located at Hume Street*	March 2018	Director of Strategy & Business Planning

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 1 June 2017

TITLE:	Chief Nurse Report - Infection Prevention and Control Update		
AUTHOR:	Dr E Rees, Director of Infection Prevention and Control	**PRESENTER:**	Siobhan Jordan Interim Chief Nurse

CORPORATE OBJECTIVES:

SO1 – Deliver a great patient experience

SO2 – Safe and caring services

SO3 – Drive service improvements, innovation and transformation

SO4 – Be the place people chose to work

SO6 – Plan for a viable future

SUMMARY OF KEY ISSUES:

For the month of May (at 22.5.17)

- No post 48 hr MRSA bacteraemia cases since 27th September 2015
- As of 22.5.17 the Trust has had 2 cases of post 48 hr Clostridium Difficile in April and 0 cases for May 2017
- No episodes of Norovirus in month
- Review of Tuberculosis Incident identified in April is underway. A total of 36 patients were identified as requiring contact tracing. All letters have been sent. No secondary cases have to date been identified. Follow up meeting is scheduled 8.6.17

IMPLICATIONS OF PAPER:

RISK	**Yes**		**Risk Description:** Failing to meet minimum standards
	Risk Register: Yes		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** Safe
	Monitor	**Yes**	**Details:** MRSA and C. difficile targets
	Other	**Yes**	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			√

RECOMMENDATIONS FOR THE BOARD:
To receive the report and note the contents.

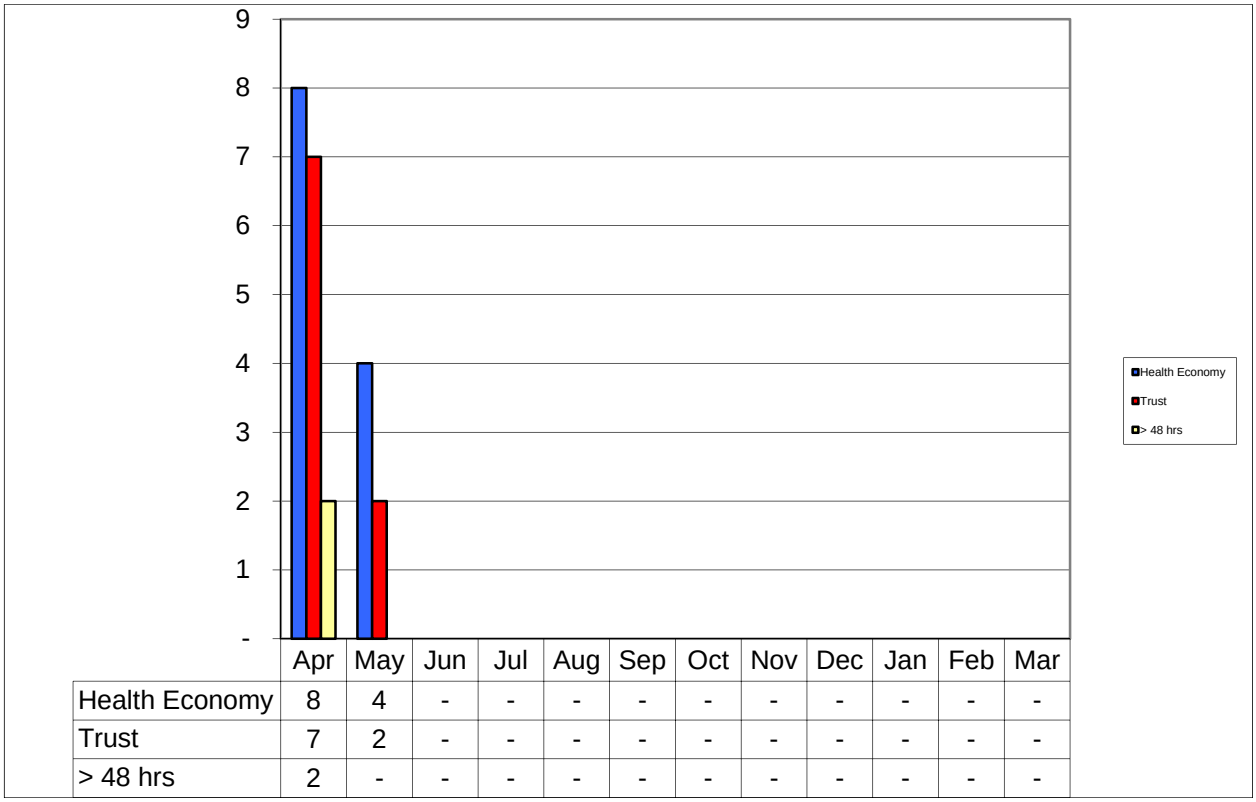
Details:

MRSA bacteraemia (Post 48 hrs) – There have been 0 post 48 hour MRSA bacteraemia cases since 27th September 2015.

Clostridium Difficile – The target is for the Trust to have less than 29 cases of *Clostridium Difficile* in 2017/18, this is equivalent to 12.39 CDI cases per 100,000 bed days.

Penalties will be associated with exceeding 29 cases associated with lapses in care. At the time of writing (22.5.17) the Trust have 0 post 48 hour cases recorded in May 2017.

C. DIFFICILE CASES 2017/18



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	4	-	-	-	-	-	-	-	-	-	-
Trust	7	2	-	-	-	-	-	-	-	-	-	-
> 48 hrs	2	-	-	-	-	-	-	-	-	-	-	-

The process to undertake an assessment of individual *Clostridium Difficile* cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance, continues.

Year to date 2017/18, there has been 2 post 48 hour case identified. To date there are 0 cases recorded for May.

There is a Trust wide *Clostridium Difficile* action plan in place to address issues identified by the Root Cause Analysis process as well as local plans for each individual case.

Progress against the plan is recorded at the Infection Prevention Forum.

Norovirus - There has been no Norovirus outbreaks in May.

Tuberculosis Incident – The index case had had a previous admission approx. 4 weeks prior to the diagnosis in April. The patient had been admitted on a surgical ward for an unrelated medical complaint. A decision was made to include this admission as part of the contact tracing programme and as a result a total of 36 patients were identified for this purpose. All letters have been sent out and no secondary cases have so far been identified.

Additional Information

The Infection Prevention & Control forum is scheduled to meet at the beginning of June to review its Terns of Reference. The forum will be supported by the Interim Chief Nurse and the frequency of meetings will be increased. Strengthened monitoring of Infection Prevention & Control metrics will be agreed and details will be included in future reports.

Members of the Infection Prevention & Control team are now mandated to support the trusts Quality & Safety Reviews and there is increased engagement with Interserve in relation to findings of environmental audits.

Reference

1. *Clostridium difficile* infection objectives for NHS organisations in 2016/17 and guidance on sanction implementation, Public Health England.

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 1st June 2017

TITLE:	Monthly Nurse/Midwife Staffing Position - May 2017 report containing April 2017 data		
AUTHOR:	Siobhan Jordan Interim Chief Nurse Derek Eaves Professional Lead for Quality	**PRESENTER:**	Siobhan Jordan Interim Chief Nurse

CORPORATE OBJECTIVE:
SO1: Deliver a great patient experience SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:

The attached paper contains the actual and planned hours for qualified and unqualified staff for both day and night shifts for each area of the hospital. The fill rates and the Care Hours per Patient Day (CHPPD) are also tabled. It can be seen that in general the fill rates are generally close to but less that one hundred percent.

With regards to the CHPPD some comparative data with two local Trusts is provided and discussed. It is clear that this is useful data but, at this stage, must be interpreted with caution as areas may not be directly comparable.

The recently commenced staffing review undertaken by the new Interim Chief Nurse is using this information and other data from a wide variety of sources to form a firm foundation for nursing and midwifery staffing at the Trust. The outcomes of the review will be reported, as agreed, to the Board of Directors in due course.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	N	**Details**:
	Monitor	Y	**Details:**
	Other	Y	**Details**: Internal Audit

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To note and consider the safe staffing data and conclusion of the report.

Monthly Nurse/Midwife Staffing Position

June 2017 Report containing April 2017 data

The attached Safer Staffing Summary (Appendix1) shows the actual and planned hours for four categories of staff, qualified and unqualified staff for both day and night shifts, for each area of the Trust for April 2017 (B6 and Evergreen wards have been omitted for this month as B6 was only open for part of the time and Evergreen's data was not initially reliable). As well as showing the actual and planned hours the report shows the fill rate for each of the four categories. The totals for the Trust are also indicated. In addition, the last four columns show the actual Care Hours Per Patient Day (CHPPD). We provide this information to NHS Improvement and part of it is utilised in the National Model Hospital dataset.

The report shows that the overall fill rates for the Trust are nearly 100% but this has been achieved by using the present establishments and a significant reliance on temporary staff (bank and agency). A number of factors make it unlikely that a full fill rate will always be achieved although this is the aim. These factors include long term issues such as vacancies, short term issues such as sickness and maternity leave, the unavailability of temporary staff and unexpected numbers of patients requiring enhanced care.

It can be seen that for individual wards the fill rates vary although in the main they are close to 100%. On occasion, the fill rate is over 100%. C2, the paediatric ward, is a particular exception with regards to this as the planned hours are derived from the RCN dependency tool. Each shift the planned hours are determined by the acuity of the children on the ward. Sometimes there are occasions (as for example with C4 and C5) when the fill rate of unqualified staff goes above 100%. This occurs when it is recognised that there will be a reduction in qualified staff.

With regards to the CHPPD, as has been explained in previous reports this is a new indicator that can be used to benchmark the Trust.

Table 1. Care Hours Per Patient Day (CHPPD) – Overall Trust Regional Comparators

2017 Month	TRUST Nurse & Midwife	Midlands & East Median	National Median	TRUST Care Support Workers	Midlands & East Median	National Median	TRUST Total number	Midlands & East Median	National Median
January	4.30	4.7	4.7	3.50	2.9	2.9	7.8	7.7	7.6
February	4.34	N/A	N/A	3.63	N/A	N/A	7.97	N/A	N/A
March	4.44	N/A	N/A	3.74	N/A	N/A	8.18	N/A	N/A
April	4.55	N/A	N/A	3.73	N/A	N/A	8.28	N/A	N/A

N/A = Data not yet available

As discussed last month, a more detailed exercise has occurred this month to further analyse this data (Table 2). As the CHPPD data is in the public domain, the results of two local hospitals for February 2017 (latest data) have been considered and compared to the Trust for April. It is important to note that although the speciality of the wards are named in the published data they may not be directly comparable and so the charts below must be interpreted with caution. For instance, obstetrics has been fully omitted from this exercise as

it is clear from the data that some hospitals publish their pre and post natal wards separately compared to ourselves.

Table 2. Care Hours Per Patient Day (CHPPD) – Trust and Local Comparators

SURGERY			
Organisation	**Qualified RN/RM**	**Unqualified CSW**	**Total**
DGFT	2.8 – 3.6	2.8 - 3.4	6.2 (B4/C6)
Trust 1	2.7 – 2.9	2.9 – 3.6	5.6 – 6.5
Trust 2	2.9 – 3.9	2.4 – 2.6	5.4 – 6.5

GENERAL MEDICINE (GASTRO)			
Organisation	**Qualified RN/RM**	**Unqualified CSW**	**Total**
DGFT	3.2	2.8	6 (C7)
Trust 1	2.5	2.9	5.4
Trust 2	3	2.8	5.8

CRITICAL CARE			
Organisation	**Qualified RN/RM**	**Unqualified CSW**	**Total**
DGFT	23.2	2	25.2
Trust 1	26.6	0	26.6
Trust 2	25.9	2.2	28.1

CARE OF THE ELDERLY CSW			
Organisation	**Qualified RN/RM**	**Unqualified CSW**	**Total**
DGFT	2.5	5.7	8.2 (C3)
Trust 1	2.2	3.1	5.2
Trust 2	3.1 – 3.4	2.8 - 3	6.1 – 6.2

GENERAL MEDICINE (NEPHROLOGY)			
Organisation	**Qualified RN/RM**	**Unqualified CSW**	**Total**
DGFT	2.6	4.1	6.7 (C1)
Trust 1	2.6	4.1	6.7
Trust 2	2.6 – 2.7	2.2	4.8 – 4.9

TRAUMA AND ORTHOPAEDICS			
Organisation	**Qualified RN/RM**	**Unqualified CSW**	**Total**
DGFT	2.7 – 2.8	4.4 – 4.8	7.1 – 7.6 (B2H/B2T)
Trust 1	2.5 – 3.3	2.3 – 3.1	5.7
Trust 2	2.9 – 3.4	4 – 4.2	6.8 - 7.6

PAEDIATRICS			
Organisation	**Qualified RN/RM**	**Unqualified CSW**	**Total**
DGFT	8	2.6	10.6 (C2)
Trust 1	7	0	7
Trust 2	7.1	1.4	8.5

Although there are similarities in the above data, there are areas with significant differences. For instance, those in paediatrics may be explained by the Trust's inpatient facility having a paediatric assessment unit which requires higher staffing that a general paediatric ward.

This is the first time that the Trust has started to use this comparative data and this will continue and become more refined as time progresses.

Conclusion

This report demonstrates that we are achieving nearly 100% fill rate and there is a continued commitment to do so. Benchmarking the Trust workforce data using the CHPPD is informative and will continue.

The staffing review which commenced in May is using data from a wide variety of sources to inform and ensure the required outcome. As well as considering the above data, the review is structured discussions with senior nurses from each area together with their managers using information on establishments, staffing ratios and vacancy, sickness and temporary staffing rates. It is also considering the outcome of the most recent six monthly Safer Nursing Tool exercise. The outcome of the review will be reported, as agreed, to the Board of Directors in due course.

Safer Staffing Summary **Apr** **Days in Month** 30

Ward	Specialty	Day RN Day RM Plan	Day RN Day RM Actual	Day CSW Day MSW Plan	Day CSW Day MSW Actual	Night RN Night RM Plan	Night RN Night RM Actual	Night CSW Night MSW Plan	Night CSW Night MSW Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Actual CHPPD Registered	Actual CHPPD Care staff	Actual CHPPD Total
A2	Short Stay	240	231	210	199	150	147	184	180	96%	95%	98%	98%	1,114	4.07	4.08	8.15
A3	Medical Short Stay /Frail Elderly	64	63	59	56	60	58	32	31	98%	95%	97%	97%	405	3.51	2.58	6.09
B1	Orthopaedics	113	110	63	60	68	68	59	58	98%	96%	100%	98%	530	3.94	2.68	6.62
B2(H)	Orthopaedics	118	117	185	186	84	84	157	155	99%	101%	100%	99%	846	2.78	4.84	7.61
B2(T)	Trauma Orthopaedics	90	89	138	137	60	60	108	109	99%	99%	100%	101%	659	2.65	4.48	7.13
B3	Gen Surgery and Vascular	188	178	190	179	142	135	154	150	95%	94%	95%	97%	1,095	3.35	3.60	6.95
B4	General Surgery	180	173	218	200	150	138	162	160	96%	92%	92%	99%	1,286	2.83	3.36	6.19
B5	Female Surgery	180	175	90	90	150	150	90	90	97%	100%	100%	100%	1,091	3.49	1.98	5.47
C1	General Medicine	180	170	317	291	150	135	198	189	94%	92%	90%	95%	1,410	2.60	4.09	6.68
C2	Paediatrics	161	217	80	79	149	172	59	56	135%	99%	115%	95%	557	7.99	2.62	10.62
C3	Care of the Elderly	183	176	376	362	156	152	380	375	96%	96%	97%	99%	1,550	2.48	5.70	8.18
C4	Oncology	150	130	60	62	90	89	90	86	87%	103%	99%	96%	641	4.00	2.77	6.77
C5	Respiratory Medicine	180	164	239	247	150	127	179	185	91%	103%	85%	103%	1,377	2.47	3.76	6.24
C6	Urology/Surgery	90	84	60	59	60	60	60	59	93%	98%	100%	98%	504	3.35	2.81	6.15
C7	GI Medicine	180	177	131	128	120	118	130	130	98%	98%	98%	100%	1,091	3.16	2.84	6.00
C8	Stroke Rehab	196	185	279	279	180	177	281	281	94%	100%	98%	100%	1,233	3.37	5.45	8.82
CCU/PCCU	Coronary Care	210	174	35	35	150	149	1	2	83%	100%	99%	200%	0			#VALUE!
Critical Care	Critical Care	322	320	63	61	324	324	-	-	99%	97%	100%		326	23.21	1.97	25.18
EAU	Emergency Assessment	180	175	150	136	150	145	150	133	97%	91%	97%	89%	653	5.88	4.94	10.82
Maternity	Maternity	528	525	210	195	510	501	150	142	99%	93%	98%	95%	499	20.46	7.91	28.37
MHDU	Medical High	107	107	46	38	108	110	18	15	100%	83%	102%	83%	192	13.29	3.21	16.50
NNU	Neo Natal	186	176	-	-	170	166	-	-	94%		97%		382	10.27	0.00	10.27
TOTAL		**4,025**	**3,913**	**3,199**	**3,078**	**3,331**	**3,265**	**2,642**	**2,586**	**97%**	**96%**	**98%**	**98%**	**17,441**	**4.55**	**3.73**	**8.28**

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board Meeting on 01/06/2017

TITLE:	Organ Donation Committee Report to Board		
AUTHOR:	**Dr Julian Sonksen** **Mrs Rebecca Evans**	**PRESENTER**	**Mrs Rebecca Evans**
CORPORATE OBJECTIVE: SO1,SO2,SO3			
SUMMARY OF KEY ISSUES: • Section 1: Report Trust Organ Donation data and activity 2016-2017 • Section 2: Report Trust Organ Donation regional Goals 2017-2018 • Section 3: Report Trust contribution to Regional and National targets			
IMPLICATIONS OF PAPER: ***(Please complete risk and compliance details below)***			

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y/N**	**Details: RESPONSIVE,CARING,EFFECTIVE**
	Monitor	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD: To receive the report and note the content.

CORPORATE OBJECTIVES : ***(Please select for inclusion on front sheet)***

SO1:	**Deliver a great patient experience**
SO2:	**Safe and Caring Services**
SO3:	**Drive service improvements, innovation and transformation**
SO4:	**Be the place people choose to work**
SO5:	**Make the best use of what we have**
SO6:	**Plan for a viable future**

CARE QUALITY COMMISSION CQC) : ***(Please select for inclusion on front sheet)***	
Care Domain	**Description**
SAFE	**Are patients protected from abuse and avoidable harm**
EFFECTIVE	**Peoples care, treatment and support achieves food outcomes, promotes a good quality of life and is based on the best available evidence**
CARING	**Staff involve and that people with compassion, kindness, dignity and respect**
RESPONSIVE	**Services are organised so that they meet people's needs**
WELL LED	**The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture**

Executive Summary
Actual and Potential Organ Donors
1 April 2016 - 31 March 2017

NHS Blood and Transplant

The Dudley Group Of Hospitals NHS Foundation Trust

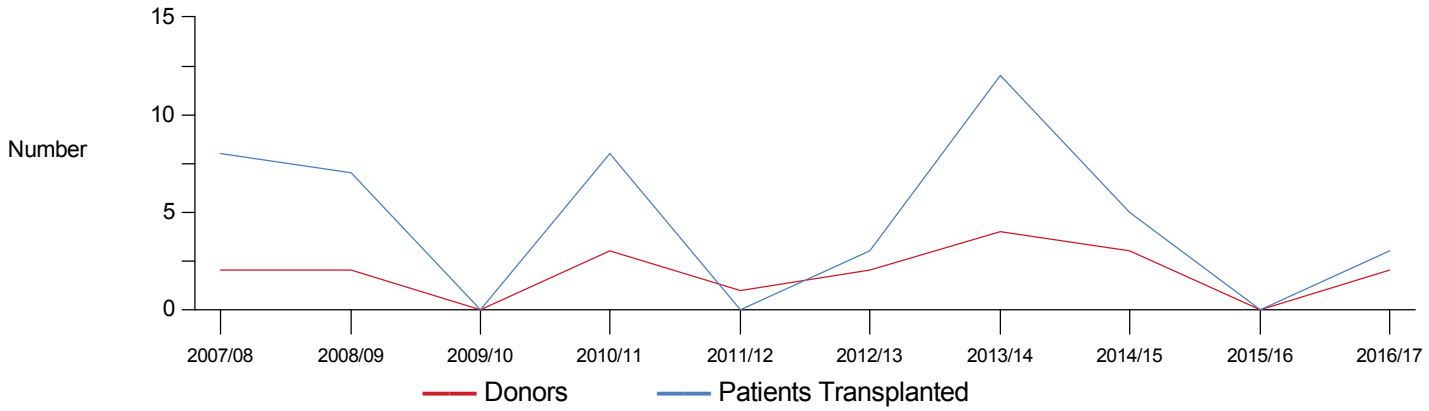
Donor outcomes

Between 1 April 2016 and 31 March 2017, your Trust had 2 deceased solid organ donors, resulting in 3 patients receiving a transplant. Further details are provided in the table and chart below. If you would like further information, please contact your local Specialist Nurse - Organ Donation (SN-OD).

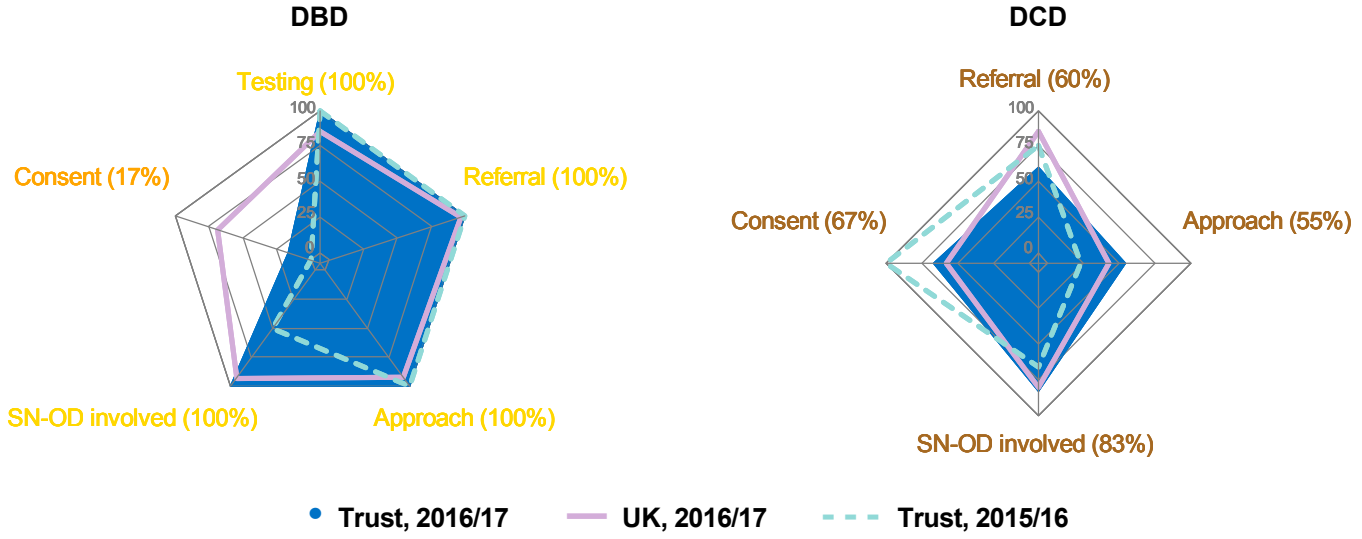
Donors, patients transplanted and organs per donor, 1 April 2016 - 31 March 2017 (1 April 2015 - 31 March 2016 for comparison)

	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		UK	
Deceased donors	2	(0)	3	(0)	2.5	(-)	3.4	(3.4)

Number of donors and patients transplanted each year



Radar charts of key rates, 1 April 2016 to 31 March 2017



The blue shaded area represents your Trust's rates for 2016/17. The latest UK rates and your Trust's rates for the equivalent period in the previous year are superimposed for comparison. The fuller the blue shaded area the better. The colour of the rate label on each of the radar charts indicates the Trust performance as shown in the appropriate funnel plot (included in the detailed report) using the gold, silver, bronze, amber, and red (GoSBAR) scheme. Additionally, the funnel plots in the detailed report can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential.

Key numbers and rates

There are nine measures on the Potential Donor Audit (PDA) which are most likely to affect the conversion of potential donors into actual donors. A comparison against funnel plot boundaries has been applied by highlighting the key rates for your Trust as gold, silver, bronze, amber, or red. Funnel plots can be found in the detailed report. Between 1 April 2016 and 31 March 2017, your Trust met a statistically acceptable level in 8 of these measures. None of the 6 potential DBD donors with suspected neurological death proceeded to donation. Of the 11 eligible DCD donors, 2 proceeded to donation and 9 did not proceed. Further details are provided below. Caution should be applied when interpreting percentages based on small numbers.

	DBD					DCD				
		2016/17		2015/16			2016/17		2015/16	
	Target	Trust	UK	Trust	UK	Target	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]		6	1,775	2	1,747		15	6,204	16	6,500
Referred to SN-OD		6	1,728	2	1,684		9	5,308	12	5,402
Referral rate %		G *100%*	*97%*	*100%*	*96%*		B *60%*	*86%*	*75%*	*83%*
Neurological death tested		6	1,522	2	1,477					
Testing rate %		G *100%*	*86%*	*100%*	*85%*					
Eligible donors[2]		6	1,444	2	1,404		11	4,237	13	4,205
Family approached		6	1,329	2	1,296		6	1,815	3	1,942
Approach rate %		G *100%*	*92%*	*100%*	*92%*		B *55%*	*43%*	*23%*	*46%*
Family approached and SN-OD involved		6	1,236	1	1,180		5	1,460	2	1,511
% of approaches where SN-OD involved		G *100%*	*93%*	*50%*	*91%*		B *83%*	*80%*	*67%*	*78%*
Consent ascertained		1	917	0	891		4	1,055	3	1,113
Consent rate %	*72%*	A *17%*	*69%*	*0%*	*69%*	*68%*	B *67%*	*58%*	*100%*	*57%*
Expected consents based on ethnic mix		3		1			1		1	
Expected consent rate based on ethnic mix %		*54%*		*74%*			*61%*		*61%*	
Actual donors from each pathway		0	819	0	786		2	565	0	564
% of consented donors that became actual donors		*0%*	*89%*	*N/A*	*88%*		*50%*	*54%*	*0%*	*51%*
Colour key - comparison with funnel plot confidence limits		G *Gold* A *Amber*		S *Silver* R *Red*			B *Bronze*			

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Further Information

- A detailed report for your Trust accompanies this Executive Summary, which also contains definitions of terms, abbreviations, table and figure descriptions, targets and tolerances, and details of the main changes made to the PDA on 1 April 2013.
- The latest Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/odt/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD).

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2017 based on data reported at 8 May 2017.

Trust Board June 2017

DR J. Sonksen & SSR R. Evans

Terminology

- WOLST- Withdrawal of life sustaining therapies.
- DBD- Neurological death. (Donation after Brain death)
- DCD- Death is imminent after WOLST. (Donation after circulatory death)
- Collaborative Approaches- conversation with family as a team: DR, Unit Nurse and SNOD.
- Stretch Goals- Targets and goals set for the forth coming year.

2016-2017

- 100% BSDT rate
- 100% family approach
- 4/6 DBD collaborative approach (66%)
- 5/6 DCD collaborative approach (83%)
- 92% Referral rate

Consent rates

The Dudley Group NHS Foundation Trust

DBD

- Only 1/6 DBD Consented – family later withdrew consent.
- 5 family declines

DCD

- 4/6 DCD consent
- 2 family declines
- 2 non-proceeding

Donation summary

2 Actual DCD donors

1 : kidney only – both sent for research

1 : Liver, kidneys and corneas- successfully transplanted.

Outcome

- One Transplanting Donor saved:

- 50 yr old with left kidney
- 54yr old with Right kidney
- 48yr old with Liver

They are all doing well.

Restored the sight of two 70 yr olds.

The year ahead..

- NHSBT Midlands ‘stretch goal’ for 2017-2018 is consent.

- Improving consent rates has been recognised nationally as well as regionally.

RHH Dudley Group

Consent and awareness is a continued goal within the Organ donation Committee within RHH.

- Involve communities from all cultural and religious background.
- Organ donation awareness week.

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board Committee on 1st June 2017

TITLE:	Transformation and Cost Improvement Programme (CIP) Summary Report		
AUTHOR:	Amanda Gaston, Head of Service Improvement and Programme Management	**PRESENTER**	Amanda Gaston, Head of Service Improvement and Programme Management

CORPORATE OBJECTIVE:
SO3: Drive service improvements, innovation and transformation
SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

The Trust identified schemes totalling **£12.5m** against a Full Year (FY) target of **£12.5m**.

As at Month 1 the Trust achieved savings of £556k against a plan of £553k, and is forecasting to deliver £12,710k.

Of the 68 projects due to deliver savings in 2017/18, 30 Project Initiation Documents (PIDs) have been approved.

6 Quality Impact Assessments (QIAs) have now been approved by the panel.

Transformation Executive Committee (TEC) met on 18th May to discuss:

- Review overall CIP delivery status and progress for 2017/18 to date.
- Review risks to delivery and agree mitigation plans.

A risk relating to the delivery of 2017/18 CIP has been raised at Risk Committee with a mitigated score of 12.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** ST001 – Capability to deliver the Programme of work ST002 – Delivery of the Programme negatively impacting on Quality of Care or Patient Experience COR080 – Failure to deliver 2017/18 CIP
	Risk Register: Y		**Risk Score:** 4, 4, 12 (respectively)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details: (*Please select from the list on the reverse of sheet)***
	Monitor	**Y**	**Details:** Non delivery of CIP plan
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE: *(Please tick or enter Y/N below)*

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COMMITTEE: Note delivery of CIP to date and the current forecast outturn.
CORPORATE OBJECTIVES : ***(Please select for inclusion on front sheet)***
SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO3: Drive service improvements, innovation and transformation
SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: Deliver a viable future
CARE QUALITY COMMISSION CQC) : ***(Please select for inclusion on front sheet)***

Care Domain	**Description**
SAFE	**Are patients protected from abuse and avoidable harm**
EFFECTIVE	**Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence**
CARING	**Staff involve and treat people with compassion, kindness, dignity and respect**
RESPONSIVE	**Services are organised so that they meet people's needs**
WELL LED	**The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture**

The Dudley Group NHS
NHS Foundation Trust

Board Committee

Programme Management Office

Summary Report

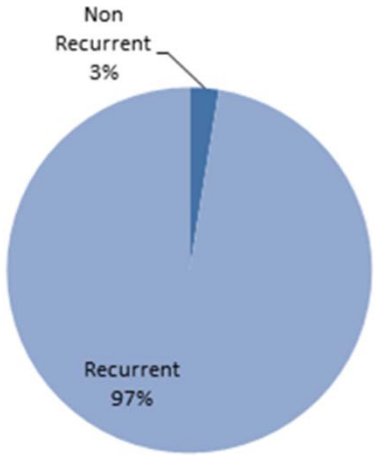
1st June 2017

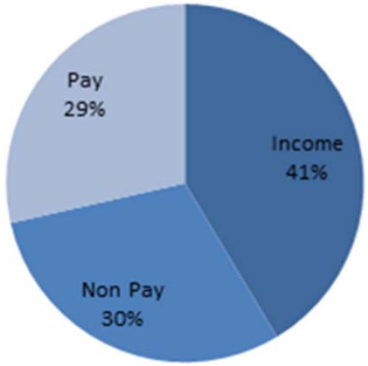
Executive Summary – 2017/18

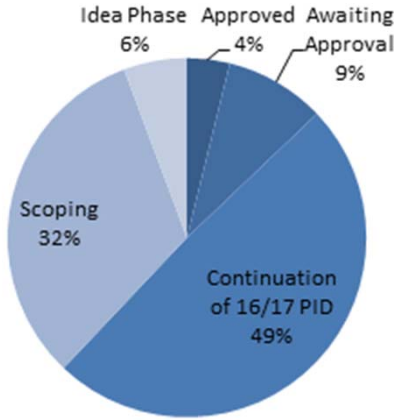
The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18. To support this, the Trust has identified 42 of 67 schemes currently on the work programme contribute to the £12.5m identified, and 3% of the CIP has currently been identified as non recurrent savings.

A summary of CIP performance as at Month 1 is provided below:

	Full Year (FY)			Year to Date (YTD) Performance against plan			Year End Forecast	
CIP Project Plans	Full Year Target	Full Year Identified	Shortfall against Full Year Target	Year To Date Plan	YTD Actual	Year To Date Variance	Year End Full Year Effect	Year End Full Year Effect Variance
TOTAL	£12,5m	£12,5m	-£0k	£553K	£556k	£3k	£12,7m	£210k







Based on the Month 1 position, the Trust has identified schemes totalling **£12.5m** against a Full Year (FY) target of **£12.5m.** As at Month 1 the Trust is forecasting to deliver £12,710k.

Of the 68 projects in the 2017/18 work programme, 30 Project Initiation Documents (PIDs) have been approved.

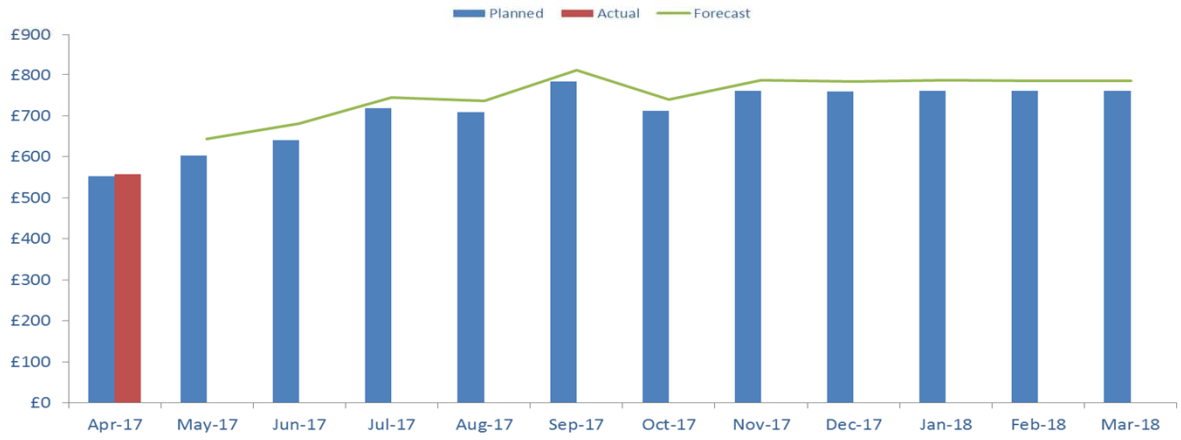
6 Quality Impact Assessments (QIAs) have now been approved by the panel.

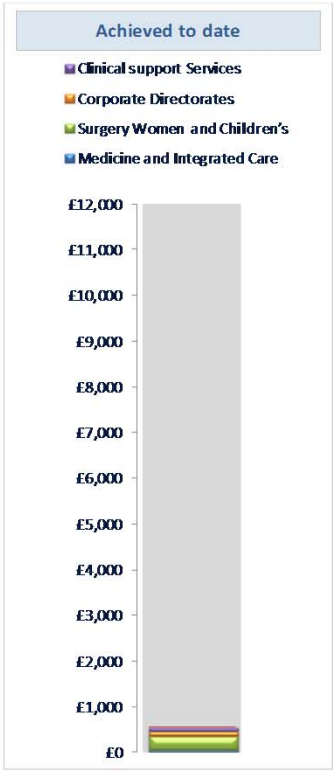
An additional risk has been identified relating to non delivery of 2017/18 CIP work programme, with a mitigated score of 12.

Executive Summary – 2017/18

	YTD	FYE		Submitted Plan
Planned	£553,142		Identified	£12,331,444
Actual	£556,894		Target	£12,500,000
Forecast		£12,710,938		
Variance	£3,752	£210,938		

Programme (Click for details)	FYE Plan	FYE Forecast	YTD Plan	YTD Actual	Forecast Shortfall
Surgery Women and Children's	£3,469,351	£3,748,107	£284,946	£301,977	£278,756
Medicine and Integrated Care	£1,438,509	£1,438,509	£71,727	£51,290	£0
Clinical support Services	£1,238,903	£1,223,044	£67,834	£77,776	-£15,859
Corporate Directorates	£2,400,684	£2,413,281	£108,136	£111,435	£12,597
Cross Workstream	£3,783,997	£3,887,997	£20,500	£14,417	£104,000
View all Projects	£12,331,444	£12,710,938	£553,142	£556,894	£379,494





2017/18 Forecast Non Recurrent	£425k
% of Total CIP Forecast as Non Recurrent	3%

Enclosure 14

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 1 June 2017

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	J Fellows Non-Executive Director
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: Summary reports from the Finance and Performance Committee meeting held on 25 May 2017.			

RISKS	**Risk Register**	**Risk Score Y**	**Details:** Risk to achievement of the overall financial target for the year
COMPLIANCE	**CQC**	**Y**	**Details:** CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.
	NHSLA	**N**	
	NHSI	**Y**	**Details:** Achievement of all Terms of Authorisation
	Other	**Y**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report.

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**25 May 2017**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- That procurement savings in Quarter 4 of 2016-17 of £278k exceeded the plan and other performance metrics were also good. The committee recognised the work of Dave Lewis who recently retired as Head of Procurement
- Progress on the Black Country Corporate Services Review was noted and discussed and the next steps required to take it forward
- The relationship between qualified and unqualified nursing staff substantive numbers, and the amount spent of agency nurses was noted in the report about workforce trends
- The work being led by the Chief Nursing Officer regarding nurse establishments was noted and agreed that reports would be brought to committee when they were available
- The additional controls set up using the "star chamber" approach for medical locum and agency shifts was noted
- That £12m of a target of £12.5m saving schemes in 2017-18 has been identified, although some additional work regarding Quality Impact Assessments and Project Initiation Documents was still to be finalised for some of the schemes
- The April 2017 financial position recorded a larger deficit than the planned figure, although April data is notoriously unreliable for a variety of reasons
- Performance for April 2017 in A&E was at 91.69% which is above the 90% target set by NHS Improvement. RTT targets continue to be met. Diagnostic targets have not been met

Decisions Made / Items Approved

- The amendments to the Annual Report 2016-17 were approved
- The recommendations in the report regarding changes to the reporting of Referral to Treatment Times were agreed
- The Overpayment policy was approved on behalf of the Board

Actions to come back to Committee

- None

Performance Issues to be referred into Executive Performance Management Process

- None

Areas of Risk to be escalated onto the Corporate or Divisional Risk Register

- Risk to staff retention of the on-going back office services proposals
- Confirm that risk estate management risk is adequately described and scored

Items referred to the Board for decision or action

- The current performance of the PFI provider regarding the estates management was discussed, and the current escalation in accordance with the terms of the contract to be reported to the Board
- Following a review, it is recommended that the Terms of Reference for the Committee remain unchanged for the next 12 months

APPENDIX 1

THE DUDLEY GROUP NHS FOUNDATION TRUST

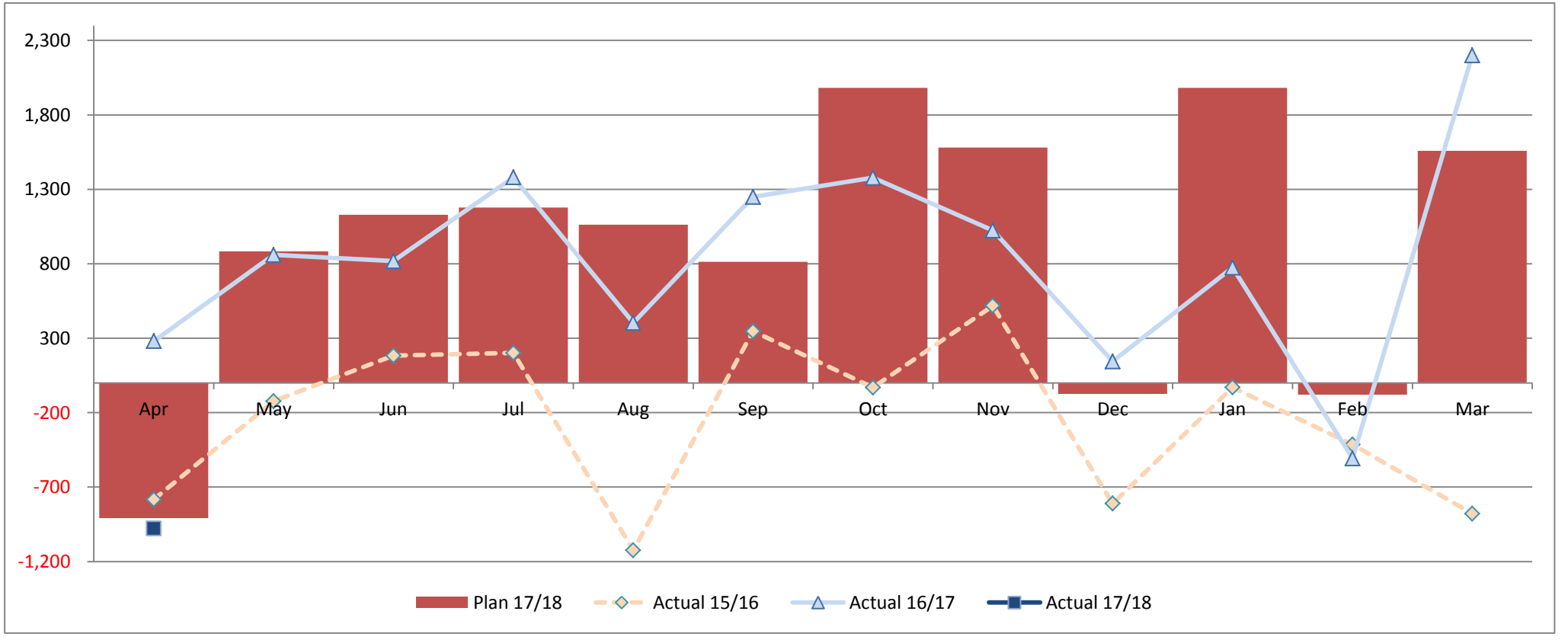
FINANCIAL SUMMARY **APRIL 2017**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£27,403	£27,285	-£118
PAY	-£16,953	-£17,106	-£153
NON PAY	-£9,463	-£9,308	£155
EBITDA	**£987**	**£871**	**-£116**
OTHER	-£1,895	-£1,851	£44
NET	**-£908**	**-£980**	**-£72**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£27,403	£27,285	-£118
PAY	-£16,953	-£17,106	-£153
NON PAY	-£9,463	-£9,308	£155
EBITDA	**£987**	**£871**	**-£116**
OTHER	-£1,895	-£1,851	£44
NET	**-£908**	**-£980**	**-£72**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£357,846	£357,846	£0
PAY	-£205,941	-£205,941	£0
NON PAY	-£118,098	-£118,098	£0
EBITDA	**£33,806**	**£33,806**	**£0**
OTHER	-£22,702	-£22,702	£0
NET	**£11,104**	**£11,104**	**£0**

NET SURPLUS/(DEFICIT) 17/18 PLAN & ACTUAL **APRIL 2017**



APPENDIX 2

The Dudley Group NHS

NHS Foundation Trust

Finance & Performance Report - April 2017

Quality & Risk			2016								2017					
Description		LYO	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	YTD	YEF
Friends & Family – Community – Footfall		1.2%	1.1%	1.5%	1.1%	1.3%	1.1%	0.6%	1.3%	1.3%	1.5%	1.2%	1.2%	1.1%	1.1%	
Friends & Family – Community – Recommended %		95.8%	94.7%	94.4%	97.3%	96.1%	96.1%	95.1%	95.5%	94%	94.4%	97.8%	97.3%	94%	94%	
Friends & Family – ED – Footfall		7.9%	3.8%	1.6%	8.4%	10.7%	5%	5%	3.7%	4.3%	13.1%	15.4%	18.6%	15.4%	15.4%	
Friends & Family – ED – Recommended %		85.1%	91.3%	88.2%	91.7%	91.8%	91.9%	93.8%	93.1%	90.1%	75.3%	76%	81%	75%	75%	
Friends & Family – Inpatients – Footfall		17.8%	15.8%	13.9%	17.9%	18.6%	20.5%	19.2%	19.2%	17%	17.9%	18.1%	18.3%	28.7%	28.7%	
Friends & Family – Inpatients – Recommended %		96.6%	96.7%	97%	94.6%	96.6%	96.6%	97.9%	95%	97.9%	95.8%	97.3%	97.3%	96.4%	96.4%	
Friends & Family – Maternity – Footfall		30.1%	33.2%	16.6%	33.8%	32.7%	32.3%	27.6%	36.5%	33.9%	34.5%	29.5%	32.7%	30.9%	30.9%	
Friends & Family – Maternity – Recommended %		98.3%	97.3%	98.9%	96%	98.6%	98.8%	98.8%	99.5%	99.4%	97.6%	98.2%	99%	98.8%	98.8%	
Friends & Family – Outpatients – Footfall		1.6%	1.1%	1%	1.7%	1.5%	1.4%	1.5%	2.5%	1.5%	2.4%	1.9%	1.7%	1.5%	1.5%	
Friends & Family – Outpatients – Recommended %		92.6%	82.2%	93.1%	91.7%	92.4%	92.4%	93.2%	94.9%	93.1%	95%	94.1%	96.2%	95.3%	95.3%	
HCAI – Post 48 hour MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI CDIFF - Total Number of Cases		-	3	2	2	-	-	-	-	-	-	-	-	-	-	
Incidents - Pressure Ulcer		15,438	1,440	1,164	1,158	1,176	1,128	1,152	1,212	1,272	1,398	1,296	1,524	227	227	
Mixed Sex Sleeping Accommodation Breaches		62	0	0	0	0	0	4	4	7	26	14	7	5	5	
Never Events		1	0	0	0	1	0	0	0	0	0	0	0	0	0	
Serious Incidents – Not Pressure Ulcer		600	36	24	72	66	36	42	54	48	72	48	60	5	5	
Serious Incidents - Pressure Ulcer		900	54	48	60	102	96	84	48	54	114	60	102	12	12	
Stroke Admissions : Swallowing Screen		77.02%	88.37%	85.11%	78.72%	73.91%	62.5%	75.68%	73.33%	77.55%	66.67%	67.31%	84.21%	71.79%	71.79%	
Stroke Admissions to Thrombolysis Time		51.25%	50%	83.33%	36.36%	54.55%	50%	66.67%	37.5%	30%	83.33%	33.33%	50%	66.67%	66.67%	

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - April 2017

Quality & Risk			2016								2017					
Description		LYO	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	YTD	YEF
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		87.56%	91.11%	91.53%	90.2%	88.64%	89.36%	97.5%	86.54%	89.8%	79.03%	83.64%	85.71%	95.74%	95.74%	
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation		79.31%	78.57%	36.36%	63.64%	66.67%	83.33%	93.33%	80%	100%	66.67%	93.75%	91.67%	100%	100%	
VTE Assessment Indicator (CQN01)		94.76%	95.5%	95.09%	93.91%	94.5%	93.91%	95.65%	95.64%	94.64%	94.18%	92.84%	96.31%	92.85%	92.85%	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

The Dudley Group NHS
NHS Foundation Trust

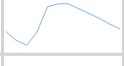
Finance & Performance Report - April 2017

Finance			2017		
Description		LYO	Apr	YTD	YEF
Budgetary Performance		£230k	(£571)k	(£571)k	
SLA Performance		£1,937k	(£389)k	(£389)k	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - April 2017

Performance			2016								2017					
Description		LYO	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	YTD	YEF
A&E - 4 Hour A&E Dept Only % (Type 1)		89.77%	92.88%	94.48%	93.34%	92.97%	92.14%	92.3%	86.08%	82.86%	77.85%	86.3%	92.46%	84.94%	84.94%	
A&E - 4 Hour UCC Dept Only % (Type 3)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)		94.16%	96.06%	96.76%	96.21%	95.81%	95.29%	95.51%	91.97%	90.78%	87.7%	92.31%	95.59%	91.69%	91.69%	
Activity - A&E Attendances		102,696	8,801	8,433	8,973	8,579	8,594	8,929	8,477	8,718	8,607	7,758	9,020	8,315	8,315	
Activity - Community Attendances		394,381	32,631	32,846	31,673	33,863	33,078	32,365	34,044	33,676	33,404	29,912	34,208	25,064	25,064	
Activity - Elective Day Case Spells		45,982	3,720	3,998	3,798	3,895	3,911	3,721	3,888	3,428	3,761	3,748	4,313	3,811	3,811	
Activity - Elective Inpatients Spells		6,029	523	549	561	482	506	540	518	454	414	440	528	479	479	
Activity - Emergency Inpatient Spells		60,748	5,246	5,077	5,054	5,002	4,933	5,038	5,119	5,171	5,107	4,765	5,412	5,023	5,023	
Activity - Outpatient First Attendances		125,869	10,527	10,560	9,890	10,006	10,799	10,445	11,007	9,158	10,610	10,450	12,172	10,393	10,393	
Activity - Outpatient Follow Up Attendances		310,607	26,733	26,893	25,084	25,384	26,492	25,427	27,159	23,292	26,406	24,567	26,804	22,686	22,686	
Activity - Outpatient Procedure Attendances		59,621	4,951	5,210	5,090	4,898	4,992	4,845	4,985	4,067	5,163	5,133	5,311	3,278	3,278	
RTT - Admitted Pathways within 18 weeks %		92.4%	93.5%	94.2%	94.2%	95%	93.2%	93.9%	92.6%	92.9%	91.4%	88%	88.5%	86.3%	86.3%	
RTT - Incomplete Waits within 18 weeks %		95.4%	96.8%	97.1%	97.1%	96.6%	96.1%	95.6%	95%	94.5%	94.2%	93.3%	92.8%	94.2%	94.2%	
RTT - Non-Admitted Pathways within 18 weeks %		96.5%	97.7%	98.1%	98%	98.4%	97.1%	95.9%	96.3%	96.3%	94.2%	94.3%	95%	93.2%	93.2%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		97.41%	99.39%	99.16%	98.96%	97.69%	98.12%	98.59%	97.38%	93.5%	92.25%	97.09%	99.29%	95.99%	95.99%	

** LYO - last year out-turn, YTD - year to date, YEF - year end forecast*

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Staff/HR			2016									2017					
Description		LYO	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	YTD	YEF
Appraisals		82.9%	80.5%	81%	78.1%	78.3%	77.4%	77%	77.1%	73.9%	71.7%	75.9%	82.9%	81.9%	81.9%	
Mandatory Training (Professional Requirements)		71.8%	71.3%	72.8%	72.5%	72.4%	70.1%	69.7%	70.7%	69.9%	68.8%	69.9%	71.8%	69.2%	69.2%	
Mandatory Training (Substantive)		83.9%	75.4%	76.3%	77.4%	78.6%	77%	78.5%	79.6%	79.4%	78.6%	80.2%	83.9%	84.6%	84.6%	
Sickness Rate (Performance Dashboard)		4.17%	4.17%	4.04%	4.07%	3.73%	4.04%	4.38%	4.29%	4.30%	4.57%	4.37%	4.16%	3.53%	3.53%	
Staff In Post (Contracted WTE)		4,278.19	4,091.47	4,083.01	4,083.49	4,112.05	4,146.74	4,199.22	4,236.4	4,230.95	4,240.77	4,280.54	4,278.19	4,309.81	4,309.81	
Vacancy Rate		7.90%	10.53%	10.78%	10.75%	10.31%	9.61%	9.18%	9.09%	9.18%	8.77%	7.93%	7.90%	8.65%	8.65%	

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Description	Target	All Tumour Sites	Brain	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Paediatric	Skin	Upper GI	Urology	Total
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	93%	-	100%	95.5%	94.5%	90.6%	100%	96.3%	87.5%	100%	96.2%	91.5%	96.3%	**94.7%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	-	97.3%	-	-	-	-	-	-	-	-	-	**97.3%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	-	100%	100%	100%	100%	66.7%	100%	-	100%	100%	92.3%	**97.5%**
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	98%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	94%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	96%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	85%	-	-	-	100%	100%	100%	66.7%	77.3%	-	100%	100%	100%	**91.4%**
Cancer - 62 day - From Referral for Treatment following national screening referral	90%	-	-	100%	0%	-	-	-	-	-	-	-	-	**92.3%**
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85%	-	-	93.1%	90.5%	90%	100%	60%	0%	-	100%	100%	80%	**85.3%**

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	2016								2017			
	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr
Cancer: Patients on a 62 day pathway treated on or over 104 days (1: patients treated at DGFT)	0	4	2	4	0	1	0	1	1	2	2	
Cancer: Patients on a 62 day pathway treated on or over 104 days (2: patients treated at a Tertiary Centre)	3	3	3	4	0	3	5	0	2	2	3	
Cancer: Patients on a 62 day pathway treated on or over 104 days (3: combined)	3	7	5	8	0	4	5	1	3	4	5