The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 1 September, 2016 at 9.00am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – A. Baines**		J Ord	To Note	9.00
2.	**Declarations of Interest**		J Ord	To Note	9.00
3.	**Announcements**		J Ord	To Note	9.00
4.	**Minutes of the previous meeting**				
	4.1 Thursday 7 July 2016	Enclosure 1	J Ord	To Approve	9.00
	4.2 Action Sheet 7 July 2016	Enclosure 2	J Ord	To Action	9.00
5.	**Patient Story**		J Dietrich	To Note & Discuss	9.05
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.15
7.	**Finance and Performance**				
	7.1 Cost Improvement Programme and Transformation Overview Report	Enclosure 4	A Gaston	To Note	9.25
	7.2 Finance and Performance Committee Exception report	Enclosure 5	R Miner	To Note & Discuss	9.35
8.	**Patient Safety and Quality**				
	8.1 Chief Nurse Report	Enclosure 6	D Wardell	To Note & Discuss	9.45
	8.2 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 7	D Wulff	To Note & Discuss	9.55
	8.3 NHS Preparedness for a Major Incident Report	Enclosure 8	P Bytheway	To Note	10.05
	8.4 Complaints Report	Enclosure 9	G Palethorpe	To Note	10.15
	8.5 Calendar of Meetings 2017	Enclosure 10	G Palethorpe	To Note	10.25
	8.6 End of Life and Palliative Care Report	Enclosure 11	D Wulff	To Note	10.30
	8.7 Support for General Practitioners Report	Enclosure 12	P Bytheway	To Note	10.40
	8.8 Urgent Care National Assurance Plan Report	Enclosure 13	P Bytheway	To Note	10.50
	8.9 Safeguarding Report	Enclosure 14	D Wardell	To Note	11.00

	8.10 Workforce Committee Exception Report	Enclosure 15	J Atkins	To Note	11.10
9.	**Any other Business**		J Ord		11.20
10.	**Date of Next Board of Directors Meeting** 9.30am 6 October 2016 Clinical Education Centre		J Ord		11.20
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		11.20

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 7th July, 2016 at 9:30am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Paul Taylor, Director of Finance and Information
Julian Atkins, Non Executive Director
Paula Clark, Chief Executive
Doug Wulff, Non Executive Director
Ann Becke, Non Executive Director
Jonathan Fellows, Non Executive Director
Paul Harrison, Medical Director

In Attendance:

Helen Forrester, PA
Glen Palethorpe, Director of Governance/Board Secretary
Liz Abbiss, Head of Communications and Customer Relations
Yvonne O'Connor, Deputy Chief Nurse
Andrew McMenemy, Director of HR Designate

16/067 Note of Apologies and Welcome
9.32am

Apologies were received from Anne Baines and Dawn Wardell. The Chairman welcomed Andrew McMenemy, who joins the Trust on 8th August, 2016, as the new Director of Human Resources to the meeting. The Chairman confirmed that Judith Smith from the University of Birmingham was observing the meeting as part of a Board effectiveness study.

16/068 Declarations of Interest
9.35am

There were no declarations of interest.

16/069 Announcements
9.35am

No announcements made.

16/070 Minutes of the previous Board meeting held on 7th July, 2016 (Enclosure 1)
9.35am

Mr Miner, Non Executive Director, asked that the minutes were amended at page 7, 4th paragraph, to read "those charged with governance".

With this amendment the minutes of the previous meeting were agreed by the Board as a true and correct record of the meetings discussion and signed by the Chairman.

16/071 Action Sheet, 7th July, 2016 (Enclosure 2)
9.37am

16/071.1 Chief Executives Report – Junior Doctors Contract

The Board noted that following the recent referendum, Junior Doctors had declined the new contract. Work would now continue on the impact assessments.

16/071.2 Clinical Quality, Safety and Patient Experience Committee – CAMHS Tier 4 Beds

The Director of Governance/Board Secretary confirmed that the CCG had commissioned a tier 3.5 service from August, 2016. The Chief Executive and Medical Director had also raised the tier 4 issue with Simon Collings at a recent meeting, he had confirmed that locally there was no short term solution. The issue would remain on the Risk Register and will continue to be monitored by the Trust.

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

16/072 Patient Story
9.42am

Liz Abbiss, Head of Communications and Patient Experience, presented the patient story. The patient had spent 5 and a half weeks in the hospital following a car accident. The patient was very positive about her care, cleaning, laundry services and communication. Some issues were noted around the response to call bells, bed pans, and food provision.

Liz confirmed that the issues around food were being investigated and acted upon. The video had also been shared with Interserve FM. Matron Jenny Bree is also looking at the issues raised around bed pans. The Chief Executive asked that the length of time patients are left on bed pans is also investigated.

The Chairman and Board noted the story and the ongoing actions to the issues raised.

16/073 Chief Executive's Overview Report (Enclosure 3)
9.56am

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

- **Friends and Family:** The Chief Executive confirmed that the format had been changed as the detailed report appears within the corporate performance dashboard that is presented to the Finance and Performance Committee. The Board report will now provide information in this area on an exception basis. The Board noted the continuing issue with footfall numbers within Outpatients.

- **Summary Hospital-Level Mortality Indicator (SHMI):** The Board noted the excellent performance. The Trust stood at just below 1 for the first time. Work continues on the Mortality Tracker.

- **Guardian of Safe Working:** Mr Babar Elahi had been appointed. Mr Atkins, Non Executive Director, asked if there had been a recruitment process. The Medical Director confirmed that there had been. Dr Wulff, Non Executive Director, commented that it would be important for the Guardian to work closely with the Freedom to Speak Up Guardian. The Chief Executive confirmed that the Freedom to Speak Up Guardian had been busy since her appointment but would be engaging with Mr Elahi. The Director of Governance/Board Secretary stated that there will be a half yearly report to Board from the Freedom to Speak Up Guardian. The first report will be presented in October 2016. The Chairman asked that work is undertaken outside of the meeting to ensure joined up working on Whistleblowing within the Trust. The Board noted that Junior Doctors had voted to turn down the new contract following the recent Referendum. The Chairman asked for an update to Board on the contract position at its September meeting.

- **Nursing Times Awards:** Day Surgery shortlisted for an award. The winners of the 2016 Awards will be announced on 26th October, 2016.

- **Delayed Transfer of Care:** Currently 102 delayed transfers of care within the Trust. The Trust continues to apply pressure to the Local Authority and CCG to resolve this situation.

- **Maternity Review:** The Trust is meeting with families. Staff have asked to be involved in feedback from the meetings and the Trust's processes which include this engagement are being followed.

- **EU Referendum Result: Valuing our Overseas Staff:** The Trust values its overseas staff and a message had been posted on the Hub. The Medical Director stated that the Trust has a significant number of Consultants from the EU who are feeling threatened by the Referendum result.
  .
- **NHS Providers Board:** Discussed the cost of "Brexit" to the NHS.

The Chairman and Board noted the report.

Update on the Junior Doctors Contract to the September Board.
Freedom to Speak Up Guardian Report to be presented to the Board in October.

16/074 Patient Safety and Quality

16/074.1 Chief Nurse Report (Enclosure 4)
10.21am

The Deputy Chief Nurse presented the Chief Nurse Report given as Enclosure 4.

The Board noted the key issues relating to infection control, including:

MRSA: No post 48 hr MRSA bacteraemia cases since 27th September, 2015.

C.Diff: The Trust has had 7 cases to date in 2016/17. These had yet to be apportioned but to date the Trust is within trajectory for April and May.

Norovirus: No cases to note.

The Chief Nurse presented on the key issues relating to safer staffing, including:

- Amber shifts (shortfall) total figure for the month is 65 which is up from the last month (52) but still better than February and March.
- The new RAG rating system had been rolled out across the wards, no red shifts in this methodology for that period.
- Red (serious shortfall) shifts: none in the month, no safety issues identified or on any of the amber shifts that affected quality of care.
- The Care Hours per Patient Day (CHPPD) had commenced collection of data in May and was reported in a limited way in the report.

The Chief Nurse presented on the key issues relating to Nursing Care Indicators, including:

- There had been 10 escalations at level 3. Improvement seen in other areas has now reduced areas in the red category and increased those in the green. More intensive support has been provided which has seen the appropriate change in results.

The Chairman and Board noted the report and improving position in respect of staffing shortfalls.

16/074.2 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 5)
10.26am

Dr Wulff, Committee Chair, presented the Clinical Quality Safety Patient Experience Committee Exception Report, given as Enclosure 5. The Board noted the following key areas from the Committee meeting:

- Assurances Received: The Board had requested the Committee to review and monitor the discharge medicines process. The Committee asked that the action plan comes back as it progresses over the summer and requested that timescales for those areas where multiple parties are involved be reviewed to ensure that these are realistic. The Committee had looked at the Mortality review process and outcomes of SHMI and HSMR. Two external mortality alerts were noted, one on Sepsis and one on Fractured Neck of Femur.

- Decisions Made: The Committee approved the Mortality Surveillance Group's Terms of Reference and will amend its own Terms of Reference to reflect this as a formal reporting group of the Committee.

- Actions back to the Committee: Delays to follow up on the Ophthalmology waiting list and the Committee to monitor and understand progress for the Friends and Family text messaging service.

The Board noted the error relating to the meeting date on the front cover.

The Director of Finance and Information asked how often mortality alerts are received. The Medical Director confirmed that timeframes are varied, but the receipt of alerts is not common.

The Chairman and Board noted the report and the assurances received, decisions made and actions back to the Committee.

16/074.3 Black Country Alliance Report (Enclosure 6)
10.34am

The Chief Executive presented the Black Country Alliance Report given as Enclosure 6.

The Board noted the following key highlights:

- The Rheumatology Service at Walsall had stabilised.

- The Endoscopic Colon Tumour Service will continue to be built upon.

- In response to the letter from Jim Mackey, the BCA will continue to look at back office functions between the 3 organisations.

- A joint BCA Procurement Director had been recently appointed.

- The national analytics tool had also been confirmed.

The CAN newsletter was appended to the report.

Mr Fellows, Non Executive Director, commented that the Jim Mackey letter raises services that rely heavily on locums should be reviewed. The Chief Executive confirmed that it is difficult to identify a service that relies on locums that can be moved to other providers as most of services are essential for Trusts, like the Emergency Department. Mr Fellows suggested that it was more important to identify that this was something that the Trust had considered.

Mr Miner, Non Executive Director, commented that now the BCA is at its first anniversary, whether the BCA Board had a sense of potential opportunities. The Chief Executive confirmed that the Board acknowledged that there were no potential savings in the short term and the work of the BCA had been more focussed on service improvement. The Chairman will raise the potential for Wolverhampton to join the BCA at its next Board meeting.

The Chairman and Board noted the report.

16/074.4 Charitable Funds Committee Report (Enclosure 7)
10.45am

Mr Julian Atkins, Committee Chair, presented the Charitable Funds Committee Report, given as Enclosure 7.

The Board noted the following key issues:

- £2.4 million fund balance.

- The Committee received a presentation from Anne Flavell on the use of fall alarms, the Committee requested that Anne reviews the need for further alarms and the need for low rise beds and brings an application to the next meeting.

- The Committee considered a report from larger funds with low spending. There had been disappointment with the amount of detail in the reports. Fund Managers will be asked to present to the Committee.

- The Committee approved the Fundraisers Programme at a total of £99k.

- The Committee approved the investment in the Charity Hub.

Dr Wulff, Non Executive Director, commented that wards need to be encouraged to use charitable funds.

The Chairman and Board noted the report.

16/074.5 Appointment of Responsible Officer for Medical Appraisal Report (Enclosure 8)
10.48am

The Medical Director presented the Appointment of Responsible Officer for Medical Appraisal Report, given as Enclosure 8.

The Board had previously agreed to split the roles of Responsible Officer and Medical Director.

The Board approved the appointment of Paul Stonelake as Responsible Officer from 1st September, 2016. The Medical Director reminded the Board that Mr Stonelake would not be his Responsible Officer but that would continue to be provided externally.

Dr Wulff, Non Executive Director, asked if there was sufficient administrative support for the role. The Medical Director confirmed that the process in being run at an efficient level but more resource will be required in the longer term.

An Annual Revalidation Report will be presented to the Board.

Mr Fellows, Non Executive Director, raised the Apprenticeship Levy and whether Apprentices could be used to assist in this area. The Director of Finance and Information confirmed that there will be some opportunities.

The Chairman and Board noted the report and approved the appointment on Mr Stonelake as the Trust's Responsible Officer.

16/074.6 NHS Equality Delivery System Report (Enclosure 9)
10.54noon

The Chief Executive presented the NHS Equality Delivery System Report, given as Enclosure 9.

The Board is asked to confirm that the Trust is committed to the NHS Equality Delivery System.

The process will be monitored by the CCG and there are nine steps to achieve by February 2017.

The Chairman and Board noted the report and gave its leadership commitment to the NHS Equality Delivery System.

16/075 Finance

16/075.1 Finance and Performance Committee Report (Enclosure 10)
10.57pm

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Report, given as Enclosure 10.

The report provided a summary of the June Finance and Performance Committee meeting.

The Board noted the key highlights as follows:

- The Trust's month 2 performance.
- Noted the pressure on the full year financial forecast position due to agency costs.
- Noted the apparent significant increase in referrals from Dudley GPs since the agreement to the Block Contract.
- The level of referrals from Wyre Forrest continues to grow.
- All Performance metrics had been met with the exception of the 62 Day Cancer target.

The Chairman and Board noted the report, risks and key areas.

16/075.2 Transformation and Cost Improvement Programme Summary Report (Enclosure 11)
11.00pm

The Director of Finance and Information presented the Transformation and Cost Improvement Programme Summary Report, given as Enclosure 11.

The Board noted the high level position as follows:

- £2M shortfall.
- CIP programmes were being significantly affected by capacity pressures.
- Part of the shortfall is a result of the lack of schemes.

- Agency and Carter Workstreams are being created.

- Some work to do for the Trust to get back into balance.

Mrs Becke, Non Executive Director, asked about progress on the use of Busheyfields to manage delayed transfer of care patients. The Chief Executive commented that the Trust would prefer to use its own two closed wards as intermediate wards. The Chief Operating Officer confirmed that the Trust is producing scenarios for the Winter Plan. The Chairman asked about timing. The Chief Executive confirmed that plans must be in place by early October.

The Chairman and Board noted the report and the gap in financial outturn, the work being undertaken to reduce agency costs and the winter scenario plans.

16/076 Any Other Business
11.13pm

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

16/077 Date of Next Meeting
11.13pm

The next Board meeting will be held on Thursday, 1st September, 2016, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 7 July 2016

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
16/051	Chief Executive's Overview Report	Results of the Junior Doctors Contract Impact Assessments to be reported to the: Clinical Quality, Safety, Patient Experience Committee Finance and Performance Committee Workforce and Staff Engagement Committee	DWu JF JA	28/6/16 30/6/16 23/8/16	Change in system. Now submitted through Unify.
16/073	Chief Executive's Overview Report	Update on the Junior Doctors Contract to the September Board.	AM	1/9/16	In Chief Executive's Report
16/064.2	Transformation and Cost Improvement Programme Summary Report	Presentation on the Outpatient Programme to be delivered to the Board in October 2016.	AB	6/10/16	
16/073	Chief Executive's Overview Report	Freedom to Speak Up Guardian Report to be presented to the October Board.	CLM	6/10/16	
16/030.3	NHS Preparedness for a Major Incident	Sharon Walford to be invited to present on Emergency Preparedness at a future Board General Clinical Presentation.	PB	1/12/16	This date is the next scheduled General Clinical Presentation.

Enclosure 3

The Dudley Gro
NHS Foundation Trust

Paper for submission to the Public Board Meeting – 1st September 2016

TITLE:	**Chief Executive Board Report**		
AUTHOR:	**Paula Clark, CEO**	**PRESENTER**	**Paula Clark, CEO**
CORPORATE OBJECTIVE: SO1, SO2, SO3, SO4, SO5, SO6			

SUMMARY OF KEY ISSUES:

- Friends and Family
- Junior Doctors Contract
- Jim Mackay Visit
- Gill Morgan Visit

IMPLICATIONS OF PAPER:

RISK	**No**		**Risk Description:**
	Risk Register: No		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details: Effective, Responsive, Caring**
	Monitor	**No**	**Details:**
	Other	**No**	**Details:**

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

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD: The Board are asked to note and comment on the contents of the report

The Dudley Group NHS
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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**

The Dudley Group NHS
NHS Foundation Trust

Chief Executive's Report – Public Board – September 2016

Patient Friends and Family Test:

Quality Priority - Patient Experience

Based on the latest published NHS figures (June 2016) the following areas of the Trust continue to meet the quality priority target of monthly scores that are equal to or better than the national average for the percentage of patients who would recommend the service to friends and family:

Community
Inpatient
A&E
Maternity

The Outpatient Department also met the quality priority for June (93% would recommend which was equal to the national average). It had not been equal to or better than the national average in April or May 2016.

Improving FFT response rates

The Trust has seen deterioration in the number of patients completing the Friends and Family Test across many areas of the Trust. Actions to improve response rates include:

- Dedicated volunteer on wards to hand out FFT cards
- Dedicated volunteer in Day Case to hand out FFT cards
- Advising patients they can fill out the survey in the new welcome booklet
- Purchasing survey pens to make available to patients
- Refreshing the FFT posters with a clear call to action (Tell us how we did)

We aim to achieve response rates that give us meaningful data that we can use to make patient experience improvements with.

Inpatient response rates for July have increased to 18% compared to 14% in June. The Emergency Department areas have increased from 2% in June to 8.4% in July. The action plan was submitted and approved at the July meeting of the Finance and Performance Committee.

Junior Doctors Contract:

The 2016 contract came into effect on 3 August 2016. The 2016 contract will start to be introduced in England for GP trainees and trainees in hospital posts approved for postgraduate medical/dental education in line with a phased implementation timetable from October 2016. A phased implementation plan has been developed which will enable the Trust to introduce the working patterns outlined in the contract.

Allocate E-Rota (Zircadian) has been updated to incorporate revised rota rules and the system is currently being used with each service to review their rotas and identify any potential service risks. As the rota rules require additional time off following period of on-call, the current rota modelling has identified less junior doctor cover on the wards. The revised rotas are being reviewed at Divisional level to identify opportunity for the introduction of new roles to support ward cover eg Physician Associates. This is a key risk which has been registered on the corporate risk register.

As detailed in a previous report, Mr Babar Elahi was appointed to the role of Guardian of Safe Working and commenced in the role on the 25 July 2016.

Whilst the plan is being actioned, we are aware that the BMA Junior Doctors' Committee (JDC) has advised, via social media, that it would be seeking approval from the BMA Council for a rolling programme of industrial action in relation to the new junior doctors' contract. It was unclear from the statement what form of action this would take but the JDC is seeking approval to begin action in early September before the planned introduction of the contract in October. The Trust is waiting for further update on this.

Jim Mackay Visit:

Jim Mackay, Chief Executive of NHS Improvement, visited the Trust on Monday, 8th August, 2106. Jim spent some time in our award winning Day Surgery Unit. He later wrote to the Trust thanking us for offering him the opportunity to visit and confirmed that it "was one of the best and most impressive visits I have had in this role. Your team, staff generally (including volunteers) and the overall atmosphere were uniformly fantastic. This all plays out in the performance of the organisation and you, and your team, should be very proud".

Gill Morgan Visit:

Gill Morgan, Chair of NHS Providers, is visiting the Trust on Wednesday, 31st August, 2016. We look forward to welcoming Gill and showing her why we are so proud of the organisation.

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 1st September 2016

TITLE:	**TITLE:** **Transformation and Cost Improvement Programme (CIP) Summary Report – August 2016**		
AUTHOR:	Amanda Gaston, Head of Service Improvement and Programme Management	**PRESENTER**	Amanda Gaston Head of Service Improvement and Programme Management (on behalf of Anne Baines, Director of Strategy and Performance)

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:

Transformation Executive Committee (TEC) met on 18th August 2016 to:

- Review overall CIP delivery status and progress.
- Scrutinise Exception Reports for projects off plan and agreed mitigations for the shortfall that will be reported next month.

Based on the Month Four position, the Trust has identified 46 schemes totalling **£11,407K** against a Full Year target of **£11,908K**, leaving a shortfall against the target of **£501K**. Further, the Trust is forecasting to deliver £10,597k of the £11,407k it has identified to date. This creates an additional shortfall of **£810k** against identified schemes. As a result, the Trust is forecasting an overall shortfall of **£1,311K** for 2016/17.

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 2016/17 CIP
	Risk Register: **Y**		**Risk Score:** 4, 4, 16 (respectively)
	CQC	**N**	**Details:**

COMPLIANCE and/or LEGAL REQUIREMENTS	**Monitor**	**Y**	**Details:** Non delivery of CIP
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y	Y	

RECOMMENDATIONS FOR THE BOARD

Note progress during July, delivery of CIP to date and the current forecast outturn proposal.

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

SO1:	**Deliver a great patient experience**
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SO3:	**Drive service improvements, innovation and transformation**
SO4:	**Be the place people choose to work**
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SO6:	**Deliver a viable future**

CARE QUALITY COMMISSION CQC) : ***(Please select for inclusion on front sheet)***

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The Dudley Group NHS
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Trust Board of Directors

Service Improvement and PMO Update

1st September 2016

Executive Summary

The Trust has an overall Cost Improvement Programme (CIP) target of £11,908K in 2016/17. To support this, the Trust has identified 46 projects to deliver savings in 2016/17.

The projects have been split into six ambitious programmes to deliver the changes and benefits required. These programmes are:

- Value for Money
- Delivering Efficiency & Productivity
- Lord Carter Efficiency & Productivity
- Workforce
- Outpatients
- Workforce Bank and Agency

A summary of CIP performance as at Month Four is provided below (with supporting detail overleaf):

	Full Year (FY)			YTD Performance against identified Plans			Y/E Forecast of identified Plans	
CIP Project Plans	FY Target	FY Identified	Shortfall against FY Target	YTD Plan (from identified schemes)	YTD Actual	YTD Variance (against identified schemes)	Y/E FOT of identified schemes	Y/E FOT Variance of identified schemes
TOTAL	£11,908k	£11,407k	-£501k	£3,620k	£2,987k	-£633k	£10,597k	-£810k

Based on the Month Four position, the Trust has identified schemes totalling **£11,407k** against a Full Year (FY) target of **£11,908k,** leaving a shortfall against the target of **£501k**. Further, the Trust is forecasting to deliver £10,597k of the £11,407k it has identified to date. This creates an additional shortfall of **£810k** against identified schemes. As a result, the Trust is forecasting an overall shortfall of **£1,311K** for 2016/17.

The Transformation Executive Committee (TEC) reviewed all projects for performance against planned delivery and agreed mitigations for the shortfall that will be reported next month.

Of the 46 projects due to deliver savings in 2016/17, 42 Project Initiation Documents (PIDs) have been approved by TEC.

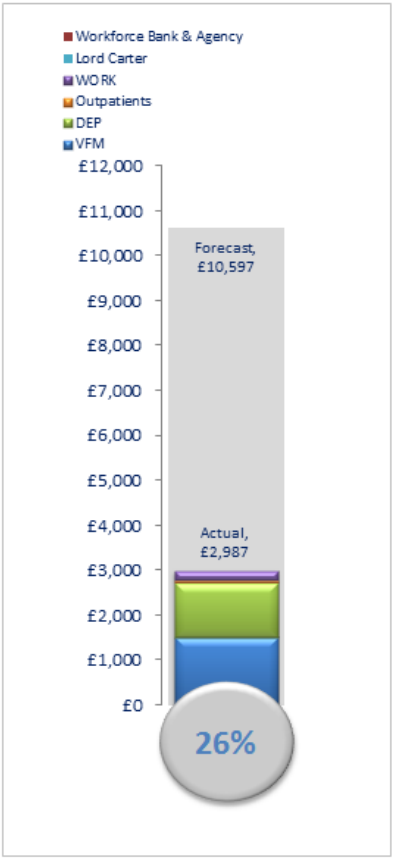
Of the 42 PIDs approved by TEC, 21 have been approved by the Quality Impact Assessment (QIA) panel. A further four projects have been reviewed by the panel and are awaiting final approval. The remaining 15 projects will be submitted to the QIA panel on 22 September 2016 which will scrutinise all projects to ensure all risks to quality are identified and suggest mitigations to address any potential risks.

Executive Summary

	YTD	FYE
Planned	£3,620,377	£11,406,963
Actual	£2,987,058	£2,987,058
Forecast	£2,987,058	£10,597,156
Variance	-£633,319	-£809,807

	Submitted Plan	Overall Shortfall
Identified	£11,406,963	
Target	£11,907,990	
Variance	-£501,027	-£1,310,834

Programme (Click for details)	Executive Lead	FYE Plan	FYE Forecast	YTD Plan	YTD Actual	Shortfall	Planned Lord Carter Contribution
Delivering Efficiency and Productivity	Paul Bytheway	£4,665,059	£4,247,282	£1,386,669	£1,206,579	-£417,778	£2,993,347
Value for Money Infrastructure	Paul Taylor	£4,895,783	£4,893,764	£1,643,332	£1,507,823	-£2,019	£1,343,000
Workforce	Dawn Wardell	£950,321	£765,289	£316,776	£216,895	-£185,033	£300,004
Outpatients	Anne Baines	£303,800	£271,156	£101,266	£55,761	-£32,644	£303,800
Lord Carter	Anne Baines	£0	£0	£0	£0	£0	£0
Workforce Bank & Agency	Paul Taylor	£592,000	£419,667	£172,333	£0	-£172,333	£592,000
View all Projects	Total	£11,406,963	£10,597,156	£3,620,377	£2,987,058	-£809,807	£5,532,151



2016/17 Forecast Non Recurrent	£2,052k	% of Total CIP Forecast as Non Recurrent	19.36%

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 1 September 2016

TITLE	Corporate Performance Report – July 2016 (Month 4)		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	Richard Miner 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 August 2016.			

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**	
	Monitor	**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

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Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance & Performance Committee	**25th August 2016**	**Richard Miner (Acting Chair)**	**yes**	

Declarations of Interest Made

None

Assurances Received

- That progress continues to be made with the procurement of the replacement Electronic Patient Record system (Digital Health) and that reference site visits are being undertaken between 6th and 9th September 2016 to assist in the non-financial evaluation of the tender options.
- Early draft financial figures identify significant differences between options, and high-light a potential revenue affordability issue in the early years of the project. It was agreed that additional efforts would be made to secure additional capital funding nationally to assist with affordability.
- The actions being taken to recover the financial position by the Nursing Division
- The current position on agency staffing and the process being undertaken to reduce agency costs in 2016-17.
- That the Trust's financial position as at 31st July 2016 remained in line with plans, but that non-recurring resources had been used to maintain the Trust's planned surplus in 2016-17 which could not be sustained for the whole of 2016-17.
- Patient activity continues to rise across all points of delivery, but particularly in emergency care (5.2% increase in emergency admissions compared to the same period in 2014-15 and 8.2% increase in A&E attendances).
- The Trust's balance sheet and liquity position remain broadly on plan although capital spend is slightly behind plan.
- Key Performance Indicators for July 2016 were all "on track" apart from 62 day cancer waits which was 81.4% compared to a target of 85%, and remedial plans for the specialties under-performing and being undertaken.
- The Transformation and Cost Improvement Plan (CIP) report for the month remains short of its target by £501k and there is a shortfall on projected delivery of schemes of £801k making a total projected shortfall of £1,311k. A number of mitigations have been identified, but generally they are filling gaps in the shortcomings of existing schemes. This shortfall is contributing to the Trust's current financial projections, and there will soon be too little time to implement a rectification plan.

Decisions Made / Items Approved

- For Dawn Wardell to attend future meetings to discuss the nurse agency position.
- The Committee confirmed the Trust response to the consultation exercises on the Single Oversight Framework and the National Tariff Proposals for 2017-18 and 2018-19.

- To re-enforce the need for the Executive Performance Management process to resolve the agency spending position in all staff groups.

Actions to come back to Committee

- The final business case for Digital Health including economic and non-financial evaluation plus affordability analysis will be presented to the Committee on 29th September 2016 before Board approval on 6th October 2016.
- A more detailed plan to reduce agency spending would be developed along the lines of the nurse agency report presented to committee to outline plans more specifically in order to allow progress to be monitored

Items referred to the Board for decision or action

- To note that the Digital Health business case due to be presented to Board on 6th October 2016 may be subject to NHS Improvement approval

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Finance & Performance Report - July 2016

Quality & Risk			2015					2016								
Description		LYO	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD	YEF
Friends & Family – Community – Footfall		1%	0.5%	0.8%	0.8%	0.6%	1.8%	1.7%	1.9%	1.8%	1.4%	1.1%	1.5%	1.4%	1.3%	
Friends & Family – Community – Recommended %		96.4%	93.9%	92.8%	96.8%	94.7%	98.8%	96.5%	97.9%	95.4%	96.8%	94.7%	94.4%	98%	96%	
Friends & Family – ED – Footfall		7.5%	6.1%	3.2%	7.4%	5.9%	6.2%	5.2%	7.4%	6.1%	5%	3.8%	1.6%	8.4%	4.8%	
Friends & Family – ED – Recommended %		92.3%	94.6%	91%	95.8%	92.5%	88.4%	95.8%	92.9%	97.9%	91.4%	91.3%	88.2%	91.7%	91.2%	
Friends & Family – Maternity – Footfall		21.6%	22.4%	23.4%	25.1%	32.1%	18%	17%	20.4%	15.9%	17.6%	33.2%	16.6%	33.8%	25.6%	
Friends & Family – Maternity – Recommended %		98.2%	98.6%	99.2%	97.9%	98.2%	96.6%	97.8%	98.2%	98.4%	97.5%	97.3%	98.9%	96%	97.2%	
Friends & Family – Outpatients – Footfall														1.7%	1.7%	
Friends & Family – Outpatients – Recommended %		87.6%	89.5%	89.3%	88.4%	83.6%	88.4%	90%	84.1%	88.9%	85%	82.2%	93.1%	91.7%	88.3%	
Friends & Family – Ward – Footfall		25.7%	30.6%	29.9%	23%	23%	17.2%	16.5%	17.6%	18.4%	18.9%	17.3%	13.6%	19.2%	17.2%	
Friends & Family – Ward – Recommended %		97%	98.3%	96.2%	96.7%	96.6%	99%	95.9%	95.5%	94.1%	93.7%	94.8%	96%	95.1%	94.8%	
HCAI – Post 48 hour MRSA		2	0	2	0	0	0	0	0	0	0	0	0	0	0	
HCAI CDIFF - Total Number of Cases		43	5	5	5	5	8	4	1	0	2	3	2	2	9	
Incidents - Patient Falls, Injuries or Accidents			97	119	111	118	114	129								
Incidents - Pressure Ulcer		2,047	120	132	125	141	172	187	242	246	253	240	194	193	880	
Mixed Sex Sleeping Accommodation Breaches		4	0	0	0	2	0	2	0	0	0	0	0	0	0	
Never Events		1	0	1	0	0	0	0	0	0	0	0	0	0	0	
Serious Incidents – Not Pressure Ulcer		104	7	11	11	11	10	9	4	7	7	6	4	12	29	
Serious Incidents - Pressure Ulcer		228	17	10	18	17	30	26	12	19	13	9	8	10	40	
Stroke - Suspected TIA Scanned < 24hrs of Presentation		85.35%	92.31%	85%	92.31%	50%	52.63%	85.71%	66.67%	94.12%	84.62%	78.57%	66.67%	34.78%	60.38%	

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Finance & Performance Report - July 2016

Quality & Risk			2015					2016								
Description		LYO	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD	YEF
Stroke Admissions : Swallowing Screen		80.58%	74.07%	75%	78.38%	88.89%	87.88%	83.78%	76.32%	86.67%	89.36%	88.37%	78.38%	78.72%	83.91%	
Stroke Admissions to Thrombolysis Time		56.31%	61.54%	75%	37.5%	71.43%	33.33%	45.45%	37.5%	50%	60%	50%	83.33%	36.36%	53.33%	
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		89.16%	88.24%	92.68%	88.68%	88.68%	90.91%	92.68%	84.09%	70.83%	82.76%	91.11%	87.76%	88%	87.13%	
VTE Assessment Indicator (CQN01)		95.96%	96.42%	96.19%	96.1%	96.67%	96.47%	95.4%	94.43%	94.46%	94.65%	95.5%	95.09%	93.09%	94.59%	

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

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Finance & Performance Report - July 2016

Finance			2016					
Description		LYO	Apr	May	Jun	Jul	YTD	YEF
Budgetary Performance		£773k	(£71)k	£266k	(£110)k	(£23)k	£62k	
Capital v Forecast		69.5%	61.8%	66.5%	76.2%	76.4%	76.4%	
Cash v Forecast		122.3%	94.8%	93.2%	96.2%	74.9%	74.9%	
Debt Service Cover		1.18	1.4	1.58	1.63	1.74	1.74	
EBITDA		£20,460k	£2,228k	£2,820k	£2,755k	£3,321k	£11,123k	
I&E (After Financing)		(£2,945)k	£280k	£859k	£818k	£1,380k	£3,338k	
Liquidity		7.07	7.1	8	8.84	10.39	10.39	
SLA Performance		£1,031k	£171k	£580k	£524k	(£1,251)k	£24k	
SLR Performance		(£2,945)k	£281k	£859k	£819k	£1,380k	£3,338k	

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Finance & Performance Report - July 2016

Performance			2015					2016								
Description		LYO	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD	YEF
A&E - 4 Hour A&E Dept Only % (Type 1)		96.79%	98.53%	97.57%	98.93%	97.5%	97.13%	91.76%	92.74%	91.53%	93.24%	92.88%	94.48%	93.34%	93.48%	
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)		98.18%	99.11%	98.53%	99.38%	98.63%	98.47%	95.73%	96.06%	95.62%	96.3%	96.06%	96.76%	96.21%	96.32%	
Activity - A&E Attendances		96,141	7,700	8,003	8,099	7,900	7,754	8,088	7,946	8,626	7,807	8,801	8,430	8,974	34,012	
Activity - Community Attendances		407,248	32,417	35,088	36,008	34,642	33,385	33,694	32,322	30,817	32,681	32,631	32,846	30,888	129,046	
Activity - Elective Day Case Spells		45,020	3,413	3,675	3,952	3,757	3,719	3,677	3,938	3,820	3,801	3,720	4,031	3,831	15,383	
Activity - Elective Inpatients Spells		6,394	508	537	572	580	481	500	515	534	514	523	549	564	2,150	
Activity - Emergency Inpatient Spells		52,037	4,077	4,105	4,296	4,265	4,552	4,573	4,359	4,714	4,823	5,246	5,074	5,103	20,246	
Activity - Outpatient First Attendances		130,956	9,298	10,758	10,712	11,159	10,604	11,304	11,569	12,255	10,329	10,632	11,266	10,242	42,469	
Activity - Outpatient Follow Up Attendances		313,888	23,254	26,290	25,988	27,022	25,643	26,438	26,699	26,435	26,540	26,976	26,837	25,046	105,399	
Activity - Outpatient Procedure Attendances		52,451	4,042	4,553	4,864	4,968	4,268	4,117	4,691	3,324	4,989	4,960	5,219	5,048	20,216	
RTT - Admitted Pathways within 18 weeks %		94.2%	96.1%	94.3%	92.5%	93.3%	93.4%	94.4%	92.8%	91.5%	92.5%	93.5%	94.2%	94.2%	93.6%	
RTT - Incomplete Waits within 18 weeks %		95.1%	94.9%	95.1%	94.6%	94.4%	94.9%	95%	95.6%	95.4%	97.1%	96.8%	97.1%	97.1%	97%	
RTT - Non-Admitted Pathways within 18 weeks %		97.7%	98.1%	98.3%	97.5%	97.8%	97.8%	97.3%	97.4%	96.7%	96.7%	97.7%	98.1%	98%	97.6%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		98.97%	98.35%	98.41%	97.87%	98.85%	99.29%	99.52%	99.53%	99.03%	98.04%	99.39%	99.16%	98.96%	98.9%	

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Finance & Performance Report - July 2016

Staff/HR			2015					2016								
Description		LYO	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	YTD	YEF
Appraisals		77.6%	80.3%	80.1%	78.4%	75.6%	80.4%	80%	79.2%	77.6%	80.9%	80.5%	81%	78.2%	78.2%	
Mandatory Training (Professional Requirements)												71.34%	72.82%			
Mandatory Training (Substantive)		83.39%	83.51%	83.16%	84.11%	84.8%	85.16%	83.97%	83.31%	83.39%	83.82%	75.41%	76.34%	77.45%	77.45%	
Sickness Rate (Performance Dashboard)		3.80%	3.22%	3.28%	3.83%	3.80%	4.10%	4.54%	4.38%	4.01%	3.81%	4.15%	3.96%	3.95%	3.97%	
Staff In Post (Contracted WTE)		4,116.31	4,018.55	4,039.04	4,075.01	4,069.24	4,064.03	4,087.57	4,125.26	4,116.31	4,093.54	4,091.47	4,083.01	4,083.49	4,083.49	
Vacancy Rate		9.41%	10.33%	9.92%	9.93%	10.31%	10.59%	10.05%	9.24%	9.41%	10.24%	10.53%	10.78%	10.75%	10.75%	

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

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Finance & Performance Report - July 2016

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%	95.8%	96.6%	98.6%	100%	96.2%	100%	88.9%	95.8%	93.5%	96.2%	**96%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	-	98%	-	-	-	-	-	-	-	-	-	**98%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	-	100%	100%	100%	100%	-	100%	-	100%	100%	94.4%	**99.1%**
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%	100%	-	100%	100%	93.3%	**98.6%**
Cancer - 62 day - From Referral for Treatment following national screening referral	90%	-	-	100%	100%	-	-	-	-	-	-	-	-	**100%**
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85%	-	-	100%	20%	0%	100%	50%	75%	-	100%	87.5%	66.7%	**81.4%**

Appendix 1:

Cancer 104 days – Breaches beyond 104 days ytd.

2015-16

	Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of patients who are untreated	Number of patients who have breached beyond 104 days							8	15	19	15	8	2
Number of patients who are untreated and either do not have a TCI date, or do not have a TCI date within target time.	Number of patients who have breached beyond 104 days							4	1	5	3	1	2

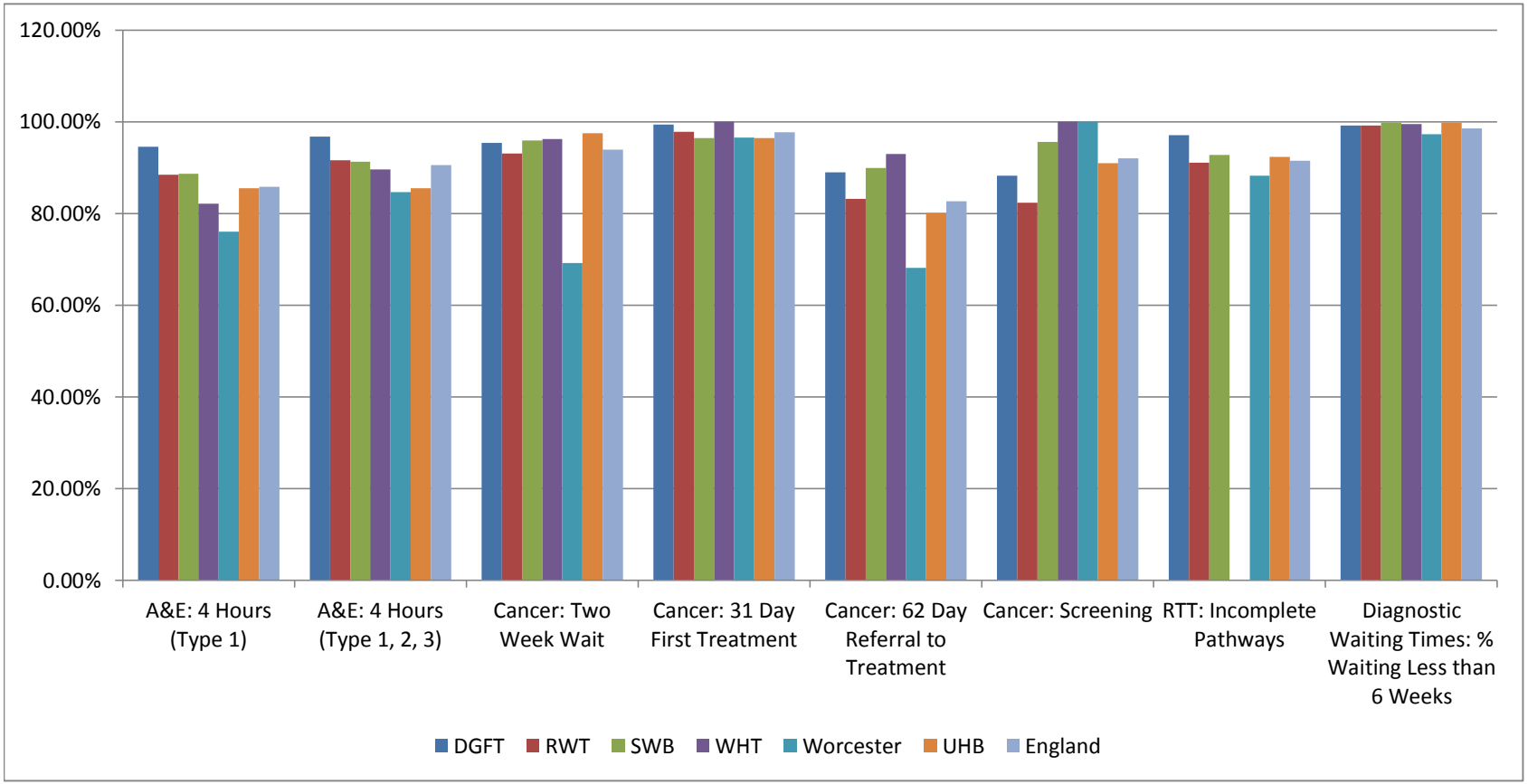
2016-17

	Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Number of patients who are untreated	Number of patients who have breached beyond 104 days	4	6	2	0								
Number of patients who are untreated and either do not have a TCI date, or do not have a TCI date within target time.	Number of patients who have breached beyond 104 days	0	0	0	4								

Appendix 2:

Comparison against national targets (June 2016)

Target	DGFT	RWT	SWB	WHT	Worcester	UHB	England
A&E: 4 Hours (Type 1)	94.48%	88.39%	88.67%	82.16%	76.04%	85.46%	85.85%
A&E: 4 Hours (Type 1, 2, 3)	96.76%	91.61%	91.31%	89.59%	84.65%	85.46%	90.52%
Cancer: Two Week Wait	95.36%	93.06%	95.87%	96.27%	69.17%	97.50%	93.86%
Cancer: 31 Day First Treatment	99.38%	97.84%	96.43%	100.00%	96.58%	96.44%	97.66%
Cancer: 62 Day Referral to Treatment	88.99%	83.16%	89.92%	92.94%	68.07%	80.11%	82.66%
Cancer: Screening	88.24%	82.35%	95.56%	100.00%	100.00%	90.91%	92.06%
RTT: Incomplete Pathways	97.11%	91.04%	92.72%	-	88.26%	92.34%	91.50%
Diagnostic Waiting Times: % Waiting Less than 6 Weeks	99.16%	99.18%	99.84%	99.51%	97.30%	99.77%	98.50%



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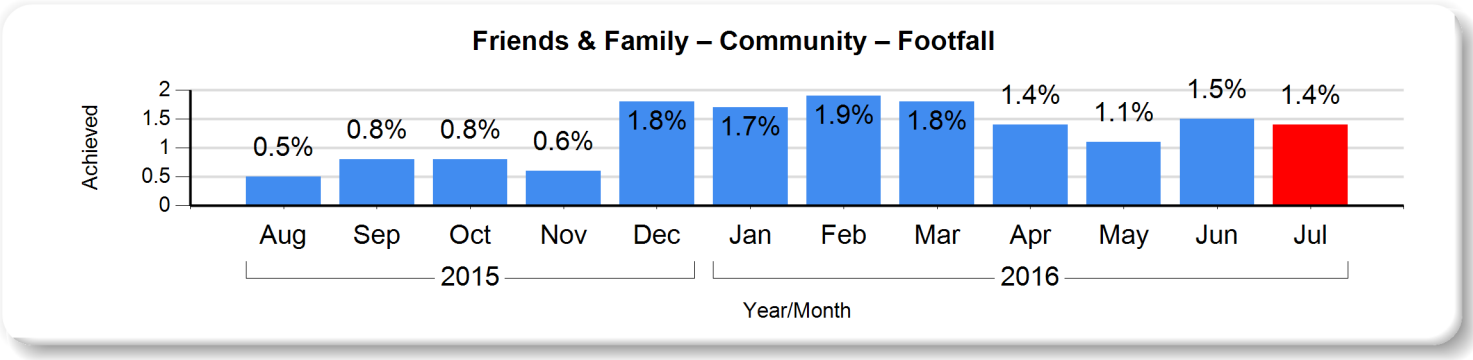
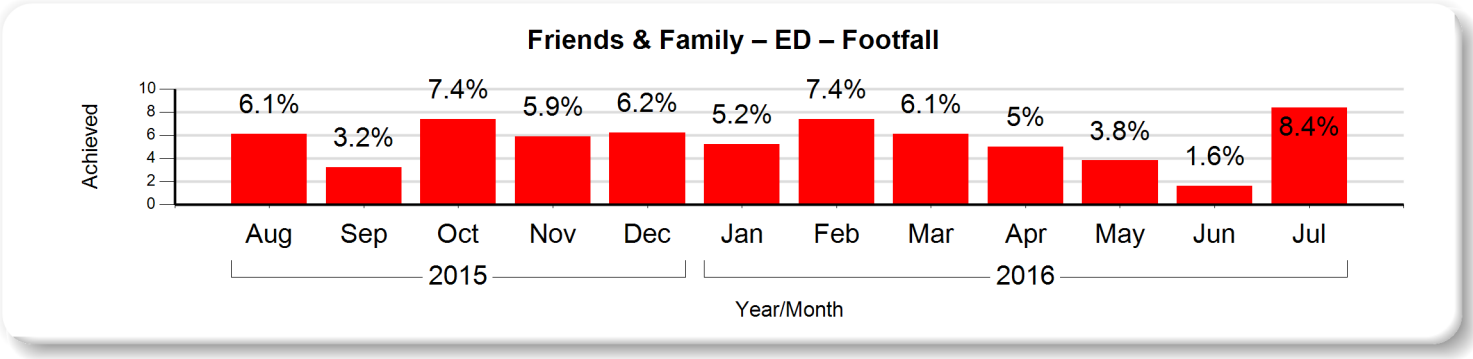
Quality & Risk Fails

Friends & Family – Community – Footfall



Friends & Family – ED – Footfall



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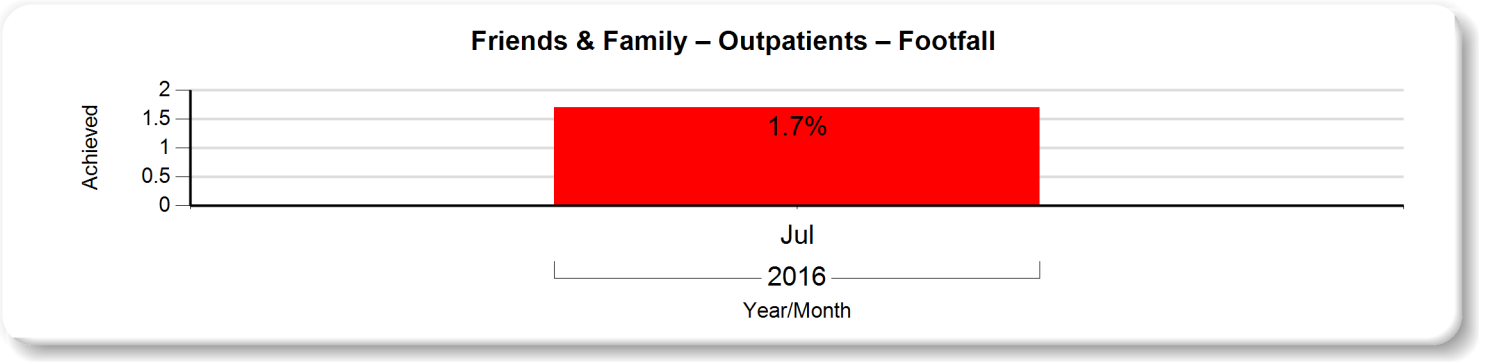
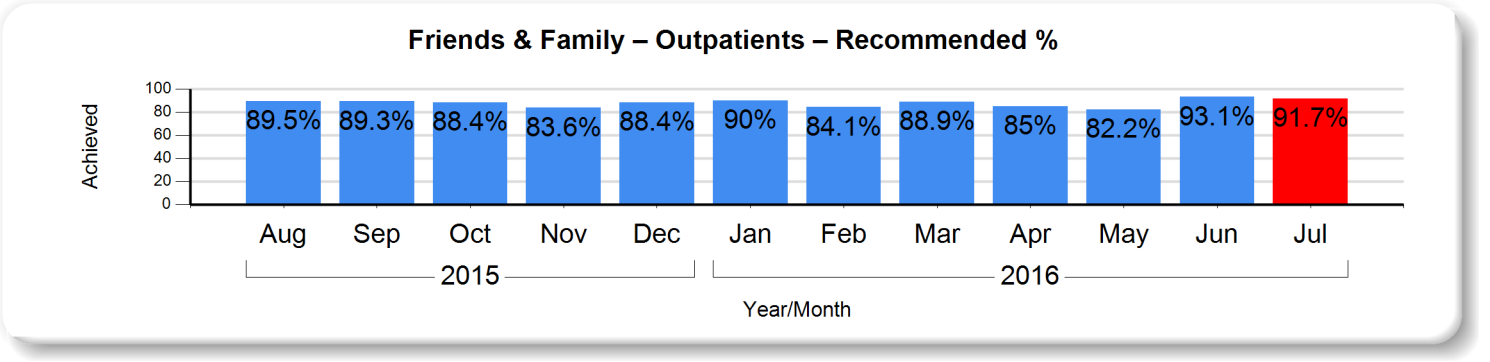
Friends & Family – Outpatients – Footfall



Friends & Family – Outpatients – Recommended %



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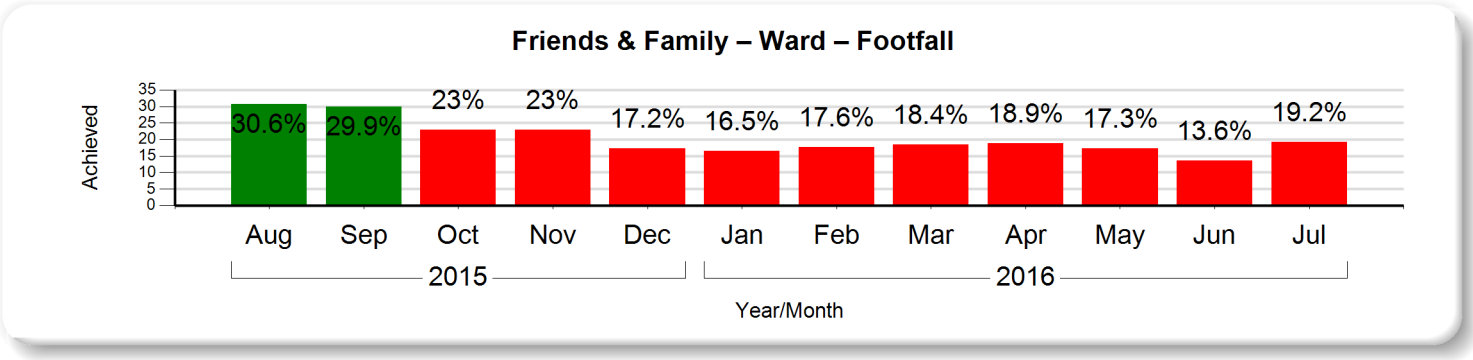
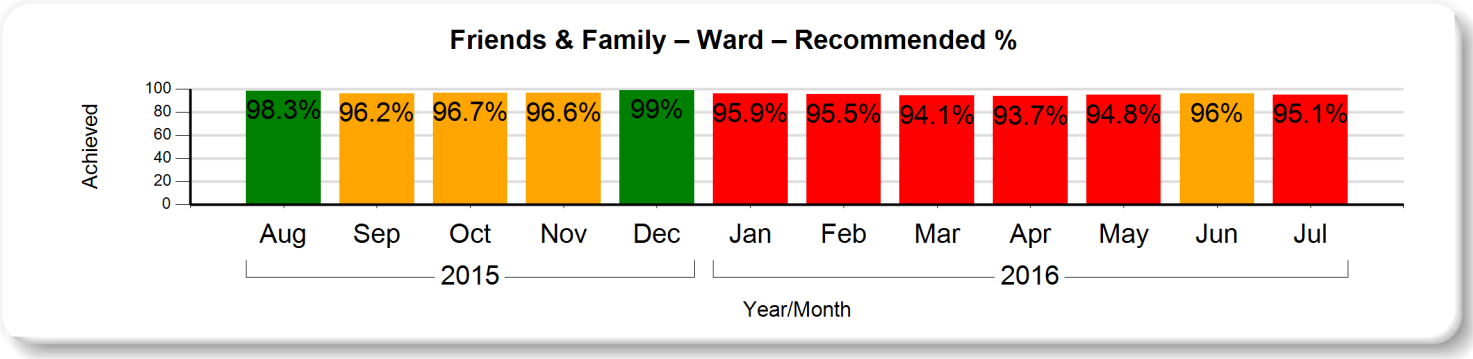
Friends & Family – Ward – Footfall



Friends & Family – Ward – Recommended %



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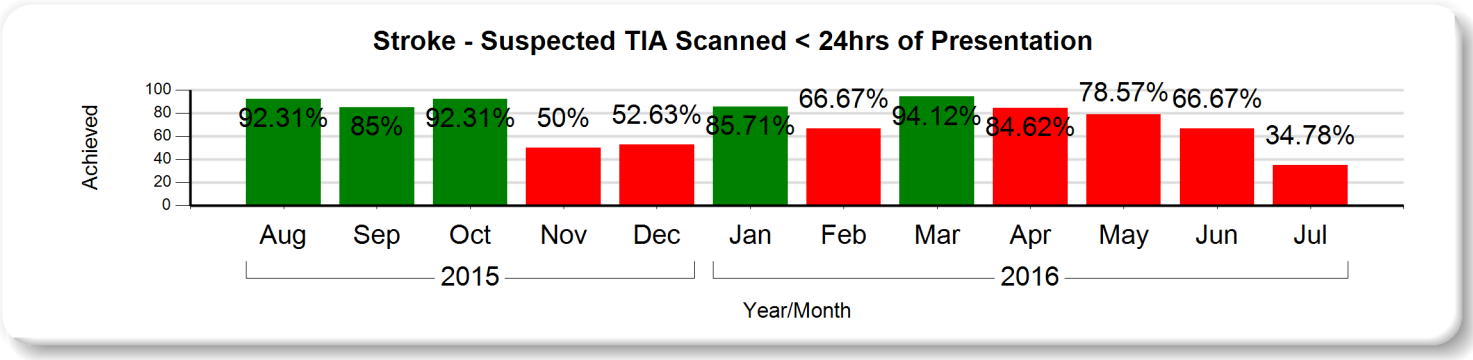
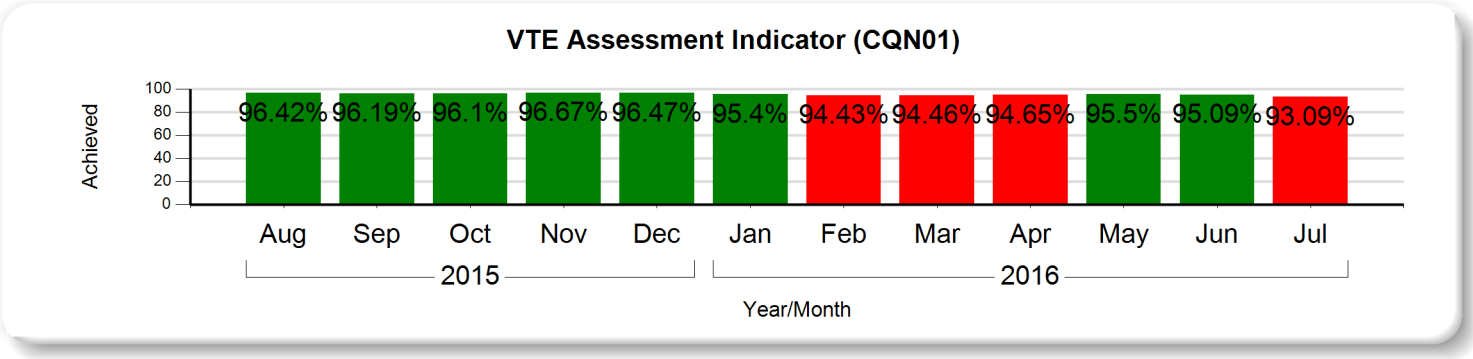
Quality & Risk Fails

Stroke - Suspected TIA Scanned < 24hrs of Presentation



VTE Assessment Indicator (CQN01)



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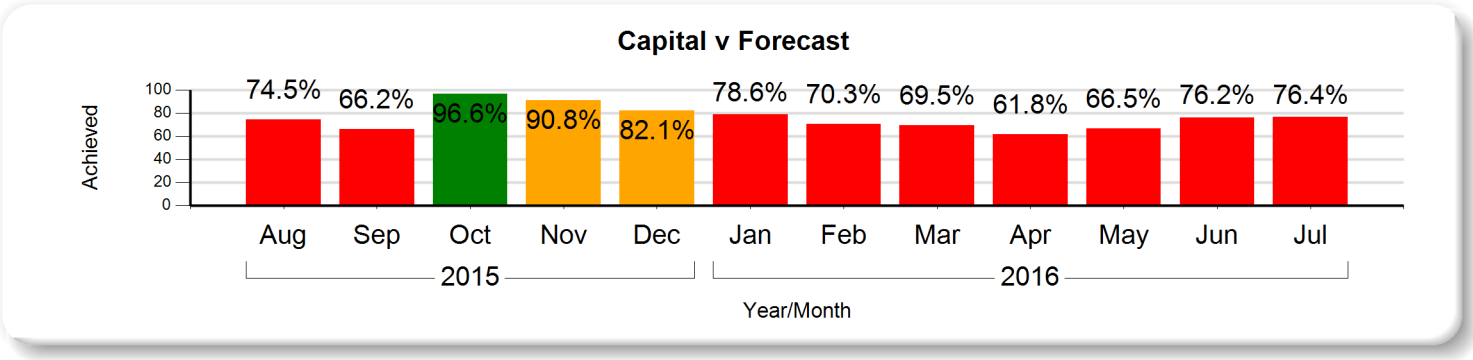
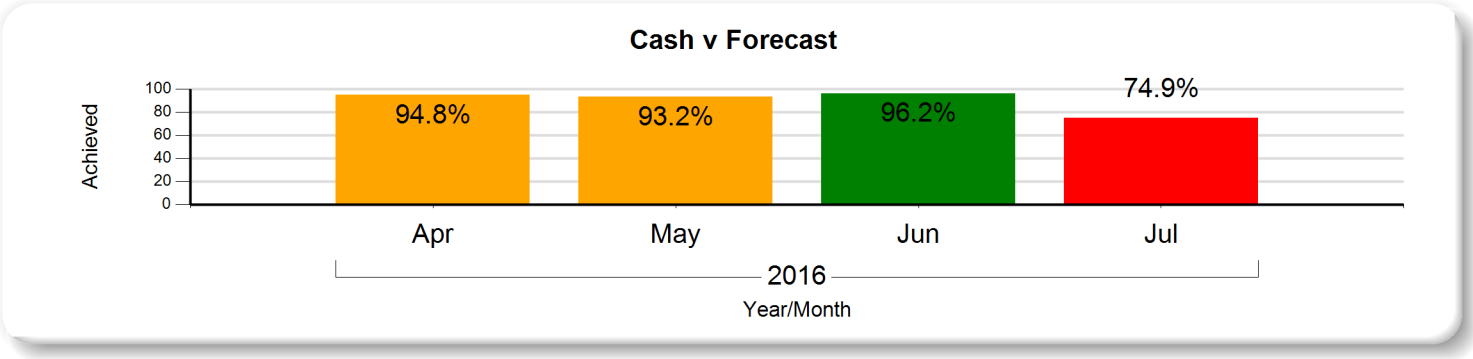
Finance Fails

Capital v Forecast



Cash v Forecast



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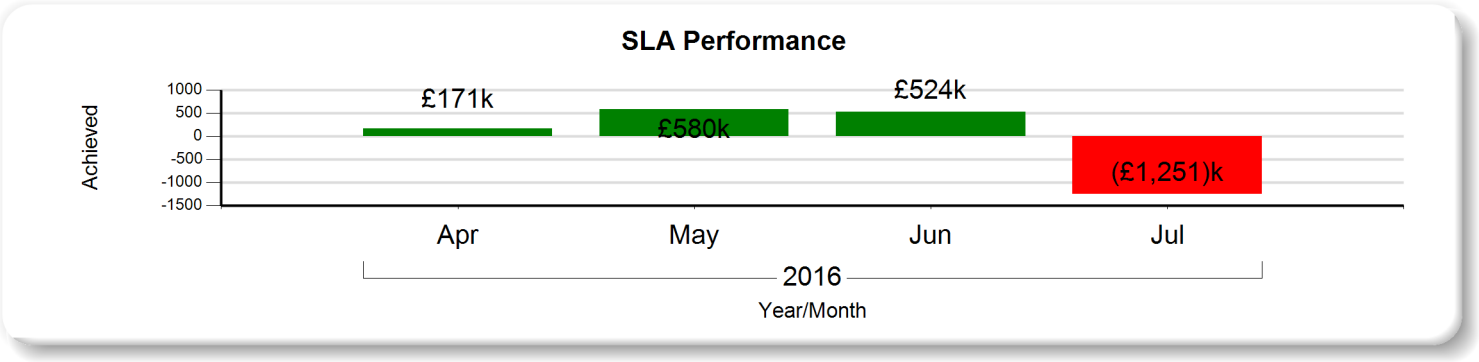
Finance Fails

SLA Performance



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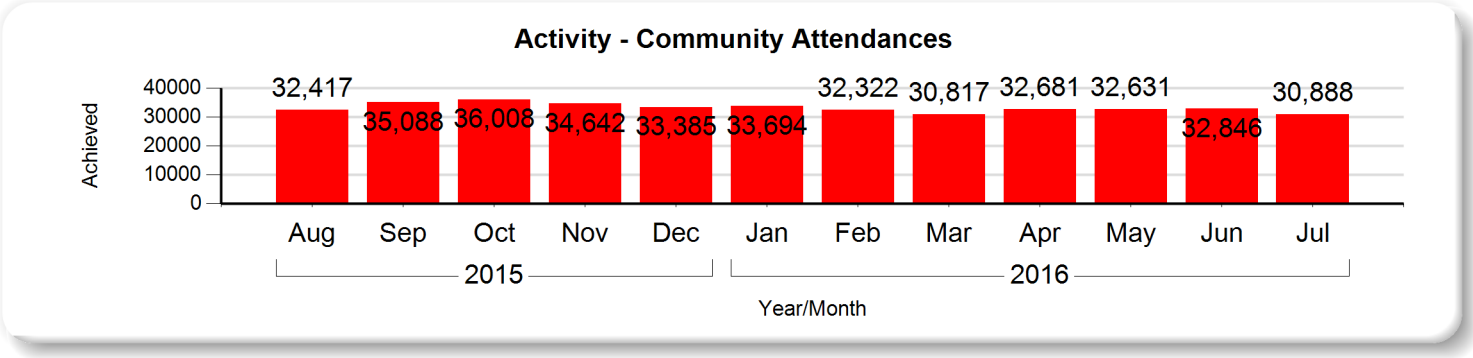
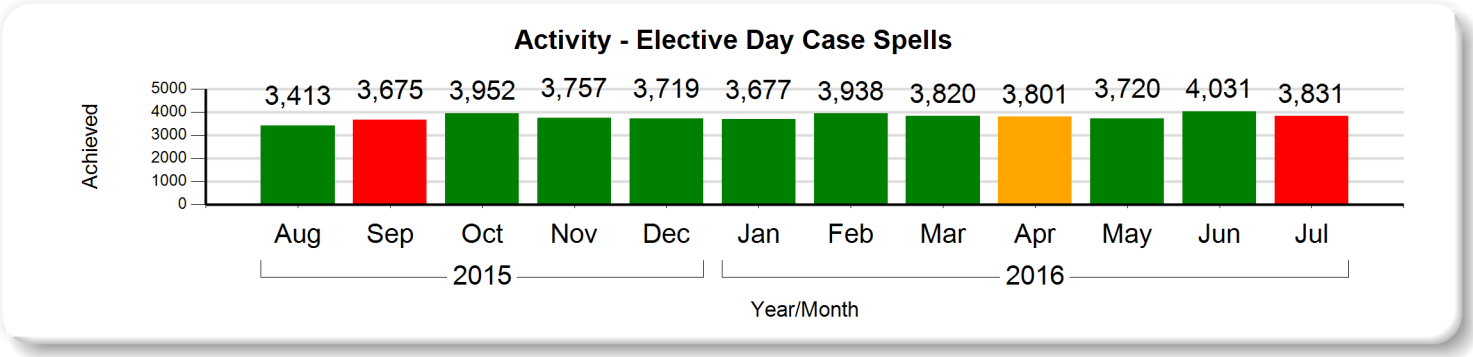
Performance Fails

Activity - Community Attendances



Activity - Elective Day Case Spells



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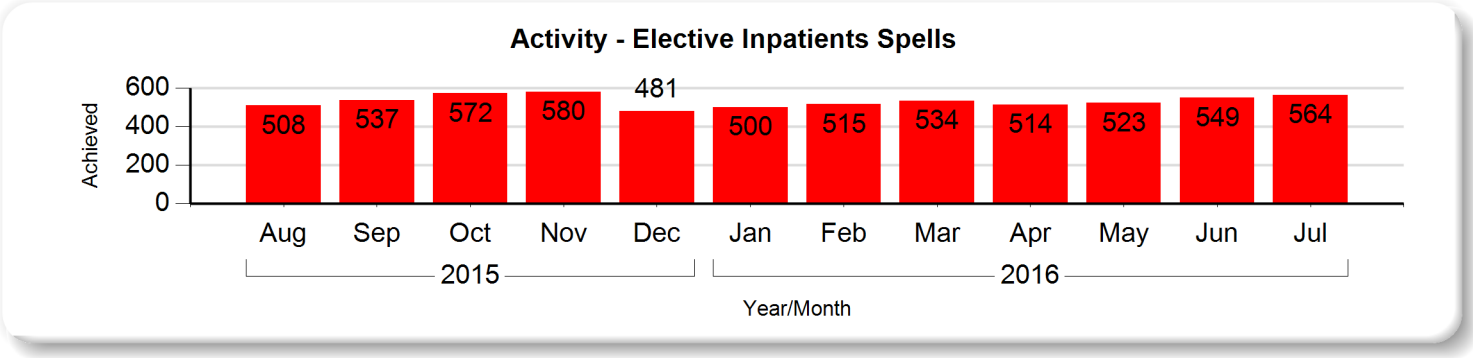
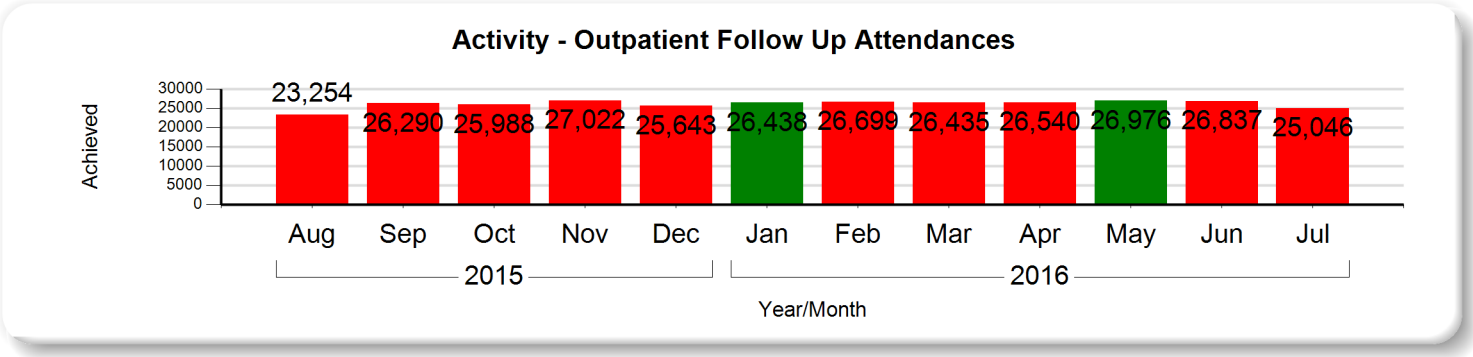
Performance Fails

Activity - Elective Inpatients Spells



Activity - Outpatient Follow Up Attendances



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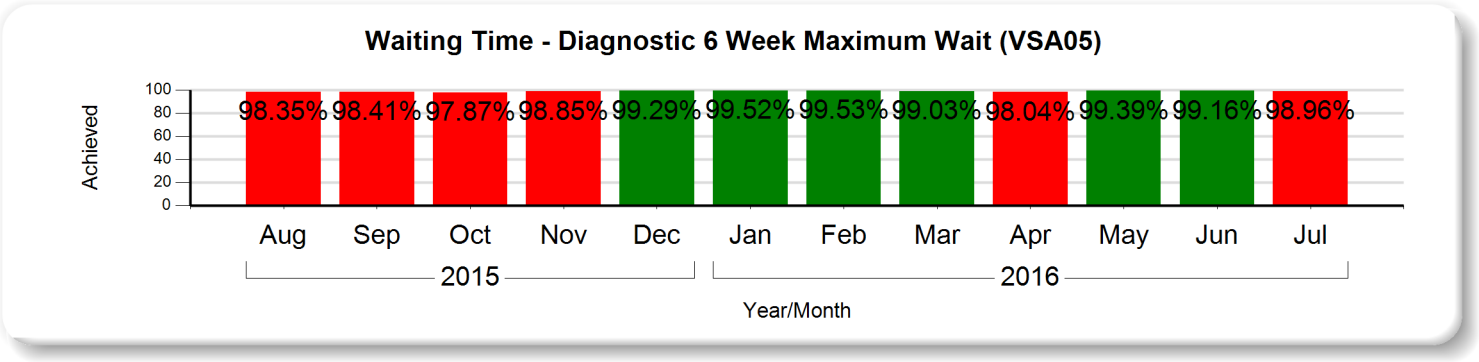
Performance Fails

Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)



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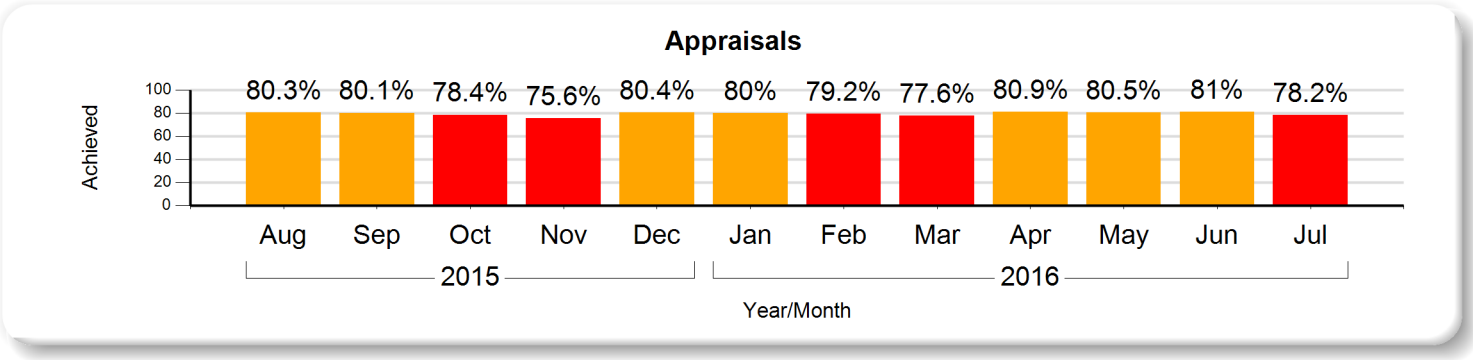
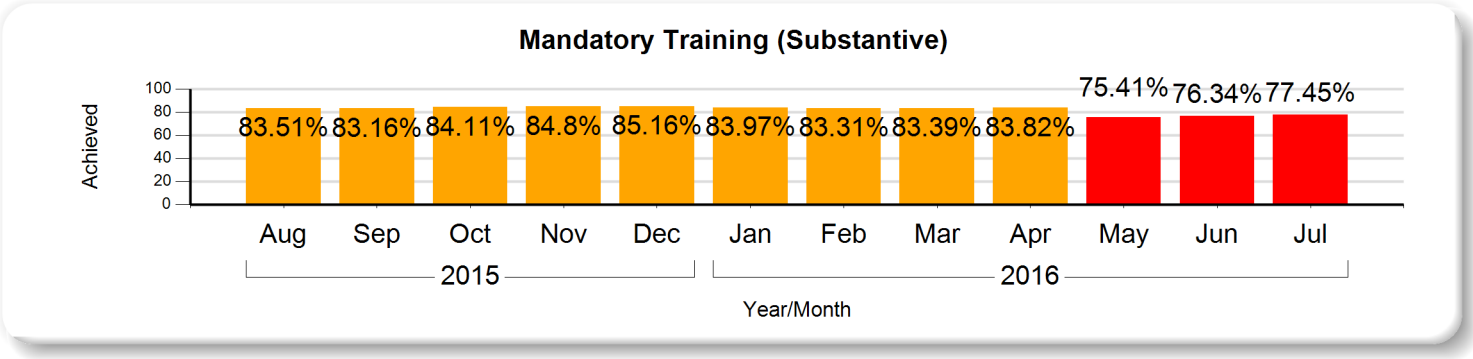
Staff/HR Fails

Appraisals



Mandatory Training (Substantive)



The Dudley NHS Foundation Trust

Enclosure 6

Paper for submission to the Board of Directors on 1st September 2016 - PUBLIC

TITLE:	Chief Nurse Report		
AUTHOR:	Dawn Wardell – Chief Nurse Dr E Rees - Director of Infection Prevention and Control Derek Eaves - Quality Manager Nursing	**PRESENTER:**	Dawn Wardell Chief Nurse

CORPORATE OBJECTIVE:
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:

Infection Control: July 16

- No post 48 hr MRSA bacteraemia cases since 27th September 2015
- No Norovirus
- As of this date the Trust has had 12 cases so far in 2016/17. So far 2 cases have had their lapses in care determined; 1 of these cases was associated with a lapse in care
- A period of Increased Incidence has been identified MDHU, RCAs are being undertaken

Safer Staffing

- Amber shifts total figure for this month is 70 for July and 47 in June which is up from the last month (52).
- The RAG rating system has been rolled out across the wards 3 in June and 12 in July red shifts in this methodology for that period.
- Red (serious shortfall) shifts no safety issues identified or on any of the amber shifts that affected the quality of care.
- The Care Hours Per Patient Day (CHPPD) has commenced collection of data since May and is reported in a limited way in this Board report.

Nursing Care Indicators

- Improvement seen in other areas reduced areas in red category and increases in the green. 1 area is in level 4 escalation and they have met with the Chief Nurse. More intensive support has been provided which has seen the appropriate change in results.

Reforming of Healthcare Education funding- Potential Impact from the outcomes of the public consultation on move from bursaries to student loans are included in the report.

IMPLICATIONS OF PAPER:

RISK	Yes		**Risk Description:** Failing to meet initial target for CDiff now amended to avoidable only
	Risk Register: Yes		**Risk Score:** 10
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Yes	**Details:** Safe and effective care
	Monitor	Yes	**Details:** MRSA and C. difficile targets
	Other	Yes	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF BOARD

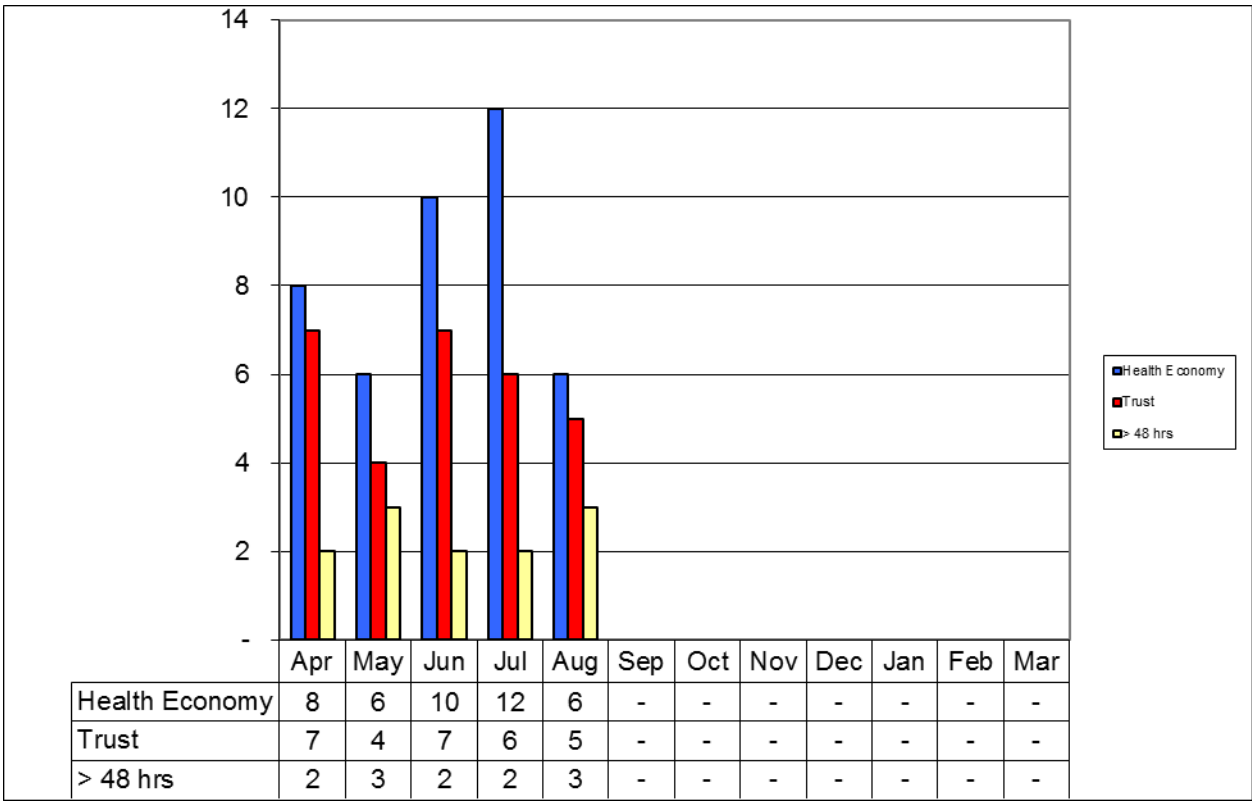
Decision	Approval	Discussion	Other
		√	

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

Chief Nurse Report

Clostridium Difficile – The target for 2016/17 is 29 cases, 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 (22.8.16) we have 3 post 48 hour case recorded in August 2016.

C. DIFFICILE CASES 2016/17



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	6	10	12	6	-	-	-	-	-	-	-
Trust	7	4	7	6	5	-	-	-	-	-	-	-
> 48 hrs	2	3	2	2	3	-	-	-	-	-	-	-

The process to undertake an assessment of individual C. 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[1], continues.

For the financial period 2016/17 of the 12 post 48 hour cases identified since 1st April 2016, 2 cases have been reviewed and apportionment has been agreed (1 case associated with lapse in care) and 10 cases are pending.

There is a Trustwide C. difficile action plan in place to address issues identified by the RCA process as well as local plans for each individual case. There will be a formal review of the Period of Increased Incidence identified on MHDU once the route cause analysis is available. Progress against the plan is recorded at the Infection Prevention Forum.

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

Norovirus - no further cases.

Reference

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

Monthly Nurse/Midwife Staffing Position

June and July 2016

One of the requirements set out in the National Quality Board (NQB) Report 'How to ensure the right people, with the right skills, are in the right place at the right time' and the Government's commitments set out in 'Hard Truths', is the need for the Board to receive monthly updates on staffing information. A revised NQB report 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' was published in July and its contents are being reviewed by the Trust.

Following the discussion at the Board at the end of 2015, this paper outlines the staffing situation on the general wards in relation to the agreed transitional 1:10 requirement for qualified nurses on the day shift, except when there is a high acuity/dependency of patients or when the actual staff on duty is two or more less than the planned staff (there is no recommended ratio for night shifts, although the 1:12 ratio is used as a benchmark). The ratios for specialist areas, such as critical care, paediatrics, maternity etc. which all have specific, more intensive requirements continue as before. It should be noted that these occurrences will not necessarily have a negative impact on patient care.

From June 2015 following each shift, the nurse/midwife in charge completes a spreadsheet indicating the planned and actual numbers and, if the actual doesn't meet the planned, what actions have been taken, if any is needed, for the patients on that shift. Each month the completed spreadsheet is checked by the Matron then staff in the Nursing Division analyse the data and the attached charts are compiled. In addition, for consistency purposes the data from the spreadsheet is now used for the UNIFY return of the care hours per patient day (CHPPD) metric as recommended by the Carter Review.

As indicated to the Board in June, from May 2016 all Trusts have had to submit this metric. The overall Trust results for June/July have been (with May figures in brackets)

Month	Registered Nurses	Un Registered Staff	Total Staff
May	4.61	3.83	8.45
June	4.60	3.84	8.45
July	4.53	3.70	8.24

These figures obviously vary widely across wards/areas
The only presently available comparative figures are from a short paragraph in the Carter Report which stated that of a sample of 25 Trusts the overall CHPPD varied from 6.3 to 15.48, which would put the Trust (8.45) in the middle 'of the pack'. The Trust awaits any further developments and feedback on this metric. It is expected that this and comparative data will be made available in the Model Hospital which the Department of Health is producing as a result of the Carter Review.

It can be seen from the accompanying charts (Figure A/Figure B) the number of shifts identified as:

- Amber (shortfall of RN/RM staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available),
- Blue (shortfall of CSW staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available),
- Red (serious shortfall).

JUNE

The total figure of shortfalls for this month is 47 which was part of a gradual reduction over the previous four months (see Table 1). When shortfalls have occurred, the reasons for the gaps and the actions being taken to address these in the future are outlined in Table 3.

Both the qualified and unqualified shortfalls fell this month. Other than maternity, the shortfalls were fairly evenly distributed across the wards with CCU/PCCU and paediatrics having specific skills requirements which are not easily sourced. The maternity unit continued to have vacancies (number of new starters awaited), high volume cases and high workload. Midwifery shortfalls have fallen this month (10, compared to 19 and 14 in the previous two months) but the unqualified staff in midwifery continues to be over 60 per cent of the total Trust unqualified shortfalls (14, compared to 15 and 13 in the previous two months). Active recruitment have concluded with all these posts now having been offered and start dates agreed.

As well as the quantifiable staffing numbers discussed above, as indicated at the June Board, from May onwards the senior clinical staff on each shift are undertaking a professional judgement RAG (Red, Amber, Green) rating system of the overall workload status on the ward. The results of this are tabulated below (June's figures in brackets - see Table 2). This assessment is based not just on staffing numbers but also on the dependency of the patients on that shift and other relevant factors such as any unusual circumstances that occurred that affected the workload e.g. presence of a highly disturbed patient, a number of MET/resuscitation calls etc

There will be some inevitable variability with these assessments at this early stage but it can be seen that the assessments are generally 'Green' with a number of wards having 10 and above 'Amber' shifts. With regards to the latter, there is some consistency with the staffing figures (e.g. Maternity and CCU/PCCU) although this is not always the case as some Amber shifts will be related to high dependency and specific circumstances on the day. Only two wards recorded either a single or two 'Red' shifts. The two recorded on Ward B5 (which includes SAU) are discussed in the Mitigating Actions chart below and the one on B1 occurred when the ward was full and the dependency of the patients was particularly high and the lead nurse worked clinically with an extra CSW to support all staff.

JULY

The total of shortfall shifts for the latest month is 70 (Table 1). It can be seen that the numbers have risen from the last and previous months. Again, when shortfalls have occurred, the reasons for the gaps and the actions being taken to address these in the future are outlined in Table 3.

Both the qualified and unqualified shortfalls have risen this month for a number of reasons. Due to the summer holidays bank staff availability has declined which is the main reason for the rise in CSW shortfall shifts from 26 to 41. The registered staff shortfalls have remained similar in most areas except NNU, which normally has no shortfalls but had ten this month. On all of these occasions there were neonatal network issues which meant that the unit had capacity problems. On two occasions the NNU had to close. Babies were moved through transitional care and discharged as appropriate. The workload was shared amongst all staff and the lead nurse worked clinically and so safety was maintained. These ten shifts account for the majority of the 12 professional judged red shifts this month. The other two were recorded on B1. This is a small 26 bed ward so any deficit of one staff member may be a potential problem. Both RN shortfall shifts were assessed as red with one having a bank nurse cancel at the last minute when there was also a CSW short and the other shift the agency nurse had to leave early for personal reasons. On both occasions no harm came to patients.

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

Table 1

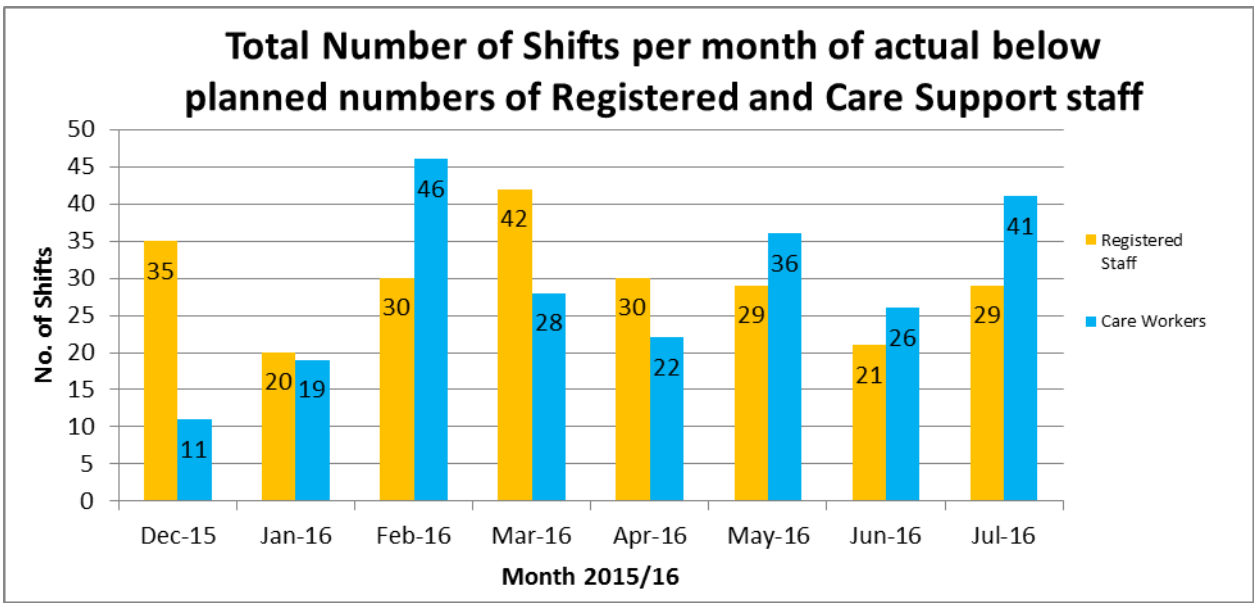


Table 2

Self-Assessment of Workload by Senior Nurses on Each Shift for July (figures in brackets from June)

Ward/Area	RED	AMBER	GREEN	Ward/Area	RED	AMBER	GREEN
Ward A1	0	18 (14)	44 (46)	Ward C3	0	9 (3)	53 (57)
Ward A2	0	0	62 (60)	Ward C4	0	0	62 (60)
Ward A3	0	1 (1)	61 (59)	Ward C5	0	0 (10)	62 (50)
Ward B1	2 (1)	8 (5)	49 (54)	Ward C6	0	17 (11)	45 (49)
Ward B2H	0	7 (0)	55 (60)	Ward C7	0	1 (0)	61 (60)
Ward B2T	0	10 (1)	52 (59)	Ward C8	0	14 (0)	48 (60)
Ward B3	0	3 (9)	59 (52)	CCU/PCCU	0	12 (13)	50 (47)
Ward B4	0	25 (25)	37 (35)	EAU	0	0	62 (60)
Ward B5	0 (2)	12 (7)	50 (51)	MHDU	0	0	62 (60)
Ward B6	-	-	-	Critical Care	0	0	62 (60)
Ward C1	0	0	62 (60)	NNU	10 (0)	16 (6)	36 (54)
Ward C2	0	0 (4)	61* (56)	Maternity	0	10 (10)	51 (50)

*1 shift not assessed

2. NURSE CARE INDICATORS (NCI'S)

The achievement of Green status has not yet been achieved for all areas however there have been improvements seen overall.

Hospital

Rating	Oct 15	Dec 15	Jan 16	Feb 16	March 16	April 16	May 16	June 16	July 16
RED	15	4	3	7	6	3	2	3	1
AMBER	5	11	14	12	13	15	14	8	7
GREEN	4	9	9	8	8	9	11	15	19

Community

Rating	Oct 15	Dec 15	Jan 16	Feb 16	March 16	April 16	May 16	June 16	July 16
RED	0	0	0	0	0	0	0	0	0
AMBER	0	0	0	0	0	0	1	0	4
GREEN	12	12	12	12	12	12	11	12	8

- The escalation procedure for those areas not yet in green remains in place and has been reviewed to ensure it maximises the time and support given to areas to achieve the requirements. 1 area is in level 4 escalation and they have met with the Chief Nurse. More intensive support has been provided and the appropriate change in results is predicted.

A general improvement in the hospital areas can be seen. With the community, there have been constantly good results and so a review of the audit criteria was undertaken in June to assess their suitability. More stretching, appropriate criteria have been now included, hence the July results.

Reforming of Healthcare Education funding

In July the Department of Health released the outcomes of their consultation into the changes around funding of Healthcare Education. In brief the effects of the changes from Bursaries to Student Loans. This should provide more funding to be in the system with no cap on training places for these groups.

The impact of this is an unknown but how it may affect the trust there are 2 initial areas of impact.

- The HEIs feel the cap being lifted will see an influx of would be nurses on to the programme increasing the eventual numbers of graduates available for us to recruit. The initial concern for us is that we have sufficient placements and can continue to meet the NMC requirements in terms of numbers and competence of mentors and sign of mentors.
- Bodies such as the NMC and RCN feel that we see a reduction in applications from certain areas e.g. older applicants with existing financial constraints and those from ethnic minorities who are generally less used to incurring debt. As a diverse employer here we feel we need to champion and support more vocational routes into nursing such as the Associate nursing role which can lead to registered nurse level through the shortened route.

Overall there needs to be monitoring and evaluation of the impact and the government have stressed that should there be adverse impacts in any of these areas it will step in to take remedial action.

Table 3

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS JULY 2016

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A2	2	CSW	Vacancy x1 Sickness x1	On both occasions the 'floating' qualified nurse assisted with CSW duties.
B1	2 2	RN CSW	Vacancy x4	This is a small 26 bed ward so any deficit of one staff member may be a potential problem. Both RN shortfall shifts were assessed as red with one having a bank nurse cancel at the last minute and there was also a CSW short.The other shift the agency nurse had to leave early for personal reasons. On both occasions no harm came to patients. On the two CSW night shifts, the complement of RNs was present and on one occasion a bank CSW did not turn up. No harm came to patients.
B2H	2	CSW	Vacancy x 2	On both occasions, the CSWs present rotated between the 1:1 patients and safety maintained
B2T	1	CSW	Sickness	Care prioritised. No harm to patients.
B4	9	CSW	1:1 patients x9	Bank unable to fill but with the dependency of the patients present on the ward safety was maintained.
B5	1 3	RN CSW	Vacancy x1 1:1 patients x3	On one occasion, due to large number of patients in SAU, GP referrals were diverted and no further patients accepted from ED. On another occasion bank staff did not turn up. No harm occurred to patients.
C1	1	CSW	1:1 patients	Bank was unable to fill the shift for the extra 1:1. Patients were cohorted together.
C3	3	RN	Vacancy x3	Bank and agency unable to fill. Staff distributed appropriately throughout elderly unit to maintain safety.
C8	8	CSW	1:1 patients x8	Staff rotated across unit to maintain safety for these patients.
CCU/ PCCU	3	RN	Vacancy x 3	Bank and agency unable to fill. On two occasions, extra CSW staff assisted and on the third occasion thee were a number of empty beds so safety was maintained.
NNU	10	RSCN	Dependency and capacity e.g. on one occasion triplets delivered overnight	On all of these occasions there were neonatal network issues which meant that the unit had capacity problems. On two occasions the NNU was closed. Babies were moved through transitional care and discharged as appropriate. The workload was shared amongst all staff and the lead nurse worked clinically and so safety was maintained.
Maternity	10 13	RM CSW	Vacancy Maternity leave	Escalation policy enacted on all occasions. Bank unable to fill. No patient safety issues occurred. On 6 shifts there were delayed inductions of labour.

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS JUNE 2016

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A1	1	RN	Vacancy	Requested bank and agency but unable to fill. A1 and A3 work closely together and so a qualified nurse was moved from the rest of the elderly care unit.
A2	1	CSW	Vacancy	An extra qualified staff was available to cover the shortage of two CSWs
B1	2	RN	Sickness x1 Vacancy x1	On one occasion, the lead nurse worked clinically and a supernumerary novice was on duty to assist. On the other occasion, the agency nurse did not turn up and a qualified nurse worked extra hours to assist.
B3	2	RN	Sickness x1 Vacancy x1	Bank and agency were unable to fill the shifts. On one occasion, a station was filled by B2 ward staff and an additional nurse came from surgery. On the other, again one station was covered by B2 staff and the VASCU nurse was able to help on the general ward.
B4	7	CSW	Maternity Leave	Bank unable to fill but with the dependency of the patients present on the ward safety was maintained.
B5	2	RN	Extra capacity/dependency in SAU x2	On both these shifts the nurse staffing was adequate for the normal flow of patients in SAU but due to the absence of medical staff (who were all in theatre) there was a massive back log of patients. On one occasion there were 14-16 patients in the waiting area. This situation has now been resolved with a registrar doctor allocated specifically to SAU. A review of the SAU is also being undertaken by the Division.
C1	3	CSW	Vacancy/Sickness	Bank was unable to fill the shifts for the extra 1:1s. Patients were cohorted and on one occasion there was an extra qualified member of staff to assist the CSWs.
C2	4	RN	Increased ward dependency and capacity	Bank and agency were unable to fill. Nurse in charge assisted on ward to maintain safety.
CCU/ PCCU	2	RN	Vacancy x 2	Bank and agency unable to fill. With the dependency of the patients and on one occasion cath lab staff assisted so that safety was maintained.
EAU	1	CSW	Sickness	The workload was shared amongst all staff and the lead nurse worked clinically and so safety was maintained.
Maternity	10 14	RM CSW	Vacancy Maternity leave	Escalation policy enacted on all occasions. Bank unable to fill. No patient safety issues occurred. On 2 shifts there were delayed inductions of labour. On 1 occasion the unit was closed to admissions and women had to be diverted to another unit.

Enclosure 7

The Dudley G
NHS Foundation Trust

Paper for submission to the Board on 1 September 2016

TITLE:	**Clinical Quality, Safety and Patient Experience Committee Meeting Summaries from the meetings on 26 July 2016 and 23 August 2016**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**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		**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 within both these meetings.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	26 July 2016	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- Executive Assurance was provided that the ophthalmology risk is on the Divisional Risk Register, that action has been taken in respect of the three SIs and that a fuller action plan will be brought to the September Committee meeting.
- Operational Management assurance was provided on the performance in respect of key quality indicators including the continued performance in respect of Stroke: Time on the Stroke Unit (the improvement having been driven by actions taken to reduce the possibility of Stroke Patients being out-lied in the evening and a reduction in the general pressure on capacity) and VTE along with infection control performance. In respect of Ward and ED FFT footfall responses and recommending the Trust this remains a challenge and still needs progress on the Texting Service being implemented. The Trust's performance in respect of the Stroke Suspected TIA Scanned in less than 24 hrs has reduced but is significantly influenced by low numbers within the indicator population, the drop was due to one patient. Maternity Breast Feeding Initiation rates has dropped as have smoking ceasing during pregnancy and as discussed at last month it is difficult to determine why these indicators are so volatile except that it is due to the cohort of mothers in the month. The Committee did raise at the last Board that it intended to continue to keep an eye on these indicators particularly the implementation of texting within ED which should be implemented shortly and make a difference.
- There continues to be a lag in reviewing Trust Policies within planned review timescales. With Policies becoming due for review each month the pressure on staff to undertake this task remains constant. There are 38 requiring review. This issue was discussed at the Risk and Standards Group chaired by the Chief Executive and the Governance Team tasked with developing a business case for an external system for Policy Management.
- Executive Management assurance was provided that the Trust has complied with the reporting requirement timescales in respect of initially reporting of Serious Incidents (SIs) and 72 hour questions from the CCG. Three SIs were not closed in the required 60 day timescale as with those in the previous month this is due to the pressure on respective team members, both operationally and within the corporate governance team. The monthly report shows performance against the

newly developed KPIs and shows the Trust is ahead at the quarter 2 trajectory in all cases except the closure of RCAs within 60 days. In respect of the 14 RCA action plans exceeded their planned dates revised dates have been sought to enable the Governance Team to track divisional performance in this area (the issue of exceeded RCA action plans are discussed at the relevant Division's Performance Management meeting);

- Management Assurance was provided in respect of the learning from closed SI investigations in the previous quarter. The assurance report also showed the learning and changes being made as a result of trends across Incidents, Complaints and PALS concerns;
- Executive Management assurance was provided in respect of progress being made against the Trust recommendations in the joint Serious Incident RCA Process Improvement plan with the CCG. This was supported by the Internal Audit review of the Trust's revised processes;
- Executive Management assurance was provided in respect of progress being made against the Learning Disability Strategy Action Plan;
- Assurance was provided over the corporate actions being taken by the Trust in respect of learning and improvements from patient feedback;
- Management Assurance was provided in respect of the delivery against the Trust's quality priories across the first quarter of 2016/17. The report provided information on actions planned to be taken across the remaining three quarters to achieve the targets across the respective priorities;
- Executive Management assurance was received via the Quality and Safety Group in respect of the last meeting's agenda items. The continued progress being made by the Trust in respect of Harm Free Care and actions taken in respect of medication storage picked up actions from previous Quality Safety reviews;
- Executive Management assurance was received via the Internal Safeguarding Board in respect of the last meeting's agenda items including the continued issues in accessing Tier 4 CAMHS Beds, the delivery of the Trust's actions in respect of the National Goddard Inquiry, the actions being taken following the National Mazars report, actions being taken by the Trust in respect of National Recommendations with regards to FGM, exploitation and domestic abuse. The Board received information on improved training compliance and plans to continue to improve these over the year.
- Executive Management assurance was received via the Patient Experience Group in respect of the last meeting's agenda items including the Adult Inpatient Survey action plan, the Community Patient Experience action plan and the actions being taken as a result of past Quality and Safety Reviews and information on patient experience within the quarter 4 report.

Decisions Made / Items Approved

- Approval of 8 policies and 7 guidelines / procedures that had all been considered by the Policy Group;
- Approval to close 28 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, actions plans completed had been evidenced; and

- Agreement that the Corporate Learning Quarterly Report be submitted to the CQRM for assurance to the CCG of actions taken by the Trust in respect of learning from incidents, complaints and PALS enquiries.

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

- A report from each Director for their Division/Directorate on progress relating to policies that are due for review and have not been reviewed within their expected timescales;
- Continued progress against the joint RCA Process Improvement Action plan with the CCG;
- Continued progress against the Quality Improvement Plan;
- The Ophthalmology full investigation action plan to come to the September Committee meeting; and
- Report on compliance to the Accessible Information Standard.

Items referred to the Board for decision or action

There are no items to be referred to the Board for decision or action, over and above the assurances received at the meeting and the decisions made by the Committee.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	23 August 2016	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- Operational Management Assurance was provided that appropriate action has been taken in respect of the ophthalmology SIs. This included information in respect of the causes of the Incidents themselves as well as information on improvements to the service redesign linked to the capacity challenges which is reflected within the Division's risk register. (The receipt of this assurance regarding the action taken and improvements made as a result of the SI links to a specific request from the Committee in their previous meetings).
- Operational Management assurance was provided on the performance in respect of key quality indicators including the continued good performance in respect of Stroke: Time on the Stroke Unit (which had been area of poorer performance in April 2016) and infection control. The Trust's performance in respect of the Stroke Suspected TIA Scanned in less than 24 hours has reduced drastically this month this is due in part by a change made to the booking of TIAs within patients with low risk and those with high risk triggers than meant there was insufficient capacity to meet this target. VTE Assessments have dropped significantly in July due to staff shortages within Nursing impacting on them supporting the Doctors to undertake these assessments. The Trust's VTE process has also been subject to an Internal Audit review which has concluded that improvements are needed to these systems including when and how VTE assessments are made and recorded. Maternity Breast Feeding Initiation rates continue to be below the performance target as is smoking ceasing during pregnancy and as discussed at last month it is difficult to determine why these indicators are so volatile except that it is due to the cohort of mothers in the month. Friends and family footfall remains low in ED and the Committee are awaiting the implementation of texting which is now set to take place in October to see if that action brings the desired results in improvement within this indicator. The Trust's revised "tear off slip" within its admission documentation seems to making an improvement in friends and family footfall response rate elsewhere in the Trust.
- There continues to be a lag in reviewing Trust Policies within planned review timescales. With Policies becoming due for review each month the pressure on staff to undertake this task remains constant. There are 30 requiring review,

slightly less than last month. Meetings have been set up with each Division / Directorate to discuss this lag and how the 47 due within the next 6 months will be completed on time as well as catching up on the backlog of 30. As requested by this Committee a report from each Director on overdue Policy reviews will come back to the next meeting of this Committee.

- Executive Management assurance was provided that the Trust has complied with the reporting requirement timescales in respect of initially reporting of Serious Incidents (SIs) and 72 hour questions from the CCG. Five SIs were not closed in the required 60 day timescale, all missing by just a few days. As with those in the previous month this is due primarily to the pressure on respective team members, both operationally and within the corporate governance team. The monthly report shows performance against the newly developed KPIs and shows the Trust is ahead at the quarter 2 trajectory in all cases except the closure of RCAs within 60 days. In respect of the RCA action plans that exceeded their planned dates revised dates have been sought to enable the Governance Team to track divisional performance in this area (the issue of exceeded RCA action plans are discussed at the relevant Division's Performance Management meetings);
- Executive Management assurance was provided in respect of progress being made against the Trust recommendations in the joint Serious Incident RCA Process Improvement plan with the CCG;
- Executive Management assurance was received via the Quality and Safety Group in respect of the last meeting's agenda items. The Group had identified areas it had concerns over relating to prescribing in particular that 4 Junior Doctors from a cohort of 40 failed their prescribing competency tests so require supervision until November until they can retake the test and the role Physicians Associates are taking in relation to prescribing. The Committee asked that reports on these issues be brought back to its next meeting;
- Executive Management assurance was received via the Internal Safeguarding Board in respect of the last meeting's agenda items including the continued issues in accessing Tier 4 CAMHS Beds, the actions being taken following the National Mazars report and an update on the recent CQC safeguarding review of health services for children looked after and safeguarding in Dudley.
- Executive Management Assurance was provided over the work of the Mortality Surveillance Group, its review of the national hip fracture database report and the clinical coding processes in respect of palliative care.
- Executive Management assurance was received via the Trust Children's Services Group in respect of the last meeting's agenda items. The Group had also discussed the recent CQC review of health services for children looked after and safeguarding in Dudley and were feeding into the action plan based on that reports findings. The Group were updated on the role of the Trust in respect of the West Midlands Quality Review action plan. The Group had highlighted the challenges with bed availability within the Neonatal Network and its impact on the Trust. This issue is being discussed within the West Midlands Network.
- Executive Management Assurance was provided in respect of the Trust's compliance with the Accessible Information Standard. The Trust was complaint at the basic level within the Standard's maturity scale. The Committee received an update on actions proposed to move the Trust up this maturity scale noting the dependency on IT improvements to move to the exemplar level.

Decisions Made / Items Approved

- Approval of 6 policies and 4 guidelines / procedures that had all been considered by the Policy Group;
- Approval to close 28 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, actions plans completed had been evidenced; and
- To share the Accessible Information Standard report with the CCG to show compliance with the NHS standard contract requirements in this area.

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

- A report from each Director for their Division/Directorate on progress relating to policies that are due for review and have not been reviewed within their expected timescales is planned for the September Committee meeting;
- Continued progress against the joint RCA Process Improvement Action plan with the CCG;
- The Ophthalmology Service to report back in approximately 6 months on the progress made in respect of their service redesign to address their capacity risk; and
- A report on VTE performance drawing out the changes made following the Internal Audit report into this area.

Items referred to the Board for decision or action

The Board should note that the implications of 4 Junior Doctors requiring extra support until November until they can re-sit their prescribing competency tests and that clarity of the Physicians Associates role in prescribing is under review by the Trust and will report back to the Committee.

The Board should note the assurances received at the meeting in particular in respect of the learning within Ophthalmology and the decisions made by the Committee.

Enclosure 8

The Dudley Grou
NHS Foundation Trust

Paper for submission to the Trust Board on September 2016

TITLE:	**NHS Preparedness for a Major Incident**		
AUTHOR:	**S Walford**	**PRESENTER**	**P Bytheway**

CORPORATE OBJECTIVE: SO1, SO2 & SO6

SUMMARY OF KEY ISSUES:-

- Confirmation of the compliance level for the Core Standard set by NHS England
- Assurance that the Trust has reviewed the 6 points raised by Dame Barbara Hakin. The Trust is compliant, these points were:-

1/ The Trust should be reporting an internal incident due to capacity as a 'Critical Incident' using an SBAR format (Situation Background Assessment, Recommendations) 2/ The Trust must give assurance that a communication cascade is used and tested.
3/ Is there good infrastructure/transport links to get staff to work if there was an incident? 4/ What is our ability to increase critical care capacity over a sustained period?
5/ Do we have a network for specialist advice with traumatic and ballistic injuries?
6/ What is our Decontamination capability?

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: The Trust is required to be prepared for a major or internal incident. COR032**
	Risk Register: Y/N		**Risk Score: 10**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Safe, responsive & well led**
	Monitor	**N/A**	**Details:**
	Other	**Y**	**Details: NHS England, Civil Contingencies Act**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
x	x		

RECOMMENDATIONS FOR THE BOARD:

- The Trust Board are assured that the Trust is compliant with the recommendations identified by Dame Barbara Hakin.
- The Trust Board has previously supported the funding associated with recertification of the decontamination suits at a cost of £3,803 plus VAT per year, this will continue yearly. NHS England will now coordinate recertification and replacement of suits and the Trust will have less control over costs (or when suits are replaced)
- The Board is asked to consider the recommendations of West Midlands Fire and Police that the decontamination unit is re-located by the South block car park.
- The Board is asked to review the Core Standards document and be assured that the Trust is 'substantially compliant' with this assessment. The Trust focus for emergency preparedness in 2016/2017 will be business continuity which was identified as a weakness following this review.

The Dudley Group NHS
NHS Foundation Trust

Trust Board of Directors September 2016
NHS Preparedness for a Major Incident

1. Background

In January a paper was submitted to Trust Board following a request from Dame Barbara Hakin (NHS England) in December 2015. The paper outlined the areas of assurance that Trusts are expected to provide in preparation for a Major Incident. These are:-

Assurance required	2015	2016
All Trusts should be reporting internal incidents due to capacity as **Critical Incidents** using **Situation, Background, Assessment and Recommendation format (SBAR)** for reporting.	The Trust already uses SBAR documents during an incident following learning at the Business Continuity table top exercise in 2015 (Dudley bug)	All on call managers and directors have been informed about the new terminology in preparation for this change.
All Trusts must give assurance that a communication cascade is tested in readiness for a major incident	This was tested twice in 2015 and the callout time reduced by 50% from 1 hr to 30 mins.	The process was retested following a further process review and took 17 minutes.
Are there good infrastructure/transport links to get staff to work if there was an incident?	Yes, local arrangements are also in place for Red Cross 4X4 and taxi hire.	Yes, local arrangements are also in place for Red Cross 4X4 and taxi hire.
Is the Trust able to increase critical care capacity and sustain this level of service?	The Critical care capacity could be increased by 8 beds once staffing has been established.	The Critical care capacity could be increased by 8 beds once staffing has been established.
Is there a network for specialist advice with traumatic and ballistic injuries?	The University Hospital Birmingham provides support to the Trust, in a Major Incident we may need to speak to Major Trauma Centres that are not likely to be taking casualties. For debridement associated with ballistic or trauma blast injuries the Trust has 24/7 on-call Consultant Vascular Surgeon cover, the Black Country Vascular Hub and Consultant Plastic Surgeon.	
What is the Trusts Decontamination capability?	100% of ED and Urgent care centre staff have had training for providing dry decontamination to patients who self present with chemicals on their clothes or body. The decontamination unit became operational in 2015 and was tested twice. On the 2nd of July it was tested again, the exercise was observed by West Midland's police & fire services who took part in the an exercise debrief. There were several recommendations that came from this which will be put in writing for the Board to consider.	

This paper provides further updates relating to current emergency preparedness and work programme for 2016/2017.

2. Progress to Date in Emergency Preparedness, Resilience and Response (EPRR) work programme for 2016/2017

Emergency planning	2015	2016	2017
The Trust is required under the Civil Contingencies Act to do a table top exercise yearly (Business Continuity)	This was tested twice in 2015 and the SBAR introduced. The scenarios included evacuation of a ward, loss of power and IT.	The table top exercise planned for this year is on the 18th of October. The scenario will include flu creating staffing problems, full capacity and high delays.	In March 2017 we are planning a table top exercise in collaboration with Interserve and security. The incident will be a security alert requiring 'lock down' of part of the site.
The Trust is required under the Civil Contingencies Act to do a live exercise every 3 years	Due in 2016.	This is planned for September 11th in collaboration with Dudley zoo, West Midland's police, fire and ambulance service. There will be an exercise debrief 2 weeks after the exercise.	Nil planned
The Trust is required under the Civil Contingencies Act to test the callout process for a major incident every 6 months.	This was tested twice in 2015 and the callout time reduced by 50% from 1 hr to 30 mins.	The process was retested following a further process review and took 17 minutes. This will be tested again in December.	All communications tests have been pre-planned with the switchboard manager to ensure different Directors and Managers are on call each time to provide a wider exposure to these calls.
On call Managers and Directors attend an on call training awareness session to provide some exposure to the key roles they may hold in a major or internal incident.	In 2015 90% of the on call managers and directors received training which included 12 hour breach reporting, capacity awareness, major incident and setting up command and control, Critical incident reporting, SBAR and decontamination awareness.	Following training, a resource folder is provided which is also available in the capacity hub (silver command) All new staff joining the on call rota are receiving this training as 1:1 sessions and their senior managers are planning shadowing and on call support when they go onto the rota.	This will continue.
The Trust requires business continuity plans for all areas to share with their teams.	In 2015 64 plans were submitted and are available on the hub.	In 2016 these plans are being reviewed and must be signed off by a senior manager. Many new areas have been asked to provide plans including community.	This will continue.

Emergency planning	2015	2016	2017
The major incident radio must be available to use during an incident and it is tested monthly.	In 2015 the radio was relocated and has been used during a live incident when the Queen came to Birmingham.	The radio has been used again for a live incident when there was a large march against immigration in Birmingham.	This will continue.
During a major incident the Trust must provide a log of decisions made. This log will be kept for 25yrs.	In 2015 16 staff were trained or updated as loggists.	There have been 2 more training sessions which were attended by 7 staff; the Trust now has 23 trained loggists.	No further training planned as other local Trusts in the area have 5 – 10 loggists.
In December 2015 NHS England stated that 100% of frontline staff must have basic training for dry decontamination	In December 31st this number was approx. 70%	In January 2016 ED and urgent care centre are 100% compliant for staff of all grades.	All new staff joining these areas will receive training for dry decontamination.
The area identified for carrying out dry decontamination does not currently provide any privacy for the patient.	An area was identified and a variation request has been made for screening.	This action is awaiting costing's and approval.	Nil to report
The decontamination unit became operational in 2015	There were 2 live exercises in 2015, the Board agreed to the funding of re-certifying the suits used for decontamination at a cost of **£3,803 plus VAT** for the 24 suits. The decontamination unit was audited by West Midlands ambulance service (WMAS) and our processes were compliant with the National guidelines.	The decon unit was used for an exercise on 2/7/16. The senior Fire and Police officers who observed this exercise have recommended that we move the unit further away from the hospital by South block car park. A meeting is planned to consider these recommendations. All suits have been re-certified and are safe to use.	Board has previously agreed to the yearly re-certification and replacement of 8 suits per year starting Jan 2017. NHS England will now be coordinating any re-certifications for all Trusts to provide a regional compliance.
Emergency Preparedness, Resilience and Response meetings are chaired by the Accountable Emergency officer.	These meetings were re-introduced in January 2015 and occur every 8 weeks.	This are timetabled throughout the year and will report to TME.	All meetings already booked.

The Core Standards document is a yearly self-assessment tool provided and assessed by NHS England to gain assurance of EPRR.	In August 2015 the Trust self-assessment was "substantial compliance".	The Core standards document is required by NHSE by the 31/07/16. This has been updated for review by the Accountable Emergency Officer (AEO) see below for identified priorities.	This document will be required yearly.

3. The 2016 priorities for Emergency Preparedness identified in the Core Standard:

- A **Business Impact Analysis** is required which will include updating current plans for all services, plans for all suppliers & contractors, identifying gaps and assessing the Corporate risk register to ensure these are reflected.
- Review of **critical functions** which will include a review of the maximum tolerable period of disruption for each service.
- The **Business Continuity Plan** and **Major Incident plan** require updating to reflect this assessment of which services are critical and restoring lost functions.
- Following completion of the Business continuity tab of the Core standard there will be sufficient data to commence the **fuel shortage plan** with a more robust understanding of what critical functions would need to continue.
- We are unable to provide **privacy** if a patient requires dry decontamination outside the Emergency Department, screening has been requested via estates. This will not provide full screening as the Fire service advice is that patients must be fully visible to the assessing nurse. The decontamination unit has been used 3 times now for live exercises, the risk assessments will need to be reviewed and the policy ratified.
- **Decontamination suits** were all re-certified this year and this is due again in January each year until they are replaced in 3 years.

4. Conclusion

Organisationally we are in a stronger position to deliver and maintain the core standards and the 6 priorities identified by NHS England (page 1).
The support and input from the Health Emergency Planning Team (which is partly funded by the Trust at a cost of £10,000 per year) has been instrumental in the Trust compliance with the Civil Contingencies Act (2004) unfortunately, this team is likely to be disbanded.
The Board is asked to note the enclosed risk review form that supports corporate risk COR032. The assessed compliance level for Core Standards are 'substantial', business continuity is the biggest piece of work for emergency preparedness in 2016/2017.

The Board is asked:

1. To note the contents of the report and to continue to support the financial impact of 2 live decontamination exercises per year as part of the rolling programme to train all of the senior and many of the junior staff in ED.
2. To note the recommendations of the fire service, a meeting has been planned to discuss risks of current position/proposed position. There will be financial implications if the unit is re-located.

The Dudley Group NHS
NHS Foundation Trust

CORPORATE RISK REVIEW FORM

ID	COR032	Risk description	The Trust is required to have an up-to-date plan to manage major incidents and business continuity so that the Trust can deliver care to patients when a major incident is declared and continue to deliver patient care in the event of a serious outage or disruption to key services	Date of review	August 2016

Assurances Received (what and when)	Category 1, 2, 3 – see key below	(P)ositive or (N)egative
There is a Major Incident plan and Business Continuity Plan which were both updated in 2014, with sections of the plan updated during 2015 to support actions learnt from tests and reviews during 2015	1 & 2	P
Actions from the annual assurance submission have been completed in relation to decontamination & communication in the event of a incident	3	P

Actions completed since last review (closed controls / improved assurances available)
To embed Business continuity awareness in the Trust the Emergency planning manager met with lead nurses and a cross reference of staff in each area during Business Continuity week in Feb 2015. This will be repeated in September 2016, date to be confirmed with the launch of the new Major Incident policy. The BC examples to be used will be flushing of tuffee wipes, the sewerage leaks that result and adverse weather.
We are required under the Civil Contingency Act to test our Business Continuity plan, there will be an exercise 18/10/2016. The exercise will be based around flu creating staffing problems, full capacity high numbers of delays requiring interventions from LA and CCG.
We are required under the Civil Contingency Act to test our communications to call staff in for a major incident. This has been tested 3 times in 18 months and the time to call out staff has been reduced from 1 hour (for 3 staff to make the calls) to 17 minutes (for 2 staff). This was made possible by changing the process to make it easier to understand for switchboard staff.
We are required under the Civil Contingency Act to do a Major Incident exercise every 3 years. This is planned for the 11/09/2016 and plans have started to carry out the Trust exercise in conjunction with Dudley zoo, West Midlands Ambulance, fire and police. This exercise will be testing the setting up of Out patients OOH and will not impact on business continuity of ED or the Trust on the day.
On call staff have been invited to attend training in support of major incident and business continuity. This training involves a walkthrough ED, decontamination awareness, outpatients for walking wounded and silver command/silver commander role. Most on call staff have now attended this session and the feedback has been that staff understand the expectations of them during an incident. New staff going onto the on call rota have had 1:1 sessions and a resource folder.
The Major Incident radio in the capacity Hub for Silver command continues to be tested monthly as per NHS England's instructions. The Trust was able to communicate directly with the Birmingham Incident Control Centre during an incident (the radio was also used during the Royal visit to Birmingham)

West Midlands Ambulance Service assessed the Trusts ability to use the decontamination unit and our ability to use the preferred method of dry decontamination. The report has not yet been received for this year but the feedback on the day was very positive with a few minor recommendations. The Trust is 100% compliant in front line staff having dry decontamination training.
ED had a live training session for using the decontamination unit on the 2nd of July and now have 45% of the ED staff trained in wet decontamination. Senior Fire and Police have advised that the decontamination unit needs to be re-positioned by the South block car park, recommendations have been sent to the COO.
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NEW - Current Risk Score.

Score following assessment of the above – this may be the same as the last score if no improvement in control and assurances received confirm initial controlled score

Likelihood (Score 1-5)	5	**Consequence** (Score 1-5)	**2**	**Total 10** Likelihood X consequence	10

New Actions to address an increased current risk score or additional sources of assurance

Action	Due by	Responsible person
1/ Business continuity plans will be reviewed in January 2016, all plans must have senior sign off and must Include staffing as a resource. There are many updates pending, email reminder sent out.	September 2016	Divisional Leads
2/ A strategy for Emergency Preparedness is required. New Cross have provided an example to use as a framework.	September 2016	Sharon Walford
3/The Major Incident plan is being updated into a policy, an adverse weather policy has been written and sent out for review, this will be going to the July policy group.	September 2016	Sharon Walford
4/ Business Continuity, Flu & fuel shortage will all be updated in 2016.	September 2016	Sharon Walford
5/ Work streams will be identified to support the improved delivery of EP across the Trust as a part of the annual planning round	September 2016	Sharon Walford / Paul Bytheway
6/ Engagement of internal audit to review business continuity and emergency planning resilience.	September 2016	Sharon Walford

Risk Manager	**Paul Bytheway**	**Director Lead**	**Paul Bytheway**

Category of assurance – 1 (provided by operational management) / 2 (provided by executive management / committee or board) / 3 (provided by external review body eg IA, EA, Accreditation Body etc)

NHS England Core Standards for Emergency preparedness, resilience and response

v4.0

The EPRR Core Standards spreadsheet has 7 tabs:

Introduction - this tab,. outlining the content of the other 6 tabs and version control history

EPRR Core Standards tab - with core standards nos 1 - 37 (green tab)

Business Continuity tab:- with deep dive questions to support the review of business continutiy planning for EPRR Assurance 2016-17 (blue tab) with a focus on organisational fuel use and supply.

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and NHS ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard (NHS Ambulance Services only): designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards (NHS Ambulance Services only): designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V4.0. The following changes have been made :

- Inclusion of Business Continuity questions to support the 'deep dive' for EPRR Assurance 2016-17, replacing the Pandemic Influenza tab
- Inclusion of the HART service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Inclusion of the MTFA service specification for ambulance service providers and the reference to this in the EPRR Core Standards
- Updated the requirements for primary care to more accurately reflect where they sit in the health economy
- update the requirement for acute service providers to have Chemical Exposure Assessment Kits (ChEAKs) (via PHE) to reflect that not all acute service providers have been issued these by PHE and to clarify the expectations for acute service providers in relation to supporting PHE in the collection of

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																				
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	• Ensuring accountaable emergency officer's commitment to the plans and giving a member of the executive management board and/or governing body overall responsibility for the Emergeny Preparedness Resilience and Response, and Business Continuity Management agendas • Having a documented process for capturing and taking forward the lessons identified from exercises and emergencies, including who is responsible. • Appointing an emergency preparedness, resilience and response (EPRR) professional(s) who can demonstrate an understanding of EPRR principles. • Appointing a business continuity management (BCM) professional(s) who can demonstrate an understanding of BCM principles. • Being able to provide evidence of a documented and agreed corporate policy or framework for building resilience across the organisation so that EPRR and Business continuity issues are mainstreamed in processes, strategies and action plans across the organisation. • That there is an appropriate budget and staff resources in place to enable the organisation to meet the requirements of these core standards. This budget and resource should be proportionate to the size and scope of the organisation.	Paul Bytheway is the Accountable Emergency Officer	Nil	Paul Bytheway	N/A
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Lessons identified from your organisation and other partner organisations. NHS organisations and providers of NHS funded care treat EPRR (including business continuity) as a systematic and continuous process and have procedures and processes in place for updating and maintaining plans to ensure that they reflect: - the undertaking of risk assessments and any changes in that risk assessment(s) - lessons identified from exercises, emergencies and business continuity incidents - restructuring and changes in the organisations - changes in key personnel - changes in guidance and policy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		The business continuity plan was tested twice in 2015 as table top exercises, changes were made to the process of dealing with an incident and have been used in many real BC incidents. Business Continuity issues are being documented now with an SBAR format and a debrief, decisions are also being logged. Copies of used SBAR and log documents are being stored in silver command for future reference. MIP call out list was tested twice in 2015 and changes made to this process which brought the callout time down from 1 hour. The call out test this year following a further review took 17 minutes. The MIP is currently being reviewed, the current plan was issued Feb 2014. Major Incidention call training has been completed for OCM, OCD and matrons. Loggist training and updates have been carried out with 2 more loggists being added June 2016 with the support of the HEPT team.	Nil, all dates arranged	Sharon Walford	ongoing
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Arrangements are put in place for emergency preparedness, resilience and response which: • Have a change control process and version control • Take account of changing business objectives and processes • Take account of any changes in the organisations functions and/ or organisational and structural and staff changes • Take account of change in key suppliers and contractual arrangements • Take account of any updates to risk assessment(s) • Have a review schedule • Use consistent unambiguous terminology, • Identify who is responsible for making sure the policies and arrangements are updated, distributed and regularly tested; • Key staff must know where to find policies and plans on the intranet or shared drive. • Have an expectation that a lessons identified report should be produced following exercises, emergencies and /or business continuity incidents and share for each exercise or incident and a corrective action plan put in place. • Include references to other sources of information and supporting documentation	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		EPRR meetings occur every 8 weeks. All planned activities, policy reviews etc go through this group. EPRR strategy is to be updated and reviewed by Directors. Key staff know where to find policies and this is also covered in the on call/Major Incident training (in line with NOS)	Strategy document to be reviewed by directors	Sharon Walford	Oct-16
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	After every significant incident a report should go to the Board/ Governing Body (or appropriate delegated governing group) . Must include information about the organisation's position in relation to the NHS England EPRR core standards self assessment.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y		The AEO reports to the Board regularly, any significant incident is reviewed in a debrief (72 hr meeting) which is also reported to the board.	Nil	Paul Bytheway	Ongoing
Duty to assess risk																				
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver it's functions.	Risk assessments should take into account community risk registers and at the very least include reasonable worst-case scenarios for: • severe weather (including snow, heatwave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment (including denial of access); • fuel shortages;	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving risk assessments • Version control • Consulting widely with relevant internal and external stakeholders during risk evaluation and analysis stages	Many areas have been reviewed and the policies tested and re-reviewed where we have found changes were needed. The heatwave plan was tested and is now part of a new adverse weather policy which will go to July policy group following feedback from senior nurses, directors and managers. Disruption	nil	Sharon Walford	ongoing
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	• surges and escalation of activity; • IT and communications; • utilities failure; • response a major incident / mass casualty event • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites) There is a process to consider if there are any internal risks that could threaten the performance of the organisation's functions in an emergency as well as external risks eg. Flooding, COMAH sites etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Assurances from suppliers which could include, statements of commitment to BC, accreditation, business continuity plans. • Sharing appropriately once risk assessment(s) completed	The Emergency Planning and Capacity manager attends regional LHRF, LHRP and Dudley Resilience Forum meetings. Any workstreams or information that comes from these meetings is escalated to the AEO and the EPRR group. Each group has been informed about DGNHSFT training exercises and have been invited to participate. The Emergency Planning and Capacity manager attends exercises organised by NHS England or other local Trusts in order to share good practice.	nil	Sharon Walford	ongoing
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Other relevant parties could include COMAH site partners, PHE etc.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Risk assessments are shared at divisional meetings, cascaded to directorates and risk assurance groups.	nil	Marina Turner	ongoing
Duty to maintain plans – emergency plans and business continuity plans																				
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity. Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	Incidents and emergencies (Incident Response Plan (IRP) (Major Incident Plan))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Relevant plans: • demonstrate appropriate and sufficient equipment (inc. vehicles if relevant) to deliver the required responses • identify locations which patients can be transferred to if there is an incident that requires an evacuation; • outline how, when required (for mental health services), Ministry of Justice approval will be gained for an evacuation; • take into account how vulnerable adults and children can be managed to avoid admissions, and include appropriate focus on providing healthcare to displaced populations in rest centres; • include arrangements to co-ordinate and provide mental health support to patients and relatives, in collaboration with Social Care if necessary, during and after an incident as required; • make sure the mental health needs of patients involved in a significant incident or emergency are met and that they are discharged home with suitable support • ensure that the needs of self-presenters from a hazardous materials or chemical, biological, nuclear or radiation incident are met. • for each of the types of emergency listed evidence can be either within existing response plans or as stand alone arrangements, as appropriate.	MIP is currently being updated, the current plan was issued Feb 2014. Internal auditors are benchmarking against other local acute Trusts.	Finalise action cards	Sharon Walford	Jun-16
		corporate and service level Business Continuity (aligned to current nationally recognised BC standards)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		All directorate managers have been asked to review the Business continuity plans for the areas they manage and to share these plans with their teams. Business continuity is discussed in the on call training (NOS) and all completed BCPs are available on the Hub. The Business continuity plan was issued June 2014.	Community teams have been asked to provide plans to add to the intranet	Sharon Walford	Oct-16
		HAZMAT/ CBRN - see separate checklist on tab overleaf	Y	Y	Y			Y	Y						Y		The Trust carried out 2 live training exercises in 2015 with support from the HEPT team, there was a further session on the 2nd of July with feedback from fire and police. The Trust CBRN preparedness has been audited by the WMAS NILO - see attached report for 2015. The report for 2016 is not yet available. Guidance for IOR compliance has been actioned and 100% of ED and Urgent Care Centre front line staff have received basic awareness training. More indepth IOR practical training is given during the 2 day CBRN competency days.	awaiting formal audit report	Anthony Savage	ongoing
		Severe Weather (heatwave, flooding, snow and cold weather)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		The NHS heatwave plan was tested and is now part of a new adverse weather policy which was approved in July. Weather is an agenda item for capacity meetings every day when the met office warns heat or cold health watch 2 or above.	Flooding from a watercourse is not a risk for any of the 3 sites. However localised flooding will be added to the BCP	Sharon Walford	Oct-16
		Pandemic Influenza (see pandemic influenza tab for deep dive 2015-16 questions)	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		Emergency planning and Capacity manager took part in the pandemic flu NHS England exercise by facilitating the Dudley health table. This was attended by a senior nurse and Occupational Health nurse. Dudley CCG, Public Heath and DGNHSFT are working towards a collaborative agreement for flu pandemic. A monthly flu 'task and finish' group has already met for 2016/2017 and is chaired by the Chief nurse.	Final agreement to be signed off for Cooperative flu agreement following Consultation	Sharon Walford/ Paul Bytheway	Oct-16
		Mass Countermeasures (eg mass prophylaxis, or mass vaccination)	Y	Y	Y			Y		Y	Y				Y		The infection prevention team and occupational Health would lead on this with guidance from Public Health. This is considered in the Cooperation agreement.	nil	Angela Murray & Liz Reece	ongoing
		Mass Casualties	Y	Y	Y			Y		Y	Y				Y		part of MIP, now covered in on call training for directors, managers and matrons.	nil	Sharon Walford	ongoing
		Fuel Disruption	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Policy in place but requires an update	Policy is to be updated	Sharon Walford	Oct-16
		Surge and Escalation Management (inc. links to appropriate clinical networks e.g. Burns, Trauma and Critical Care)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		would be managed via NILO (WMAS) and ICC	nil	Sharon Walford	ongoing
		Infectious Disease Outbreak	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y		Infection prevention policy, inter agency work with Public Health team	nil	Angela Murray & Liz Reece	ongoing
		Evacuation	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y		The winter ward could accommodate up to 23 patients if evacuation of part of a ward is required assuming this ward is not in use. There is an additional ward no longer in use X 17 beds, medical day case X 10 beds, surgical day case X 10 beds, Ambulatory Emergency Care X 4 beds. A ward evacuation was practiced as part of an exercise last year and a second evacuation due to real incident. Both were quick, effective and managed well. The Trust would work in collaboration with the Dudley Council Emergency Planning Officers who have plans for evacuation sites all over the borough.	Plan a meeting to discuss how this would be managed. Amanda Baldwin from West Midlands Police and Helen Lowe/Sarah Hill have agreed to attend any planning meetings.	Sharon Walford	ongoing
		Lockdown	Y	Y	Y			Y	Y					Y	Y		The policy has been updated again for 2016 by the security manager and has been sent out for senior review before going to policy group. The security manager has been asked to confirm that all current security staff are aware of this policy.	Review ratified policy	Julie Mee & Sharon Walford	Oct-16
		Utilities, IT and Telecommunications Failure	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		This was included in the BCP table top exercises in 2015. There have been several incidents in the past 12 months. The incident control room is set up and the incident logged with an action plan following debrief. Copies of all incident logs are available in the control room for reference.	All incidents logged are divided into categories. Incidents will be reviewed to ensure lessons learned will be reflected in the new BCP policy.	Sharon Walford	ongoing
		Excess Deaths/ Mass Fatalities	Y	Y	Y					Y	Y				Y		MIP is currently being updated, the current plan was issued Feb 2014. Dudley group were planning to attend the mass casualty training on the 29th of June but there are insufficient spaces.	SW to ensure this is in the updated MIP	Sharon Walford	ongoing
		having a Hazardous Area Response Team (HART) (in line with the current national service specification, including a vehicles and equipment replacement programme) - see HART core standard tab			Y												Via WMAS and the NILO. Contact details are on the Hub and in silver command	nil	Sharon Walford	ongoing
		firearms incidents in line with National Joint Operating Procedures; - see MTFA core standard tab			Y												The procedure would be a 999 response who would escalate to local firearms officers.	SW to ensure this is reflected in the updated lockdown policy that is under review	Security team & Sharon Walford	ongoing

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
9	Ensure that plans are prepared in line with current guidance and good practice which includes:	• Aim of the plan, including links with plans of other responders • Information about the specific hazard or contingency or site for which the plan has been prepared and realistic assumptions • Trigger for activation of the plan, including alert and standby procedures • Activation procedures • Identification, roles and actions (including action cards) of incident response team • Identification, roles and actions (including action cards) of support staff including communications • Location of incident co-ordination centre (ICC) from which emergency or business continuity incident will be managed • Generic roles of all parts of the organisation in relation to responding to emergencies or business continuity incidents • Complementary generic arrangements of other responders (including acknowledgement of multi-agency working) • Stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • Contact details of key personnel and relevant partner agencies • Plan maintenance procedures (Based on Cabinet Office publication Emergency Preparedness, Emergency Planning, Annexes 5B and 5C (2006))	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Being able to provide documentary evidence that plans are regularly monitored, reviewed and systematically updated, based on sound assumptions: • Being able to provide evidence of an approval process for EPRR plans and documents • Asking peers to review and comment on your plans via consultation • Using identified good practice examples to develop emergency plans • Adopting plans which are flexible, allowing for the unexpected and can be scaled up or down • Version control and change process controls • List of contributors • References and list of sources • Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	This has been discussed with WMAS and HEPT to ensure same terms are used i.e Gold is now Gold strategic, silver is silver tactical. Trigger for activation procedure is in the MIP. Callout test has been tested 6 monthly and reviewed to improve the process. The Trust ICC (Silver/tactical command) is in the capacity Hub where all incidents are managed. Recovery will have more visibility in the new MIP and will begin earlier in the plan. Contacts for key personnel and relevant partners is Gold and Silver command and is also available on the Hub. Maintenance procedures should be discussed in the EPRR meetings, the estates manager now attends these meetings.	Finalise MIP update	sharon walford	Oct-16
10	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	Enable an identified person to determine whether an emergency has occurred - Specify the procedure that person should adopt in making the decision - Specify who should be consulted before making the decision - Specify who should be informed once the decision has been made (including clinical staff)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Oncall Standards and expectations are set out • Include 24-hour arrangements for alerting managers and other key staff.	A flow chart has been developed and circulated Trust wide following review at EPRR. This is also available on the intranet and in the incident control room. This flow chart is also in the resource folders for on call managers and directors to aid their decision re: if an incident control is required (particularly out of hours) This flow chart has been circulated throughout the Trust to assist staff with good escalation during an incident. Clinical Site Coordinators have a competency assessment for emergency planning and the immediate response by them OOH.	SW to ask random wards and clinical areas where their plans are and flow chart.	Sharon Walford	ongoing
11	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Decide: - Which activities and functions are critical - What is an acceptable level of service in the event of different types of emergency for all your services - Identifying in your risk assessments in what way emergencies and business continuity incidents threaten the performance of your organisation's functions, especially critical activities	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Critical functions would be discussed and agreed in silver command with the relevant staff. Divisions are currently reviewing the critical functions for their areas using the EPRR toolkit - BIA template (NHS England)	SW to work with the divisions to complete this very large piece of work.	Sharon Walford	ongoing
12	Arrangements explain how VIP and/or high profile patients will be managed.	This refers to both clinical (including HAZMAT incidents) management and media / communications management of VIPs and / or high profile management	Y	Y	Y			Y	Y								The Trust policy for VIPs includes media advice & communication management	nil	Communications team	Jan-17
13	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Specifiy who has been consulted on the relevant documents/ plans etc.	The BCP tabletops in 2015 included the HEPT team and EPOs from other Trusts X 4. The BCP tabletop we are planning for 2016 will also include CCG, Dudley council EPO, Public health and Interserve.	Planned for November 2016, room booked, invites to be sent out.	Sharon Walford	Jan 2017
14	Arrangements include a debrief process so as to identify learning and inform future arrangements	Explain the de-briefing process (hot, local and multi-agency, cold)at the end of an incident.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Formal SBAR documents have been created for hot debrief at the end of an incident and cold debrief at 72 hours.	These will need to be reviewed as a collection to assess lessons learned and actions required.	Sharon Walford	ongoing
Command and Control (C2)																				
15	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	Organisation to have a 24/7 on call rota in place with access to strategic and/or executive level personnel	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Explain how the emergency on-call rota will be set up and managed over the short and longer term.	There is a resilient single point of contact 24/7 when there is a problem. The Clinical Site Coordinators escalate to the relevant managers, directors etc. Directors are given the on call rota for CCG Directors for Sandwell, Birmingham and the Black Country to put in their on call pack.	**nil**	sharon Walford	ongoing
16	Those on-call must meet identified competencies and key knowledge and skills for staff.	NHS England publised competencies are based upon National Occupation Standards .	Y	Y	Y		Y	Y	Y	Y	Y	Y			Y	Training is delivered at the level for which the individual is expected to operate (ie operational/ bronze, tactical/ silver and strategic/gold). for example strategic/gold level leadership is delivered via the 'Strategic Leadership in a Crisis' course and other similar courses.	Training was given to on call managers, directors and matrons. This training was based on NOS and was suported by the HEPT and the Regional capacity team.	**nil**	Sharon Walford	ongoing
17	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	This should be proportionate to the size and scope of the organisation.	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements detail operating procedures to help manage the ICC (for example, set-up, contact lists etc.), contact details for all key stakeholders and flexible IT and staff arrangements so that they can operate more than one control/coOordination centre and manage any events required.	This is included in the MIP and BCP. HEPT have provided training for new loggists, updates for current loggists and practice sessions in Silver command have been arranged.	nil	Sharon Walford	ongoing
18	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		This is discussed with Clinical Site Coordiantors in their competency training for emergency planning, loggist training and on call training. During on call training logging an incident is discussed and the importance of making own log if no-one is available.	nil	Sharon Walford	ongoing
19	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y		The information team have set up UNIFY to provide information, we also give regular upddates to Regisoinal capacity via EMS. NHS England have emails for key personnel in the Trust to	nil	Sharon Walford	ongoing
20	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	Both acute and ambulance providers are expected to have in place arrangements for accessing specialist advice in the event of incidents chemical, biological, radiological, nuclear, explosive or hazardous materials	Y		Y												There is 24 hour cover for all of these incidents, firearms via 999 who will escalate to local firearms officers, WMAS for CBRN	nil	Sharon Walford	ongoing
21	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	Both acute and ambulance providers are expected to have arrangements in place for accessing specialist advice in the event of a radiation incident	Y		Y												Support is available via City Hospital Physics department where specialist advice is required. There is a link on the emergency planning page on the intranet to take staff to NAIR.	nil	Sharon Walford	ongoing
Duty to communicate with the public																				
22	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Arrangements include a process to inform and advise the public by providing relevant timely information about the nature of the unfolding event and about: - Any immediate actions to be taken by responders - Actions the public can take - How further information can be obtained - The end of an emergency and the return to normal arrangements Communications arrangements/ protocols: - have regard to managing the media (including both on and off site implications) - include the process of communication with internal staff - consider what should be published on intranet/internet sites - have regard for the warning and informing arrangements of other Category 1 and 2 responders and other organisations.	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Have emergency communications response arrangements in place • Be able to demonstrate that you have considered which target audience you are aiming at or addressing in publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous information campaigns to inform the development of future campaigns • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'. • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes. • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work.	There is a resilient single point of contact 24/7 when there is a problem. The Clinical Site Coordinators escalate to the relevant managers, directors etc. Directors are given the on call rota for CCG Directors for Sandwell, Birmingham and the Black Country to put in their on call pack. Clinical Site Coordinators have a major incident/BCP competency assessment as they manage the site 24/7. The communications team would deal with any media interest via the COO/CEO or the on call Director OOH for anything that couldn't wait until normal working hours.	**nil**	sharon Walford	ongoing

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23	Arrangements ensure the ability to communicate internally and externally during communication equipment failures		Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Have arrangements in place for resilient communications, as far as reasonably practicable, based on risk.	The Trust has a BCP for loss of communications which will include the use of radios in addition to mobile phones if this is possible. In June 2016 the Trust also purchased 12 air call pagers to ensure senior communication and engagement in an internal incident.	SOP written, awaiting final approval and rollout of this process	**sharon Walford**	Aug-16
Information Sharing – mandatory requirements																				
24	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	These must take into account and inclue DH (2007) Data Protection and Sharing – Guidance for Emergency Planners and Responders or any guidance which supercedes this, the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public', or subsequent / additional legislation and/or guidance.	Y	Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y	• Where possible channelling formal information requests through as small as possible a number of known routes. •Sharing information via the Local Resilience Forum(s) / Borough Resilience Forum(s) and other groups. • Collectively developing an information sharing protocol with the Local Resilience Forum(s) / Borough Resilience Forum(s). •Social networking tools may be of use here.	Formal information sharing will continue via CCG, NHS England, Public Health England depending on the incident. The Trust has always got Silver (tactical) command prepared for use. This included the MI radio for communications with the NHSE ICC.Attendance at LHRF and LHRP meeting also ensures good communication throughout the EPRR network.	nil	**Sharon Walford**	Ongoing
Co-operation																				
25	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)		Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	• Attendance at or receipt of minutes from relevant Local Resilience Forum(s) / Borough Resilience Forum(s) meetings, that meetings take place and memebership is quorat. • Treating the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership as strategic level groups	There is 24 hour cover for all of these incidents. firearms via 999 who will escalate to local firearms officers, WMAS for CBRN	nil	Sharon Walford	ongoing
26	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	•Taking lessons learned from all resilience activities • Using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to consider policy initiatives • Establish mutual aid agreements	Support is available via City Hospital Physics department where specialist advice is required. There is a link on the emergency planning page on the intranet to take staff to NAIR.	nil	Sharon Walford	ongoing
27	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	NB: mutual aid agreements are wider than staff and should include equipment, services and supplies.	Y	Y	Y			Y	Y	Y	Y	Y		Y	Y	•Identifying useful lessons from your own practice and those learned from collaboration with other responders and strategic thinking and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership to share them with colleagues •Having a list of contacts among both Cat. 1 and Cat 2. responders with in the Local Resilience Forum(s) / Borough Resilience Forum(s) area	The Black Country Alliance between Dudley, Walsall, Sandwell & Birmingham Trusts will provide a forum for matual aid agreements.	To confirm with the Alliance leads	Sharon Walford	ongoing
28	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.				Y					Y	Y				Y		Arrangements would be via the EPRR locality team	nil	Sharon Walford & Paul Bytheway	ongoing
29	Arrangements outline the procedure for responding to incidents which affect two or more regions.				Y						Y				Y		Via WMAS - NILO details are on the Hub. NILO is assisting with the MI exercise in September	nil	Sharon Walford	ongoing
30	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	Examples include completing of SITREPs, cascading of information, supporting mutual aid discussions, prioritising activities and/or services etc.	Y	Y	Y			Y	Y			Y		Y			As a Trust we have had lots of practice in preparing for industrial action and protests where information is shared with NHS	nil	Sharon Walford	ongoing
31	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared										Y						The West Midlands Conurbation Resilience Contact List is available on the Hub for on call managers and directors to gain	nil	Sharon Walford	ongoing
32	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months									Y	Y						This meeting is every other month and is attended by the Emergency Planning and capacity manager or AEO.	nil	Sharon Walford	ongoing
33	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level		Y	Y	Y			Y	Y	Y		Y			Y		This is attended by the emergency planning lead and the AEO will also attend some of these meetings.	Dates are forwarded to the AEO	Sharon Walford/ Paul Bytheway	ongoing
Training And Exercising																				
34	Arrangements include a training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	• Staff are clear about their roles in a plan • Training is linked to the National Occupational Standards and is relevant and proportionate to the organisation type. • Training is linked to Joint Emergency Response Interoperability Programme (JESIP) where appropriate •Arrangements demonstrate the provision to train an appropriate number of staff and anyone else for whom training would be appropriate for the purpose of ensuring that the plan(s) is effective •Arrangements include providing training to an appropriate number of staff to ensure that warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Taking lessons from all resilience activities and using the Local Resilience Forum(s) / Borough Resilience Forum(s) and the Local Health Resilience Partnership and network meetings to share good practice •Being able to demonstrate that people responsible for carrying out function in the plan are aware of their roles •Through direct and bilateral collaboration, requesting that other Cat 1. and Cat 2 responders take part in your exercises •Refer to the NHS England guidance and National Occupational Standards For Civil Contingencies when identifying training needs. •Developing and documenting a training and briefing programme for staff and key stakeholders •Being able to demonstrate lessons identified in exercises and emergencies and business continuity incidentshave been taken forward • Programme and schedule for future updates of training and exercising (with links to multi-agency exercising where appropriate) • Communications exercise every 6 months, table top exercise annually and live exercise at least every three years	On call training linked to the NOS includes managers and directors. We also invite matrons to attend to improve a high level of involvement in emergency planning. Clinical Site Coordinators also have a competency pack for emergency planning which involves early escalation, command and control and setting up silver (tactical) command.	nil	Sharon Walford	ongoing
35	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	• Exercises consider the need to validate plans and capabilities • Arrangements must identify exercises which are relevant to local risks and meet the needs of the organisation type and of other interested parties. •Arrangements are in line with NHS England requirements which include a six-monthly communications test, annual table-top exercise and live exercise at least once every three years. • If possible, these exercises should involve relevant interested parties. •Lessons identified must be acted on as part of continuous improvement. • Arrangements include provision for carrying out exercises for the purpose of ensuring warning and informing arrangements are effective	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Exercises to test Business Continuity were carried out twice last year and is planned for October. A live exercise (multi-agency) is being planned for the September 2016 in collaboration with Dudley zoo. Learning from previous incidents (real and BCP tabletops) have resulted in changes to the BCP resource, MIP resource and format of meetings during an emergency (SBAR)	nil	Sharon Walford	ongoing
36	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises		Y	Y	Y			Y	Y	Y	Y	Y			Y		On call personnel are being given the opportunity to participate or observe multi agency exercises. In the past 12 months we have had several real BCP incidents where incident control has been set up and senior staff have been exposed to this method of incident control.	nil	Sharon Walford	ongoing
37	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.		Y	Y	Y		Y	Y	Y	Y	Y	Y			Y		A resource folder is given to staff that attend on call training with a certificate of attendance. Any other relevant information that is deemed useful for an on call manager or director would be forwarded by email to put in their resource folder. It is suggested that it is kept at home for use when the person is not in the Trust. This folder contains a Log book to record **decisions** made in the beginnings of an incident.	nil	Sharon Walford	ongoing

Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSSx (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2015 Deep Dive																		
DD1	Organisation has undertaken a Business Impact Assesment	• The organisation has undertaken a risk based Business Impact Assessment of services it delivers, taking into account the resouces required against staffing, premises, information and information systems, supplies and suppliers • The organisation has identified interdependencies within its own services and with other NHS organisations and 3rd party providers • Risks identified thought the Business Impact Assessment are present on the organisations Corporate Risk Register	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• updated Business Imact Assessment • corporate risk register	BIA is required to ensure that all areas of the Corporate Risk Register have been included. The BIA template provided by NHS England is being used to complete this work.	Risk meeting to be planned for review of this document.	**Sharon Walford/Glen Palethorpe**	Oct-16
DD2	Organisation has explicitly identified its Critical Functions and set Minimum Tolorable Peroiods of disruption for these	• The organisaiton has identified their Critical Functions through the Business Impact Assesment. • Maximum Tolerable Periods of Disruption have been set for all organisaional functions - including the Critical Functions	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• Business Continuity plan explicitly details the Critical Functions • Business Continuity plan explicitly outlines all organisations functions and the maximum torlerable period of disrution	The BCP requires an update to include critical functions, maximum tolerable period of disruption, and recovery to restore lost functions.	Continue to update, lessons learned from BC table top exercises will be incorporated into this plan.	**Sharon Walford**	Oct-16
DD3	There is a plan in place for the organisation to follow to maintain critical functions and restore other functions following a disruptive event.	• The organisation has an up to date plan which has been approved by its Board/Governing Body that will support staff to maintain critical functions and restore lost functions • The plan outlines roles and responsibilities for key staff and includes how a disrutive event will be communicated both internally and externally	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	• an organisation wide Business Continuity plan that has been updated in the last 12 months and agreed the Board/Governing Body	This plan requires an update, previous plan is from 2014. Internal auditors have reviewed the business continuity plan including benchmarking against plans for similar sized Trusts. Recommendations will be presented mid July and will be incorporated into the work plan for 2016/2017.	Continue to update	Sharon Walford	Oct-16
DD4	Within the plan there are arrangements in place to manage a shortage of road fuel and heating fuel	• The plan details arrangements in place to maintain critical functions during disruption to fuel. These arrangements include both road fuel and were applicable heating fuel.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	• detail within the plan that explicitly makes reference to shortage of fuel and its impact of the business.	A link within this policy takes the reader to the fuel shortage plan which requires update.	Continue to update	Sharon Walford	Oct-16
DD5	The Accountable Emergency Officers has ensured that their organisation, any providers they commission and any sub-contractors have robust business continuity planning arrangements in place which are aligned to ISO 22301 or subsequent guidance which may supersede this .	EPRR Framework 2015 requirement, page 17	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	The estates team and procurement have been asked to contact all suppliers to ask for an up to date business continuity plan. This information will be transferred onto a database and risks will be reviewed.	This information has been requested by the 31st of August.	Confirmation required that the request has been been submitted	Sharon Walford/Andrew Rigby/David Lewis	Oct-16
DD6	Review of Critical Services Fuel Requirement Data Collection Programme (F1:F18)	Please complete the data collection below - this data set does not count towards the RAG score for the organisations. Please provide any additional information in the "Other comments" free text box.	Y	Y		Y	Y	Y	Y						Y	• NHS Ambulance Trusts have already provided this information in a national collection in May 2016.	Divisions have been asked to provide an assessment of the critical areas they manage	Confirmation required that critical areas have been identified	Sharon Walford/Andrew Rigby	31/08/2016

Fuel Demand Summary

When providing information on the fuel requirements for both business as usual and to operate a critical service please ensure the supply and demand balances whereby:

Total Daily fuel use (F1) = own bunkered fuel use (F5) + any 3rd party bunkered fuel use (F6) + any forecourt fuel use (F9)

Section 1: Business as Usual Demand

		Petrol	Diesel	Other (inc LPG, Kerosene
F1	How much fuel do you use daily when providing a business as usual service? (litres)		8,600	

Section 2: Bunkered Fuel

		Petrol	Diesel	Other (inc LPG, Kerosene
F2	Do you hold bunkered fuel (Yes/No) If no go to F6		Yes	
F3	What is the total bunkered fuel capacity? (litres)		440,000	
F4	On average, what volume of bunkered fuel do you hold? (litres)		440,000	
F5	Do you use your own bunkered fuel when providing a business as usual service? If no go to F6		0	
F6	Do you access a 3rd party or another service's bunkered fuel when providing a business as usual service? If no go to F8		0	
F7	If you have answered "Yes" to F6 or have bilateral supply agreements to operate a business as usual service, please provide a description of any agreement(s), amount of supply and companies / organisations involved.			

1) What happens if I have mutual aid agreements with another Critical Service provider to utilise their bunkered stock, do I need to record the bunkered stock or will they?
DECC is requesting that the supplier records the bunkered stock holdings and the user records the demand. As the user of these bunkered fuels in this instance, please record the use of these stocks under the section referring to access to third party bunkered stock.

2) Should we assume that in the build up to an emergency our bunkered stocks would be full, as we would be prioritising deliveries and therefore the days' stock held calculations should be based on full capacity and not average daily stock holdings?
The prioritisation of supply will be dependent on the facts of any fuel shortage scenario, and will be a decision taken at the time. Data provided in the template should provide DECC with a sufficient evidence base to make decisions based on capacity and BAU bunkered stocks. Therefore please fill out the template as requested, providing notes where you think that estimates are required, or where you have had to average data in order to fit the template.

3) Our choice of bunkered fuel supplier varies depending on supply cost or availability. Who do I record as the primary supplier?
Please provide the supplier you get most of your fuel from, but also note that this varies and provide details of the other suppliers and average quantities.

4) The terminal our bunkered fuel is supplied from varies depending on who our supplier is. What should we report?
Please report your largest supplier based on average BAU, but also provide notes on any secondary service providers and average quantities obtained from those providers.

Section 3: Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene
F8	Do you use forecourts to operate a business as usual service? (Yes/No) If no go to F10		No	
F9	What is the average daily forecourt fuel use to operate a business as usual service? (litres)			

Critical Service Operation Only

Please refer to question 4 of the guidance notes for further information on how to identify the fuel requirements of a critical service.
During an emergency it is expected that organisations will not be operating as normal and will only be delivering those essential services that are Critical.
Low fuel consumption alternatives should also be explored as part of the Critical Service identification process. For example, if there is the possibility that a Critical Service activity can be carried out remotely, and therefore does not require the use of fuel, this should be removed from the supply requirements to
The below section refers to the fuel requirements to deliver a Critical Service only.

Section 4: Critical Service Demand

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F10	How much fuel would you use daily if you were providing a critical service? (litres)		6,125	

Section 5: Critical Service Bunkered Fue

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F11	Do you have access to either your own or 3rd party bunkered fuel if you were providing a critical service (either from general access or mutual supply agreements)? (Yes/No) If no go to F14		Yes	
F12	What volume of your own bunkered fuel would you use daily if you were providing a critical service? (litres)		6,125	
F13	What volume of 3rd party or another service bunkered fuel (either from general access or mutual supply agreements) would you use daily if you were providing a critical service? (litres)		0	
F14	If you have answered "Yes" to F13 or have bilateral supply agreements to operate a critical service, please provide a description of any agreement(s), amount of supply and companies / organisations involved. If no go to F15			

Section 6: Critical Service Petrol Stations / Forecourts

		Petrol	Diesel	Other (inc LPG, Kerosene, Gas Oil)
F15	Will you need access to Designated Filling Stations (DFS) if you were providing a critical service? (Yes/No) If no go to F17		Yes	
F16	What volume of fuel would you use daily from Designated Filling Stations (DFS) if you were providing a critical service? (litres)		118	

Critical Service Operation Only

F17 To ensure that there are adequate Designated Filling Stations* (DFS) to meet the demands of all critical users , please detail in the table below the number of vehicles required to operate a critical service
A Designated Filling Station (DFS) is a retail filling station with the purpose of only supplying road fuel for critical use only. The DFS list will be compiled to provide sites giving a good geographic coverage of the UK to meet the predicted regional demand for fuel for critical services.

Vehicles	Number of Vehicles required to operate a critical service		
	Petrol	Diesel	Other (inc LPG)
With NHS Logo			
Without NHS Logo	36	22	14
Private vehicles	300	200	100
Total	336		

F18 If you have answered "Yes" to question 2 (Do you hold bunkered fuel?) please detail which company primarily supplies your bunkered fuel and where known which local or regional supply depot or terminal does the fuel gets delivered from. Please select from drop down list provided or select "other" and please detail.

Who primarily supplies your bunkered fuel? Please Select from drop down list:	If other or multiple suppliers please state:	Which Terminal is your bunkered fuel supplied from? Please Select from drop down list:	If other please state:	Average Number of Deliveries per Month
Other	n Fuel	Birmingham Esso		1

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	Core standard	Clarifying information						Evidence of assurance				
	Preparedness											
38	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	Y	Y	Y	Y	Y	• Being able to provide documentary evidence of a regular process for monitoring, reviewing and updating and approving arrangements • Version control	There is a plan for CBRN/HAZMAT which is now being updated again following a second exercise in 2015. The updated plan will be reviewed by the ED team and EPRR group. The final version will have version control etc. The training day involved a refresher for Step 123 Plus and IOR introduction with the new DVD. During the training which included WMAS NILO and HART team member the ED team cordoned off the area and worked as if this was a real event. Comms were included to inform the public, staff and patients. There was a hot debrief after and a cold debrief following each day of training.	Feedback was to improve action cards so that they are more user friendly.	Karen Jennings & Liz Allmark, Sharon Walford	Oct-16
39	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	Y	Y	Y	Y	Y	• Site inspection • IT system screen dump	Yes	more staff need to be trained	Karen Jennings & Liz Allmark	ongoing
40	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Y	Y	Y	Y	Y	• Appropriate HAZMAT/ CBRN risk assessments are incorporated into EPRR risk assessments (see core standards 5-7)	Risk assessments were completed now there is a working decontamination unit. The competency document used by the ED trainers is to be reviewed. WMAS NILO assessessed the Trust in 2015 and 2016	Risk assessments to be reviewed.	Sharon Walford	Oct-16
41	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Y		Y			• Resource provision / % staff trained and available • Rota / rostering arrangements	Trust Board agreed that ED will run the training exercises twice per year until sufficient staff are trained and requiring a yearly refresher.	More staff training required	Dawn Powell	Oct-16
42	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	Y	Y	Y	Y	Y	• Provision documented in plan / procedures • Staff awareness	Contact details are in the ED plan for these incidents and on the Hub in the emergency planning page (West Midlands Connurbation contact list)	Ensure this is in the revised plan	Dawn Powell	Oct-16
	Decontamination Equipment											
43	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• completed inventory list (see overleaf) or Response Box (see Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities (NHS London, 2011))	This is in the work plan for the ED leads to complete. A response box for dry decontamination in the reception area has been prepared and is ready to use.	inventory list and Dry decon box is now available.	Dawn Powell	Oct-16
44	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017	Y		Y				All suits have been revalidated and the Trust Board have agreed to a plan for the replacement of 8 suits per year until all have been replaced	nil	Paul Bytheway	ongoing
45	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	Y		Y				All systems checked and tested during the exercise on the 4th of July. There is a named link nurse for monthly checks	Emergency planning officer or matron to review records of check list	Sharon Walford & Dawn Powell	ongoing
46	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment		Y		Y				As previous	Emergency planning officer or matron to review records of check list	Sharon Walford & Dawn Powell	ongoing
47	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	Y		Y				This will be via Respirex who the suits were purchased from.	nil	**Karen Jennings/Anthony Savage**	Jan-16
	Training											
48	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training		Y		Y				Yes	nil	Sharon Walford	Oct-16
49	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Y	Y	Y	Y	• Show evidence that achievement records are kept of staff trained and refresher training attended • Incorporation of HAZMAT/ CBRN issues into exercising programme	There is a good training package in ED for CBRN wet and dry decontamination. This was tested twice in 2015 and again in July 2016. Feedback from HEPT, WMAS NILO, West Midlands Fire service and police was positive. There are a team of senior staff involved in providing this training who are supported from a senior level to plan further training.	nil	Sharon Walford, Karen Jennings & Elizabeth Allmark	ongoing
50	The organisation has sufficient number of trained decontamination trainers to fully support it's staff HAZMAT/ CBRN training programme.		Y		Y				Yes	nil	Karen Jennings	ongoing

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental Health care providers		Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**						**Evidence of assurance**				
51	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	Y	Y	Y	Y	Y		The IOR DVD is on the emergency planning page of the Hub so access to this training is easy. The Trust is 100% compliant in providing basic IOR training to all ED and UCC front line staff. Receptionists are aware of the process for identifying self presenters very quickly. There is an agreement from the AEO that we can do an unannounced presentation of a patient requiring dry decontamination.	nil	Sharon Walford & Karen Jennings	ongoing

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame	N/A - the Trust has a purpose built CBRN unit	
E1.1	Liner	N/A - the Trust has a purpose built CBRN unit	
E1.2	Air inflator pump	N/A - the Trust has a purpose built CBRN unit	
E1.3	Repair kit	N/A - the Trust has a purpose built CBRN unit	
E1.2	Tethering equipment	N/A - the Trust has a purpose built CBRN unit	
	OR: Rigid/ cantilever structure		
E2	Tent shell	N/A - the Trust has a purpose built CBRN unit	
	OR: Built structure		
E3	Decontamination unit or room	Yes	
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)	Yes	
E5	Shower heads	Yes	
E6	Hose connectors and shower heads	Fixed shower units X 4	
E7	Flooring appropriate to tent in use (with decontamination basin if needed)	Solid floor with rubber mats to allow water to drain out of the unit	
E8	Waste water pump and pipe	Yes	
E9	Waste water bladder	Yes	
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).	The Trust have the 23 suits that we have been told we need. 10 X small, 5 X medium, 6 large & 2 X extra large. All suits have been revalidated in May 2016.	
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme	The Trust has 7 training suits, 1 large suit is required to have the requirement of 8.	
	Ancillary		
E12	A facility to provide privacy and dignity to patients	Yes when in the decon unit, not when outside stripping off. Screens were used but blew over several times. This would be a hazard and so fixed screens have been requested from estates	
E13	Buckets, sponges, cloths and blue roll	Yes	
E14	Decontamination liquid (COSHH compliant)	Yes although a very small amount of liquid stays in the sump unit and would require specialist	
E15	Entry control board (including clock)	Yes	
E16	A means to prevent contamination of the water supply	Yes	
E17	Poly boom (if required by local Fire and Rescue Service)	No	
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)	Yes	
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)	Yes	
E20	Waste bins	Yes	
	Disposable gloves	Yes	
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe	Yes	
E22	FFP3 masks	Yes	
E23	Cordon tape	Yes	
E24	Loud Hailer	Yes	
E25	Signage	No, removable signage is required	
E26	Tabbards identifying members of the decontamination team	Yes	
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.	On July 2nd 2016 a 3rd decon training day will be held to increase the percentage of ED staff who can take part in decontamination. Staff will assist Public Health England with collection of samples.	
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)	Yes	
E29	Hooded paper suits	Yes	
E30	Goggles	Yes	
E31	FFP3 Masks - for HART personnel only	Yes	
E32	Overshoes & Gloves	Yes	

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene wi 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipmen				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deploymen				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deploymen training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications iss for MTFA by NARU within 7 days				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures			Y													
19	Organisations ensure that staff view the appropriate DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	NHS Ambulance service providers	Community services providers	Mental healthcare providers	NHS England Regional Teams	NHS England Central Team	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organiations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organiations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organiations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organiations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organiations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organiations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Organiations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y												
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.				Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minute These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minim training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y												
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards a in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deploymen				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications iss for HART by NARU within 7 days.				Y													

The Dudley NHS Foundation Trust

Enclosure 9

Paper for submission to the Board on 1 September 2016

TITLE:	**Complaints and claims report for Q1, ending 30 June 2016**		
AUTHOR:	Maria Smith (Complaints & litigation manager)	**PRESENTER:**	Glen Palethorpe - Director of Governance/ Board Secretary
CORPORATE OBJECTIVE: SO1 – Deliver a great patient experience			

SUMMARY OF KEY ISSUES: Key aspects from this report are:-

Complaints for Q1 ending 30 June 2016

Complaints continue to be complex, requiring extensive investigation and detailed responses. Local resolution meetings continue to be offered prior to the commencement of an investigation, particularly when there has been a bereavement. As previously reported, the local resolution meetings required careful preparation and although they are recorded, a summary is still provided to the complainants. The figures in [ ] refer to Q4.

100% [100%] of complaints received during Q1 were acknowledged within 3 working days

95% [38%] The revised timescale for a reply (within 40 working days) has shown a big improvement in response times during Q1. ***NOTE a response time is indicative only, as the 2009 regulations state that timescales should be agreed with complainants. A local resolution meeting actually brings clarity and realism to these timescales.***

67% [54%] of complaints received and closed were upheld/partially upheld during Q1

9 [2] complainants expressed dissatisfaction with their response (received and investigated) during Q1. Of these - 4 raised further concerns not covered in their first complaint, 1 requested a further review of imaging based on the response the Trust provided, 1 asked why a member of staff had not given evidence during a Coroner's Inquest, 1 requested further assurance of learning referred to in the Tryst response with just 2 who felt the initial response did not answer concerns.

36 [37] local resolution meetings held with complainants during Q1

6 [3] Inquests held and closed during Q1

0 [0] rule 28 - reports on 'Action to Prevent Future Deaths' received from Senior Coroner during Q1

An analysis of the cases referred to the PHSO indicated that 'communication' is an issue included in many of the complaints they investigate.

Claims - Q1

11 [11] CNST claims ***closed*** during Q1

13 [10] CNST claims ***opened*** during Q1

3 [3] Employer's/Public liability claims ***closed*** *during Q1*

2 [1] ***new*** Employer/Public liability claims during Q1

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Domains Safe, effective and caring**
	Monitor	**Y**	**Details: supports effective governance**
	Other **Ombudsman**	**Y**	**The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 No. 309** **0 complaints accepted for investigation by Ombudsman during the quarter**

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
			x
RECOMMENDATIONS: To note details of complaints and claims activity during Q1 ending 30 June 2016			

Key Facts – Complaints, Inquests & Ombudsman

Key facts During qtr/year	Year ending 31/03/15	Qtr 1 ending 30/06/15	Qtr 2 ending 30/09/15	Qtr 3 ending 31/12/15	Qtr 4 ending 31/03/16	Year ending 31/03/16	Qtr 1 Ending 30/6/16
Total number of complaints rec'd within qtr/year	**313** 12 - high 179-mod 122 - low	**70** 5 - high 32 - mod 33 - low	**86** 3 – high 42 – mod 41 – low	**72** 2 - high 35 - mod 35 - low	**66** 2 – high 37 – mod 27 - low	**294** 12- high 146-mod 136 -low	**81** 0 – high 44 - mod 37- low
% Complaints ack'd within 3 working days	100%	100%	100%	100%	100%	100%	100%
% Complaints rec'd and replied within 40 working days	61% "*	44%**	44%**	**25**% ** [see note below]	**38%** [see note below]	**38% ** [see note below]	**95%** [see note below]
Number of upheld/ partially upheld complaints replied within qtr/year	**143*** (46%)	**34***	**60***	**43***	**36***	**173*** (59%)	**54***
Complaints accepted for investigation by PHSO	9	0	2	0	2	4	0
Privacy/dignity incl as a concern in complaint	6	0	0	1	3	4	3
Complaints referring to shared accommodation	0	0	0	0	0	0	0
Complaints incl safeguarding issue	1	0	0	1	2	3	1
Number of meetings held with complainants (% of complaints rec'd)	**71** (23%)	**19** (27%)	**17** (20%)	**28** (38%)	**37** (56%)	**101** (34%)	**36** (44%)
Total number and % of dissatisfied complaints rec'd	20 (6%)	6	1	2	2	11 (4%	**9** (11%)
Total CCG/CSU led complaints	8	3	0	1	3	7	3
New Coroner's cases opened	7	7	1	1	7	16	8
Coroner's Inquests held/closed	18	4	5	0	3	12	6
Coroner's Rule 28 (was rule 43)	1	1	0	0	0	1	0

Note

* Includes c/fwd from previous quarters

** Complainants are opting to attend a local resolution meeting before receiving a response or requesting a meeting instead of a formal response

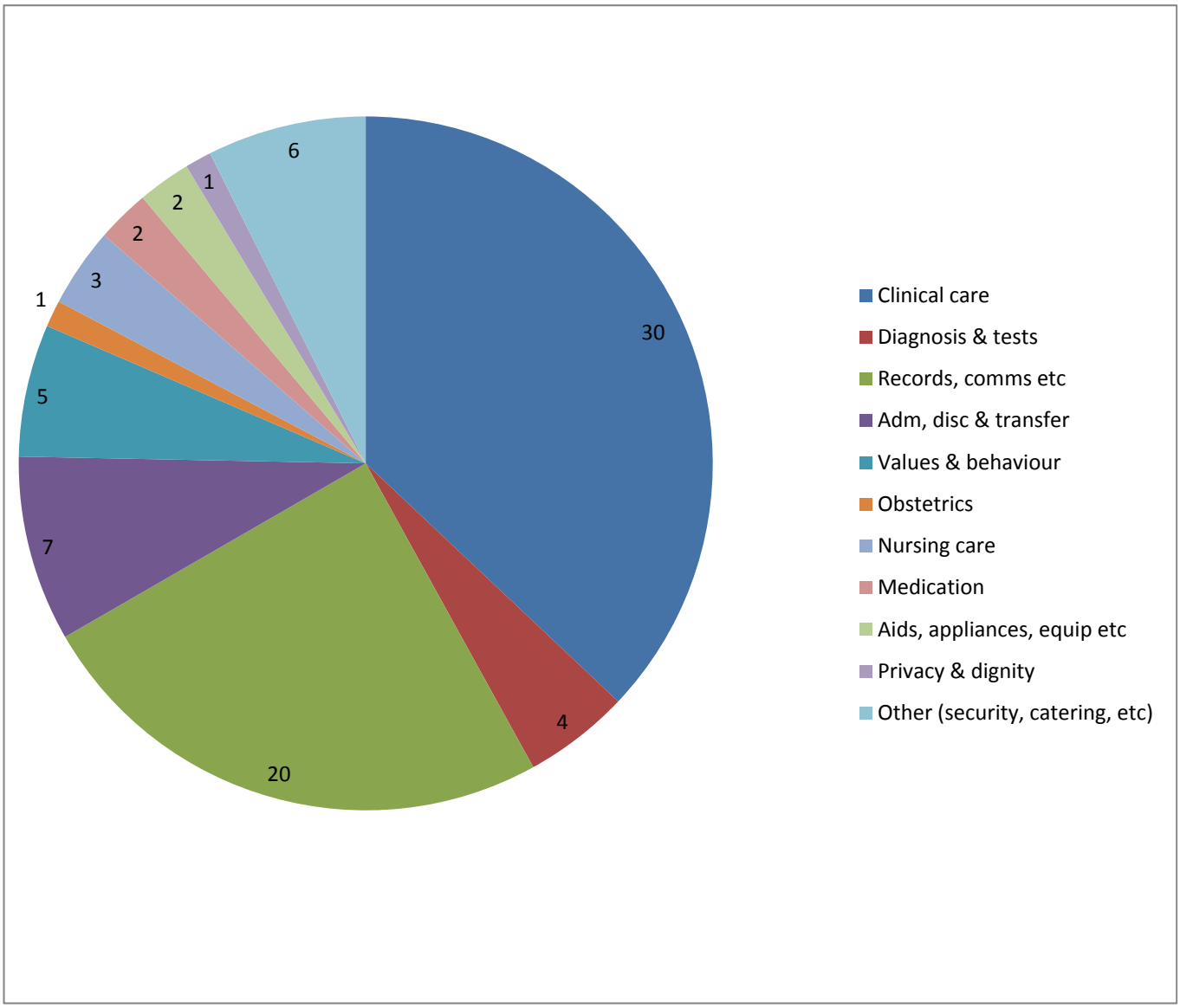
Category * [see note below]	Trust yr ending 31/3/15	National yr ending 31/3/15	Qtr 1 ending 30/6/15	Qtr 2 ending 30/9/15	Qtr 3 ending 31/12/15	Qtr 4 ending 31/3/16	Trust yr ending 31/3/16	Qtr 1 ending 30/06/16
Clinical Care (Assessment/Monitoring)	**134 (43%)**	**45%**	38 (54%)	43 (50%)	23 (32%)	20 (31%)	**124 (42%)**	**30 (37%)**
Diagnosis & Tests	**56 (18%)**	NA	12 (17%)	7 (8%)	8 (11%)	3 (5%)	**30 (10%)**	**4 (5%)**
Records, comms, Information or appts (incl delay)	**17 (5%)**	**22%**	4 (6%)	17 (20%)	18 (25%)	17 (26%)	**56 (19%)**	**20 (25%)**
Admission, discharge & transfers	**33 (11%)**	**5%**	6 (9%)	7 (8%)	8 (11%)	6 (10%)	**27 (9%)**	**7 (9%)**
Values & behaviour of staff (prev 'staff attitude')	**20 (6%)**	**11%**	6 (9%)	2 (2%)	3 (4%)	4 (6%)	**15 (5%)**	**5 (6%)**
Obstetrics	**12 (4%)**	**3%**	3 (4%)	3 (4%)	3 (4%)	7 (11%)	**16 (5%)**	**1 (1%)**
Nursing care (District Nurses)	**2 1%)**	NA	0	0	1 (1%)	1 (1%)	**2 (1%)**	**3 (4%)**
Medication	**13 (4%)**	NA	0	3 (4%)	0 (1%)	4 (6%)	**7 (2%)**	**2 (2%)**
Patient Falls, Injuries or Accidents	**5 (1%)**	NA	1 (1%)	2 (2%)	2 (3%)	0	**5 (2%)**	**0**
Aids, appliances, equipment,	**4 (1%)**	**1%**	0	0	3 (4%)	1	**4 (1%)**	**2 (2%)**
Safeguarding	**1 (1%)**	NA	0	0	1 (1%)	0	**1 (1%)**	**0**
Theatres	**4 (1%)**	NA	0	0	0	1 (1%)	**1 (1%)**	**0**
Privacy & dignity	**6 (1%)**	1%	0	0	1 (1%)	1 (1%)	**2 (1%)**	**1 (1%)**
Pressure ulcer	**2 (1%)**	NA	0	0	0	0	**0**	**0**
Violence, aggression	**2 (1%)**	NA	0	0	0	0	**0**	**0**
Other (security, workforce)	**2 (1%)**	**4%**	0	2 (2%)	1 (1%)	1 (1%)	**4 (1%)**	**6 (6%)**
Total:	**313 (100%)**		**70 (100%)**	**86 (100%)**	**72 (100%)**	**66 (100%)**	**294 (100%)**	**81 (100%)**

Complaints received in Q1 shows an increase over those received in Q2 and Q3, with 'communication' as an area of concern continuing to show an increase.

Note

***** Complaints are allocated to a main complaint category

Analysis of complaints received by category – Q1



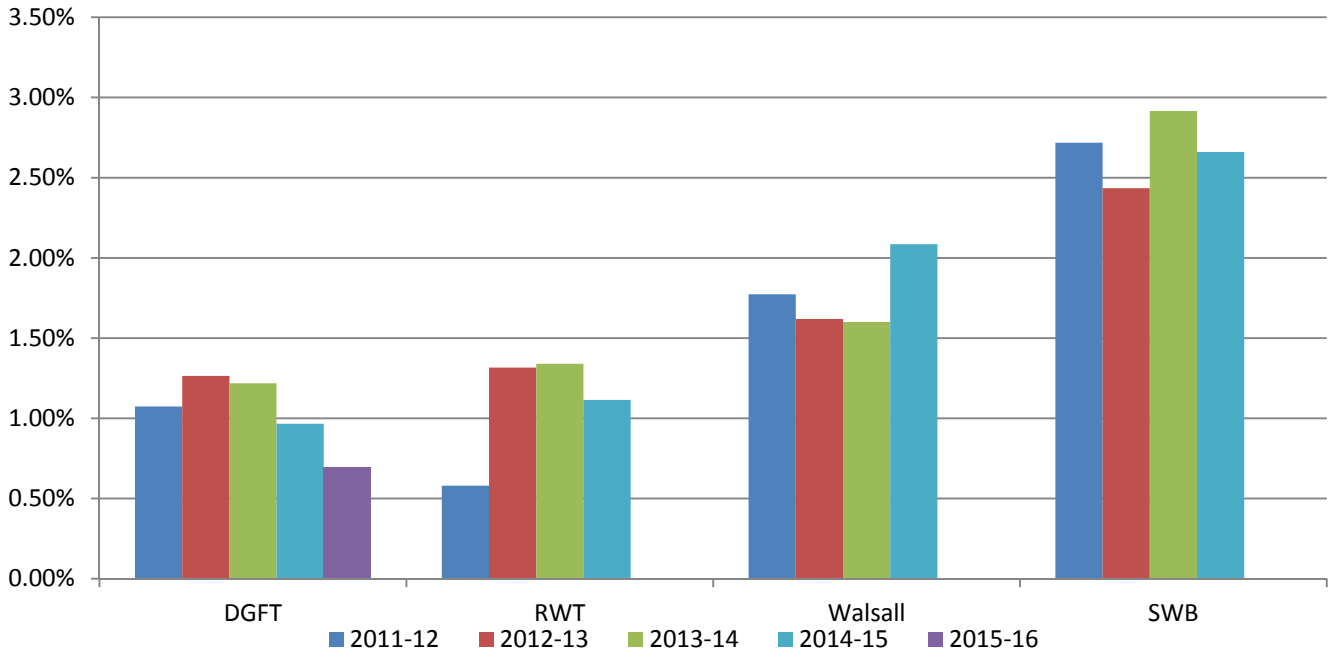
Complaints relating to incidents

15 (18%) of complaints received were linked to a reported incident

Benchmarking - Birmingham & Black Country – Yr ending 31/3/2015 (Yr ending 31 March 2016 not yet available

	Total yr ending 31/3/15	Total yr ending 31/3/16
Dudley and Walsall Mental Health Partnership NHS Trust	94	Data not available
The Royal Orthopaedic Hospital NHS Foundation Trust	105	
Birmingham Children's Hospital NHS Foundation Trust	121	
Black Country Partnership NHS Foundation Trust	137	
Birmingham Women's NHS Foundation Trust	140	
Birmingham and Solihull Mental Health NHS Foundation Trust	163	
Birmingham Community Healthcare NHS Trust	225	
The Dudley Group NHS Foundation Trust	313	294
Heart of England NHS Foundation Trust	1,035	Data not available
Sandwell and West Birmingham Hospitals NHS Trust	837	
The Royal Wolverhampton NHS Trust	365	
University Hospitals Birmingham NHS Foundation Trust	792	
Walsall Healthcare NHS Trust	379	
West Midlands Ambulance Service NHS Foundation Trust	522	
Worcestershire Acute Hospitals NHS Trust	566	

Complaints as percentage of admissions



Complaints as a % of patient safety incidents
Yr ending 31/03/15 (yr ending 31/3/16 not available)

	Complaints	Pt Safety Incidents	% complaints against incidents
The Dudley Group NHS Foundation Trust	313	12401	3%
Sandwell and West Birmingham Hospitals NHS Trust	837	13180	6%
The Royal Wolverhampton NHS Trust	365	9853	4%
Walsall Healthcare NHS Trust	379	10440	4%
Worcestershire Acute Hospitals NHS Trust	566	10070	6%

Complaints as % total hospital activity

ACTIVITY	TOTAL year ending 31/3/15	Total Qtr 1 ending 30/06/15	Total Qtr 2 ending 30/9/15	Total Qtr 3 ending 31/12/15	Total Qtr 4 ending 31/3/16	TOTAL year ending 31/3/16	Total Qtr 1 Ending 30/6/16
Total patient activity	736,510	189260	181895	185460	188840	745455	198194
% Complaints against activity	0.04%	0.03%	0.04%	0.03%	0.03%	0.03%	0.04%

Compliments received during Q1

1647 compliments received during Q1 which equates to 0.8% of patient activity.

Senior Coroner – Inquests held during Q1

6 inquests held
0 rule 28 (formerly rule 43) 'preventing future deaths' letter received from the Senior Coroner

	Total complaints rec'd by PHSO	Total complaints accepted for investigation by PHSO	Complaints part/fully upheld by PHSO	Complaints not upheld by PHSO	Discontinued/ Resolved by PHSO without findings
Q3 2014/5	10	1	0	0	0
Q4 2014/5	11	4	1	1	0
Q1 2015/6	7	1	1	1	0
Q2 2015/6	4	2	3	0	0
Q3 2015/6	3	0	2	0	0
Q4 2015/6	8	3	2	0	1

Benchmarking with other Trusts – Qtr 4

	Total complaints rec'd by PHSO	Total complaints accepted for investigation by PHSO	Complaints part/fully upheld by PHSO	Complaints not upheld by PHSO	Discontinued/ Resolved by PHSO without findings
Russells Hall Hospital	8	3	2	0	1
Heart of England	19	7	2	3	0
Sandwell & West B'ham	24	7	3	5	1
Royal W'ton	16	5	4	2	0
Walsall Healthcare	9	3	2	2	0

The summary analysis of recent investigations carried out by PHSO (over the last 12 to 18 months)

Comp ref	Date complaint rec'd	Category	Upheld	Partly upheld	Not upheld	Report awaited
798	13/05/2012	All aspects of clinical care	✓			
1398	02/05/2013	All aspects of clinical care	Reinvestigating			
1492	17/06/2013	Medical/nursing care		✓		
1587	19/07/2013	Poor pain control		✓		
1828	08/10/2013	Communication/information		✓		
1946	11/12/2013	Delay commencing treatment		✓		
1987	20/12/2013	Values and behaviour of staff			✓	

Comp ref	Date complaint rec'd	Category	Upheld	Partly upheld	Not upheld	Report awaited
2183	13/02/2014	Nursing care		✓		
2136	26/02/2014	Diagnosis			✓	
2314	27/03/2014	All aspects of clinical care		✓		
2360	07/04/2014	Unhappy with diagnosis		✓		
2480	12/05/2014	Delay in diagnosis/treatment		✓		
2577	04/06/2014	Communication/information			✓	
2871	08/08/2014	Communication/information		✓		
3674	22/04/2015	Communication/lack of interpreters	Discontinued – ref back to Trust			
2190	04/01/2014	Clinical care			✓	
3273	10/11/2014	Medical/nursing care				✓
		TOTAL:	**1**	**9**	**4**	**1**

It should be noted that in a number of cases the PHSO's conclusion of upholding or partially upholding the complaint is the same as the view expressed by the Trust in our response to the complainant. This is because in every response, not just those were we do not accept there were any issues or any grounds for their complaint, we signpost the complainant to the Ombudsman if they are dissatisfied with our response.

In respect to the rulings by the Ombudsman in the above timeframe there is only one case where the Ombudsman has ruled against our original response and directed us to take more action. This case however is not resolved as we have provided information to the ombudsman which supported our response and they are now considering that information.

Closed claims – Q1

11 clinical negligence claims closed during Q1 with 5 of these claims resulting in costs be awarded against the Trust

2 personal injury claims closed during Q1 with 1 of these claims resulting in costs be awarded against the Trust

1 public liability claim closed during Q1 with no costs awarded against the Trust

New Claims received during Q1

There have been 16 new claims lodged against the Trust in Q1 but one of these does not relate to the Trust.

The Dudley NHS Foundation Trust

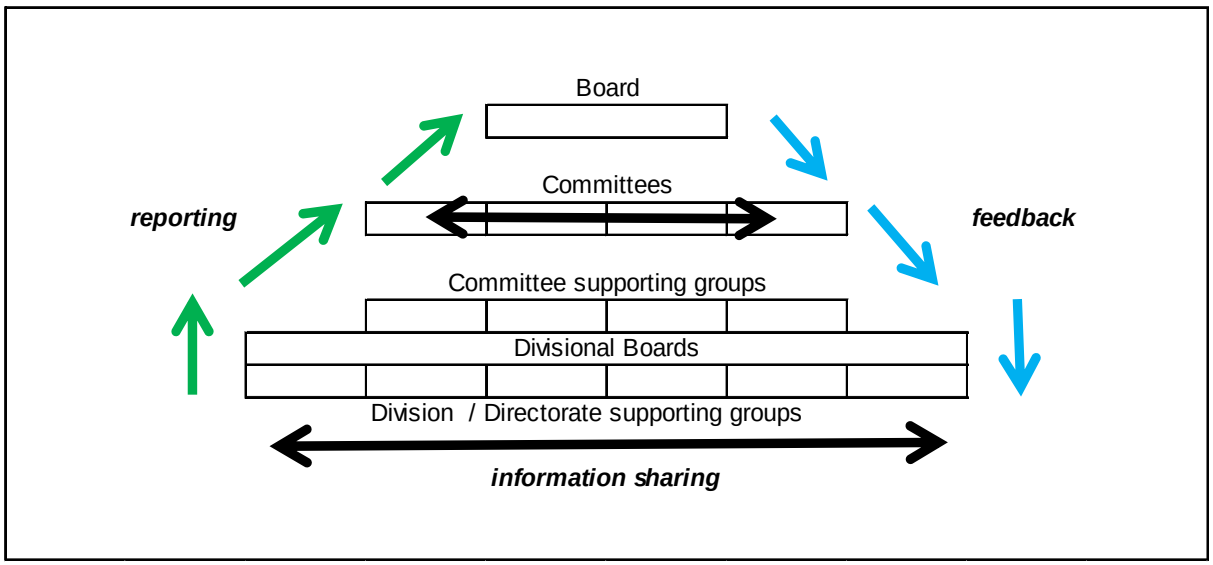
Enclosure 10

Paper for submission to the Board of Directors
1 September 2016

TITLE:	**Board and Committee Meeting Calendar 2017**		
AUTHOR:	**Director of Governance / Board Secretary – Glen Palethorpe**	**PRESENTER**	**Director of Governance / Board Secretary – Glen Palethorpe**
CORPORATE OBJECTIVES: ALL			

Background:

Last year work was done to align the meeting dates of key groups, committees to the dates of the Board meeting calendar to ensure a timely, consistent and complete flow of information to the Board.



The same principles, have been followed for setting the dates of the meeting calendar for 2017. It continues to be recognised, as it was back in February 2015, that there is a small trade off to be made in the dissemination of the final performance report to the Board and the timings of the Finance and Performance Committee and that of the Board itself. Moving the timing of the Board back by a week was considered, but this revised date then cut across other meetings for Board Members which would mean that they may not be able to attend the Board and that consequent impact was felt to outweigh the benefit of the performance report being a to follow item by a couple of working days.

The following calendar is therefore proposed, recognising that the Board Performance Dashboard Report may be a “to follow item” as the main papers are distributed, but would be sent by the Monday of the week of the Board meeting. It is also recognised that the reports from the Committee Chairs would continue to need to be prepared immediately after the relevant Committee meeting to enable their flow to the Board to be timely, however, with the revision to the structure of the Committee Summary Report to the Board this has been achieved in 2015/16.

The Dudley Group NHS
NHS Foundation Trust

Calendar of Board and Committee meetings (including provisional Operational Divisional meetings) for 2017

	Board of Directors £	Board Workshops *	Finance & Performance Committee	Workforce and Staff Engagement	Clinical Quality, Safety & Patient Experience	Charitable Funds Committee	Audit Committee	Council of Governors	Annual General Members Meeting	Medicine and Integrated Care Division	Surgery Division	TEC	IT Steering Group
JAN 2017	5		26		24		24			17	16	19	13
FEB 2017	2	9	23	28	21	23				$21	20	16	10
MAR 2017	2		30		28		21	2		21	20	23	9
APR 2017	6		27		25					18	19	20	13
MAY 2017	4	11	25	16$	23	25	16#	4		16	15	18	11
JUNE 2017	1		29		27					20	19	22	8
JULY 2017	6		27		25				20	18	17	20	13
AUG 2017	3	3	31	22$	29	31	22#			15	14	17	10
SEPT 2017	7		28		26			7		19	18	21	14
OCT 2017	5		26		31					17	16	19	12
NOV 201	2	9	30	28$	28	30	28#			21	20	16	9
DEC 2017	7		21		19			7		$19	18	14	14

# morning meetings
$ afternoon meetings

***** Denotes half day (Board Workshops)
£ preceeding each Board is a NED meeting commencing at 7.45

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: all domains (Safe, Responsive, Effective, Caring and Well-led)**
	Monitor	**Y**	**Details: links to monitor's governance framework**
	Other	**N**	**Details:**

The Dudley Group NHS
NHS Foundation Trust

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	x	x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To approve the proposed calendar of meetings for 2017.

To agree that the Monthly Performance Dashboard Report, where necessary will be a “to follow” item for the Board, with it being issued on the Monday of the week of the meeting.

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 1st September 2016

TITLE:	**End of Life and Palliative Care Strategy Group Report**		
AUTHOR:	**Dr Doug Wulff**	**PRESENTER**	**Dr Doug Wulff**
CORPORATE OBJECTIVE: S01/S02			
SUMMARY OF KEY ISSUES: **Exception report from the End of Life and Palliative Care Strategy Group meeting held on 12th July, 2016.**			

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	Monitor	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			To Note

RECOMMENDATIONS FOR THE BOARD:
To note the assurances received, decisions made/items approved and actions back to the Committee.

Committee Highlights

Committee	Meeting Date	Chair	Quorate	
End of Life and Palliative Care Strategy Group	**12 July 2016**	**Dr Doug Wulff**	**Yes**	**No**
			X	

Declarations of Interest Made
Nil

Assurances Received
Updated assurance on progress of work streams relating to Key Milestones, Concerns, Work Completed, Work Planned: 1 Priorities for Care - assurance received on progress and re-launch of work on 1 July 2016 with positive feedback. 2 Rapid Discharge - meetings currently on hold. Plan to re-launch document and aim to co-ordinate with frail elderly care pathway. 3 AMBER - assurance of implementation although some degree of uncertainty amongst clinicians on implementation in individual cases. Plan to address through the use of stickers. 4 Macmillan Specialist at Home - assurance received through the initial evaluation of pilot, full report to be provided when available. 5 Advance Care Planning - assurance received on provisional agreement for funding documentation. 6 Education - no assurance receive as report not available. An e-learning programme to be progressed. 7 EPaCCS - negative assurance on lack of progress. Discussions now taking place with DGH IT Team. 8 Bereavement - assurance received that booklet ready to go to print. 9 VOICES - assurance received of completion of hospital survey and start of Hospice survey.

Decisions Made / Items Approved
1 End of Life and Palliative Care Implementation Plan draft agreed with recommendations for inclusion of relevant issues raised at End of Life Care Workshop. In particular to include organ donation, children, transitional care and hard to reach groups.
Actions to come back to Committee (items Committee keeping an eye on)
1 End of Life and Palliative Care Implementation Plan. 2 Proposal on utilisation of funds available for Health Care Assistants for End of Life and Palliative Care. 3 Confirm reporting route to Partnership Board as agreed in Terms of Reference.
Items referred to the Partnership Board for decision or action
Assurances received on progress.

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors August 2016

TITLE:	**Six New Requirements in NHS Standard Contracts for Hospitals in Relation to Hospital/General Practice**		
AUTHOR:	**Louise McMahon Divisional Manager Patient Access**	**PRESENTER**	**Paul Bytheway Chief Operating Officer**

CORPORATE OBJECTIVE:
SGO4 - To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO6 - To deliver an infrastructure that supports delivery

SUMMARY OF KEY ISSUES:

- There is a requirement for acute provider organisations to meet 6 new requirements set out in the NHS Standard Contract
- DGNHSFT is fully compliant with 3 requirements, partially complete with 1 and currently non-compliant with 2 requirements
- This paper seeks to offer assurance relating to the areas of compliance and seek approval for suggested process improvements to be developed.

IMPLICATIONS OF PAPER: (*Please complete risk and compliance details below)*

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE COMMITTEE: For information

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

The Dudley Group NHS
NHS Foundation Trust

Improving how hospitals work with general practice – new requirements on hospital in the NHS Standard Contract 2016/17

Background

In July 2016 both CCG and Trust Executives were notified of six new requirements for hospitals being introduced in the 2016/17 NHS Standard Contract.

The letter sent from Mathew Swindells, National Director Operations and Information, NHSE and Robert Alexander Deputy Chief Executive NHSI outlined that;

> *"One of the strongest themes to come out of the research for the Making Time in General Practice report was the unnecessary extra workload".*
>
> *Time taken in setting up and rearranging hospital appointments, as well as chasing up delays in discharge letters and details of changes in medication accounted for 4.5% of GP appointments that could have potentially been avoided.*
>
> *Freeing up this time will enable GPs the ability to see patients more quickly, thereby reducing the likelihood of A&E attendances and emergency admissions."*

The letter states that the six new requirements introduced will enable Trusts to improve communication process between acute and primary care and organisational leads are urged to ensure they are fully implemented in a robust and timely way.

The letter concluded that a working Group, including representatives from NHS England, NHS Improvement, the Royal College of GPs, the British Medical Association's General Practitioners Committee, and the Royal College of Physicians, will be established from September 2016 to drive further action to improve the interface between primary and secondary care.

Dudley Group Position

Initial scoping of compliance against each of the standards indicates Dudley Group to be fully or partially compliant for all but one of the 6 standards. Suggested options for process development or improvement are outlined in the table below (attachment 1).

This paper seeks to give assurance of Dudley Groups current partial compliance against the new standards and to seek agreement to develop processes in order to meet full compliance.

Attachment 1

Six new requirements in NHS Standard Contract for hospitals in relation to hospital/general practice interface

Position as of 24th August 2016

Requirement	Current Position	Required Actions
1. Hospitals cannot adopt blanket policies under which patients who do not attend an outpatient clinic appointment are automatically discharged back to their GP for re-referral. Hospitals must publish local access policies and demonstrate evidence of having taken account of GP feedback when considering service development and redesign.	**Compliant** DG Access Policy currently specifies adult & paeds patients are to be discharged following 1 new or F/U DNA. DNA's for Rapid Access are contacted by Rapid Access team.	Suggested Options: Share current policy with CCG for agreement to continue with one DNA due to negative impact on unfilled slots. Or, Gain agreement to increase to 2 x DNA's before discharge for NP.
2. Hospitals are required to send discharge summaries by direct electronic or email transmission for inpatient, day case or A&E care within 24 hours, with local standards being set for discharge summaries from other settings. Discharge summaries from inpatient or day case care must also use the Academy of Medical Colleges endorsed clinical headings, so GPs can find key information in the summary more easily. Commissioners are also required to provide all reasonable assistance to providers in implementing electronic submission.	**Partially Compliant** Discharge summaries sent within 24 hours.	We are not yet compliant with all specified clinical headings as unable to change until new EPR implemented. Commissioners have approved the current format of the letters for the interim. A solution for ED letters is in development.
3. Hospitals to communicate clearly and promptly with GPs following outpatient clinic attendance, where there is information which the GP needs quickly in order to manage a patient's care (certainly no later than 14 days after the appointment). For 2017/18, the intention is to strengthen this by requiring electronic transmission of clinic letters within 24 hours.	**Partially-Compliant** Big Hand reports indicate – Trust average turnaround = 25 days Worst speciality = 85 days Best speciality = 5 days Some specialities email letters (i.e., Paeds)	EPR solution will improve ability to comply. An interim solution has been identified but requires further project development to; - Identify project lead, - Scope variation in current processing of clinical correspondence, - clarify intended outcomes and project strategy, - Facilitate consultation, workshops, training, testing etc. Suggested Options: Patient Access Division to report via Big Hand system clinic letter performance by speciality and

		monitor Directorate specified improvement plans. Patient Access Division to work with IT to facilitate and support pilot programme for above interim solution.
4. Unless a CCG requests otherwise, for a non-urgent condition directly related to the complaint or condition which caused the original referral, onward referral to and treatment by another professional within the same provider is permitted, and there is no need to refer back to the GP. Re-referral for GP approval is only required for onward referral of non-urgent, unrelated conditions.	**Compliant** (C50% of referrals processed are internal)	
5. Providers to supply patients with medication following discharge from inpatient or day case care. Medication must be supplied for the period established in local practice or protocols, but must be for a minimum of seven days (unless a shorter period is clinically necessary).	**Compliant**	
6. Hospitals to organise the different steps in a care pathway promptly and to communicate clearly with patients and GPs. This specifically includes a requirement for hospitals to notify patients of the results of clinical investigations and treatments in an appropriate and cost-effective manner, for example, telephoning the patient.	**Non-Compliant** Difficult to measure. Routinely copying GP's into every investigation would create extra work, duplication and possibility of confusion.	Suggested Options: Telephone patients with -/ve results. Copy clinic letter to patients. Patient phone in for results or notification of OPA required as with primary care. Patient portal to access -/ve results or notification of OPA required.

The Dudley Gro
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Enclosure 13

Paper for submission to the Board of Directors on *1st September, 2016*

TITLE:	NHS Improvement National A&E Improvement Plan		
AUTHOR:	**Richard Brownhill**	**PRESENTER**	**Paul Bytheway**

CORPORATE OBJECTIVE: S02, S03

SUMMARY OF KEY ISSUES:

A series of mandates have been issued by NHS Improvement as part of the National A&E Improvement Plan. The timelines are short and the intensity of the work is high. Some of the work has already been realised as part of the Quality and Safety in Patient Flow Project but now needs to progress at pace. The attached plan highlights the areas that have been mandated along with an indication of the current risk of not achieving within the required time. Plans need to be in place by November at the latest.

In particular, consultant review within 14 hours post admission is a significant challenge in some specialties. A draft roll out programme of the SAFER bundle has been included but this will require a dedicated resource to ensure it is appropriately embedded. The work aligns to other work including 7 day services and is appropriate to have in place for the winter period.

Without putting these actions into operation there is a risk that the organisation would be criticised for not implementing them, with a risk of not achieving EAS performance.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: Inability to deliver changes at pace mandated by NHS Improvement**
	Risk Register: N		**Risk Score: 16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: (*Please select from the list on the reverse of sheet)*** Safe, Effective , Responsive
	Monitor	**Y**	**Details:** Ensure assurance around EAS planning
	Other	**Y**	**Details:** NHS Improvement compliance

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
x			

RECOMMENDATIONS FOR THE BOARD: The board needs to consider whether it supports all elements of delivery of the planned work and will ensure sufficient supernumerary resource is available to meet the deadlines.

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**

The Dudley Group NHS
NHS Foundation Trust

NHS Improvement National A&E Improvement Plan

Key	In place or easily deliverable		Partly in place		High Risk	

Risk	Improvement Action	Standard	By	Statement	Comments re:risks
	Ambulatory Emergency Care	Ambulatory Emergency Care: All Acute hospitals must have a consultant led AEC service operating at least 10hrs each week day before the	End of **Nov 16**	Ambulatory Care 8am - 9pm 7 days a week. Achieving over 30% of the Acute medical take	Already in place
	Frailty pathways	All Trusts should have consultant led, multidisciplinary frailty teams working the front of the pathway by **Sept 16**	by **Sept 16**	Currently have a Frail Elderly Short Stay Unit (FESU) with a dedicated MDT and a consultant lead. Further plans to enhance consultant presence in the ED	Impact team: social work, therapy and nursing team. Currently also pull patients from the short stay areas
	Improved Flow – SAFER	All trusts must ensure that SAFER is implemented on assessment and medical wards	by **Nov 16.**	Initial improvements evident on ward C3,(significant increase in Discharge) Next ward Roll out draft plan attached SAFERttable.xlsx	Links to resource to deliver – supernumerary team
	Improved Flow – SAFER	Hospitals must ensure	by **Nov 16.**	Has been scoped across	Will require resource and

		that every patient is reviewed every day by a senior clinician on a board or ward round and twice daily consultant rounds must be mandatory on all assessment units		various teams including the consultants 6 weekly report produced in medicine Division to ensure that it is clear who is doing a particular review on specific days	focus to roll out across the Trust to be effective ? secondment of a team/matron for next 3 months for roll out Risks in surgery and paeds 7 days as cover not in evenings
	Improved Flow – SAFER	All patients must have a written care plan that includes clinical criteria for discharge and an expected date of discharge so that multi disciplinary teams have clear goals for each patient. The care plan must be determined and signed off by the consultant within 14 hrs of a patients admission. This standard must also be met	**by Nov 16.**		Risks in surgery and paeds 7 days Clinical criteria plans will need to be audited and continue to be reviewed as part of ongoing 7 day work
	Improved Flow – SAFER	The care plan must be determined and signed off within 14 hours	by **Nov 16.**		Risks in surgery and paeds 7 days as cover not in evenings
	Length of Stay (over 7 day meeting)	All hospitals must establish a systematic process to review the	by **Nov 16**	Discussed with KH – needs to be formalised and set up. List from Info	Will be set up and established – working through methodology

		reason for any inpatient stay that exceeds 6 days.		team weekly and then to address	
	Team resources	All providers must develop an adequately resourced, super-numerary team experienced in improvement methodologies to support delivery of the priorities above. Systems must assess their capacity and capability to deliver and sustain change using a recognised evaluation tool	end of **Aug 16**.	Project plan is currently in place and staff are leading streams of work which support the areas outlined above but are not supernumerary. RB currently offering some supernumerary support	Project Board needs to be fully established and leads need some backfill to ensure timely progress of actions

Paper for submission to the Board of Directors on 1st September 2016

TITLE:	Quarterly Safeguarding Report to the Board of Directors on 1st September 2016		
AUTHOR:	Pam Smith Deputy Chief Nurse	**PRESENTER:**	Dawn Wardell Chief Nurse

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

SUMMARY OF KEY ISSUES:

OFSTED INSPECTION CHILDREN'S SAFEGUARDING
The Trust continues to work with Dudley Safeguarding Children's Board and the local authority to address the actions identified by the Ofsted inspection into Children's Safeguarding in January 2016.

CQC REVIEW OF HEALTH SERVICES FOR CHILDREN LOOKED AFTER AND SAFEGUARDING IN DUDLEY
A review of health services for Children Looked After and Safeguarding in Dudley was undertaken by the Care Quality Commission (CQC) in May 2016. Fourteen recommendations for the Trust to address and eleven recommendations for the Trust to address in partnership with the Clinical Commissioning Group (CCG) and Black Country Partnership Foundation Trust were identified. The Trust's action plan has been submitted to CQC. This will be reviewed at the Internal Safeguarding Board on the 19th September 2016 and a progress update will be reported to the Clinical Quality Safety Patient Experience committee in September 2016. The Trust is also working collaboratively with Dudley CCG and other health providers to address the health economy wide recommendations.

INDEPENDENT MANAGEMENT REVIEW – MATERNITY CASE
All actions on the Trust's Independent Management Review for this Serious Case Review have been completed. The case has been discussed in the media, however, maternity services within the Trust were not discussed.

MAZARS REPORT
An action plan to address the key messages identified in the Mazars report (a review of all deaths of people in receipt of care from Mental Health and Learning Disability services in the Trust between April 2011 and March 2015) has been developed. A summary of the actions taken by the Trust to address the key messages is tabled at appendix one.

TRAINING COMPLIANCE
Safeguarding training compliance is being monitored at the Internal Safeguarding Board monthly. Overall the compliance percentages are in Amber and Red. Recovery plans have been developed by the Named Professionals and actions are in progress in consultation with senior managers to improve the compliance rates.

ACCESS TO CAMHS TIER 4 BEDS
Concerns regarding access to CAMHS tier 4 beds remain. The risk for the Trust continues. All concerns relating to delays in access to Tier 4 services are escalated to the Deputy Chief Nurse, Chief Nurse, Chief Operating Officer and Chief Executive to ensure that additional support from the Safeguarding Children's Board, Dudley CCG, Dudley and Walsall Mental Health NHS Trust and NHS England is requested.

A CAMHS Tier 3.5 service has been commissioned; however, the team is currently being recruited. The lead for the service has been appointed and has met with the Lead Nurse and Matron for Paediatrics to discuss the concerns experienced within the Trust.

GODDARD INQUIRY – Independent inquiry into child sexual abuse
Professor Alex Jay has been appointed as the chair of the inquiry following the resignation of Dame Lowell Goddard QC on 4th August 2016. There has been no further progress with the

inquiry and currently the Trust is required to take no actions.

REVIEW OF SAFEGUARDING SERVICE
The review of the safeguarding service to ensure that lead roles are identified will be completed by the end of September 2016.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** Lack of Safeguarding Intermediate Training Access to CAMHS Tier 4 services
	Risk Register: COR093		**Risk Score:** 8
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details**: Safe and responsive
	Monitor	Y	**Details:** Ability to maintain at least level 1 NHSLA
	Other	Y	**Details:** Care Act: Safeguarding

ACTION REQUIRED OF BOARD			
Decision	**Approval**	**Discussion**	**Other**
		Y	

RECOMMENDATIONS FOR THE BOARD: To note the key issues arising from the Quarterly Safeguarding Report to identify any actions arising for follow up.

The Dudley Group NHS
NHS Foundation Trust

SAFEGUARDING REPORT TO TRUST BOARD
1st SEPTEMBER 2016

1. OFSTED INSPECTION CHILDREN'S SAFEGUARDING

The Trust continues to work with Dudley Safeguarding Children's Board and the local authority to address the actions identified by the Ofsted inspection into Children's Safeguarding in January 2016. The structure of the Dudley Safeguarding Children's Board and its constitution has been reviewed and there have been some changes to the Board's sub groups. The Trust Safeguarding team continue to support the DSCB by attending the board and sub group meetings.

2. CQC REVIEW OF HEALTH SERVICES FOR CHILDREN LOOKED AFTER AND SAFEGUARDING IN DUDLEY

A review of health services for Children Looked After and Safeguarding in Dudley was undertaken by the Care Quality Commission (CQC) on 23rd May 2016 – 27th May 2016. The Trust developed an action plan following the verbal feedback from CQC on 27th May 2016. This was shared at an extra ordinary meeting of the Trust Children's Services Group on the 10 June 2016. Areas are implementing the actions identified in the action plan.

CQC identified fourteen recommendations for the Trust to address and eleven recommendations for the Trust to address in partnership with the Clinical Commissioning Group (CCG) and Black Country Partnership Foundation Trust. A revised action plan has been developed. This will be reviewed at the Internal Safeguarding Board on the 19th September 2016 and a progress update will be reported to the Clinical Quality Safety Patient Experience committee in September 2016.

The Trust has also contributed to the development of the health economy action plan and is working collaboratively with Dudley CCG and Black Country Partnership Foundation Trust to address the recommendations.

3. INDEPENDENT MANAGEMENT REVIEW – MATERNITY CASE

This Serious Case Review was published on the 31st March 2016. The case has been discussed in the media, however, maternity services within the Trust were not discussed. All actions on the Trust's Independent Management Review have been completed.

4. LEARNING DISABILITY

4.1 Learning Disability Strategy

The Learning Disability Strategy action plan has been updated. There are currently 19 actions identified in green, 6 actions which are in amber with work still in progress. A progress update is due to be submitted to the Clinical Quality and Patient Experience committee in September 2016.

4.2 Mazars Report

An action plan to address the key messages identified in the Mazars report (a review of all deaths of people in receipt of care from Mental Health and Learning Disability

services in the Trust between April 2011 and March 2015) has been developed. This is being monitored by the Internal Safeguarding Board and progress will be reported to the Clinical Quality and Patient Experience committee until the actions are fully completed. A summary of the actions taken by the Trust to address the key messages is tabled at appendix one.

5. TRAINING COMPLIANCE

5.1 Safeguarding Children compliance

Safeguarding Children Foundation training compliance is at 89% (381 Staff require training) – Amber.

Intermediate 67.61% (331 staff require training) - Red.
There has been a 2.19% increase in compliance.
Bespoke sessions have been held with ED staff as part of the CQC Looked after and Safeguarding in Dudley action plan.

5.2 Safeguarding Adults compliance

Safeguarding Adults training compliance is 86.29% - Amber

Training compliance has fallen from 86.31% to 86.29%. A recovery plan has been developed by the Named Nurse for Safeguarding Adults. Compliance rates are being monitored and all senior managers and practice development nurses have been made aware of their specialties training compliance and additional training sessions by the Mental Health team are being implemented.

5.3 Mental Health Compliance

Corporate Management - 75% (17 individuals outstanding) – Red
Nursing - 83.93% (188 individuals outstanding) – Amber
Surgery - 79.23% (38 individuals outstanding) – Red
Medicine and Integrated Care - 82.34% (110 individuals outstanding) – Amber
Grand Total 82.73% (353 individuals outstanding) – Amber

May 2016 figures unavailable until 10/6/16.

Training compliance has fallen from 83.82% to 82.73%. A recovery plan has been developed by the Clinical Lead for Mental Health. Compliance rates are being monitored and additional training sessions by the Mental Health team are being implemented.

5.4 Safeguarding Maternity Compliance

Safeguarding Maternity Compliance:
Safeguarding Children Level 1 and 2 - 84% - Amber
Safeguarding Children Level 3 - 63% - Red

Compliance rates are being monitored and staff have been emailed to access safeguarding training. Staff have also been notified via maternity ‘Chatter’ newsletter and by the Matron and Deputy Matrons to access a training session or on line training.

5.5 Learning Disability Compliance

Learning Disability awareness training is not included in Mandatory training. A training programme is being implemented for the Learning Disability champions. The acute liaison nurse for Learning Disability is supporting those champions who have completed training to complete a self-assessment of ward areas.

5.6 Prevent Training compliance
Level 1 and 2
Training compliancy is 90% end of May 2016.

Level 3 WRAP (Workshop to Raise Awareness of Prevent)
Figures will be available at the end of August 2016.
15 WRAP approved trainers now in Trust.
WRAP will be included on the mandatory training programme next month.
Training Needs Analysis is completed.

5.7 Interserve Safeguarding Training Compliance
An update on Interserve safeguarding compliance is due to be reported to the Internal Safeguarding Board in September 2016.

6. ACCESS TO CAMHS TIER 4 BEDS
Concerns regarding access to CAMHS tier 4 beds remain. The risks for the Trust continues to be highlighted at the Safeguarding Children's Board. A CAMHS Tier 3.5 service has been commissioned from Dudley and Walsall Mental Health NHS Trust. The lead for the service has been appointed and has met with the Lead Nurse and Matron for Paediatrics to discuss the concerns experienced within the Trust. A risk assessment, checklist and care plan has been introduced within the Trust to support staff. All concerns relating to delays in access to Tier 4 services are escalated to the Deputy Chief Nurse, Chief Nurse, Chief Operating Officer and Chief Executive to ensure that additional support from the Safeguarding Children's Board, the Clinical Commissioning Group, Dudley and Walsall Mental Health NHS Trust and NHS England is requested.

7. SECTION 11 AUDIT
The Trust's Section 11 audit action plan has been reviewed at the Internal Safeguarding Board and the Trust Children's Services Group in July 2016 to ensure that the actions are being implemented. A progress update will be reported to the Clinical Quality and Patient Experience committee in September 2016.

8. LAMPARD REPORT
The action plan which was developed in response to the Lampard Report which was continues to be monitored at the Internal Safeguarding Board quarterly. Three actions remain in amber as work is still in progress. This will be reported to the Clinical Quality and Patient Experience committee in October 2016.

9. FEMALE GENITAL MUTILATION (FGM)
The FGM working group continue to progress work to raise the profile of FGM within the Trust. Progress continues to be reported to the Clinical Quality and Patient Experience committee.

10. GODDARD INQUIRY – Independent inquiry into child sexual abuse
Professor Alex Jay has been appointed as the chair of the inquiry on the 11th August 2016 following the resignation of Dame Lowell Goddard QC on 4th August 2016. In May/June 2016 the inquiry invited applications for core participant status in relation to seven investigations and a large number of applications were granted in relation to each of the investigations. There has been no further progress with the inquiry and currently

the Trust is required to take no actions. The inquiry will continue to be monitored at the Internal Safeguarding Board to ensure that any actions identified for acute Trusts will be implemented.

11. REVIEW OF SAFEGUARDING SERVICE

It is anticipated that the review of the safeguarding service to ensure that lead roles are Identified for Female Genital Mutilation (FGM), Child Sexual Exploitation (CSE) and Domestic abuse will be completed by the end of September 2016.

12. ANNUAL SAFEGUARDING REPORT

The annual safeguarding report for 2015/16 in the process of being finalised and will be presented to the Clinical Quality Safety and Patient Experience committed in September 2016.

Pam Smith
Deputy Chief Nurse
24th August 2016

The Dudley Group NHS
NHS Foundation Trust

APPENDIX ONE

MAZARS REPORT 2015

ACTIONS UNDERTAKEN BY DUDLEY GROUP NHS FOUNDATION TRUST

The actions taken within Trust are reflected in the table below with the overarching support of the Learning Disability Strategy. The key principles of Choice Rights Independence and Inclusion enable people with a learning disability to access health provision to meet their needs.

Key message	Actions taken by Dudley Group
A lack of transparency in investigations into deaths in detention or at times any investigation.	Dudley Group has a well-established process for reviewing deaths in Trust .The Mortality panel reviews all deaths in Trust. The Trusts Mortality Tracking System (MTS) allows all information and documentation surrounding each individual death to be readily accessible from one place so that it is ready for review and audit by clinical staff.
A lack of challenge in investigations into death and poor quality reporting	Internal Learning disability Mortality review panel established- reviewing all deaths against the identified criteria of premature death in the Confidential Enquiry (CIPOLD)as below. There has been an internal audit commenced following the recommendations of the Learning Disabilities Mortality Review (LeDeR) Programme –Bristol University. Initial scoping has established that of the 16 (known) deaths within Dudley Borough of people with a learning disability between April 2015 and April 2016 - 12 of these deaths occurred in Dudley Group. This cohort of 12 patients will form the basis of the investigation of the learning disability mortality panel in Trust.
Early deaths of people with a Learning Disability, which are, on average, younger than the CIPOLD cohort.	All deaths of patients who are flagged on Trust IT systems as having a learning disability are reviewed in line with the 11 key recommendations from the CIPOLD report. **Delays in a correct diagnosis being made, this included** • Problems with the investigations • Patient died with undiagnosed serious illness • Concerns of family/paid cares not being taken seriously • Problems with referral to specialist • Misdiagnosis • Other delays in diagnosis • Symptoms/events in hindsight should have been investigated but were not • Investigations conducted but no diagnosis

	Delays in treatment options • Problems with giving and receiving treatment • Problems with the treatment itself • No treatment given
A lack of joined up health and social care provision and adjustments for people with both Learning Disability and Mental Health needs.	Best Interest meeting guidance written and used within Trust to support patient who have been assessed as lacking capacity to consent to the treatment options offered to them. Best interest meetings held regularly in Trust often in partnership with social care and social care providers to enable all aspects of the patients best interest to be established. The use of care providers own risk assessment documentation for patient's whose behaviour can become challenging has ensured a joined up approach for these very complex patients.
Little involvement of families in investigations including in inpatient deaths	The Trust has a robust Duty of Candour policy ensuring that patients, families, carers and staff are given full information and support in the event they have been the subject of/or are involved in an event where they have been harmed.
Hospital liaison services including learning disability liaison nurses, are an important aspect of ensuring reasonable adjustments are made to make acute care a safe place for people who cannot communicate and whose behaviour can become challenging when either in pain or in a strange environment. A number of cases reviewed highlighted the role of this service and the need to ensure joint decision-making including when making best interest decisions.	Complex admissions for surgical intervention or diagnostic procedures are very carefully planned for patients whose behaviour can become challenging. Reasonable adjustments are made to enable person centred care to be delivered for patients- the day surgery unit in Trust have been very instrumental in this with many examples of how careful planning between day surgery, the learning disability liaison nurse and social care providers has meant that some of the most complex, challenging patients have received safe appropriate and timely care. There has been recognition within the Black Country health economy of the excellent practice within the Trust within the Anaesthetic department of the application of the Mental Capacity Act 2005.
A lack of advocacy for vulnerable people in a number of 'groups'.	Close working links are established with the local advocacy services in Dudley. This includes the use of IMCA services for serious medical decision making and the use of Advocacy within the Care Act 2014
Delays in treatment by the health system in responding to the needs of people with a Learning Disability.	The use of the Mental Capacity Act 2005 to support patients with a learning disability is promoted through the mandatory training programme. This is incorporated within the

	Mental health awareness mandatory session. This supports clinical staff in the decision making process for patients with a learning disability and helps to reduce delays in treatment.
A number of incidents in which the physical care made available to people with a mental health problem and or a learning disability was insufficient and which should be subject to review and closer monitoring	Teaching to clinical staff provided by the learning disability liaison nurse highlights the danger of diagnostic overshadowing of patients with a learning disability. The learning disability awareness sessions are extended to all junior doctors, newly qualified nurses, Band 6 nurse development programme, Clinical support workers and student nurse. Ad Hoc sessions are also delivered to ward areas. The learning disability CQUINs of 2013/14 and 2014/15 were delivered to provide awareness of the needs of people with a learning disability when they came into Trust.

Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 1st September 2016

TITLE:	**Workforce & Staff Engagement Committee Meeting Summary**		
AUTHOR:	Andrew McMenemy, Director of Human Resources	**PRESENTER**	Julian Atkins– Committee Chair

CORPORATE OBJECTIVES

The assurance and actions from the Workforce & Staff Engagement Committee were consistent with the following Corporate Objectives:

- Be the place people choose to work;
- Drive service improvement, innovation and transformation; and
- Plan and deliver a viable future.

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	**Y**		**Risk Description: COR85, NO32 and COR109.**
	Risk Register: Y		**Risk Score: 20, 16 and 20.**
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.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	24th August 2016	Julian Atkins	**yes**	**no**
			Yes	

Declarations of Interest Made
None

Assurances received
1. The Committee provided an update on the forthcoming National Staff Survey due to commence on 3rd October 2016 for a period of 8 weeks. The proposal put forward was to consider additional questions within the survey directly linked to our values and employee well-being. In addition a report was provided on Staff Friends and Family for Q1. This demonstrated continued positive feedback with respondents recommending the Trust as a place to work rising from 75% to 78% and those recommending the Trust as a place to receive care reducing slightly from 89% to 88%.
2. A report was received on progress for Q1 objectives indicated in the Trust People Plan. On the whole the majority of actions were on track with exceptions indicated associated to roll out of Allocate, recruitment plans and mandatory training. It was recognized that greater focus would be associated with the People Plan in order to support the areas of priority regarding the workforce and also demonstrate tangible outcomes as evidence of progress.
3. An encouraging report was provided regarding the utilization of apprenticeships in the Trust with the Committee supporting further developments in order to be cost effective alongside the levy as well as supporting hard to fill areas within our workforce.
4. The workforce key performance indicators continued to demonstrate good performance with sickness rate, improvements in turnover rate alongside continued concerns in relation to compliance for mandatory training and appraisal. However, confirmation was provided by the HRD regarding a new forum to support better outcomes for mandatory training as an immediate priority. The report on staffing indicated some concerns as a significant gap in the workforce was demonstrated between funded establishment and staff in post. It was agreed that this required further analysis and explanation working alongside the finance team.
5. An action plan was provided to support the forthcoming flu vaccination programme as well as the staff well-being initiatives. These were within the context of the CQUINs associated to these areas and it was recommended that a

business case was developed to provide some project support in order to achieve the required levels expected in order to support the receipt of the £664,934 funding that is available.

6. A review of nursing specific recruitment provided some encouragement as the predicted level of vacancies as at July 2016 were lower than expected. The Chief Nurse commented that the nursing division struggles to cope with vacancies over a threshold of 50. Despite vacancies being less than expected therefore, the Committee recognised and were concerned that current vacancies are more than double this figure. In addition an update was provided on Physician associates and there were some concerns that we may not be realizing our full potential in this area.
7. The Committee was presented with assurance on the implementation progress alongside the junior doctor contract with a request that further analysis was required for the next meeting that indicated specific risks, costs and mitigations.
8. An update was provided with the actions associated to Health & Safety Group with confirmation of agreed terms of reference and assurance provided regarding COSHH assessments and reclassification of Formaldehyde.
9. Assurance was provided regarding the revalidation process for medical staff within the annual report for medical appraisal and revalidation that indicated strong performance at the Trust.

Decisions Made / Items Approved

1. The current terms of reference were approved and agreed.
2. To increase the frequency of the meetings from quarterly to bi-monthly based on the significance of the workforce agenda and priorities and how these have an impact on the Trust.
3. That further work would be undertaken to determine where vacant posts could be considered alongside alternative workforce solutions with an emphasis on apprentices and physician associates.
4. The Committee ratified the following policies:
    - Extension Lead and Portable Appliance Policy;
    - RIDDOR Policy;
    - Health & Safety Risk Assessment Policy;
    - Stress Management and Risk Assessment Policy.

The annual leave policy was agreed in the most part but the HRD indicated further revision of the section associated to carry forward of leave in order that this adequately addressed the financial savings associated with this control. This was agreed in principle.

Actions to come back to Committee (items the Committee is keeping an eye on)
1. It was agreed that greater degree of focus was required within the Trust People Plan and for this to be reviewed by the new Director of HR and presented at the next meeting. 2. The continued review and monitoring of nursing vacancies taking consideration of assumptions of recruitment and the expected positive impact on agency and bank expenditure. 3. The Committee requires further analysis on particular parts of the workforce performance and in particular the funded establishment figure presented alongside the staff in post.
Items referred to the Board for decision or action
To increase the frequency of the meetings from quarterly to bi-monthly based on the significance of the workforce agenda and priorities and how these have an impact on the Trust.