The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 3 November, 2016 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	9.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	9.30
3.	**Announcements**		J Ord	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 6 October 2016	Enclosure 1	J Ord	To Approve	9.30
	4.2 Action Sheet 6 October 2016	Enclosure 2	J Ord	To Action	9.35
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Harrison	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Chief Nurse Report	Enclosure 4	D Wardell	To Note & Discuss	10.00
	7.2 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 5	D Wulff	To Note & Discuss	10.10
	7.3 Annual Plan Quarter 1 and 2 Report	Enclosure 6	L Peaty	To Note	10.20
	7.4 Complaints and Claims Report	Enclosure 7	G Palethorpe	To Note	10.30
	7.5 BCA Report	Enclosure 8	P Harrison	To Note	10.40
	7.6 Corporate Risk Register/Assurance Framework	Enclosure 9	G Palethorpe	To Note	10.50
	7.7 End of Life Care Report	Enclosure 10	D Wulff	To Note	11.00
8.	**Finance and Performance**				
	8.1 Cost Improvement Programme and Transformation Overview Report	Enclosure 11	A Gaston	To Note	11.10
	8.2 Finance and Performance Committee Exception report	Enclosure 12	J Fellows	To Note & Discuss	11.20
9.	**Any other Business**		J Ord		11.30
10.	**Date of Next Board of Directors Meeting** 9.30am 1 December 2016 Clinical Education Centre		J Ord		11.30

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		11.30

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 6th October, 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
Doug Wulff, Non Executive Director
Ann Becke, Non Executive Director
Jonathan Fellows, Non Executive Director
Paul Harrison, Chief Executive
Dawn Wardell, Chief Nurse
Matt Banks, Medical Director

In Attendance:

Helen Forrester, EA
Glen Palethorpe, Director of Governance/Board Secretary
Andrew McMenemy, Director of HR
Liz Abbiss, Head of Communications and Patient Experience
Jacqui Howells, Learning Disabilities Nurse (Item 16/094)
Julian Sonksen, Organ Donation Clinical Lead (Item 16/096.1)
Andrew Whallett, Head of Medical Education (Item 16/096.6)
Paul Stonelake, Responsible Officer (Item 16/096.7)
Carol Love Mecrow, Speak Up Guardian (Item 16/096.9)
Louise McMahon, Patient Access Manager (Item 16/096.10)
Steve Gaskin, Outpatients Transformation Project Manager (Item 16/096.10)
Amanda Gaston, Head of Service Improvement (Item 16/097.1)

16/089 Note of Apologies and Welcome
9.32am

Apologies were received from Anne Baines and Paul Bytheway. The Chairman welcomed Jacqui Howells, Learning Disabilities Nurse, who was attending Board for the Patient Story.

16/090 Declarations of Interest
9.33am

The Chief Executive confirmed that he was married to a local GP. The Board considered this declaration and agreed that there were no decisions that were planned to be made for which this may cause a potential for any conflict. It was noted that this should be a standing declaration but would be reviewed against the agenda items for any potential conflicts.

There were no other declarations of interest.

16/091 Announcements
9.34am

The Chairman and Board voiced their heartfelt thanks to Paula Clark for her hard work and commitment to the Trust over the last 7 years and wished her well in her new role at Stoke.

The Chairman welcomed Paul Harrison to his first meeting as Chief Executive and Matt Banks as Medical Director.

16/092 Minutes of the previous Board meeting held on 1st September, 2016 (Enclosure 1)
9.37am

Dr Wulff, Non Executive Director, commented on page 2, 5th paragraph the second last word was misspelt and should read "bring to bear from their work". The Chairman commented that on the same page, 6th paragraph, there should be a space between "any supplier".

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

16/093 Action Sheet, 1st September, 2016 (Enclosure 2)
9.33am

16/093.1 Quarterly Safeguarding Report

The Chairman confirmed that the Board wanted a letter to be sent to NHSI regarding Tier 4 CAHMS beds. The Chief Nurse and Chief Executive to meet to progress this before the next Board meeting.

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

Chief Executive and Chief Nurse to meet to produce a letter to NHSI regarding Tier 4 CAHMS beds prior to the next Board meeting.

16/094 Patient Story
9.35am

Liz Abbiss, Head of Communications and Patient Experience, presented the patient story. The video was of the father of a child with severe autism who had been treated at Russells Hall since birth and diagnosed with autism at the age of two years.

The father had found the initial care by the Trust not to be suitable for a child with his son's disabilities.

The father was extremely happy with the Trust's recent progress and commented that a huge culture change has taken place within the organisation in terms of care for children with disabilities.

Mrs Becke, Non Executive Director, commented that it was very important not to disregard the role of the parent in discussing the clinical care of their children.

The Chief Executive confirmed that the Trust should also investigate the possibility of providing outpatient appointments in the child's own environment e.g. the school setting. The Chief Nurse confirmed that the Trust was looking at the provision of outreach clinics.

Dr Wulff, Non Executive Director, commented that lessons from this patient story could also be transferred to other patient groups, in particular care of the elderly/dementia patients. The Chairman recognised the work that had already been undertaken by the Trust for patients with Dementia.

The Medical Director commented that Consultants need to continue to work on individualising patient care.

The Chairman and Board noted the story content and the significant change in the patient's experience at the Trust and thanked Jacqui Howells for the hard work she had put into this. The Chief Nurse confirmed that she would share the action plan with her clinical colleagues.

16/095 Chief Executive's Overview Report (Enclosure 3)
9.45am

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

- **Friends and Family:** The detailed report had been presented to the Finance and Performance Committee. The Trust continues to perform well in most areas in respect of the strong feedback provided albeit the numbers providing the feedback has reduced in some areas.

- **Industrial Action Assurance:** The Chief Executive confirmed that strike action had been suspended. The BMA had recently written to the Trust regarding actions required before implementation of the new contract.

- **Update from September Patient Story:** This was in response to the issues raised in the previous patient story about the community equipment stores.

The Chairman and Board noted the report.

16/096 Patient Safety and Quality

16/096.1 Organ Donation Annual Report (Enclosure 4)
9.55am

Dr Sonksen, Organ Donation Clinical Lead presented the Organ Donation Annual Report, given as Enclosure 4.

Dr Sonksen briefed the Board on Donation activity within the Trust. The Board noted that the embedded Specialist Nurse had now taken up a new role elsewhere. The Trust had discussed the role of the embedded nurse within NHS Blood and Transfusion, who due to their own financial constraints are looking to centralise specialist nurse provision. This Black Country resource would now be based at New Cross Hospital, with "call off" arrangements for Dudley and Walsall.

There had been no successful donor outcomes during the previous year.

There were only 2 potential patients suitable for donation after brain death and both of these had been referred to the specialist nurse but the actual donation was not able to be progressed for good reason.

There had been 12 potential patients suitable for donation after circulatory death and 75% of these had been referred to the specialist nurse. None had progressed to an actual donation, again for good reasons.

There had been an increase to 27% of our population signing on to the Organ Donation Register against the national figure of 17%.

The Chief Nurse suggested that the Trust could look at the existing competencies of its own nursing teams in relation to organ donation and communication with relatives which may help families in these difficult times. The Board agreed this was worth undertaking, although the support of the Specialist Nurse could provide should always be part of those conversations with families.

Chief Nurse to look at the competencies of the nursing teams with respect to being able to support the communication with families in relation to organ donation

The Chief Executive stated that it was positive to see the work being undertaken with ethnic minorities in respect of Organ Donation.

Mrs Becke, Non Executive Director, commented that the Trust still needs to find a prominent site in the hospital for the small Organ Donation statue.

The Chairman and Board noted the report and confirmed that the Trust continues to hold its Organ Donation Committee meetings on a quarterly basis.

16/096.2 Chief Nurse Report (Enclosure 5)
10.05am

The Chief Nurse presented the Chief Nurse Report given as Enclosure 5.

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 19 cases to date in 2016/17, 4 of these cases were associated with a lapse in care at the Trust, 4 had been attributed to no lapse at the Trust. There are still 11 cases yet to be determined.

Norovirus: No cases to note.

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

- Amber shifts (shortfall). Total figure for the month was 44 which is down from the last month (70), but in each case the ward was safe.

- The RAG rating system had been rolled out across the wards. 6 red shifts were identified utilising this methodology for that period but in each case the risk was managed within the shift, by redeploying staff.

- The collection of Care Hours per Patient Day (CHPPD) data had commenced in May and will be more detailed in future reports.

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

- Two wards have escalations at level 4 and two wards have escalations at level 3. Improvement had been seen, with no red category areas being identified from these audits. More intensive support had been provided to wards. This has seen the appropriate change in results, which indicates the escalation process is working.

The Chief Nurse presented an update on Recruitment, including:

- Registered Nurse vacancies are still in excess of 100.
- Existing recruitment streams are continuing with limited success.
- New English language tests have resulted in a reduction in availability of NMC registered EU nurses and made both EU and non EU recruitment increasingly challenging.

Mr Miner, Non Executive Director, asked about the C.Diff target and what the forecast trajectory is. The Chief Nurse confirmed it is difficult to be certain because of the backlog in cases but initial views show a positive trajectory.

The Director of Finance and Information asked about the appointment of the Philippono nurses, and suggested moving current staff within the Trust by using the red, amber, green dashboard. This might help with agency usage.

The Chief Nurse confirmed that we were expecting the Philippono nurses to join the Trust in March and this was as a result of the different elements of the recruitment process taking longer than originally planned.

The HR Director suggested that the Trust needs to consider where to focus its nurse recruitment efforts and there may still be more that could be done on local recruitment.

Mr Atkins, Non Executive Director, stated that the Trust has spent considerable time and energy on overseas nurse recruitment and it should follow through this work.

The Chairman asked that the Directors of Finance, HR and Chief Nurse to meet to discuss and understand the best way forward for the Trust in terms of nurse recruitment.

The Board noted that there was also some room for improvement in terms of the movement of staff by using the red, amber, green dashboard.

The Chairman and Board noted the report and asked that the Finance and Performance Committee have a deep dive into nurse recruitment at its meeting at the end of October.

The Director of Finance, Director of HR and Chief Nurse to meet to look at nurse recruitment.

The Finance and Performance Committee to undertake a deep dive on nurse recruitment at its meeting at the end of October.

16/096.3 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6)
10.15am

Dr Wulff, Committee Chair, presented the Clinical Quality, Safety and Patient Experience Committee Exception Report, given as Enclosure 6. The Board noted the following key areas from the previous Committee meeting:

- Concern was noted around the drop in performance in TIA and VTE assessment. The Committee had asked the team to attend and explain the issues. A change had been identified in the definition of the indicator for TIA assessment and also a high level of poor referrals and the Trust was seeing double the number of referrals to the national average. People were using the service as a quick way into Neurological assessment. Work is being undertaken by the Trust with regard to this. An action plan had been produced and will come back to the Committee at the end of October. For VTE risk assessments an internal audit report was presented to the Audit Committee and individual ward dashboards had been established. The Committee had received assurance from the team and the plans in place. Mr Miner, Non Executive Director, raised issues around data quality in both of these areas and commented that these problems need to be rectified and that his Committee had tasked Internal Audit to follow up on management's delivery of the agreed actions in the area of data quality.

- The Committee also had concerns around policy reviews that were out of date. 18 policies had exceeded their review date with 12 of these going to the Policy Group on 30th September, 2016. This left only 6 policies for review at the meeting on 10th October, 2016. The Board noted that the Trust will be have an improved position by the next meeting.

The Chief Executive raised the excellent performance around mortality indicators. The Chairman confirmed that she was meeting with the Chief Executive and Dr Wulff to look at the format of the Chair/Chief Executive mortality meetings. The Chief Executive commented that the Trust needs to seek active CCG/GP engagement.

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

16/096.4 Audit Committee Summary Report (Enclosure 7)
10.25am

Mr Miner, Committee Chair, presented the Audit Committee Summary Report given as Enclosure 7.

The Board noted the following key areas:

- The Trust system ensuring its submitted reference costs are compliant was good and the external review has verified the Trust's systems as compliant with required guidance.

- The Committee had approved a change to the accounting policy for PFI buildings and this will now exclude VAT. This will bring a benefit in reduced depreciation costs.

- The issue of data quality on VTE and TIA had been discussed and the actions agreed by management in respect of the red opinions given by internal audit are being followed up with vigour.

- There were a number of outstanding internal audit actions which were being escalated with the Executive Team.

- The Committee were content with the Trust's Risk and Assurance Register.

- The Committee asked that data quality was brought to the Board's attention for follow up by the Executive Team. The Director of Governance/Board Secretary confirmed that the Executive Team had already had discussions on data quality.

The Chairman and Board noted the report and the items referred to the Board.

16/096.5 Charitable Funds Committee Summary Report (Enclosure 8)
10.35am

Mt Atkins, Committee Chair, presented the Charitable Funds Committee Summary Report, given as Enclosure 8.

The Board noted the following key issues:

- The Committee was due to receive a presentation from 2 fund holders on their spending plans. They unfortunately could not attend and the presentations had been carried forward to the November meeting.

- The Board noted that fund spending had improved.

- The Committee received the Fundraisers update and noted that income and expenditure was to plan.

- The Charity Football match had taken place and had been very successful.

- A Charity dinner is taking place the following Saturday and tickets were still available.

- The Charity hub in reception is being developed and will have a modest charging system for third parties.

- Charity financial balance stood at £2.3m.

- General fund balance stands at £250k.

- The Committee noted that there was no policy for the support of the long service recognition events and agreed to the provision of £150 charitable fund monies to provide catering for long service retirement events.

- The Committee approved the use of charitable funds for the winter flu fighters campaign.

The Chairman asked about the potential for the Charitable Funds Committee to consider providing funding for educational requirements. The Director of Finance and Information confirmed that this will be discussed at next Committee meeting.

The Chairman and Board noted the report.

The use of Charitable Funds for educational requirements to be discussed at the next Committee meeting.

16/096.6 Medical Education and Training Update (Enclosure 9)
10.45am

Dr Whallett, Head of Medical Education presented the Medical Education and Training Update, given as Enclosure 9.

Dr Whallet confirmed that the GMC look at Board minutes to see where Medical Education has been discussed.

The Board noted that the GMC had released a document on Promoting Excellence: Standards for Medical Education and Training. This came into force in January 2016. It is a single set of standards and requirements for all stages of medical education and training, with five themes which are all centred around patient safety. The themes have been mapped to the Trust's objectives as displayed in the table in the report.

The Director of HR raised Physicians Associates and commented that he had been asked by a Governor whether the Trust was taking the use of Physicians Associates seriously. Dr Whallett confirmed that the Trust was investing a considerable amount of work into the Physicians Associates programme.

The Chief Executive stated that the Trust must ensure it has the capacity to train Physicians Associates sufficiently.

Dr Banks commented that the role of Physicians Associate does not appear to have reached maturity and it needs to be strategically nurtured.

Mr Atkins, Non Executive Director, raised the Trust's association with Birmingham Medical School and asked how many graduates the Trust takes. Dr Whallet confirmed that a sizeable proportion of the graduates come to Dudley.

The Chairman and Board noted the report and the Medical Education achievements made by the Trust.

16/096.7 Medical Appraisal and Revalidation Annual Report (Enclosure 10)
10.55am

Mr Paul Stonelake, Responsible Officer, presented the Medical Appraisal and Revalidation Annual Report, given as Enclosure 10.

The Board noted that the role had now been moved away from the Medical Director.

Mr Stonelake commented that moving the role gave the Trust more opportunities to focus around Medical Revalidation improvement options going forward.

A Medical Revalidation Group is being established which will meet monthly and the Trust needs to look at the reporting structure for the Group. A sub group will also be established.

The Board noted that policies will be reviewed as a result of the change to role responsibilites.

The Chairman and Board noted the report and work to be undertaken to streamline policies and processes. The Board noted the Governance hierarchy contained within the report.

The Medical Director and Responsible Officer to meet to look at the approach following the role changes

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The Medical Director and Responsible Officer to meet to look at the Trust's approach to Revalidation following the role changes.

16/096.8 People Plan – Workforce Strategy Update (Enclosure 11)
11.05am

The Director of Human Resources presented the People Plan – Workforce Strategy Update Report, given as Enclosure 11.

The Board noted the following key issues:

- A revised People Plan will be presented to the Workforce Committee in November.
- A Mandatory Training review is taking place and will provide better infrastructure for the Trust in its delivery of this training.
- A review of the Trust's bank process is also being undertaken.
- Apprentice performance is good at the Trust and the target for the year is 100 placements.

Mr Miner, Non Executive Director, asked what the Trust would look like as a result of the People Plan. The HR Director confirmed that it is good to have skills available internally and an effective talent management approach. However, it is sometimes important to bring in new external skills.

The Director of Finance and Information asked about the Apprentice Levy for the following year and that it will cost the Trust £900k. The Director of HR confirmed that the Trust needs to achieve its target of 120 Apprenticeships as a minimum but this might not mean there would be a full return of the £900k levy.

Mr Atkins, Non Executive Director, commented on cultural values and that how this needs to be protected and promoted within the People Plan. The Director of HR confirmed that it would be.

The Chairman and Board noted the report and that a full report would be presented to the December Board.

Full People Plan/Workforce Strategy Report to be presented to the December Board.

16/096.9 Freedom to Speak Up Guardian Report (Enclosure 12)
11.15am

Carol Love-Mecrow, Freedom to Speak Up Guardian presented her Report, given as Enclosure 14.

Carol provided an update following her first 6 months in the role, including the following key issues:

- The Trust has two raising concerns policies, one for staff, and one for management on dealing with concerns raised.

- Carol is currently working with the Communications Team to update the raising concerns page on the hub.

- The table on page 4 of the report shows concerns raised from May to September, 2016. 4 concerns had been raised in May, 5 in June and no concerns raised from July to September. Two concerns had been raised to date in October. The Board noted that the majority of concerns did not relate directly to lapses in patient care.

- Carol confirmed that her dual role had been difficult to balance due to workload during the summer period but was now proving easier to manage.

- Future plans for the role include undertaking evaluation and making the role more visible around the Trust.

- Carol works closely with the Guardian for Safer Staffing and had been introduced to the junior doctors as part of their induction.

Dr Wulff, Non Executive Director, stated that the role's workload must be monitored carefully to ensure that Carol is not placed under too much pressure going forward.

The Chairman and Board noted the report, the good progress made and that a report will be presented to Board on a regular basis.

16/096.10 Outpatient Optimisation Programme Report (Enclosure 13)
11.25am

Louise McMahon, Patient Access Manager and Steve Gaskin Outpatients Transformation Project Manager presented the Outpatient Optimisation Programme Report, given as Enclosure 13.

The Board noted the following key issues:

- Optimising Outpatients: This was a highly complex transformation with multiple interdependencies.
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- Outpatient Programme: Includes referral management, clinic management and records management.

- Referral Management: Three areas to focus on – booking process and standards, cancellations and reschedules and demand and capacity management.

- Clinical Management: Three areas to focus on – Booking process and standards, clinic "cashing up" (work undertake at the end of each clinic) and environment.

- Records Management: Three areas to focus on – Service performance, process and standards, and library management.

Mr Miner, Non Executive Director, asked about the potential with the new EPR. Louise confirmed that the potential for transformation is huge with the possibility of vast improvements for this area.

Mr Fellows, Non Executive Director, commented that posters could be displayed in the Outpatients Department notifying users of the improvements being undertaken to publicise what was covered in this presentation so our patients know what has been achieved and what is planned.

Louise McMahon to develop posters to show the public the improvements made and give them information on those that are being worked on.

The Chairman and Board noted the report.

16/097 Finance and Performance

16/097.1 Cost Improvement Programme and Transformation Overview Report (Enclosure 14)
11.35am

Amanda Gaston, Head of Service Improvement, presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 14.

The Board noted the following key highlights:

- CIP Forecast Shortfall has grown to £1.89m.
- The Transformation Executive Committee had met earlier in the month and the meeting focussed on the gap, with the main actions being targeted at the need to suppress and stop spend in the final 6 months of the year to reduce the gap.
- Projects that are slipping are being escalated through the Trust's governance structure. The biggest slippage is around planned bed closures that have not materialised due to demand issues.
- The Trust is starting to robustly co-ordinate the 2017/18 Plan.
- 7 Quality Impact Assessments outstanding.

The Director of Finance and Information agreed that the Trust must do what it can to supress expenditure to close the financial gap. The Trust is using some external assistance for the development of the 2017/18 schemes.

Mrs Becke, Non Executive Director, asked if the Trust has approached staff for ideas in closing the gap. Amanda confirmed that there is an ideas portal but stated that communications around the position could be stronger and would be considered.

The Chairman and Board noted the report and the work being undertaken to close the financial forecast shortfall.

16/097.2 Finance and Performance Committee Exception Report (Enclosure 15)
11.45am

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 15.

The Board noted the following key issues:

- The surplus at the end of month 5 is £3.7m which is slightly ahead of plan. The Trust is on plan to get the 2nd instalment of the STP fund.

- The rest of year looks challenging particularly due to the high level of agency spend. .

- Other local Trusts face bigger challenges.

- Performance remains good except for diagnostic waits.

- EPR system and update on financial model was considered by the Committee.

The Chairman and Board noted the report and the financial challenges faced by the Trust.

16/098 Any Other Business
11.55am

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

16/099 Date of Next Meeting
11.55pm

The next Board meeting will be held on Thursday, 3rd November, 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 6 October 2016

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
16/086.9 & 16/093	Quarterly Safeguarding Report	The Trust to contact NHSI for their support and involvement in the access to Tier 4 CAHMS beds issue. Chief Executive and Chief Nurse to meet to produce a letter to NHSI regarding Tier 4 CAHMS beds prior to the next Board meeting.	DWa DWa/PH	6/10/16 3/11/16	Done Done
16/096.2	Chief Nurse Report	The Director of Finance, Director of HR and Chief Nurse to meet to look at nurse recruitment. The Finance and Performance Committee to undertake a deep dive on nurse recruitment at its meeting at the end of October.	PT/AM/DWa JF	3/11/16 27/10/16	Done Done
16/086.4	Complaints and Claims Report	Further analysis on dissatisfied complainants to be included in future reports, including friends and family and patient experience.	GP	3/11/16	On Agenda (Enclosure 7)
16/096.5	Charitable Funds Committee	The use of Charitable Funds for educational requirements to be discussed at the next Committee meeting.	JA	30/11/16	
16/030.3 & 16/086.3	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.
16/096.7	Medical Appraisal and Revalidation Annual Report	The Medical Director and Responsible Officer to meet to look at the Trust's approach to Revalidation following the split in role.	MB/PS	1/12/16	
16/096.8	People Plan/Workforce Strategy	Full People Plan/ Workforce Strategy to be presented to the December Board.	AM	1/12/16	

16/096.1	Organ Donation Annual Report	Chief Nurse to look at the competencies of the nursing teams with respect to being able to support the communication with families in relation to organ donation.	DWa	1/12/16	
16/096.10	Outpatient Optimisation Programme Report	Louise McMahon to develop posters to show the public the improvements made and give them information on those that are being worked on.	LM	1/12/16	
16/086.7	Six New Requirements in NHS Standard Contracts for Hospitals in Relation to Hospital/General Practice Report	Further update on NHS Standard Contracts in relation to Hospital/General Practice to the January 2017 Board meeting.	PB	5/1/17	

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Public Board Meeting – 3rd November 2016

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

SUMMARY OF KEY ISSUES:

- Friends and Family
- Outpatient Friends and Family Test Results
- Visits and Events
- Committed to Excellence
- Flu
- National Staff Survey
- Chief Executive's Video Briefing

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

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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
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Chief Executive's Report – Public Board – November 2016

Patient Friends and Family Test:

Quality Priority - Patient Experience

Based on the latest published NHS figures (August 2016), all but one area continued 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.

The exception was outpatients which, with a score of 92.4% in August, narrowly missed the target of 93%. This has significantly improved compared to April 2016 where the score was 85%.

% recommended	Apr 16	May 16	Jun 16	Jul 16	Aug 16
Inpatient Trust	**97%**	**97%**	**97%**	**95%**	**96.6%**
National	96%	96%	96%	96%	95%
A and E Trust	**91%**	**91%**	**88%**	**92%**	**91.8%**
National	86%	85%	86%	85%	87%
Maternity Antenatal Trust	**95%**	**100%**	**100%**	**96%**	**98%**
National	96%	96%	95%	95%	95%
Maternity Birth Trust	**100%**	**96%**	**99%**	**96%**	**100%**
National	96%	97%	97%	97%	96%
Maternity Postnatal Ward Trust	**95%**	**96%**	**99%**	**94%**	**98%**
National	94%	94%	94%	93%	93%
Maternity Postnatal Community Trust	**100%**	**100%**	**100%**	**99%**	**99%**
National	97%	98%	98%	98%	97%
Community Trust	**97%**	**95%**	**94%**	**98%**	**96.1%**
National	95%	95%	95%	95%	96%

Description	Jun	Jul	Aug	Sep
ED – Response rate	1.6%	8.4%	10.7%	5%
Inpatients – Response rate	13.9%	17.9%	18.6%	20.5%

Outpatients Trust	**85%**	**82%**	**93%**	**92%**	**92.4%**
National	93%	93%	93%	93%	93%

The FFT response rate rectification plan continues to be implemented and, whilst an increase is evident in the inpatient response rate, more work needs to be done to improve responses in ED.
We aim to achieve response rates which give us meaningful data that we can use to make patient experience improvements.

Inpatient response rates for September have increased to 20.5%, compared to 18.6% in June. We were pleased to see an improvement in the response rate in the Emergency Department from July to August and disappointed that, in September, the response rate more than halved. Actions taken to improve ED response rates include:

- Refresh of the FFT posters with a clear call to action
- All staff reminded to ensure all patients are given an opportunity to complete the FFT survey
- Proposal under consideration to implement an FFT SMS response solution

RAG rating legend

Area	Red (below national average)	Amber (national average and above but below top 20% of trusts nationally	Green (equal to top 20% of trusts)
Accident & Emergency	<=14.4%	14.5% - 21.2%	21.3% +
Acute Inpatients	<=25.9%	26% - 34.4%	35.1% +

Outpatient Friends and Family Test Results:

Since May there has been a 10% increase in those friends and family who would recommend the Out Patients Department.

There are three workstreams in the Outpatient Optimisation Programme all aiming to improve patient experience. These are:

Referral Management Workstream:
- Improved call answering time with the outpatient booking team.
- Changed the way clinics are block moved to reduce the number of cancellations and reschedules.

Clinic Management:
- Enhanced the environment by removing waste and clutter.
- Changed the way patients flow through the department by better use of waiting areas.

Records Management:
- Improved case note deliveries for requests so records can be updated and pathways managed more quickly by the Specialties.

The programme is currently reviewing demand and capacity across the organisation, changing clinic templates and improving reporting and performance management which will further improve the service over the coming months.

Visits and Events

4th October: West Midlands Clinical Forum
5th October: Trust visit from NHS Improvement
6th October: Getting it Right First Time – Vascular Visit by Prof. Tim Briggs
12th October: Medical School Monitoring Visit
12th October: Black Country Alliance Board and Strategy Meeting
12th October: Black Country STP Horizontal Integration Meeting
13th October: Senior Medical Staff Update
14th October: West Midlands Provider Chief Executives Meeting
17th October: Trust/CCG Board to Board Meeting
24th October: Black Country STP Horizontal Integration Meeting
25th October: Senior Medical Staff Update
26th October: Dudley Partnership Board Meeting
26th October: Nursing Times Awards
2nd November: West Midlands Local Delivery Board

Committed to Excellence

We have successfully launched our staff Committed to Excellence Awards with over 100 nominations received already.

If you know individuals or teams who go the extra mile, and you think they deserve to be recognised for their efforts, please nominate them for an award.

Patients can enter a nomination in the category of Excellence in Patient Care. Staff can nominate colleagues in any of the five categories.

Use the online form available from the front page of the website or complete a paper nomination form available throughout the hospital, Corbett and Guest outpatient centres and at a selection of health centres across Dudley, including Brierley Hill Health and Social Care Centre.

Winners will be announced at an awards ceremony, hosted by television newsreader Nicholas Owen, on 16th March 2017.

Flu:

Even a mild flu season can contribute to more than 2,000 deaths each winter across the country, the majority of which could be prevented if these individuals had been vaccinated against the seasonal flu virus. The Trust has a CQUIN attached to the number of staff who receive the vaccine of 75% of frontline staff.

As of 21st October, 2016, 28% of frontline staff had received the vaccine.

Staff can get their flu vaccine free of charge. We're encouraging everyone who has their vaccine to take a 'Flu Fighter Selfie' to share on social media.

National Staff Survey

The National Staff Survey is underway. Staff will have a unique link in an email.

We are asking staff to give us their views about what it's like to work at The Dudley Group so we can act on their feedback and make things better for all our staff.

We are running the survey online again this year which is great news both for the environment and our finances, plus it is easier for staff to complete. This year staff can part complete the survey and then pick up where they left off. They can also forward their unique link to their home email address if they wish.

To make sure we can effectively influence changes based on the way staff feel about working for The Dudley Group, we need as many staff as possible to fill out a survey and tell us what they think.

The survey is being conducted by on behalf of the Trust by Picker Institute Europe.

The Dudley Group NHS
NHS Foundation Trust

Chief Executive's Video Briefing

The Chief Executive filmed his first update on 13th October, 2016. It is interesting to note that the previous 3 Chief Executive videos had achieved a combined reach of 12,319 hits across social media.

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd November 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:

For the month of September (as at 26.10.16)

- No post 48 hour MRSA bacteraemia cases since 27th September 2015
- No Norovirus has been reported at time of report
- CDifficile - the Trust has had 23 cases so far in 2016/17 4 of these cases were associated with a lapse in care. There are still 15 cases without an outcome determined.

Safer Staffing

- Amber shifts (shortfall) total figure for this month is 59 which is increased from the last month (44).
- The RAG rating system has been rolled out across the wards 1 red shift in this methodology for that period on the Neonatal Unit, no safety issues were identified.
- Shortfall shifts were reviewed and no safety issues identified that affected the quality of care, reduction in the amber RN shifts was due new staff in post in midwifery.
- The Care Hours Per Patient Day (CHPPD) is reported in a limited way in this board report.

Nursing Care Indicators

- There is one escalation at level 4 which is a different area to the last report and four escalations at level 3 now in place. The Red category area is receiving more intensive support has been provided which has seen the appropriate change in results.

Recruitment Update

- Registered Nurse vacancies at DGH are currently at 95 WTE after new graduates commenced in September and October.
- Existing RN recruitment streams are continuing with limited success.
- 9 International Nurses have completed IELTS successfully. They are required to pass the CBT (Test of Clinical Expertise) then apply for Visas.
- Band 2 recruitment has seen 46 support workers join the trust (Aug-Oct).

Allied Health Professionals

- A listening into action event was held in October which was very well attended by a range of AHPs. Information is now being collated from the feedback to agree actions.

IMPLICATIONS OF PAPER:

RISK	Yes		**Risk Description:** • Failing to meet initial target for CDiff now amended to avoidable only (Score 10) • Nurse Recruitment – unable to recruit to vacancies in nursing establishments to meet NICE guidance for nurse staffing ratios (Score 20)
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:** Safe and effective care
	Monitor	Y	**Details:** MRSA and C. difficile targets Agency capping targets
	Other	Y	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		√	

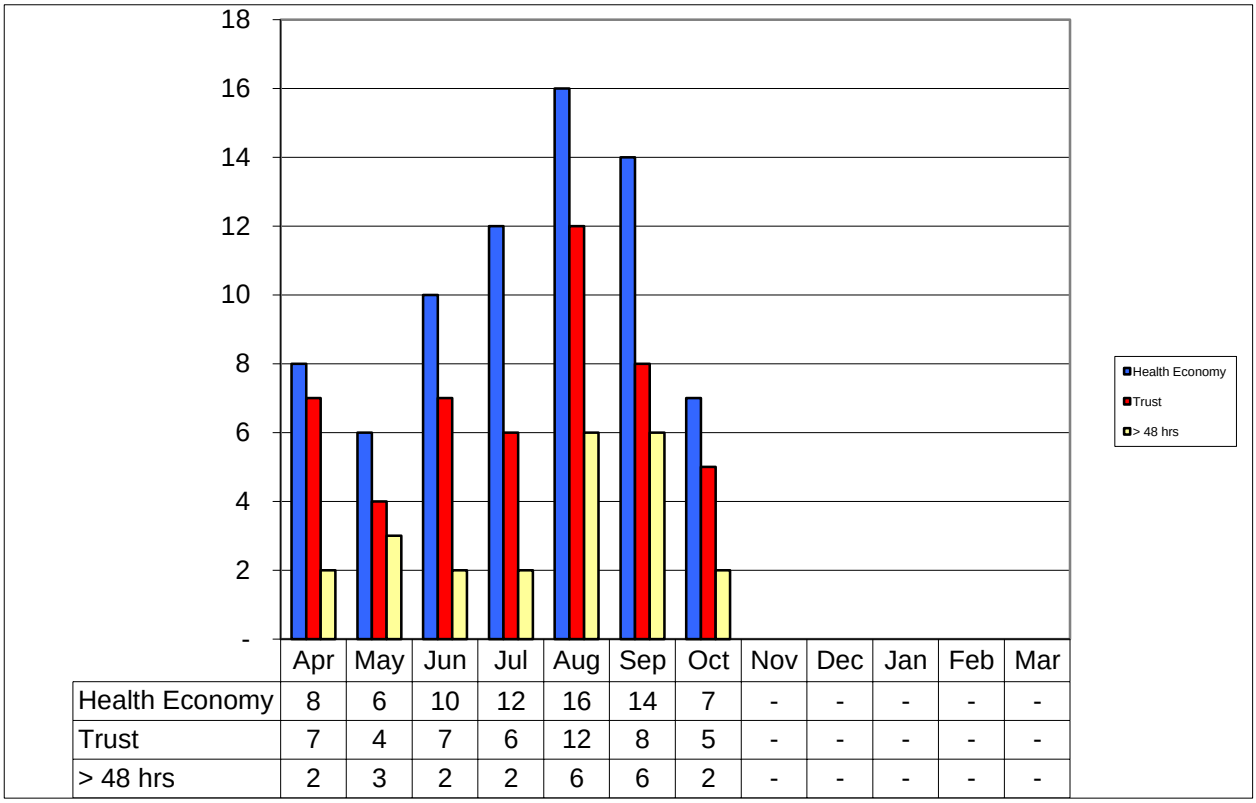
RECOMMENDATIONS FOR THE BOARD: To receive the report and note the contents.

Chief Nurse Report

Infection Prevention and Control 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 (26.10.16) we have 4 post 48 hour case recorded in October 2016.

C. DIFFICILE CASES 2016/17



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	6	10	12	16	14	7	-	-	-	-	-
Trust	7	4	7	6	12	8	5	-	-	-	-	-
> 48 hrs	2	3	2	2	6	6	2	-	-	-	-	-

Clostridium Difficile -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 23 post 48 hour cases identified since 1st April 2016, 8 cases have been reviewed and apportionment has been agreed (4 cases associated with lapse in care) and 15 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. Progress against the plan is recorded at the Infection Prevention Forum.

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

Norovirus - no cases reported in month.

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
September 2016

One of the requirements set out in the 2014 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 2016, the contents of which have had no impact on the requirement to produce these monthly reports.

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 the last three months have been:

Month	RN	Unregistered	Total
July	4.53	3.70	8.24
August	4.65	3.76	8.41
September	4.44	3.63	8.07

These figures obviously vary widely across wards/areas (e.g. 22.79, 1.95 and 24.74 for critical care and 2.41, 3.29 and 5.71 on Ward C5)

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 (8.07) 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. The Trust has recently become a pilot site for the ward element of the Model Hospital.

It can be seen from the accompanying chart (Figure A) 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).

The total figure of shortfalls for this month is 59 which is a rise from last month but similar to previous months, although the shortfalls in qualified staff are the lowest since last year (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.

The overall drop in the qualified shortfalls is due to the drop in midwifery (2 shortfalls compared to 7, 10 and 19 in the previous three months). The area with the largest qualified shortfalls is now CCU/PCCU which is an area with specific skills requirements that are not easily available. The considerable rise in unqualified shortfalls is generally spread across the whole Trust.

As well as the quantifiable staffing numbers discussed above, as indicated at the June 2016 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 (August'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, 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 3 of the 24 areas having 10 and above 'Amber' shifts (there were 6 last month). With regards to the latter, there is consistency with the staffing figures (e.g. 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. This month the accumulative totals of all assessed Red, Amber and Green shifts have been indicated. From now on, these will be reported on each month to indicate future overall trends.

One area has assessed a single 'Red' shift this month. NNU (which had 4 red shifts last month) had a shift when the dependency of the babies was so high that an extra qualified staff member was required but the bank/agency could not fill so the unit was closed for the whole shift.

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

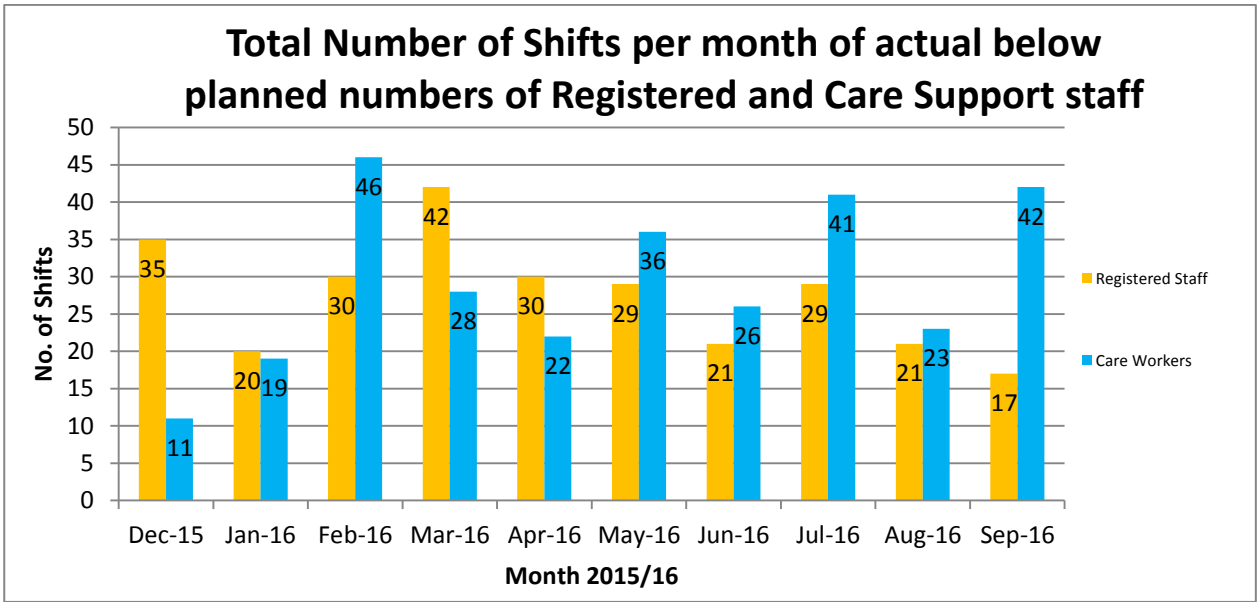


Table 2
Self-Assessment of Workload by Senior Nurses on Each Shift for August (figures in brackets from July)

Ward/Area	RED	AMBER	GREEN	Ward/Area	RED	AMBER	GREEN
Ward A1	0 (0)	2 (9)	58 (53)	**Ward C3**	0 (0)	3 (9)	57 (53)
Ward A2	0 (0)	1 (0)	59 (62)	**Ward C4**	0 (0)	0 (0)	60 (62)
Ward A3	0 (0)	5 (2)	55 (60)	**Ward C5**	0 (0)	3 (1)	57 (61)
Ward B1	0 (0)	17 (10)	43 (52)	**Ward C6**	0 (0)	8 (11)	52 (51)
Ward B2H	0 (0)	5 (3)	55 (59)	**Ward C7**	0 (0)	2 (3)	58 (59)
Ward B2T	0 (0)	1 (5)	59 (55)	**Ward C8**	0 (0)	6 (16)	54 (46)
Ward B3	0 (0)	12 (2)	48 (60)	**CCU/PCCU**	0 (0)	23 (19)	37 (43)
Ward B4	0 (0)	17 (16)	43 (46)	**EAU**	0 (0)	0 (0)	60 (62)
Ward B5	0 (0)	9 (8)	51 (54)	**MHDU**	0 (0)	0 (1)	60 (61)
Ward B6	-	-	-	**Critical Care**	0 (0)	0 (0)	60 (62)
Ward C1	0	1 (1)	59 (61)	**NNU**	1 (4)	1 (25)	58 (33)
Ward C2	0	8 (0)	52 (61*)	**Maternity**	0 (0)	2 (6)	58 (56)

*1 shift not assessed

Totals	RED	AMBER	GREEN
September	1	126	1253

Nurse Care Indicators (NCI's)

The achievement of Green status has not yet been achieved for a number of areas despite improvements seen overall.

Rating	Oct 15 Areas (Launch)	Dec 15 Areas	Jan 16 Areas	Feb 16 Areas	Mar 16 Areas	Apr 16 Areas	May 16 Areas	Jun 16 Areas	Jul 16 Areas	Aug 16 Areas	Sept 16 Areas	Oct 16 Areas
RED	15	4	3	7	6	3	2	3	1	3	0	1
AMBER	5	11	14	12	13	15	14	10	7	2	11	8
GREEN	4	9	9	8	8	9	11	14	19	22	16	18

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.

Escalations for October:

NCIs	
Level 1 Matron Level	6
Level 2 Head of Nursing Level	5
Level 3 Deputy Chief Nurse level	4
Level 4 Chief Nurse	1

The level 4 area reported is different to the last report; they have now achieved green status for two months and have been de-escalated to level 3. However, a new area has been identified from level 3 for escalation and a Chief Nurse Level 4 meeting has been held to provide a clear plan for delivery of the standards with appropriate intensive support.

Recruitment Update RN and CSW

Current Vacancy Position

Following successful recruitment of new graduate nurses from the September and October cohorts the current vacancy position at time of report is 95 WTE. The next outturn will be 31st January 2017 which is within the predictor tool.

Recruitment

Clearly, the biggest vacancy deficit is registered nurses however, the active recruitment and development of clinical support workers to assist with continued provision of quality care is a pivotal component of our future workforce plans.

Planned Clinical Support Worker Recruitment

- Clinical Apprentice Programme
- Introduction to Care Programme [Novice Programme]
- CSW Programme

CSW Recruitment numbers until May 2017	
Month	**Recruitment**
August 2016	15 CSW commenced
October 2016	33 Novices commenced
November 2016	7 Clinical Apprentices
January 2017	35 CSWs
January 2017	*9 Nursing Associates*
May 2017	35 Novices
Totals	**123** *This number excludes the Nursing Associates who will be recruited from our existing clinical support workforce.*

Planned Registered Nurse Recruitment

- Graduate Recruitment
- International Recruitment
- Recruitment Event/Open days and Fairs
- Open Registered Nurse advertising

RN Recruitment

Month	Acute	Community
Commenced in September 2016	26 RNs	6 RNs
October 2016	10 RNs	0
November 2016	0	0
December 2016	1	
February 2017	39 RNs	3
Totals	81	9

International RN Recruitment

Latest report shows 76 **candidates** from the Philippines remaining:

- 9 passed academic IELTS at level 7
- 9 candidates have booked IELTS
- 2 passed CBT
    - 1 NMC application approved, expected in trust December 2016
- 35 places on fast track IELTS preparation course 30 places currently allocated
- Estimated arrival next financial year.

Allied Health Professionals

A Listening into Action (LiA) event was held in October for this group of staff to get some feedback on areas of strength for the trust and areas where improvements can be made. This was led by Pam Ricketts, Quality Lead for AHPs and supported by Paul Bytheway, Chief Operating Officer and Dawn Wardell, Chief Nurse. It was a very well attended event and well received by staff. The outcomes from this event are being collated and will be fed back to staff with further workshops planned to take work forward.

A recruitment event for AHPs is planned for 5th November in the Education Centre. Tours will be given to interested parties and a Facebook campaign launched to publicise the event.

Table 3 (Monthly Nurse/Midwife Staffing Position)

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS SEPTEMBER 2016

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A1	4	CSW	Vacancy x4	Bank unable to fill. With the patient dependency on the day and assistance from A3, when required, patient safety maintained.
A2	3	CSW	Vacancy x2 Sickness x1	On one occasion a qualified nurse from another ward assisted and on the other two a CSW 'floated' between two stations.
A3	2	RN	Vacancy x2	Bank/Agency unable to fill. With current caseload and support from A1 patient safety maintained.
B1	1	CSW	Sickness x1	Unfilled via agency Lead nurse clinical and support provided by T&O OPD staff, no patient harm occurred, care prioritised.
B2H	2	CSW	Sickness x2	Lead nurse worked clinically to support the staff.
B3	5	CSW	Vacancy x5	On three occasions, B2 CSW covered Station 3 to ensure safety of patients and on the other occasions care was prioritised so 1:1 patient safety maintained.
B4	4	CSW	Sickness x2	1:1 patients were cohorted with no adverse patient effect.
B5	4	CSW	All 1:1 patients	1:1 patients were cohorted and qualified staff assisted the CSWs with their duties. Safety maintained.
C1	4	CSW	Vacancy x3 1:1 patient	Existing staff were appropriately delegated to patients to maintain patient safety. No harm occurred to patients.
C3	4 5	RN CSW	Vacancy x4 1:1 patient	For the qualified shortfalls, bank and agency unable to fill for three shifts and booked bank staff did not attend on one. Assistance was received from the rest of the elderly unit. For the unqualified shortfalls, the lead nurse worked clinical and care was appropriately distributed. No patient harm occurred.
C5	1	RN	Vacancy	Nurse in charge worked clinically and an extra CSW was employed.
C7	2	CSW	Sickness x2	Shift lead assisted staff. No patient harm occurred.
C8	2	CSW	Sickness x1 Vacancy x1	On one occasion, Led nurse and CNS assisted staff as did the bleep holder on the other shift.
CCU/PCCU	7 1	RN CSW	Vacancy x8 Sickness x8	Bank/agency could not fill. To mitigate, the lead nurse, CNS team or CAT nurse worked clinically. On one occasion a CSW was employed to assist.
NNU	1	RSCN	Dependency	The dependency of the babies was so high that an extra staff member was required but the bank/agency could not fill so the unit was closed for the whole shift.
Maternity	2 5	RM CSW	Vacancy Maternity leave	Escalation policy enacted on all occasions. Bank unable to fill. No patient safety issues occurred. On 1 shift there were delayed inductions of labour.

FIGURE A

Sep-16

SHIFT

	NCI		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16	
WARD		STAFF	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	94	Reg																																
		Unreg																														4/2		
WARD A2	92	Reg																																
		Unreg																			9/7						7/5							
WARD A3	94	Reg						4/2																										
		Unreg																																
WARD B1	99	Reg																																
		Unreg																									3/1							
WARD B2 HIP	100	Reg																																
		Unreg		7/5																					8/6									
WARD B2 TRAUMA	92	Reg																																
		Unreg																																
WARD B3	88	Reg																																
		Unreg																																
WARD B4	94	Reg																																
		Unreg			7/5														8/5															
WARD B5	85	Reg																																
		Unreg															5/3		5/3															
WARD B6		Reg																																
		Unreg																																
WARD C1	99	Reg																																
		Unreg			10/8		10/8								10/8																			
WARD C2***	99	Reg																																
		Unreg																																
WARD C3	94	Reg					6/5					6/4													7/5									
		Unreg			14/12													13/11										13/11						
WARD C4	99	Reg																																
		Unreg																																
WARD C5	91	Reg																							6/4									
		Unreg																																
WARD C6	94	Reg																																
		Unreg																																
WARD C7	89	Reg																																
		Unreg																																
WARD C8	95	Reg																																
		Unreg													8/5																			
CCU/PCCU	100	Reg			7/5		7/5				7/5										7/5		7/5		7/5									
		Unreg																																
EAU	96	Reg																																
		Unreg																																
MHDU	100	Reg																																
		Unreg																																
CRITICAL CARE*	99	Reg																																
		Unreg																																
NEONATAL**	98	Reg																																
MATERNITY ****	98	Reg											18/16																					
		Unreg																	7/5									5/2						

		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
WARD	STAFF	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	Reg																														
	Unreg				4/2					4/2												4/2									
WARD A2	Reg																														
	Unreg								6/4																						
WARD A3	Reg				4/2																										
	Unreg																														
WARD B1	Reg																														
	Unreg																														
WARD B2 HIP	Reg																														
	Unreg																														
WARD B2 TRAUMA	Reg																														
	Unreg																														
WARD B3	Reg																														
	Unreg																			6/4		6/4			5/3	5/3		6/2			
WARD B4	Reg																														
	Unreg													8/6												9/7					
WARD B5	Reg																														
	Unreg	5/3			5/2																										
WARD B6	Reg																														
	Unreg																														
WARD C1	Reg																														
	Unreg													10/8																	
WARD C2***	Reg																														
	Unreg																														
WARD C3	Reg																											7/5			
	Unreg				13/11	13/11																									
WARD C4	Reg																														
	Unreg																														
WARD C5	Reg																														
	Unreg																														
WARD C6	Reg																														
	Unreg																														
WARD C7	Reg																														
	Unreg				5/3					5/3																					
WARD C8	Reg																														
	Unreg	7/5																													
CCU/PCCU	Reg																	7/5													
	Unreg										7/5																				
EAU	Reg																														
	Unreg																														
MHDU	Reg																														
	Unreg																														
CRITICAL CARE*	Reg																														
	Unreg																														
NEONATAL**	Reg															5/4															
MATERNITY ****	Reg																						17/14								
	Unreg			7/5						7/5		7/5																			

Key: Serious Shortfall | Registered nurse/midwife shortfall | Care Support Worker shortfall

* Critical Care has 6 ITU beds and 8 HDU beds

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

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

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

Any coloured shifts without numbers indicate that the planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available

The Dudley Grou
NHS Foundation Trust

Enclosure 5

Paper for submission to the Board on 3 November 2016

TITLE:	**25 October 2016 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Julian Atkins – Committee Chair for this meeting

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.

To note that Trust management continue to draw out specific and coporate learning and share this across the Trust.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	25 October 2016	J Atkins (for this meeting)	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- Operational Management assurance was provided on the performance in respect of key quality indicators. This month saw a continued challenge in securing a good level Friends and Family responses. Maternity Breast Feeding Initiation rates and smoking ceasing during pregnancy performance continues to be a challenge despite efforts of the staff to engage and provide information to mothers. The unvalidated Stroke Swallow Screen recorded performance shows a reduction this month after a period of stronger performance and more staff training is being implemented to ensure that a greater number of staff are competent to undertake swallow assessments reducing the impact of staff absence. A stroke coordinator has been appointed which will also assist in maintaining focus on this area. VTE performance remained poor this month as was predicted in last month's report so did Stroke TIA performance but for both of these management provided assurance that they were on plan to achieve their compliance trajectory in October and November respectfully.
- Three policies failed to be presented to the 10th October Policy Group meeting as planned, these plus the scheduled final out of date policy in September are planned to go to the 9th November meeting. There are 7 further polices due to go to the November meeting. The Executive Director challenge meetings are scheduled to take place to ensure the November date is achieved for the 11 Polices.
- 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 the closure of the investigations within the 60 day timescale. The monthly report shows performance against the agreed developed KPIs and shows that whilst there has been a reduction on the number of RCAs closed with no questions and an increase in the number closed after resolving initial questions from the CCG, there has been a reduction in the number requiring the resolution of subsequent questions from the CCG. For the quarter the Trust achieved the target for closing RCAs with no questions. The issue of exceeded RCA action plans is discussed at the relevant Division's Performance Management meeting.

- Executive Management assurance was provided in respect of the closure of all the Trust's recommendations in the joint Serious Incident RCA Process Improvement plan with the CCG.
- 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. The Committee asked for a report to come from the Deteriorating Patient Group on their activity including the work they do to promote learning and improvement within the Trust (see items the Committee has asked to come back to a subsequent meeting).
- Executive Management assurance was provided in respect of progress being made against the Learning Disability Strategy Action Plan. The most notable actions taken in the quarter were
    - A "Virtual Tour of Russells Hall hospital" is now available on the Trust's website.
    - Local ward based learning disability champion training has been delivered in August 2016
    - Internal Learning Disability Mortality review panels meet monthly to review all deaths against the identified criteria of premature death in the Confidential Enquiry (CIPOLD)
    - The first parent and patient engagement committee is scheduled to be held in November 2016 following the successful children's outpatient LiA (the children's outpatient LiA links to the patient story at the last Board meeting).
- Assurance was provided in respect of the outcome of the Quality and Safety reviews undertaken since in quarter 2 of the year. The reviews continue to show patient feedback remains positive and identify good practice within the organisation. The Trust continues to support areas to improve their knowledge and understanding of the Trust governance and risk management systems through the deployment of governance boards within each area, including those within community.
- Management Assurance was provided in respect of the delivery against the Trust's quality priories across the first two quarters of 2016/17. The report provided information on actions planned to be taken across the remaining two quarters to achieve the targets across the respective priorities. The report provided strong assurance in respect of the achievement of the 3 quality priorities relating to patient experience, pressure ulcers and infection control alongside the weaker assurance in respect of the remaining 2 priorities of nutrition & hydration and medication.
- Executive Management Assurance was provided in respect of the delivery of all the recommendations made by External Audit as part of their audit of the 2015/16 Quality Account.
- Executive Management assurance was received via the Quality and Safety Group in respect of the last meeting's agenda items including the work of the falls prevention and management group and the resuscitation group. The Committee asked for a report to come from the falls group on their activity including the work they do to promote better falls management and prevention within the Trust (see items the Committee has asked to come back to a subsequent 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 outcome of the case reviews in relation to Internal Learning Disability Mortality review panel meeting, the delivery of safeguarding training across the Trust and actions being taken to continue to improve compliance in this area and updates on the delivery of actions plans developed following the CQC safeguarding review across Dudley and the Section 11 Audit.

Decisions Made / Items Approved

- Approval of 11 policies and 12 guidelines / procedures that had all been considered by the Policy Group.
- Approval to close 34 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.
- The Committee discussed the current reporting in relation to the Safety Thermometer and asked if greater clarity around the Trust's own performance in relation to falls etc. could be better presented within the report.

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

- The Committee asked for the deferred results of the Blood taking audit in ED to come to the next meeting of the Committee
- The Committee asked for a report to come from the falls group on their activity including the work they do to promote better falls management and prevention within the Trust.
- The Committee asked for a report to come from the Deteriorating Patient Group on their activity including the work they do to promote learning and improvement within the Trust
- The Committee asked for an update on the outstanding corporate actions in respect of the Trust's Quality and Safety reviews given that a number remained in progress although their completion date had passed.

Items referred to the Board for decision or action

There are no specific items to be referred to the Board for decision or action.

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

The Committee asked the Board to note specifically that Trust Management continue to draw out specific and corporate learning and share this across the Trust.

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd November, 2016

TITLE:	**Operational Plan 2016/17 Quarter One and Quarter Two progress against the annual goals**		
AUTHOR:	**Lisa Peaty Deputy Director: Strategy & Performance**	**PRESENTER**	**Lisa Peaty Deputy Director: Strategy & Performance**
CORPORATE OBJECTIVE: **All Objectives**			

SUMMARY OF KEY ISSUES:

The attached table identifies the progress of both Quarter One and Quarter Two position against the annual goals identified in the 2016/17 Operational Plan.

The recommendations contained in the March 2016 audit report relating to reporting of the operational plan have been implemented. These include:

- definition of red, amber, green to ensure consistent application of the ratings;
- the introduction of a 'no status' category where a RAG rating cannot yet be given (e.g. because the goal relies on annual data);
- where possible, replacement of some qualitative measures of success with those that are quantifiable.

The summary of the **Quarter One** position is:

Strategic Objective	RAG rating			
	Red	Amber	Green	No Status
Deliver a great patient experience	1	1	3	1
Deliver safe and caring services	4	4	8	1
Drive service improvement, innovation and transformation	3	2	1	2
Be the place people choose to work	1	4	2	1
Make the best use of what we have	1	4	1	2
Plan for a viable future	0	0	3	1
Total	10	15	18	8

The summary of the **Quarter Two** position is:

Strategic Objective	RAG rating			
	Red	Amber	Green	No Status
Deliver a great patient experience	0	1	2	3
Deliver safe and caring services	2	5	7	3
Drive service improvement, innovation and transformation	2	3	2	1
Be the place people choose to work	1	4	2	1
Make the best use of what we have	2	3	1	2
Plan for a viable future	0	0	3	1
Total	7	16	17	11

There are fewer actions RAG rated as red and as green in Quarter Two compared to Quarter

One. The following actions are RAG rated as red in Quarter Two:

- achievement of nursing care indicators for MUST (hospital);
- deliver requirements from key quality inspections;
- improvements in service performance delivered for Imaging;
- expand Research & Development / Academic Health Sciences Network;
- leadership development/OD/Talent management;
- deliver the agency threshold targets;
- deliver CIP and financial target.

Mitigating actions have been identified by leads where the target or measure is not likely to be achieved within timescale.

Two actions have changed from red to green between Quarter One and Quarter Two:

- efficacy of analgesia;
- introduce caseload management system;

One action has changed from red to amber between Quarter One and Quarter Two:

- develop a risk management process.

There were eight actions rated as 'no status' in Quarter One and eleven in Quarter Two. In each case, there is a legitimate reason for this rating which include:

- data not being available or being unvalidated at the time of this report because data processing/validation takes place after quarter end;
- information being available on an annual basis only;
- targets not being set due to changed systems for measurement and rating;
- external factors which have impacted on progress of activity.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: All**
	NHSI	**Y**	**Details:**
	Other	**N**	**Details:** Operational Plan is submitted to & approved by NHSI

ACTION REQUIRED OF BOARD OF DIRECTORS

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS

- The progress against each of the goals is noted
- Confirm whether the remedial actions are being taken are sufficient to improve performance
- Approve that the timescale for achieving the annual goal relating to Develop operational risk management process is extended from end of June 2016 to end of November 2016
- Approve that the timescale for achieving the annual goal relating to Deliver requirements

from key quality inspections is extended from end of September 2016 to end of December 2016

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Operational Plan 2016/17 Corporate Annual Goals

Key to RAG rating:

	Achieved within timescale
	Not yet achieved fully, but there are no major risks which would prevent achievement within timescale (e.g. delivery of an on-going scheme or action plan).
	Not achieved within timescale or unlikely to be achieved within timescale.
	RAG rating cannot yet be given (e.g. an annual one-off survey which has not yet taken place, up to data not yet available).

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
Strategic objective: deliver a great patient experience						
➢ Achieve good FFT results/patients survey	✓ Monthly scores equal or better than national average	Monthly	Chief Executive	Q1: maintained equal to or better scores in all areas except for outpatients (achieved 1 month out of 3), maternity birth and maternity antenatal (both achieved 2 months out of 3).	Q1	Q1: continue to work with local managers to support performance for percentage recommended and response rate.
				Q2: based on published data for July and August, DGFT maintained equal to or better scores in all areas except for outpatients (both months), maternity birth (July) and inpatients (July). Awaiting Quarter Two data.	Q2 (awaiting September data)	Q2: continue to support local managers to achieve performance improvement. Developed a response rate rectification plan to deliver actions to improve response rates.

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
➢ Ensure patients, carers & public fully engaged & involved	✓ Improved National Patient Survey results	On-going	Chief Executive	Q1: Data will be available in early 2017. A score of 8.00 was achieved in the 2015 survey, compared to 7.8 in 2014.	Q1	Q1: An Improvement Group chaired by the Chief Nurse met each month during the quarter to deliver actions for improvement.
				Q2: As above.	Q2	Q2: An Improvement Group chaired by the Chief Nurse met each month during the quarter to deliver actions for improvement.
	✓ Demonstrate engagement through feedback	Annual	Chief Executive	Q1: 'You said, we have' feedback and improvements were reported to the Patient Experience Group whose membership includes external stakeholders.	Q1	Q1: Local improvement actions and feedback have been displayed in individual wards/areas and departments, including community locations.
				Q2: As per Quarter 1. Feedback was shared at the Annual Members' Meeting; in 'Your Trust' publication; to the FT Membership and wider public.	Q2	Q2: Local improvement actions and feedback have been displayed in individual wards/areas and departments, including community locations.
➢ Achieve key performance standards	✓ 95% emergency access standard met	Monthly	Chief Operating Officer	Q1: 96.4% - standard has been met .	Q1	
				Q2: 95.7% - standard has been met. Combined Type I and B activity in Q2 despite significant activity challenges.	Q2	
	✓ 18 weeks RTT met	Monthly		Q1: April 2016: 97.1%. May 2016: 96.8%. June 2016: 97.1%. RTT performance continues to be significantly above the required performance.	Q1	
				Q2: July 2016: 97.1%. Aug 2016: 97.1%. Sept 2016: 96.1%. RTT performance continues to be significantly above the required performance	Q2	

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
	✓ Cancer treatment standards met	Monthly		Q1: 2WW: 95.1% (Target 93%). 31 Day First Treatment: 99.4% (Target 96%). 62 Day Traditional: 87.8% (Target 85%). Screening: 97% (Target 90%).	Q1	
				Q2: Un-validated data suggests we have met this standard.	Q2	
Strategic objective: deliver safe and caring services						
➢ Deliver quality improvements	✓ Achievement of nursing care indicators Targets: Pain Score, Efficacy of Analgesia, MUST (Hospital), MUST (Community) & Omission codes: ≥95% Medications Signed and Dated: ≥98%	Quarterly measure-ment for year-end achieve-ment.	Chief Nurse	Q1: Pain Score: 92%	Q1	Q1: Plans are in place to improve processes: posters, extra training, teaching package, changes in documentation, electronic MUST calculator, nutrition link nurse meetings.
				Efficacy of Analgesia: 92%	Q1	
				MUST (Hospital): 88%	Q1	
				MUST (Community): 100%	Q1	
				Medications Signed and Dated: 94%	Q1	
				Omission codes: 92%	Q1	
				Q2: Pain Score: 92%	Q2	Q2: Plans are in place to improve processes: posters, extra training, teaching package, changes in documentation, electronic MUST calculator, nutrition link nurse meetings.
				Efficacy of Analgesia: 95%	Q2	
					Q2	

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
				MUST (Hospital): 89%		
				MUST (Community): 94%	Q2	
				Medications Signed and Dated: 95%	Q2	
				Omission codes: 93%	Q2	
	✓ Zero avoidable stage 4 pressure ulcers	Monthly		Q1: Achieved.	Q1	
				Q2: Achieved.	Q2	
	✓ Reduction in stage 3 pressure ulcers from 15/16	Monthly		Q1: Achieved.	Q1	
				Q2: Achieved.	Q2	
	✓ Zero post 48 hour MRSA cases	Monthly		Q1: Achieved.	Q1	
				Q2: Achieved.	Q2	
	✓ No more than 29 post 48 hour *Clostridium difficile* lapses in care	Monthly		Q1: Achieved.	Q1	
				Q2: Achieved. 4 in total for Q1/ Q2 total. 13 to be agreed.	Q2	

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
	✓ Achievement of improvement trajectory in nutritional audit ending year in all wards as green (93%).	Monthly		Q1: 97%	Q1	
				Q2: 95%	Q2	
➢ Deliver agreed CQUIN requirements	✓ Deliver CQUIN schemes to expected levels	On-going	Director of Strategy & Performance	Q1: fully achieved for 62% of schemes, 33% required further ratification and 5% were undelivered.	Q1	Q1: PMO governance structure and reporting has been instigated to provide assurance and highlight risks/issues.
				Q2: Awaiting Quarter 2 data.	Q2	Q2: Monthly meetings with the Chief Operating Officer have been arranged to review previous month's performance and escalate issues for resolution as required.
➢ Maintain good mortality performance	✓ SHMI/HSMR within expected range	On-going	Medical Director	Q1: SHMI (Jan-Dec 2015) was published June 2016: 1.00 HSMR for SHMI Period: 103 Q2: SHMI Published for September 2016: 0.98 HSMR for SHMI Period: 95.88	Q1 Q2	
	✓ 85% of in hospital deaths have a multidisciplinary review within 12 weeks	On-going	Medical Director	Q1: 86.9% were reviewed within 12 weeks.	Q1	
				Q2: 98.6% predicted. Full data not available for 12 weeks past end of quarter.	Q2	

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
➢ Develop operational risk management process	✓ Implement a standardised agreement process and reporting framework to replicate the Corporate report	June 2016	Director of Governance	Q1: A standard operational reporting template that emulates the corporate risk trend report has been shared with each of the key divisions (surgery, nursing and medicine & integrated care) along with key directorates (e.g. pharmacy, finance, HR, IT etc). The revised reporting framework was not in place by the end of the quarter.	Q1	Q1: Meetings have taken place with the nursing governance and risk lead, the Deputy Chief Nurse, and discussed their framework and how it can be aligned to the corporate framework and the corporate risk reporting replicated within their division.
				Q2: The revised reporting framework was in place for the Risk and Assurance Meeting in July 2016. A meeting is scheduled with surgery divisional director to discuss risk management and their local framework. An audit is taking place for additional of assurance.	Q2	Q2: An internal audit is currently taking place to look at operational risk management processes with the intention that any resulting actions will be implemented as part of the work in delivering this goal. As an audit is being undertaken in September, a revised implementation date of November is proposed to allow for confirmation of the work done in Q1. On this basis, Q2 is rated as Amber.
➢ Deliver requirements from key quality inspections eg WMQRS, CQC, Deanery	✓ Deliver inspection action plans as required and develop a monitoring tool with baselines (e.g. deliver x% within x timescale – to be agreed following baseline audit)	September 2016	Director of Governance	Q1: engagement is taking place with divisions as to how they track external inspections. A central database is being established of reported inspections and associated action plans.	Q1	Q1: There has been poor engagement from the divisions which is being escalated through the Chief Operating Officer.
				Q2: there has been a poor response to the request for information on external inspection action plans.	Q2	Q2: This is being raised at the Chief Operation Officers Meeting with the divisions. A revised date of December is suggested for this goal.

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
➢ Safe staffing levels	✓ Deliver safe staffing	Monthly	Chief Nurse	Q1: Apr = 0, May = 0, Jun = 2	Q1	Q1: From June a new system of rating was introduced - the target/tolerance for red shifts not yet agreed.
				Q2: J = 11, Aug = 6, Sep = 0	Q2	Q2: From June a new system of rating was introduced - the target/tolerance for red shifts not yet agreed.
Strategic objective: drive service improvement, innovation and transformation						
➢ Develop integrated services & redesigned community provision	✓ Introduce case load management systems	June 2016	Chief Operating Officer	Q1: Caseload Management System will be in place from July 2016 and work is on-going.	Q1	June timescale not met, but introduction of Caseload Management System by July is achievable with plans that are currently in place.
				Q2: All caseloads are now RAG-rated based on individual needs. Currently this is a manual system but mobile solutions are being explored to further enhance this work. Care Coordinators commence in the next few weeks.	Q2	
	✓ Introduce SPA	June 2016		Q1: Work is currently under review based on the needs of the health economy and the MCP.	Q1	
				Q2: A further review is underway based on health economy needs associated with the MCP.	Q2	Q2: the outcome of the MCP process is required before decisions to progress are made.
➢ Increase access to 7 day services	✓ Maintain the position from the	March 2017		Q1:Awaiting April 2016 audit results to define appropriate actions.	Q1	Q1: progress can be made once audit results are available.

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
In the key standards: • Inpatients seen by a consultant within 14 hours • Diagnostic services available 7 days a week • Interventional services available 7 days a week • On-going review of patients by consultants	audit completed in April 2016			Q2: On-going work continues with key messages being distributed in support of this. Participation in the September audit has been completed. There is concern about management capacity to embed, lead and implement the structure for implementing 7 day services.	Q2	Q2: Solutions to management capacity being considered and discussed.
➢ Continued improvement in key services	✓ Improvements in service performance delivered for: ▪ Theatres ▪ Out Patients ▪ Renal ▪ Imaging	Review quarterly	Chief Operating Officer	Q1: • Theatres - optimisation programme currently underway in identified areas of improved performance. • Outpatient – on-going work with the optimisation programme, positive results being seen with improved FoF results noted. • Renal – improved financial and operational performance, renal business satellite case agreed and being implemented. • Imaging – compliance with DM01 remains difficult with last 2 months failing this target due to imaging facility further business case for community facility is in draft.	Q1 Q1 Q1 Q1	Q1: On-going development and implementation of business cases and project plans.

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
				Q2: • Theatres - optimisation programme currently underway in identified areas of improved performance. Outpatient – on-going work with the optimisation programme, positive results being seen with improved FoF results noted. • Renal – improved financial and operational performance, renal business satellite case agreed and being implemented. • Imaging – compliance with DM01 remains difficult with last 2 months failing this target due to imaging facility further business case for community finally is in DRAFT currently.	Q2 Q2 Q2 Q2	Q2: Further development and implementation of business cases and project plans.
➢ Expand Research & Development / Academic Health Sciences Network role	✓ Demonstrate greater involvement & engagement	On-going	Medical Director	Q1: HLO 1 and HLO2: Red. HLO3: Green. Recruitment is reported below target. Q2: HLO 1 and HLO2: Red. HLO3: Green. Recruitment is reported below target.	Q1 Q2	Q1 &2: Performance Management & Leadership: -Department Restructure: Senior R&D Recruitment & Performance Manager recruitment underway. Data reporting improvement: EDGE Recruitment management IT system readiness for CRN switchover on track for March 2017. Interim monthly comparison between CRN figures and EDGE accuracy to improve reporting ahead of national switchover. Clinical Research (Recruitment) Time: Increased Administrative and Data Management support

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
						for Level 1 laboratory studies in place in improve figures and free clinical time.
Strategic objective: be the place people choose to work						
➢ Develop a programme to enhance colleague engagement eg , Board to Ward, Listening into action	✓ Regular events in place	On-going	Chief Executive	Q1: The following events have taken place: • CE briefings • AMM • Your Trust magazine • LiA Consultants • Further development of social media as a tool for staff engagement • Long service awards. Q2: The following events have taken place: • LiA Diabetes • LiA AHP's • MCP consultation events.	Q1 Q2	Q1: Back to the Floor events are being organised for Directors during Q3/4. There will be a Chair walk about in Q3 and an Acting CE walk about Q3.
	✓ Improved scores in National Staff Survey	Annually	Chief Executive	Q1: The following events have taken place: • CE briefings • AMM • Your Trust magazine • LiA Consultants • Further development of social media as a tool for staff engagement • Long service award. Q2: The following events have taken place: • LiA Diabetes • LiA AHP's • MCP consultation events.	Q1 Q2	

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
➢ Improve workforce performance in sickness, mandatory training, appraisal	✓ Sickness absence target 3.5% met by end of year.	Data collected monthly	Director of HR	Q1: Sickness absence was 3.99%. Q2: Sickness absence was 3.88% - an improvement from Quarter One.	Q1: Q2:	Q1: More focused meetings will take place to support managers alongside further training on the management of absence. Q2: A monthly surgery will be developed for managers to get coordinated support from HR and Occupational Health in the most effective ways to manage absence. There will be a change to absence reporting so that it highlights short term and long term absence as well as being broken down by staff group.
	✓ Mandatory training target of 90% met be end of year	Data collected monthly		Q1: Mandatory training was 76.34%. Q2: Mandatory training was 77.09% - an improvement from Quarter One.	Q1 Q2	Q1: Review of infrastructure to support mandatory training and induction in order minimise data quality issues and make attendance and recording of information more straightforward. Q2: As above.
	✓ Appraisal target of 90% met by end of year	Data collected monthly		Q1: 81.03% of appraisals have taken place. Q2: 77.49% of appraisals have taken place.	Q1 Q2	Q1: A review of how appraisal rate is presented, including a review of infrastructure to support appraisals, will commence in January 2017. Performance management by area with clear trajectories of compliance will be required and management teams held to account. Q2: as above.
	✓ Information Governance training target of	Data collected monthly		Q1: Completion of Information Governance training was 78.62%.	Q1	Q1: A review of infrastructure to support mandatory training and induction will take place to be completed by November 2016 to

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
	95% met by end of the year			Q2: Completion Information Governance training was 79.48% - an improvement from Quarter One.	Q2	minimise data quality issues and make attendance and recording of information more straightforward. Q2: As above.
➢ Achievement of staff health & well-being CQUIN	✓ Achieve 5% improvement in each of the 3 health & well-being staff survey questions	Annual		Q1: Results will be available in February 2017.	Q1	Q1: The National Staff Survey was available to all staff week commencing 10th October, 2016 and results will be available in February 2017. Alongside the survey are initiatives to support staff well-being.
				Q2: Results will be available in February 2017.	Q2	Q2: As above.
➢ Leadership development/OD/ Talent management	✓ Achieve a 50% target of potential successors in the Ready Now or Ready with Development category for all leadership posts at 8a & above on the talent map	Quarterly		Q1:	Q1	Q1: A business cases was developed in June 2016 to support this goal and has not yet been agreed. However, this area will be reviewed by the new Director of HR as part of the overall review of the Workforce Strategy (People Plan).
				Q2:	Q2	Q2: As above.
Strategic objective: make the best use of what we have						
➢ Develop the Digital Roadmap	✓ Procurement of EPR completed	November 2016	Chief Information Officer	Q1: Procurement activity with suppliers will be complete October 2016 with the Final Business case being presented to the board in November 2016.	Q1	Q1: Procurement activities will be completed within timescales, however final contract signature is dependent upon Trust affordability and NHS I approval. This is being progressed with Finance.
				Q2: On track to complete procurement exercise within timescales.	Q2	Q2: Procurement to be completed during Q3.

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
	✓ Leverage from clinical systems & increasing orders from order comms. 5% each quarter	March 2017		Q1: On target to increase orders from <5% to 20% for March 2017. Q2: On target to increase orders from <5% to 20% for March 2017.	Q1 Q2	Q1: On target . Q2: On target.
➢ Match capacity to demand	✓ Optimise capacity to match demand	Quarterly	Chief Operating Officer	Q1: Awaiting information relating to annual planning. Q2: Work as part of annual planning has commenced.	Q1 Q2	Q2: Work relating to the annual planning cycle will support this.
➢ Deliver agreed financial plan	✓ Effective plans in place & monitored	Monthly	Director of Finance	Q1: Year to date position achieved and forecast outturn. Q2: Quarter two position achieved, but there is still a risk on the forecast outrun. There is a risk of not achieving cancer target costing £130k.	Q1 Q2	
➢ Deliver the agency threshold targets	✓ Meet the trajectory	Monthly	Chief Nurse	Q1:Above threshold. Q2: Above threshold.	Q1 Q2	Q1: Local action implemented. Q2: Recovery plan for Nursing Agency in Place discussed at Directors 10th October. CIP work stream commenced. Executive lead is Director of Finance. Sub-groups in place. The Nursing Agency Group is chaired by the Chief Nurse. Weekly monitoring in place. Finance and Performance presentation took place on 27th

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
						October.
➢ Deliver the CIP	✓ Deliver CIP & financial target	Monthly	Director Strategy & Performance	Q1: There is a shortfall in plans identified from start of the year of £0.5m, and slippage against identified plans of £0.8m. Total gap in CIP of £1.3m. However, work is on-going to identify opportunities to close the shortfall.	Q1	Q1: Escalation meetings for slippage against identified schemes led by Executive Leads during Confirm and Challenge session. Gathering of additional CIP ideas during the quarter to identify plans to close the gap.
				Q2: Shortfall in plans identified from start of the year of £0.5m, and slippage against identified plans of £1.3m. Total gap in CIP of £1.8m reported at Month 5.	Q2	Q2: Continuation of PMO escalation process for slippage in identified schemes. Agreement to action £0.6m. against DTOC project in Month 6.
➢ Deliver the Lord Carter targets	✓ Deliver against the agreed targets	Annual	Director of Strategy & Performance	Q1: Work has commenced to develop a dedicated work stream for this. A review of the Model Hospital Portal has started and the outputs are being used to develop specialty level workshops. The recommendations log has been assessed: 13% of actions complete; 58% of actions in progress; 23% awaiting further guidance; 6% plans require development.	Q1	Q1: Executive Lead assigned to the work stream (Director of Strategy & Performance). Terms of Reference and meeting structure developed for a Lord Carter Steering Group.
				Q2: First specialty level workshops held - Cardiology and Urology. Further workshops to be held over coming months. The recommendations log has been assessed: 18% of actions complete; 63% of actions in progress; 13% awaiting further guidance; 6% plans require development;	Q2	Q2: First Steering Group meeting took place on 10th October. Revised approach to monitoring discussed and to be implemented.
➢ Review the Clinical Strategy	✓ Revised plans in place	December 2016	Director of Strategy & Performance	Q1: On hold pending MCP outcome.	Q1	Q1:
				Q2: On hold pending MCP outcome.	Q2	Q2:
Strategic objective: deliver a viable future						

Annual Goal	Measures of Achievement	Timescale	Lead	Performance (April – June 2016 & July-September 2016)	RAG	Remedial Actions
➢ Develop an economy-wide Sustainability & Transformation Plan, (STP), with CCG & other providers in the Black Country footprint	✓ Play a full part in this work	July 2016	Chief Executive/ Director of Strategy & Performance	Q1: There has been full participation in STP meetings. Briefings have taken place for Board and Council of Governors. We have taken a leadership role for workforce in Q1.	Q1	Q1:
				Q2: There has been full participation in STP meetings. Briefings have taken place for Board and Council of Governors. We have taken a leadership role for workforce in Q2.	Q2	Q2:
➢ Play a part in the continued development of the Black Country Alliance	✓ Plan & Programme in place across alliance	Throughout 2016/17	Chief Executive	Q1: Board and BCA meetings have been attended. Leadership of work streams.	Q1	Q1:
				Q2: Board and BCA meetings attended. Leadership of work streams. Prompted Strategy Board meeting in August.	Q2	Q2:
➢ Dudley Partnership – ensure that the new care model works in the best interest of the Trust	✓ An agreed position in place regarding the shadow contract.	June 2016	Chief Executive	Q1: Trust engaged in discussions in relation to development of MCP.	Q1	Q1:
				Q2: Contract delayed by CCG into Q3. Financial contractual discussions underway led by Director of Finance and his team.	Q2	Q2:
	✓ Play a clear role in the delivery of the MCP to ensure the financial impact is minimised.	March 2017	Chief Executive	Q1: Role unclear until CCG procurement process is at an appropriate stage.	Q1	Q1:
				Q2: Role unclear until CCG procurement process is at an appropriate stage.	Q2	Q2:

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to Board
3 November 2016

TITLE:	**Complaints and claims report for Q2, ending 30 September 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: The key aspects from this report are:-

Complaints for Q2 ending 30 September 2016 *The figures in [ ] refer to Q1.*

Although the numbers of complaints are reducing, they continue to be extremely complex, with some containing up to many pages of typewritten concerns, which require complex investigations 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, these meetings require careful preparation and although they are recorded, a summary is still provided to the complainants.

100% [100%] of complaints received during Q2 were acknowledged within 3 working days

95% [95%] 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.***

34% [67%] of complaints received and closed were upheld/partially upheld during Q2

7 [9] complainants expressed dissatisfaction with their response (received and investigated) during Q2. It is worth noting that none of these 7 had taken up the offer of an initial meeting to discuss their concerns.

31 [36] local resolution meetings held with complainants during Q2

3 [6] Inquests held and closed during Q2

0 [0] rule 28 - reports on 'Action to Prevent Future Deaths' received from Senior Coroner during Q2

Claims - Q2

14 [11] CNST claims ***closed*** during Q2

10 [13] CNST claims ***opened*** during Q2

2 [2] Employer's/Public liability claims ***closed*** *during Q2*

2 [2] ***new*** Employer/Public liability claims during Q2

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 September 2016

Key Facts – Complaints, Inquests & Ombudsman

Key facts During qtr/year	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	Qtr 2 Ending 30/9/16
Total number of complaints rec'd within qtr/year	**70**	**86**	**72**	**66**	**294**	**81**	**64**
% Complaints ack'd within 3 working days	100%	100%	100%	100%	100%	100%	100%
% Complaints rec'd and replied within 40 working days	44%**	44%**	**25**% ** [see note below]	**38%** [see note below]	**38% ** [see note below]	**95%** [see note below]	**85%** [see note below]
Number of upheld/ partially upheld complaints replied within qtr/year	**34***	**60***	**43***	**36***	**173*** (59%)	**54*** (67%)	**22** 34%
Complaints accepted for investigation by PHSO	0	2	0	2	4	0	2
Privacy/dignity incl as a concern in complaint	0	0	1	3	4	3	0
Complaints referring to shared accommodation	0	0	0	0	0	0	0
Complaints incl safeguarding issue	0	0	1	2	3	1	1
Number of meetings held with complainants (% of complaints rec'd)	**19** (27%)	**17** (20%)	**28** (38%)	**37** (56%)	**101** (34%)	**36** (44%)	**31** 48%
Total number and % of dissatisfied complaints rec'd	6	1	2	2	11 (4%	**9** (11%)	**7 (11%)**
Total CCG/DWMH led complaints	3	0	1	3	7	3	4
New Coroner's cases opened	7	1	1	7	16	8	6
Coroner's Inquests held/closed	4	5	0	3	12	6	3
Coroner's Rule 28 (was rule 43)	1	0	0	0	1	0	0

Note

* Includes c/fwd from previous quarters

** More 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 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	Qtr 2 Ending 30/9/16
Clinical Care (Assessment/Monitoring)	**134 (43%)**	**45%**	43 (50%)	23 (32%)	20 (31%)	**124 (42%)**	**30 (37%)**	**24 (36%)**
Diagnosis & Tests	**56 (18%)**	NA	7 (8%)	8 (11%)	3 (5%)	**30 (10%)**	**4 (5%)**	**4 (6%)**
Records, comms, Information or appts (incl delay)	**17 (5%)**	**22%**	17 (20%)	18 (25%)	17 (26%)	**56 (19%)**	**20 (25%)**	**10 (16%)**
Admission, discharge & transfers	**33 (11%)**	**5%**	7 (8%)	8 (11%)	6 (10%)	**27 (9%)**	**7 (9%)**	**10 (16%)**
Values & behaviour of staff (prev 'staff attitude')	**20 (6%)**	**11%**	2 (2%)	3 (4%)	4 (6%)	**15 (5%)**	**5 (6%)**	**5 (8%)**
Obstetrics	**12 (4%)**	**3%**	3 (4%)	3 (4%)	7 (11%)	**16 (5%)**	**1 (1%)**	**2 (5%)**
Nursing care (incl District Nurses)	**2 1%)**	NA	0	1 (1%)	1 (1%)	**2 (1%)**	**3 (4%)**	**2 (3%)**
Medication	**13 (4%)**	NA	3 (4%)	0 (1%)	4 (6%)	**7 (2%)**	**2 (2%)**	**3 (5%)**
Patient Falls, Injuries or Accidents	**5 (1%)**	NA	2 (2%)	2 (3%)	0	**5 (2%)**	**0**	**0**
Aids, appliances, equipment,	**4 (1%)**	**1%**	0	3 (4%)	1	**4 (1%)**	**2 (2%)**	**2 (3%)**
Safeguarding	**1 (1%)**	NA	0	1 (1%)	0	**1 (1%)**	**0**	**0**
Theatres	**4 (1%)**	NA	0	0	1 (1%)	**1 (1%)**	**0**	**0**
Privacy & dignity	**6 (1%)**	1%	0	1 (1%)	1 (1%)	**2 (1%)**	**1 (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 (incl security, workforce, catering)	**2 (1%)**	**4%**	2 (2%)	1 (1%)	1 (1%)	**4 (1%)**	**6 (6%)**	**1 (1%)**
Total:	**313 (100%)**		**86 (100%)**	**72 (100%)**	**66 (100%)**	**294 (100%)**	**81 (100%)**	**64 (100%)**

Complaints received in Q2 shows a slight decrease when compared to the same quarter in the previous year and when compared to Q1 of this year.

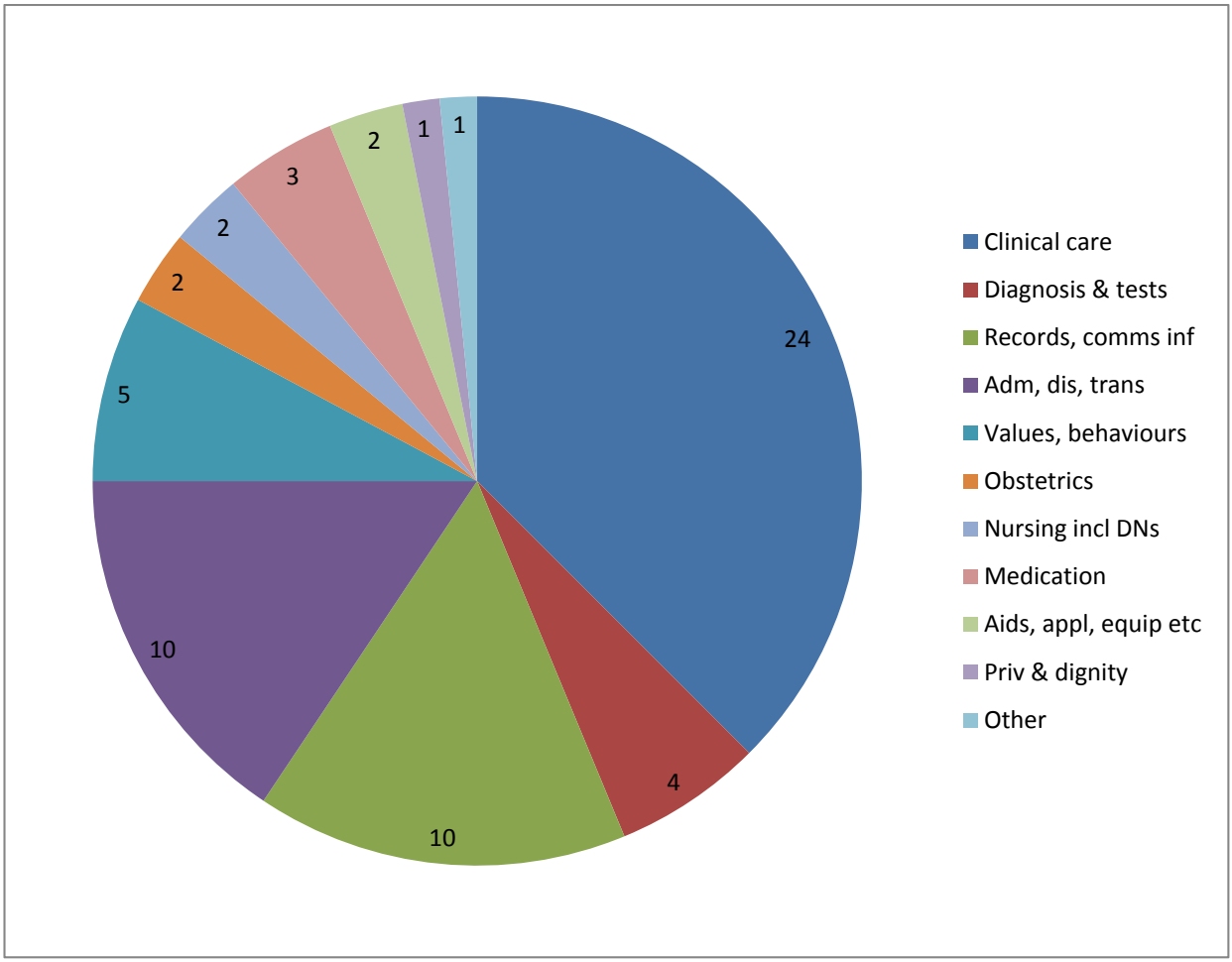
This quarter has seen a decrease in those where the main issue related to commination, but communication is still raised as a secondary issue in a number of the other complaints. This is particularly evident in the area of transfers and discharges, which has seen an increase whereas better communication about the delay in the transfer, or the time the discharge would

occur or why a discharge was ultimately not undertaken may well have helped the patient and their family with their experience. The undertaking of the meetings with the patients and families does allow the lead nurses, consultants to assess the impact of poor communication and take this back to their colleagues to improve this area going forward for future patients.

Note

* Complaints are allocated to a main complaint category

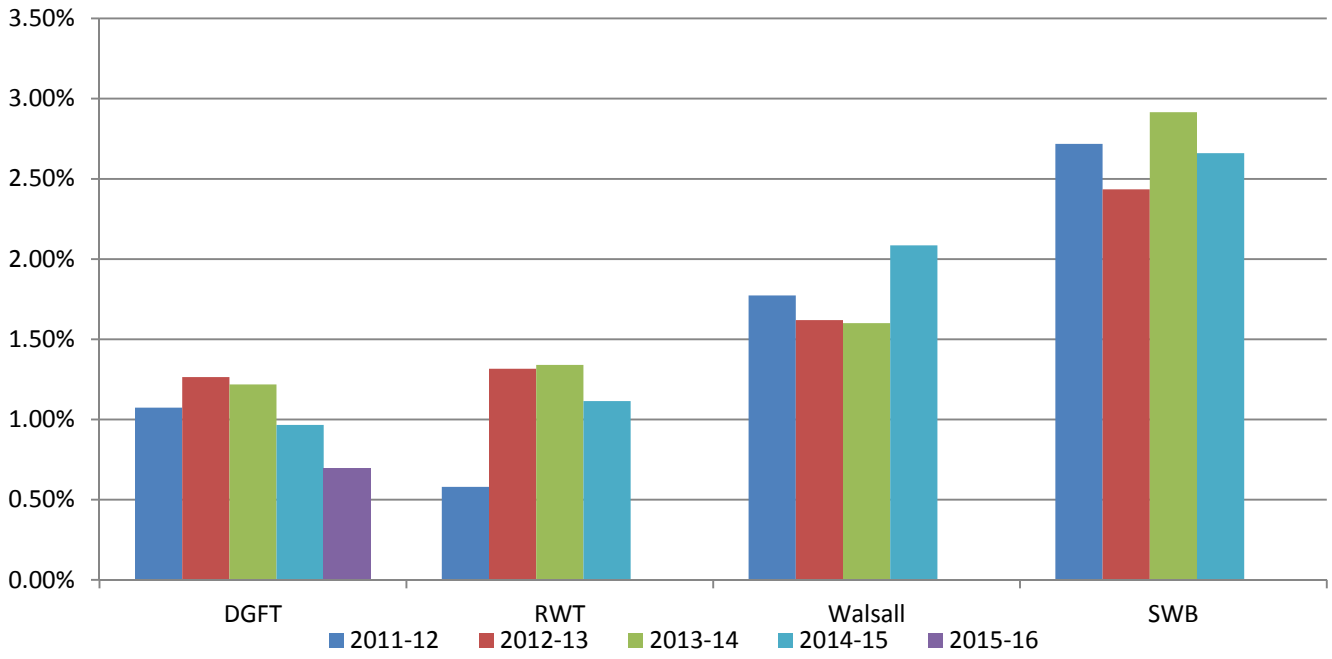
Analysis of complaints received by category – Q2



Benchmarking - Birmingham & Black Country – 2014/15 & 2015/16

	Total yr ending 31/3/15	Total yr ending 31/3/16
Dudley and Walsall Mental Health Partnership NHS Trust	94	94
The Royal Orthopaedic Hospital NHS Foundation Trust	105	113
Birmingham Children's Hospital NHS Foundation Trust	121	101
Birmingham Women's NHS Foundation Trust	140	94
The Dudley Group NHS Foundation Trust	313	294
Heart of England NHS Foundation Trust	1,035	1043
Sandwell and West Birmingham Hospitals NHS Trust	837	929
The Royal Wolverhampton NHS Trust	365	401
University Hospitals Birmingham NHS Foundation Trust	792	629
University Hospital North Midlands NHS Trust	824	877
Walsall Healthcare NHS Trust	379	403
West Midlands Ambulance Service NHS Foundation Trust	522	354
Worcestershire Acute Hospitals NHS Trust	566	658

- Complaints as percentage of admissions



Note we are awaiting activity information to update the above chart

Dudley Group – complaints as % of patient safety incidents

	Complaints	Pt Safety Incidents	% complaints against incidents
Year ending 31 March 2016	294	12575	2%
Qtr 1 ending 30 June 3016	81	2927	3%
Qtr 2 ending 30 September 2016	64	3008	2%

Complaints as % total hospital activity

ACTIVITY	TOTAL year ending 31/3/15	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 Qtr 2 Ending 30/9/16
Total patient activity	736,510	181895	185460	188840	745455	198194	189578
% Complaints against activity	0.04%	0.04%	0.03%	0.03%	0.03%	0.04%	0.03%

Compliments received during Q2

1480 compliments received during Q2 which is 0.78% of activity (noting these compliments do not include the informal thanks and cards provided locally to the wards or medical teams)

Senior Coroner – Inquests opened/closed during Q2

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

Closed claims in Q2

14 clinical negligence claims closed during Q2 only 5 resulted in costs being awarded against the Trust

2 public liability claims closed during Q2, both resulting in costs being awarded against the Trust

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on Thursday, 3rd November, 2106

TITLE:	**Black Country Alliance Report**		
AUTHOR:	**Terry Whalley**	**PRESENTER**	**Paul Harrison**
CORPORATE OBJECTIVE: S01/S02/S03/S05/S06			
SUMMARY OF KEY ISSUES: **BCA Report including the Programme Directors Report and CAN Update.**			

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 contents of report.

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**

ENC 6

The Black Country Alliance

Programme Director's Update – October 2016

TITLE:	BCA Programme Director's Report	**EXEC SPONSOR:**	BCA Board
AUTHOR:	Terry Whalley	**PRESENTER**	Terry Whalley

OBJECTIVE:
The purpose of this paper is to provide a brief update from the Programme Director on the projects within the scope of the Black Country Alliance, together with other matters of interest to the Black Country Alliance Board

KEY ISSUES:
None other than those covered in the paper

IMPLICATIONS OF PAPER:

RISK	**Risk Register:**		None
COMMS, COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	Not required
	Patient / Citizen Engagement	**N**	Not required
	Monitor / TDA	**N**	Not required
	Equality Assured	**N**	Not required
	Competition & Mergers	**N**	Not required
	Comms Lead OK	**N**	Not required
	Governance Lead OK	**Y**	Not required

ACTION REQUIRED OF BCA BOARD:

Decision	**Approval**	**Discussion**	**Other**
	X	**X**	

RECOMMENDATIONS FOR THE BCA BOARD:

The Black Country Alliance Board is invited to;

1. Receive and comment on the above update.
2. Endorse the Mortality Review Network Terms of Reference.

1 Purpose

The purpose of this paper is to provide a brief update from the Programme Director on the projects within the scope of the Black Country Alliance, together with other matters of interest to the Black Country Alliance Board.

2 Project updates

2.1 Urology

Further to recent updates, the team have now produced first draft Quality Impact Assessment using the Clinical Reference Group's newly defined QIA Process. These QIAs went to the last Clinical Reference Group and while there is a little more detail the CRG have asked to see included, there were no concerns raised about the revised proposed pathways and positive endorsement of the patient benefits associated with these changes.

Good progress is being made with establishing the virtual BCA Urology MDT. Focussing initially on Complex Stones cases, the intention is to broaden the scope of this as demand from Urologists determines.

Planning is now under way for our first Black Country Alliance Urology Network conference, likely to be held toward the end of November 2016. In addition to sharing and celebrating the progress we've made, the purpose of this conference will be to get as many Urology colleagues as possible involved in determining opportunities to go further faster together within our BCA Urology Network. Further details of this conference will be shared in subsequent updates to the BCA Board.

2.2 Medical Training Initiative

The Department of Health in association with the Academy of Medical Royal Colleges established in 2009 a national Medical Training Initiative (MTI) Scheme. In the BCA, a small task and finish group has been established to explore how a collaborative MTI may be of benefit to all Trusts.

The 3 BCA Trusts have made varying degrees of progress in establishing MTIs and some benefits are expected to be realised in the current financial year within each Trust as a result of this:

- SWBH recruited an MTI Fellow who started with the Trust in May, This will realise a financial saving of approximately £51,000 based on reduced need for Locum cover;
- At WHC, the first group of MTI placements have been recruited from Pakistan across Medicine, Paediatrics and Orthopaedics and will join the Trust in October 16. Detailed numbers haven't been provided, but based on SWBH numbers we can expect a financial benefit of around £34k per Fellow in 16/17. Assuming 1 trainee per area, this would mean around £102k in total in 16/17.
- DGFT has received trainees from Sri Lanka in Rheumatology, vascular surgery and Urology. Detailed numbers haven't been provided, but based on SWBH numbers we can expect a financial benefit of around £34k per Fellow in 16/17. Assuming 1 trainee per area, this would mean around £102k in total in 16/17

It is believed that greater benefits could be realised through the creation of a collaborative MTI for the Black Country. The proposal will include the availability of rotational posts across the BCA Trusts and the group is also exploring options to combine with a post-graduate qualification from the University of Wolverhampton's Academic Institute of Medicine (AIM). This approach will make the BCA particularly attractive thereby securing regular supply and

high quality candidates. The group continue to aim to identify and recruit a further round of Fellows before the end of 16/17.

Benefits will be realised through reduced reliance on locum and agency doctors, joint recruitment processes across the Black Country, and improved quality of care provision.

2.3 Rheumatology

The BCA rheumatology project is now at operational implementation stage.

Medical - All of the 4 consultant rheumatologists posts have now been appointed to by SWBH. Additionally, they also have a 'retire and return' consultant rheumatologist in place. The appointments of the new consultants are phased (linked to start dates) and so the cover for the BCA service will be defined accordingly. This is reflected in the job plans for the team. The first 2 consultants are job planned to deliver clinics at WHC from the 3rd October 2016 this will increase to provide optimum cover over 5 days and be completed by March 2017 when the 4th consultant is in post. WHC operational team are confident that the phased approach will match the service demand and will also allow for key milestone reviews to assess the service model.

As the current situation is that there will be no locum cover at WHC from the end of September 2016, Dr Situnayake and Dr Elamanchi have developed a contingency with the operational team at WHC to provide rheumatology cover. The medical team will receive a group induction at WHC, which is now being arranged. DGFT consultant recruitment drive to recruit 2 rheumatologists has at time of report been unsuccessful and the clinical and operational team are in the process of reviewing options.

Nursing - The nursing model mirrors the team based approach of the consultant model. The job plans for the Clinical Nurse Specialists (CNS) have been drafted and are ready to be implemented on request from WHC. The current Band 7 CNS from SWBH and B6 from WHC are meeting the demand. Additional 4 sessions of nursing cover is on standby and will be put in place once WHC have confirmed need. The current B7 cover at WHC is a 'retire and return' CNS contracted until 2017.

IT - SWBH are leading on IT plans with support from WHC. All the SWBH consultants and nurses who are job-planned to provide clinics at Walsall will be provided with a laptop which is compatible with WiFi access at WHC. This will be sufficient to meet the immediate requirements of accessing relevant patient information portals from different sites.

Other Matters – work continues on drafting detailed **Service Level Agreements**, overall principles have been agreed and detailed draft has been submitted to and reviewed by colleagues at WHC, who have raised some queries around the assumptions which are being addressed by the SWBH operational team. A document defining the **clinical governance model** has been drafted by Dr Situnayake and is out for comment before being finalised in the coming month. A comprehensive **Standard Operational Model** is in the process of being drafted by the 3 Operational teams and is expected to be completed by the mid October.

2.4 Children's Acute & Community Services

It has continued to be challenging to get designated Stakeholders from across all 3 Trusts together to determine priorities and specific opportunities for collaboration. In part due to summer holidays and in part due to the realities of services delivery. That said, progress has been made, and a draft speciality map has been produced and was reviewed at the Steering Group in September. In addition to mapping services, this will also contain a view by service

on the level of challenge associated with Geography (hand over from one locale to another), Transition from Child to Adult, Out of Hours (24 hours 7 days a week) and overall Sustainability. The Group have committed to finalising this map by the end of the calendar year, following which it is expected some priorities will emerge for work in 2017. In the meantime, the group have identified some immediate opportunity to explore how we tackle the risk associated with CAMHS better together, reinforcing the discussion from last month's risk discussion at the BCA Board. Out of Hours Sexual Abuse, Home IVs, 24/7 Palliative Care and MRI/CT scans were all areas felt to be quick wins where immediate discussion to progress would be useful. Further updates will be brought back to BCA Board in due course.

2.5 Interventional Radiology

This is covered in a separate paper on the agenda.

2.6 FINCH

Collaboration between SWBH and DGFT colleagues continues to progress well. As reported at the August Board, the next stage of the project is to explore opportunities for collaboration between WHC and SWBH for the small number of services identified at the workshop in July. The project group is due to meet again in October and a further update will be available to the BCA Board in November.

2.7 Atrial Fibrillation / Stroke Prevention

In August, the group reported on a grant application being made to Pfizer for proposals that will improve the care of AF patients in order to reduce the risk of stroke. Despite the very tight turnaround, a credible and collaborative application was submitted on behalf of the 3 BCA Trusts with endorsement from the West Midlands Academic Health Sciences Network (WMAHSN) and clinical commissioners. The proposal is based on an integrated model of care developed originally in Maastricht, Netherlands. It incorporates technological innovation, using an app to educate non-specialist clinicians and patients, and to increase the uptake of proven treatments across primary and secondary care. Additional aspects of the bid include:

- Education and upskilling of GPs via ECHO (Extension for Community Healthcare Outcomes), a multimedia information sharing platform aimed at moving knowledge and information from specialists to generalists;
- AF screening in general practices using innovative mobile technology to identify abnormal ECG readings (subsequently undergo a 12-lead ECG to confirm new AF diagnoses).

The outcome of the application is expected toward the end of October. In the interim, the project group is looking to prioritise and mobilise the key elements of the proposal that can be implemented within existing resources. There are meetings scheduled throughout October and early November with clinical colleagues across the BCA Trusts as well as external partners including clinical commissioners and, most recently, Cerner. Cerner are confirmed providers of SWBH EPR and are one of 2 shortlisted within DGFT's selection process. Cerner are a provider of population health management through their health information exchange, which operate agnostic to the EPR or system being used and is already at the heart of a Vanguard PACS model elsewhere in the country. At this stage, we are holding exploratory discussions to understand how this approach might help achieve our triple aim.

In terms of benefits, the proposal has the potential to reduce outpatient appointments and delays to treatment in the short to medium term. In the long term, it has the potential to

identify, diagnose and improve the management of more patients with AF. This will reduce the risk of stroke, which has multiple long term benefits to the health sector and wider economy.

2.8 Community Services

It has continued to be challenging to get designated Community Stakeholders from across all 3 Trusts together to determine priorities and specific opportunities for collaboration. In part due to summer holidays and in part due to the realities of community service delivery. That said, progress has been made, and a detailed assessment of Strengths, Weaknesses, Opportunities & Threats (SWOT) has been produced by each Trust, **see appendix B**. This was reviewed at the Steering Group in September. From this, some emerging themes have been identified where the group feel there may be opportunity for collaboration. These include Workforce development, Single Point of Access, Patient Transport Services and Mobile Technology. Additionally, the group agreed that to stimulate more organic collaboration, a joint BCA Community Services Conference might be really valuable. The Group have committed to reflecting further on this analysis ahead of the next Steering Group in October/November. Following which it is expected some priorities will emerge for work in 2017. Wheelchair Services, Podiatry and Rapid Response Teams were all areas felt to be quick wins where immediate discussion to progress would be useful. Further updates will be brought back to BCA Board in due course.

2.9 Upper Limb Trauma Centre

As reported at the August BCA Board, the Upper Limb Trauma group is focussed on 3 emerging work streams:

1. Define and agree a comprehensive service map, including sub specialties where appropriate, covering the BCA and which can be used to identify strengths, weaknesses, opportunities and threats and so inform future opportunities for collaboration;
2. Establish a virtual MDT for upper limb that would support diagnosis and prevent some patients from being referred out of the area;
3. Consider the specialist hand care that is currently referred out of the area in terms of clinic assessment, surgery and rehab (starting initially with a review of hand fractures and flexor tendons/ hand lacerations).

Mobilisation of these work streams has been particularly challenging due to the large number of stakeholders involved from each Trust. This includes T&O Consultants, Therapies Leads and Operational Managers. There are also continued difficulties experienced in obtaining the relevant inter-hospital referral data. This poses a risk to the aspirational timeline and our ability to realise any benefits of collaboration within the 16/17 financial year.

Since the last report, some progress has been made:

- WHC has provided service mapping information;
- WHC and SWBH information leads have supported discussions to overcome the challenges relating to inter-hospital referral data;
- Therapies and operational leads for all 3 Trusts have now been identified.

Further progress is expected to be made during October and an update will be provided to the BCA Board in November.

2.10 Procurement

The Steering Group met for the first time with the newly appointed Director of Procurement. BCA members have received from NHSi the Local Procurement Transformation templates and the Steering Group agreed a timetable for completion and ratification in each Trust and across the BCA.

- Baseline and gap analysis reported within each Trust Oct 16
- Working draft of plans internal and BCA reports Nov 16
- Final plans at Trust and BCA level Feb 17

These plans will in turn inform a BCA wide Procurement Strategy for endorsement in the Spring of 2017.

Carter rightly majors on e-enablement and the modernisation of NHS supply chains which will take investment and time to deliver.

Earlier in the year the DH ran a competition for Trusts to bid for monies to deliver fully GS1 compliant hospitals. The process concluded with 6 'demonstrator' sites chosen who would develop templates and 'how to' guides for the NHS – the ultimate object is to deliver business cases with clear ROIs. We believe there is a very high chance that a further bid process will be announced in November with award of monies confirmed in February 2017. We plan to develop a multi-trust application & understand DH initial reaction is extremely favourable to this approach. Royal Wolverhampton who came 8th in the first bid round has agreed in principle to join the BCA in a joint bid.

A key strand in Carter and our potential GS1 bid is the BCA commencing a journey towards e-enablement. The most fundamental thing we can do quickly and at a low cost is adopt one catalogue solution that will manage improvements in the following areas:

- Reduced PO and Invoice matching issues.
- Lack of control over the items available to requisitioners.
- Integration into existing IT infrastructure.
- Savings through access & visibility of contracts and price comparison.
- Contracts and compliance reporting functionality.

A full cost model will be developed for the November Procurement Steering Group meeting.

Other areas that will be developed during the autumn include some opportunities identified with Chief Pharmacists around procurement of biologics, outpatient dispensing, capital purchases and other stock reduction initiatives. The group will also consider the case for more focussed Clinical Nurse Procurement model, similar to the one at Nottingham that have delivered multi £m benefit.

2.11 BCA Mortality Review Network

The BCA Clinical Reference Group (CRG) commissioned the establishment of a BCA Mortality Review Network. Mortality Leads across all 3 Trusts were identified and met for the first time on 26th September. Each Trust shared their current processes for identifying and undertaking Mortality Reviews, identifying and learning lessons and for providing assurances through to Trust Boards. The MRN identified a number of key themes where collaboration is highly desirable across the Black Country Alliance;

1. Identifying and reducing undesirable variation in process, rates of return and mortality / quality of care indicators

2. Improving distribution of lessons learned locally (within Trust) and across the BCA where quality of care could/should have been better and Local Health Economies in cases where deaths were predictable and patients perhaps shouldn't have been admitted for acute care.
3. Improving logistics to enable timely, consistent process and provision of robust assurances
4. Improving ability to perform Common Cause Analysis / spot trends over time
5. Embedding culture of continuous improvement / learning across the patch

The MRN have now approved a terms of reference, see appendix A, and will meet quarterly to drive this Black Country Alliance Mortality Review Network forward. Focus in final quarter of 2016 will be a comprehensive definition of our starting position, processes, metrics and performance to enable identification of variation and enable a better definition of granular opportunity for improvement in each of the 5 key themes identified above. The December 2016 MRN will then set out a proposed programme of interventions for 2017. A further report on this proposed programme of work will be taken back to the Clinical Reference Group and BCA Board in January / February 2017.

3. Other News

BCA Team; we have successfully completed the recruitment of our second project Manager for the core Black Country Alliance team. Grace Hodgetts joins us on 31st October from Health Education England where she was managing a number of accreditation programmes with national institutions. Prior to HEE, Grace has had spells working as Project Manager with NHS Property Services, PCTs and Providers in an NHS career spanning more than 20 years. This will enable more support to be provided to the growing scope of work for BCA.

WMAHSN Meridian Portal; a small SWBH team has been formed to explore how WMAHSN's Meridian innovation portal may be of benefit to Trusts in the BCA. WMAHSN are prepared to support us create and run a 'campaign' so we may test & learn. This feature is normally only available to enhanced members of the AHSN. It is likely that the topic we will develop in this campaign will be centred on 'developing the resilience of Midwives'.

4. The Ask of the Black Country Alliance Board

The Black Country Alliance Board is invited to;

1. Receive and comment on the above update.
2. Endorse the Mortality Review Network Terms of Reference.

The Black Country Alliance CAN – October 2016

Welcome to the latest edition of the Black Country Alliance CAN newsletter. Here is a brief update on the current projects being undertaken within the Black Country Alliance together with a roundup of other news items. This update follows the BCA Board meeting held on the 12th October 2016. The BCA Board will meet again in public on 9th November 2016 at 10.30am in Ground Floor Committee Room, Management Block, Sandwell General Hospital. You can find papers from the public BCA Board on www.blackcountryalliance.org

Interventional Radiology (IR)

The pilot of our 7-day non vascular interventional radiology service has proved to be a great success. The BCA board received a comprehensive report on this from the IR Steering Group. Feedback has been uniformly positive, with many patients benefiting from weekend access to clinically necessary nephrostomy procedures. Colleagues from all three BCA Trusts and at Royal Wolverhampton, who have been a key part of this pilot, have also expressed satisfaction with the service and are keen to see it established and indeed extended to cover other Urology and Gastro procedures. Based on the report received, the BCA Board approved the continuation of the 9-5 weekend and bank holiday service on a substantive basis. The Board also endorsed the groups' proposal to now plan extending the range of procedures covered. This planning will be done over the winter ahead of a potential pilot extension in Spring 2017.

Dawn Wardell, Chief Nurse for Dudley, is the executive sponsor and can be contacted via email on dawn.wardell@dgh.nhs.uk

Urology

We have now launched our Black Country Alliance Urology Network. We have established a virtual MDT each month during which complex cases will be reviewed by colleagues from all three trusts. We are planning the first Urology Network Conference in November where colleagues will hear more about the successes and progress we've made to date and spend some time defining the work we'll do together going into 2017.

Dawn Wardell, Chief Nurse for Dudley, is the executive sponsor for Urology and can be contacted via email (dawn.wardell@dgh.nhs.uk).

Workforce Development

We continue to make good progress developing a Black Country Alliance Medical Training Initiative (MTI), with all three trusts having taken steps already to secure MTI Fellows to work with us. The Group will meet again later this month to consider next steps, including further recruitment of fellows and working in partnership with academia to offer a Masters post-graduate degree to enhance our offering and secure additional high calibre Fellows.

In another exciting development, BCA Trusts along with other health care providers in the West Midlands will pilot the training of care staff in a brand new nursing support role. In December 2015, the Government announced a plan to create a new healthcare support role – the nursing associate – that will sit alongside existing nursing care support workers and fully-qualified registered nurses to deliver hands-on care for patients. It has the potential to transform the future of the nursing and care workforce. At the end of June 2016, Health Education England announced its call for applications for test site partnerships to introduce the new role of nursing associate with the goal of having 1,000 nursing associate trainees recruited and ready to start in December. In England eleven sites have been chosen to deliver the first wave of training, so it's a tremendous boost to be one of those selected. On qualification, these trainees will become the first nursing associates in the country. The course is full time and will run for two years and is a practice based course with academic input from Wolverhampton University.

The BCA Board endorsed proposals from HR Directors and colleagues to establish a Black Country Bank for Nursing and Allied Health Professional roles. This, along with developing our substantive workforce, is essential to tackling the challenges associated with reliance on expensive agency staff. We firmly believe that a more stable workforce will improve health outcomes, experience of healthcare and of course make better use of our resources.

The BCA Board also endorsed plans to establish a Clinical Coding apprenticeship programme, which will form a core component of our collaboration to tackle national shortage of qualified clinical coders. Alongside the creation of a Black Country Data Quality Network, and more focus on enabling home working as we enable digital hospitals through EPR, this will enable improved accuracy of clinical coding and our ability to attract, develop and retain colleagues in this important discipline.

There will be much more by way of update on all of this in the coming weeks and months. For more information contact BCA Senior Project Manager, Michelle McManus on michelle.mcmanus3@nhs.net

Community Services

Community colleagues from across all three Trusts have met to determine priorities and specific opportunities for collaboration. The group have shared a detailed assessment of Strengths, Weaknesses, Opportunities and Threats. Some emerging themes have been identified where the group feel there may be opportunity for collaboration. These include workforce development, Single Point of Access, patient transport services and mobile technology. Additionally, the group agreed that to stimulate collaboration, a joint BCA community services conference might be really valuable. The Group have committed to reflecting further on this analysis ahead of the next steering group in October/November. Following which it is expected some priorities will emerge for work in 2017. Wheelchair Services, Podiatry and Rapid Response Teams were all areas it was felt immediate discussions would be useful.

Daren Fradgley at WHC is the Executive Sponsor for this piece of work and can be contacted on daren.fradgley@walsallhealthcare.nhs.uk

Children's Services

Colleagues from across all three Trusts have met to determine priorities and specific opportunities for collaboration for children's acute & community services. A draft specialty map has been produced and in addition to mapping our services, this will also contain a view by service on the level of challenge associated with geography (hand over from one locality to another), transition from child to adult, Out of Hours (24 hours 7 days a week) and overall sustainability. The group have committed to finalising this map by the end of the calendar year, following which it is expected some priorities will emerge for work in 2017. In the meantime, the group have identified some immediate opportunity to explore how we tackle the risk associated with CAMHS better together. Out of Hours Sexual Abuse, Home IVs, 24/7 Palliative Care and MRI/CT scans were all areas felt to be worth exploring together.

Rachel Overfield, Director of Nursing at Walsall Healthcare is the executive sponsor for this piece of work and can be contacted on rachel.overfield@walsallhealthcare.nhs.uk

Mortality Review Network (MRN)

We're delighted to announce the formation of a BCA Mortality Review Network. Mortality Leads across all three Trusts met for the first time last month. Each Trust shared their current processes for identifying and undertaking Mortality Reviews, learning lessons and for providing assurances through to Trust Boards. The MRN identified a number of key themes where collaboration is highly desirable across the Black Country Alliance;

1. Identify and reduce undesirable variation in process, rates of return and mortality / quality of care indicators
2. Improve distribution of lessons learned locally (within Trust) and across the BCA where quality of care could/should have been better and across Local Health Economies.
3. Improve logistics to enable timely, consistent process and provision of robust assurances

4. Improve ability to perform common cause analysis / spot trends over time
5. Embed culture of continuous improvement / learning across the patch

The MRN will meet quarterly and their focus in quarter four of 2016 will be a comprehensive definition of our starting position, processes, metrics and performance to enable improvement in each of the five key themes identified above. The December 2016 MRN will then set out a proposed programme of interventions for 2017.

Roger Stedman is the Chair of the Mortality Review Network and can be contacted for more information on roger.stedman@nhs.net

Back Office

We have made good progress on a number of fronts relating to some reviews of back office services that we began in the spring. Our research management and governance colleagues have implemented a common cloud based clinical management system enabling them to share clinical trial information. There are also a number of joint research projects in progress now in areas such as Rheumatology, Cardiology, Dermatology and Haematology.

Our Information Governance colleagues have established a network to provide resilience and information sharing, and continue to collaborate on initiatives such as our information sharing protocol, which enables and supports safe and secure sharing of data and information as may be required to enable collaboration.

Our Legal Services teams are working together to improve the sharing of legal advices / opinions that each sources, and to explore means by which we may make better use of the external legal support we use.

Our newly appointed BCA Director of Procurement started with us on 1st October. Dave Coley will lead our continued collaboration on non-pay spend with the intent to make better use of the resources we have. Dave can be contacted on davidcoley@nhs.net

Find out more about the Black Country Alliance at www.blackcountryalliance.org or follow us on twitter @TheBCAlliance

Paul Harrison	**Toby Lewis**	**Richard Kirby**
Chief Executive	Chief Executive	Chief Executive
The Dudley Group	Sandwell and West Birmingham	Walsall Healthcare

The Dudley Gro
NHS Foundation Trust

Paper for submission to the Board
3 November 2016

TITLE:	**Corporate Risk Register and Assurance Report**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary
CORPORATE OBJECTIVES ALL			

Attached are the Corporate Risk Register and the Corporate Risk Assurance Report.

Corporate Risk Register

The Corporate Risk Register records the Trust's key risks linked to each of the Trust's six objectives. The Register includes those key risks to the Trust's objectives as recorded with the Trust's annual plan (these are seen as the top down risks), it also includes those risks that have been escalated from the Trust's Divisions / Directorates (these are seen as bottom up risks).

<u>New / escalated risks</u>

There have been no new or escalated risks within quarter 2 of the year.

<u>Risks where the current score has increased since the last meeting</u>

There are **2 increased risks** within the 2nd quarter of the year. These relate to:1
COR069 – Diagnostic Standard is at risk if the demand rises to a level above capacity. This risk has increased despite positive assurance being logged in the quarter as the Trust performance has deteriorated.
COR091 – The IT DR arrangements are not effective. This risk has increased despite positive assurance being logged in the quarter.

<u>Risks where the current score has decreased since the last meeting</u>

There are **5 risks where their score has decreased** within the 2nd quarter of the year. These relate to:-
COR104 – failure of the electricity supply to the hospital site. This is supported by the receipt of positive assurance in the quarter.
COR081 – Nurse / Midwifery revalidation fails. This is supported by the receipt of positive assurance in the quarter.
COR087 – An inability to reduce the incidence of hospital and community service acquired stage 3 and 4 pressure ulcers to an acceptable level resulting in suboptimal care. This has been reduced based on the balance of positive assurance received (all stage 3 and 4 pressure ulcers verified by Tissue Viability Team and revised process for reporting and management) when weighed up against the negative

assurance (attrition of 3 staff members) also received in the 2nd quarter.
COR093 – Management of young people requiring care under the mental health act (tier 4 beds not being available). This has been reduced based on the balance of positive assurance received (CCG agreed to commission CAHMs Tier 3.5 service from Dudley and Walsall Mental Health) when weighed up against the negative assurance (Dudley and Sandwell Mental Health remain in the process of recruiting) also received in the 2nd quarter.
COR106 - Failure to comply with Fire Safety requirements. This is supported by the receipt of positive assurance in the quarter.

De-escalated risks and Achieved risks since the last report

There has been one risk de-escalated this quarter (this was debated and agreed at the Risk and Assurance Group meeting in October). This risk is COR081 nurse revalidation fails. This risk has been de-escalated based on the level of positive assurance that the Trusts controls were working, including the recent Internal Audit report which provided substantial assurance (a green opinion) over these controls

Corporate Assurance register

The corporate assurance report shows the details of the assurances received to date, noting that this relates to assurances received in the first four or five months of the year. The assurance register also records the origin of the assurance, operational management through to an external source. As this assurance is collated across the year, Management and the Board will be able to see the relative strength of assurance against each risk underpinning each objective.

Assurance gaps

There are a number of risks for which assurance has not been logged in this quarter These include:-

COR061 Failure to maintian financial sustainability

COR101 The risk to the delivery of the number of capital schemes the Board would like to commit to which require external financial support

COR107 The agreed outcome of the STP is not aligned with the current Trust Business Strategy (Note - there was no assurance logged against this risk last quarter)

In each of the above cases the risk score has not changed since the last quarter.

Negative Assurance

Negative assurance has been logged in this quarter across risks, this has caused no

risks to increase but for those risks the score has not been reduced except for risks COT87 and COR93 where the balance of positive assurance outweighed the negative allowing the risk to be reduced.

IMPLICATIONS OF PAPER:

RISK	**Yes all risks**		**Risk Description: N/A**
	Risk Register: all on CRR		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains but particularly well led**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y	Y	

ACTION FOR THE BOARD

To confirm based on the review undertaken by the Risk and Assurance Group that the attached Risk Register reflects the key risks facing the Trust.

The Dudley Group NHS
NHS Foundation Trust

CORPORATE RISK REGISTER – SEPTEMBER 2016

Risk Dashboard – rolling risk score trend

Strategic Objective	Oversight Committee	Risk Lead	ID	Risk Description	Inherent risk score	Current Score								Trend	Target Risk Score
						17/03/15	05/06/15	26/08/15	21/12/15	02/03/16	04/05/16	30/06/16	30/09/16		
SO1	F	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer)	20	15	20	15	15	15	20	20	20	→	8
	F	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	20	16	16	16	16	16	16	16	20	↑	8
	C	DG	COR084	Failure to learn and be ready for our next CQC inspection*	16	new	8	12	12	12	12	12	12	→	6
	C	DG	COR098	Failure to meet the expectations of the Accessible Information Standard	16					new	16	12	12	→	8
	F	COO	COR099	Failure to reduce the number of delayed transfer of care may result in poor patient experience and may impact on patient safety, as patients will have to be managed in outlying / contingency areas	20					new	20	20	20	→	16
	C	DN	COR108	An inability to consistently maintain confidence in the quality of delivery of maternity care, resulting in negative reputation, loss of public and national confidence, reduction to bookings and financial loss	16						new	16	16	→	8
SO2	F	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	15	15	15	15	10	10	10	10	→	10
	F	DF	COR104	Failure of the electricty supply to Hospital Site	20					esc	16	16	12	↓	4
	C	CN	COR085	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing	20	20	20	20	15	20	20	20	20	→	10
	C	CN	COR081	Nurse / Midwifery revalidation fails	12	new	16	8	4	4	8	8	4 **de - esc**	↓	4
	C	CN	COR082a	Failure to achieve the target of no more than 29 C.Diff cases where a laspe in care is judged by the CCG to have occured	8	Clarified that risk relates to lapses in care			10	8	8	8	8	→	8
	C	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16	new	16	8	4	8	8	8	8	→	4
	C	CN	COR087	An inability to reduce the incidence of hospital and community service acquired avoidable stage 3 and 4 pressure ulcers to an acceptable level resulting in suboptimal care for patients	12	esc	12	12	8	8	8	12	9	↓	4

Strategic Objective	Oversight Committee	Risk Lead	ID	Risk Description	Inherent risk score	Current Score								Trend	Target Risk Score
						17/03/15	05/06/15	26/08/15	21/12/15	02/03/16	04/05/16	30/06/16	30/09/16		
	C	CN	COR093	Management of young people requiring care under the mental health act (tier 4 beds are not available)	20		new	12	8	12	16	16	12	↓	8
	F	CN	COR097	Fail to achieve the best practice target for falls in hospital	12					new	9	9	9	↓	6
	C	CN	COR096	Failure to prevent avoidable deterioration of patients leading to cardiac arrests	20			new	10	10	10	10	10	↓	8
	F	DF	COR106	Failure to comply with Fire Safety requirements	20					esc	15	15	12	↓	10
S03	C	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20	new	20	20	16	16	16	16	16	↓	15
	F	DIT	COR089	EPR programme is delayed and fails to deliver expected benefits **	16	new	16	12	12	12	16	16	16	↓	12
SO4	W	COO	COR102	The implementation of the revised JD contract may result in reduced avaiavility of JD leading to gaps in rotas	16					new	16	16	16	↓	8
SO5	F	DIT	COR091	The IT DR arrangements are not effective	20	esc	20	15	15	15	10	10	12	↑	4
	F	DSP	COR080	Failure to deliver our 2016/17 CIP programme ***	20	20	12	9	4	4	20	20	20	↓	9
SO6	F	DF	COR061	Failure to maintian financial sustainability	20	20	16	16	12	12	16	16	16	↓	5
	F	DSP	COR103	Potentail for MCP procurement exercise adversly impacts on Trust sustainability	12					new	12	20	20	↓	8
	F	DF	COR101	The risk to the delivery of the number of capital schemes the Board would like to commit to which require external financial support	20					new	20	20	20	↓	15
	F	CN	COR105	Reduced ablity to control temporary staffing resulting in Nurising Divisional Overspend.	16						esc	16	16	↓	12
	F	DSP	COR107	The agreed outcome of the STP is not aligned with the current Trust Business Strategy.	16						new	16	16	↓	12
	W	DHR	COR109	Inability to recruit and retain staff in key posts could impact on service quality, patient and staff experience of the Trust coupled with a need to then fill via agency use putting further pressure on the Trust's budget and its ability to secure the Sustainability and Transformation Fund in quarters 2, 3 and 4	20						new	20	20	↓	12

* reworded risk but it remains similar to risk COR084 tracked last year
** reworded risk but very similar to risk COR089 tracked last year
*** reworded risk but it remains similar to risk COR080 tracked last year

Key for Risk Lead		Key for Strategic Objectives		Key to Oversight Committee	Key for risk	
CE	Chief Executive	**SO1:**	Deliver a great patient experience	**A = Audit**	**New**	New risk identifed
MD	Medical Director	**SO2:**	Safe and Caring Services	**B = Board**	**Esc**	Risk esculated from lower division / directorate etc
CN	Chief Nurse	**SO3:**	Drive service improvements, innovation and transformation	**C = CQSPE**	**De-esc**	Risk de-esculated to the lower division / directorate to manage
DF	Director of Finance and Information	**SO4:**	Be the place people choose to work	**F = F&P**	**Arc**	Risk no longer valid
COO	Chief Operating officer	**SO5:**	Make the best use of what we have	**W = W&SE**		
DSP	Director of Strategy and Performance	**SO6:**	Deliver a viable future			
DG	Director of Governance					
CHR	Chief HR Advisor					
DIT	Director of IT					

The Dudley Group NHS
NHS Foundation Trust

CORPORATE RISK ASSURANCE SUMMARY – SEPTEMBER 2016

Assurance Dashboard – rolling assurance trend

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 30/06/16	Level 1	Level 2	Level 3	Risk Sept 16	Level 1	Level 2	Level 3	Risk Dec 16	Level 1	Level 2	Level 3	Risk March 16	Level 1	Level 2	Level 3	
SO1	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer)	20	10	A	A		20		G										8
	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	20	16	G	G		20		G										8
	DG	COR084	Failure to learn and be ready for our next CQC inspection*	16	12	A	A		12	G	R										6
	DG	COR098	Failure to comply with Accessible Information Standard	16	12	G			12	G											8
	COO	COR099	Failure to reduce the number of delayed transfer of care may result in poor patient experience and may impact on patient safety, as patients will have to be managed in outlying / contingency areas	20	20	R	R		20	R	R										16
	CN	COR108	An inability to consistently maintain confidence in the quality of delivery of maternity care,	16	16	New - no assurance logged			16	G	G	A									8
SO2	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	10	G	G		10	G	G	G									10
	DF	COR104	Failure of the electricty supply to Hospital Site	20	16	No assurance logged			12			G									4
	CN	COR085	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing	20	20	G	G		20	A	G										10

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 30/06/16	Level 1	Level 2	Level 3	Risk Sept 16	Level 1	Level 2	Level 3	Risk Dec 16	Level 1	Level 2	Level 3	Risk March 16	Level 1	Level 2	Level 3	
	CN	COR081	Nurse / Midwifery revalidation fails	12	8	G			4	G	G	G									4
	CN	COR082a	Failure to achieve the target of no more than 29 C.Diff cases where a laspe in care is judged by the CCG to have occured	8	8	G	G		8	G											8
	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16	8	A	A		8	A	G										4
	CN	COR087	An inability to reduce the incidence of hospital and community service acquired avoidable stage 3 and 4 pressure ulcers to an acceptable level resulting in suboptimal care for patients	12	12	A			9	A											4
	CN	COR093	Management of young people requiring care under the mental health act (tier 4 beds are not available)	20	16	R	R		12	R		G									8
	CN	COR097	Fail to achieve the best practice target for falls in hospital	12	9		G		9	G											6
	CN	COR096	Failure to prevent avoidable deterioration of patients leading to cardiac arrests	20	10		G		10		G										8
	DF	COR106	Failure to comply with Fire Safety requirements	20	15	No assurance logged			12	G		G									10
S03	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20	16		G			A											16
	DIT	COR089	EPR programme is delayed and fails to deliver expected benefits **	16	16	No assurance logged			16		G										12

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 30/06/16	Level 1	Level 2	Level 3	Risk Sept 16	Level 1	Level 2	Level 3	Risk Dec 16	Level 1	Level 2	Level 3	Risk March 16	Level 1	Level 2	Level 3	
SO4	COO	COR102	The implementation of the revised JD contract may result in reduced avaiavility of JD leading to gaps in rotas	16	16	G			16	A											8
SO5	DIT	COR091	The IT DR arrangements are not effective	20	10	No assurance logged			12		G										4
	DSP	COR080	Failure to deliver our CIP programme **	20	20	A	A		20		A										9
SO6	DF	COR061	Failure to maintian financial sustainability	20	16	A	A		16	No assurance logged											5
	DSP	COR103	Potentail for MCP procurement exercise adversly impacts on Trust sustainability	12	20	A	A		20		A										8
	DF	COR101	The risk to the delivery of the number of capital schemes the Board would like to commit to which require external financial support	20	20		R		20	No assurance logged											15
	CN	COR105	Reduced ability to control temporary staffing resulting in Division financial overspend	16	16	New - no assurance logged			16	A	R										12
	DSP	COR107	The agreed outcome of the STP is not aligned with the current Trust Business Strategy	16	16	New - no assurance logged			16	No assurance logged											12
	CN	COR109	Inability to recruit and retain staff in key posts could impact on service quality, patient and staff experience. agency use putting further pressure on the Trust's budget and its ability to secure the Sustainability and Transformation Fund in quarters 2, 3 and 4	20	20	New - no assurance logged			20	A											12

* reworded risk but it remains similar to risk COR084 tracked last year
** reworded risk but very similar to risk COR089 tracked last year
*** reworded risk but it remains similar to risk COR080 tracked last year

Key for Risk Lead			Key for Strategic Objectives			Key for source of assurance	Key for assurance grading
CE	Chief Executive		**SO1:**	Deliver a great patient experience		**Level 1 – assurance provided by Operational Management**	**G reen** **ALL** Positive assurance
MD	Medical Director		**SO2:**	Safe and Caring Services		**Level 2 – assurance provided by Executive Manangement / Board Committee**	**A mber** **A MIX** of positive and negative assurance
CN	Chief Nurse		**SO3:**	Drive service improvements, innovation and transformation		**Level 3 – assurance provided by an external source**	**R ed** **ALL** Negative assurance
DF	Director of Finance and Information		**SO4:**	Be the place people choose to work			**A blank indicates no asurance was noted for that quarter**
COO	Chief Operating officer		**SO5:**	Make the best use of what we have			
DSP	Director of Strategy and Performance		**SO6:**	Plan for a viable future			
DG	Director of Governance						
CHR	Chief HR Advisor						
DIT	Director of IT						

Analysis of Risk

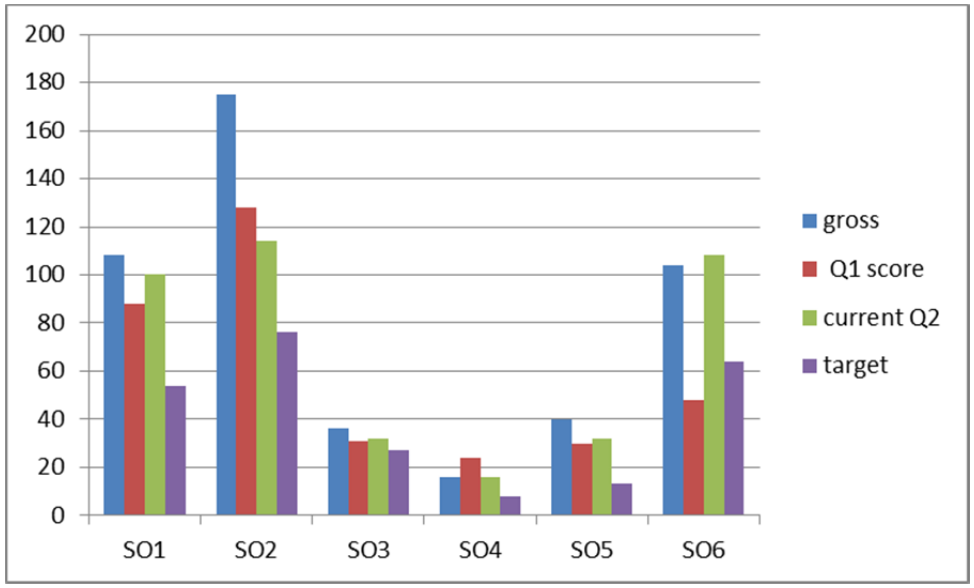
Overview of current positon

Number of risks at start of the year	Total number CURRENT risks	Total Gross Risk	Prior Quarter total risk score	CURRENT total risk score	Target risk score
25	28	479	349	402	242

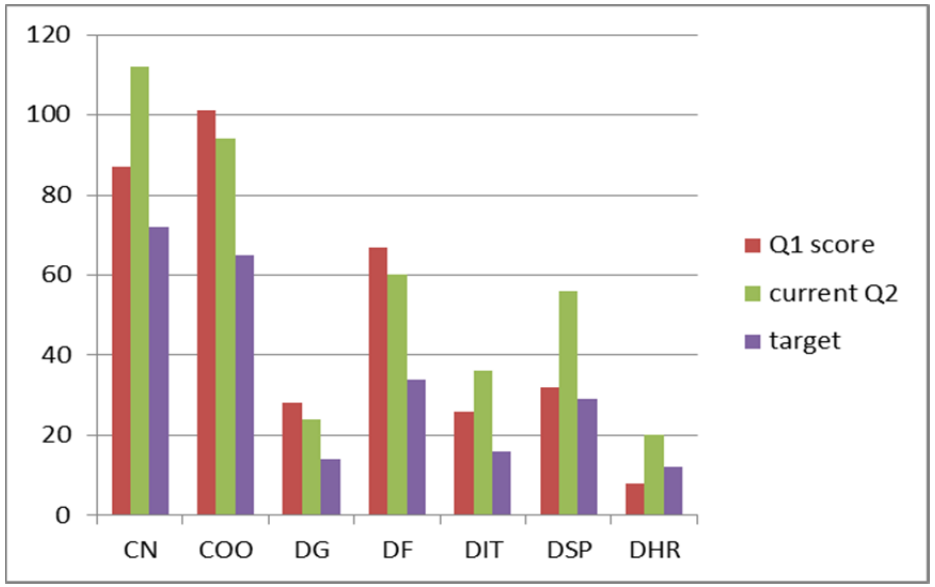
Whilst 3 new risks were added at the June Board meeting (one at SO1, 2 at SO6) these new risks do not account for the full value of the chnages within these objectives which shows that other risks have increased.

Risk Analysis by Trust Objective

	number of risks	gross	Q1 score	current Q2	target
SO1	6	108	88	100	54
SO2	11	175	128	114	76
SO3	2	36	31	32	27
SO4	1	16	24	16	8
SO5	2	40	30	32	13
SO6	6	104	48	108	64
Totals	28	479	349	402	242



Risk Analysis by Director	number of risks	gross	Q1 score	current Q2	target
CN	10	152	87	112	72
COO	6	111	101	94	65
DG	2	32	28	24	14
DF	4	80	67	60	34
DIT	2	36	26	36	16
DSP	3	48	32	56	29
DHR	1	20	8	20	12
Totals	28	479	349	402	242



Whilst the new risks added related to one for the chief nurse, one for he director of workforce and one for director of director of strategy and performance the chart above confirms that increased risk is recorded outside of these.

The increased risks relate to the inter-related areas of workforce, agency use and finance including the delivery of identified cost improvement measures. In relation to these inter-related risks then the Finance and Performance Committee in conjunction with the Workforce Committee are undertaking deep dives into the control environment and assurances to mitigate these risks and will report back to the Board.

Risk Assessment Matrix

Contingency Group
Where risk management will ensure that contingency plans are in place

Primary Group (issues for Board)
Where risk management should focus most of its time

Risks that fall in to the group highlighted as primary will require immediate attention. Both the status of the risk will require to be monitored with regard to effect on the organisations activities and the progress of action taken to ensure its effective completion.

Risks that fall in to the group highlighted as contingency may require immediate action but will require to be monitored for any changes in the risk or control environment which may result in the risk attracting a higher score. This will be a key area for assurance work to be undertaken in.

Impact					
5. Catastrophic	C5	C10	C15	P20	P25
4. Major	C4	C8	C12	P16	P20
3. Moderate	L3	L6	L9	HK12	HK15
2. Minor	L2	L4	L6	HK8	HK10
1. Slight	L1	L2	L4	HK4	HK5
	1. Rare	**2. Unlikely**	**3. Possible**	**4. Likely**	**5. Almost Certain**

Likelihood

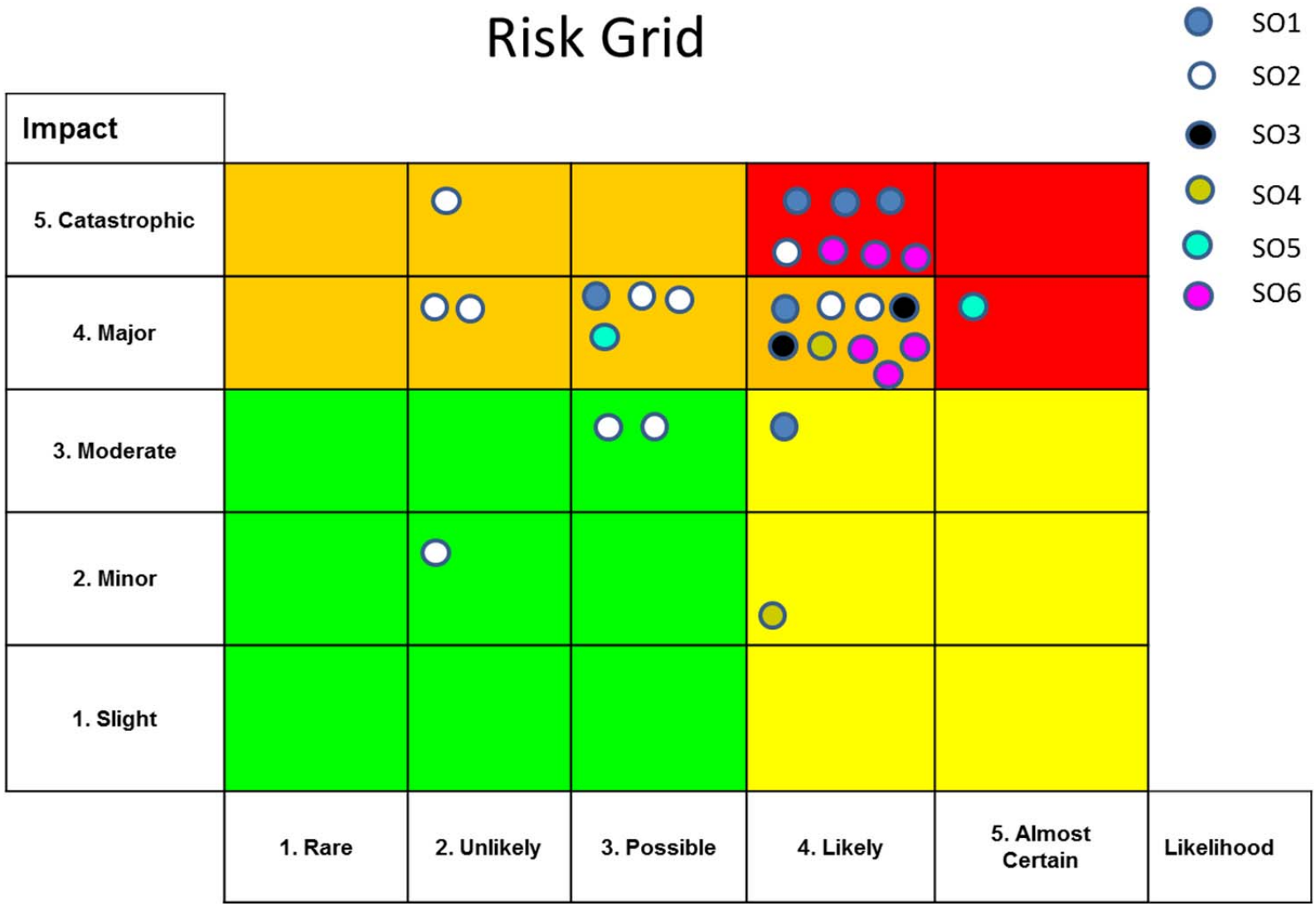
House Keeping Group
Basic mechanisms should be in place - Risk Management will confirm

Low Group
Where risk is so minimal it does not demand specific attention

Risks that fall in to the group highlighted as negligible will require review only, but no further action.

Risks that fall in to the group highlighted as house keeping will require to be monitored by management and assurance provided.

Risk Grid


SO1
SO2
SO3
SO4
SO5
SO6
Impact
5. Catastrophic
4. Major
3. Moderate
2. Minor
1. Slight
1. Rare
2. Unlikely
3. Possible
4. Likely
5. Almost Certain
Likelihood

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 3 November 2016

TITLE:	**Update for End of Life and Palliative Care Strategy Group meeting on 11 October 2016**		
AUTHOR:	Doug Wulff	**PRESENTER**	Doug Wulff – Group 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 Group and the action the Group 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 Group, the decisions taken in accordance with the Group's terms of reference.

The Dudley Group NHS
NHS Foundation Trust

Group Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
End of Life and Palliative Care Strategy Group	**11 October 2016**	**Dr Doug Wulff**	**yes**	**no**
			Yes	

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 regarding implementation across Health Economy 2 Rapid Discharge - negative assurance due to lack of progress 3 AMBER - negative assurance as not progressing due to time pressures on wards 4 Macmillan Specialist at Home - project on-going. Concern regarding an exit strategy and continuity for funding of posts beyond October 2017. 5 Advance Care Planning - limited assurance that is continuing across the Health Economy including education and evaluation without agreement for funding the documentation. 6 Education - limited assurance received due to poor uptake of training 7 EPaCCS - negative assurance on lack of progress. No clarity on funding and no decision has been made in relation to the IT solution 8 Bereavement - negative assurance received as not progressing due to delays and no clear forward plan 9 VOICES - assurance received that the survey was progressing in hospital and within community; however the Hospice survey was different to the rest of the economy

Decisions Made / Items Approved
1 Group noted the changes to the national Transforming end of life care in hospitals programme. The impact on the current work streams noted and that these enablers are still relevant and important: • Advance care planning • Sharing records in real time e.g. Electronic Palliative Care Coordinating Systems • Recognising and managing uncertainty e.g. AMBER care bundle • Rapid discharge to home • Caring in the last days of life i.e. Priorities for Care of the dying person 2 End of Life and Palliative Care Implementation Plan - agreed that a sub-group meeting be arranged to discuss the way forward and to establish target dates 3 Group noted that there is still no clarity on the reporting route to the Partnership Board and resultant lack of progress
Actions to come back to Group (items Group keeping an eye on)
1 End of Life and Palliative Care Implementation Plan 2 Confirm reporting route to Partnership Board as agreed in Terms of Reference
Items referred to the Partnership Board for decision or action
1 Lack of progress across Health Economy in areas of limited or negative assurance

Enclosure 11

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 3rd November 2016

TITLE:	**Transformation and Cost Improvement Programme (CIP) Summary Report**		
AUTHOR:	Amanda Gaston, Head of Service Improvement and Programme Management	**PRESENTER**	Amanda Gaston Head of Service Improvement and Programme Management (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 24th October 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 Six 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 £9,764k of the £11,407k it has identified to date. This creates an additional shortfall of **£1,642k** against identified schemes. As a result, the Trust's is forecasting an overall shortfall of **£2,143K** for 2016/17.

Agreement by TEC on 22nd September to action CIP relating to improvements made in LOS reduction but bed closures not occurred due to increased numbers of DTOC patients. An additional £723k will be added to the CIP achieved in Month 7 reducing the overall shortfall to **£1,420k**.

Of the 42 PIDs approved by TEC, 37 have been approved by the Quality Impact Assessment (QIA) panel. The remaining 2 projects will be submitted to the QIA panel on 8th November 2016 which will scrutinise all projects to ensure all risks to quality are identified and suggest mitigations to address any potential risks.

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)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	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 September, 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**
SO2:	**Safe and Caring Services**
SO3:	**Drive service improvements, innovation and transformation**
SO4:	**Be the place people choose to work**
SO5:	**Make the best use of what we have**
SO6:	**Deliver a viable future**

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

Care Domain	Description
SAFE	**Are patients protected from abuse and avoidable harm**

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

The Dudley Group NHS
NHS Foundation Trust

Trust Board of Directors

Service Improvement and PMO Update

3rd November 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 Six 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	£5,545k	£4,443k	-£1,102k	£9,764k	-£1,642k

Based on the Month Six 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 £9,764k of the £11,407k it has identified to date. This creates an additional shortfall of **£1,642k** against identified schemes. As a result, the Trust is forecasting an overall shortfall of **£2,143K** for 2016/17.

Agreement by TEC on 22nd September to action CIP relating to improvements made in LOS reduction but bed closures not occurred due to increased numbers of DTOC patients. An additional £723k will be added to the CIP achieved in Month 7 reducing the overall shortfall to **£1,420k.**

There was one project in Exception Reporting mode this month.

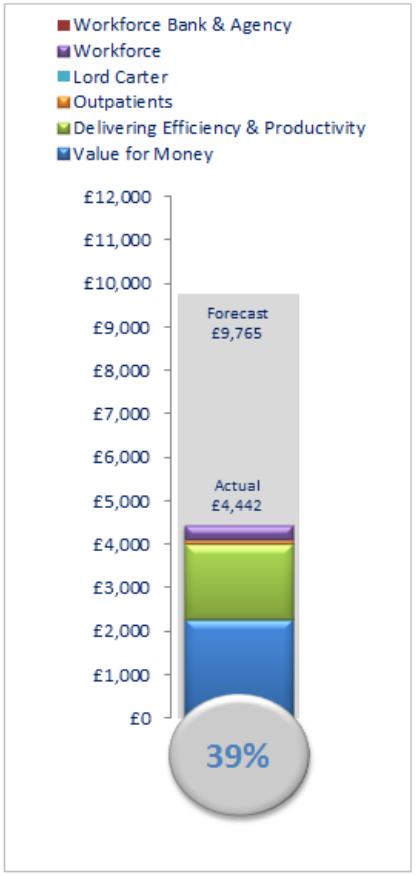
Of the 46 projects due to deliver savings in 2016/17, 42 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC).

Of the 42 PIDs approved by TEC, 37 have been approved by the Quality Impact Assessment (QIA) panel. The remaining 2 projects will be submitted to the QIA panel on 8th November 2016 which will scrutinise all projects to ensure all risks to quality are identified and suggest mitigations to address any potential risks. The remaining 3 PIDs do not require QIAs.

Executive Summary

	YTD	FYE
Planned	£5,545,209	£11,406,963
Actual	£4,443,162	£4,441,740
Forecast		£9,764,650
Variance	-£1,102,047	-£1,642,314

	Submitted Plan	Overall Shortfall
Identified	£11,406,963	
Target	£11,907,990	
Variance	-£501,027	-£2,143,340



Programme (Click for details)	Executive Lead	FYE Plan	FYE Forecast	YTD Plan	YTD Actual	Forecast Shortfall	Planned Lord Carter Contribution
Delivering Efficiency and Productivity	Paul Bytheway	£4,665,059	£3,653,606	£2,203,301	£1,734,347	-£1,011,453	£2,993,347
Value for Money Infrastructure	Paul Taylor	£4,895,783	£4,760,814	£2,456,347	£2,266,505	-£134,969	£1,343,000
Workforce	Dawn Wardell	£950,321	£760,058	£475,163	£344,145	-£190,263	£300,004
Outpatients	Anne Baines	£303,800	£256,671	£151,899	£98,166	-£47,129	£303,800
Lord Carter	Anne Baines	£0	£0	£0	£0	£0	£0
Workforce Bank & Agency	Paul Taylor	£592,000	£333,500	£258,500	£0	-£258,500	£592,000
View all Projects	Total	£11,406,963	£9,764,650	£5,545,209	£4,443,162	-£1,642,314	£5,532,151

2016/17 Forecast Non Recurrent	£2,041k	% of Total CIP Forecast as Non Recurrent	21.24%

2017/18 and 18/19 CIP Planning

- **CIP guide for Divisions and departments;**
  - Lord Carter Model Hospital Portal Indicators
  - HED Benchmarking tool
  - Validated CIP ideas list from Deloittes
- **Engagement with Divisions and Departments;**
  - Lord Carter Specialty level workshops for 6 Medicine and 6 Surgery, Women & Children's Specialties
  - Divisional CIP workshops to include Chief of Division, Director of Operations, Head of Nursing, Finance Business Partner and Head of Service Improvement
  - Validation sessions for CIP Ideas list with Deloittes and Heads of Services
- **External Support**
  - NHS Improvement CIP Network – Documentation being used in CIP guide
  - Deloittes Team

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 3 November 2016

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	Jonathan Fellows Non-Executive Director
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: Summary reports from the Finance and Performance Committee meeting held on 27 October 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

The Dudley Group NHS
NHS Foundation Trust

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**29 September 2016**	**Jonathan Fellows**	**yes**	**no**
			yes	

Declarations of Interest Made

None

Assurances Received

- The Nursing and Midwifery Directorate reported on actions being taken to reduce agency spending in the rest of the financial year
- The plan to improve the diagnostic waiting times, and the speed that recovery happens was reported and agreed
- The month 6 financial position was discussed and the achievement of the second quarter Sustainability and Transformation Funding confirmed
- The Revised process from NHS Improvement regarding the reporting of a deteriorating financial position was noted
- Noted that the Q2 62 day cancer target had been met, and that all other constitution targets were being met apart from diagnostic waits
- The Caret implementation plans in Procurement and Pharmacy were “in hand” with action plans for implementation in place.
- The proposals for 2017-19 Transformation Plans were being developed with Divisions and an early view of financial and activity plans for 2017-19 would be available for the Board Workshop on 10th November 2016.
- Plans for the implementation of the new junior doctor’s contract were in place and on time

Decisions Made / Items Approved

- The package of measures to reduce spending in 2016-17 was agreed in full, and that communications should take place immediately to all Trust staff to create some ownership of the solution.
- The Performance Management policy was agreed

Actions to come back to Committee

- Nursing and Midwifery Directorate to report back to the Committee at their meeting on 22md December 2016.

Performance Issues to be referred into Executive Performance Management Process

- The Diagnostic waits action plan
- Challenges of meeting the ED 95% target on Type 1 attendances only

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

- None

Items referred to the Board for decision or action

- The Financial aspects of the EPR business case were debated and it was agreed that the Executive Directors would make a recommendation to the Board on the next steps re procurement

- The agency self-certification check-list required Board approval
- The risks associated with the Package of Measures for Financial Recovery, and their impact on the forecast out-turn for 2016-17

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - September 2016

Quality & Risk			2015			2016										
Description		LYO	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	YTD	YEF
Friends & Family – Community – Footfall		1%	0.8%	0.6%	1.8%	1.7%	1.9%	1.8%	1.4%	1.1%	1.5%	1.4%	1.3%	1.1%	1.3%	
Friends & Family – Community – Recommended %		96.4%	96.8%	94.7%	98.8%	96.5%	97.9%	95.4%	96.8%	94.7%	94.4%	98%	96.1%	96.1%	96%	
Friends & Family – ED – Footfall		7.5%	7.4%	5.9%	6.2%	5.2%	7.4%	6.1%	5%	3.8%	1.6%	8.4%	10.7%	5%	5.9%	
Friends & Family – ED – Recommended %		92.3%	95.8%	92.5%	88.4%	95.8%	92.9%	97.9%	91.4%	91.3%	88.2%	91.7%	91.8%	91.9%	91.5%	
Friends & Family – Inpatients – Footfall		25.7%	23%	23%	17.2%	16.5%	17.6%	18.4%	17.7%	15.8%	13.9%	17.9%	18.6%	20.5%	17.3%	
Friends & Family – Inpatients – Recommended %		97%	96.7%	96.6%	99%	95.9%	95.5%	94.1%	96.8%	96.7%	97%	94.6%	96.6%	96.6%	96.3%	
Friends & Family – Maternity – Footfall		21.6%	25.1%	32.1%	18%	17%	20.4%	15.9%	17.6%	33.2%	16.6%	33.8%	32.7%	32.3%	28%	
Friends & Family – Maternity – Recommended %		98.2%	97.9%	98.2%	96.6%	97.8%	98.2%	98.4%	97.5%	97.3%	98.9%	96%	98.6%	98.8%	97.8%	
Friends & Family – Outpatients – Footfall		-	-	-	-	-	-	-	1.2%	1.1%	1%	1.7%	1.5%	1.4%	1.3%	
Friends & Family – Outpatients – Recommended %		87.6%	88.4%	83.6%	88.4%	90%	84.1%	88.9%	85%	82.2%	93.1%	91.7%	92.4%	92.4%	89.8%	
HCAI – Post 48 hour MRSA		2	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI CDIFF - Total Number of Cases		-	5	5	8	4	1	0	2	3	2	2	-	-	-	
Incidents - Patient Falls, Injuries or Accidents		-	111	118	114	129	-	-	-	-	-	-	-	-	-	
Incidents - Pressure Ulcer		2,047	125	141	172	187	242	246	253	240	194	193	196	188	1,264	
Mixed Sex Sleeping Accommodation Breaches		4	0	2	0	2	0	0	0	0	0	0	0	0	0	
Never Events		1	0	0	0	0	0	0	0	0	0	0	1	0	1	
Serious Incidents – Not Pressure Ulcer		104	11	11	10	9	4	7	7	6	4	12	11	6	46	
Serious Incidents - Pressure Ulcer		228	18	17	30	26	12	19	13	9	8	10	17	16	73	
Stroke - Suspected TIA Scanned < 24hrs of Presentation		85.35%	92.31%	50%	52.63%	85.71%	66.67%	94.12%	84.62%	78.57%	36.36%	63.64%	66.67%	76.47%	69.23%	

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - September 2016

Quality & Risk			2015			2016										
Description		LYO	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	YTD	YEF
Stroke Admissions : Swallowing Screen		80.58%	78.38%	88.89%	87.88%	83.78%	76.32%	86.67%	89.36%	88.37%	85.11%	78.72%	94.44%	43.75%	81.35%	
Stroke Admissions to Thrombolysis Time		56.31%	37.5%	71.43%	33.33%	45.45%	37.5%	50%	60%	50%	83.33%	36.36%	54.55%	50%	53.49%	
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		89.16%	88.68%	88.68%	90.91%	92.68%	84.09%	70.83%	82.76%	91.11%	91.53%	90.2%	88.64%	85.37%	88.26%	
VTE Assessment Indicator (CQN01)		95.96%	96.1%	96.67%	96.47%	95.4%	94.43%	94.46%	94.65%	95.5%	95.09%	93.91%	94.5%	93.41%	94.52%	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - September 2016

Finance			2016							
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	YTD	YEF
Budgetary Performance		£773k	(£71)k	£266k	(£110)k	(£23)k	£3k	(£1)k	£65k	
Capital v Forecast		69.5%	61.8%	66.5%	76.2%	76.4%	73.9%	72.1%	72.1%	
Cash v Forecast		122.3%	94.8%	93.2%	96.2%	74.9%	89%	93.7%	93.7%	
Debt Service Cover		1.18	1.4	1.58	1.63	1.74	1.69	1.72	1.72	
EBITDA		£20,460k	£2,228k	£2,820k	£2,755k	£3,321k	£2,358k	£2,550k	£16,032k	
I&E (After Financing)		(£2,945)k	£280k	£859k	£818k	£1,380k	£403k	£1,249k	£4,991k	
Liquidity		7.07	7.1	8	8.84	10.39	10.93	11.94	11.94	
SLA Performance		£1,031k	(£122)k	£326k	£144k	£15k	£194k	(£303)k	£254k	
SLR Performance		(£2,945)k	£281k	£859k	£819k	£1,381k	£403k	£1,249k	£4,992k	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - September 2016

Performance			2015			2016										
Description		LYO	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	YTD	YEF
A&E - 4 Hour A&E Dept Only % (Type 1)		96.79%	98.93%	97.5%	97.13%	91.76%	92.74%	91.53%	93.24%	92.88%	94.48%	93.34%	92.97%	92.14%	93.17%	
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%	99.38%	98.63%	98.47%	95.73%	96.06%	95.62%	96.3%	96.06%	96.76%	96.21%	95.81%	95.29%	96.07%	
Activity - A&E Attendances		96,141	8,099	7,900	7,754	8,088	7,946	8,626	7,807	8,801	8,430	8,973	8,580	8,598	51,189	
Activity - Community Attendances		407,248	36,008	34,642	33,385	33,694	32,322	30,817	32,681	32,631	32,846	31,673	33,781	33,224	196,836	
Activity - Elective Day Case Spells		45,020	3,952	3,757	3,719	3,677	3,938	3,820	3,801	3,720	3,998	3,798	3,924	3,925	23,166	
Activity - Elective Inpatients Spells		6,394	572	580	481	500	515	534	514	523	549	561	482	509	3,138	
Activity - Emergency Inpatient Spells		52,037	4,296	4,265	4,552	4,573	4,359	4,714	4,823	5,246	5,076	5,056	5,002	4,959	30,162	
Activity - Outpatient First Attendances		130,956	10,712	11,159	10,604	11,304	11,569	12,255	10,329	10,632	10,618	9,943	10,708	12,147	64,377	
Activity - Outpatient Follow Up Attendances		313,888	25,988	27,022	25,643	26,438	26,699	26,435	26,540	26,976	27,061	25,260	25,758	27,320	158,915	
Activity - Outpatient Procedure Attendances		52,451	4,864	4,968	4,268	4,117	4,691	3,324	4,989	4,960	5,219	5,099	4,891	4,407	29,565	
RTT - Admitted Pathways within 18 weeks %		94.2%	92.5%	93.3%	93.4%	94.4%	92.8%	91.5%	92.5%	93.5%	94.2%	94.2%	95%	93.2%	93.8%	
RTT - Incomplete Waits within 18 weeks %		95.1%	94.6%	94.4%	94.9%	95%	95.6%	95.4%	97.1%	96.8%	97.1%	97.1%	96.6%	96.1%	96.8%	
RTT - Non-Admitted Pathways within 18 weeks %		97.7%	97.5%	97.8%	97.8%	97.3%	97.4%	96.7%	96.7%	97.7%	98.1%	98%	98.4%	97.1%	97.7%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		98.97%	97.87%	98.85%	99.29%	99.52%	99.53%	99.03%	98.04%	99.39%	99.16%	98.96%	97.69%	98.12%	98.57%	

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

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Finance & Performance Report - September 2016

Staff/HR			2015			2016										
Description		LYO	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	YTD	YEF
Appraisals		77.5%	78.3%	75.5%	80.3%	79.9%	79.2%	77.5%	80.9%	80.5%	81%	78.1%	78.3%	77.4%	77.4%	
Mandatory Training (Professional Requirements)		-	-	-	-	-	-	-	-	71.3%	72.8%	72.5%	72.4%	70.1%	70.1%	
Mandatory Training (Substantive)		83.3%	84.1%	84.7%	85.1%	83.9%	83.3%	83.3%	83.8%	75.4%	76.3%	77.4%	78.6%	77%	77%	
Sickness Rate (Performance Dashboard)		3.80%	3.83%	3.80%	4.10%	4.54%	4.38%	4.01%	3.82%	4.15%	3.95%	4.02%	3.64%	3.90%	3.91%	
Staff In Post (Contracted WTE)		4,116.31	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	4,112.05	4,146.74	4,146.74	
Vacancy Rate		9.41%	9.93%	10.31%	10.59%	10.05%	9.24%	9.41%	10.24%	10.53%	10.78%	10.75%	10.31%	9.61%	9.61%	

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

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Description	Target	All Tumour Sites	Brain	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Paediatric	Skin	Upper GI	Urology	Total
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	93%	-	100%	98.7%	92.6%	93.4%	94.1%	97.2%	100%	100%	93.2%	89.4%	95.5%	**94.2%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	-	98.8%	-	-	-	-	-	-	-	-	-	**98.8%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	-	100%	100%	100%	100%	-	100%	-	100%	100%	91.7%	**98.4%**
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%	80%	-	100%	100%	100%	**96.3%**
Cancer - 62 day - From Referral for Treatment following national screening referral	90%	-	-	100%	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85%	-	-	100%	94.7%	100%	100%	33.3%	100%	-	100%	80%	74.1%	**91.7%**

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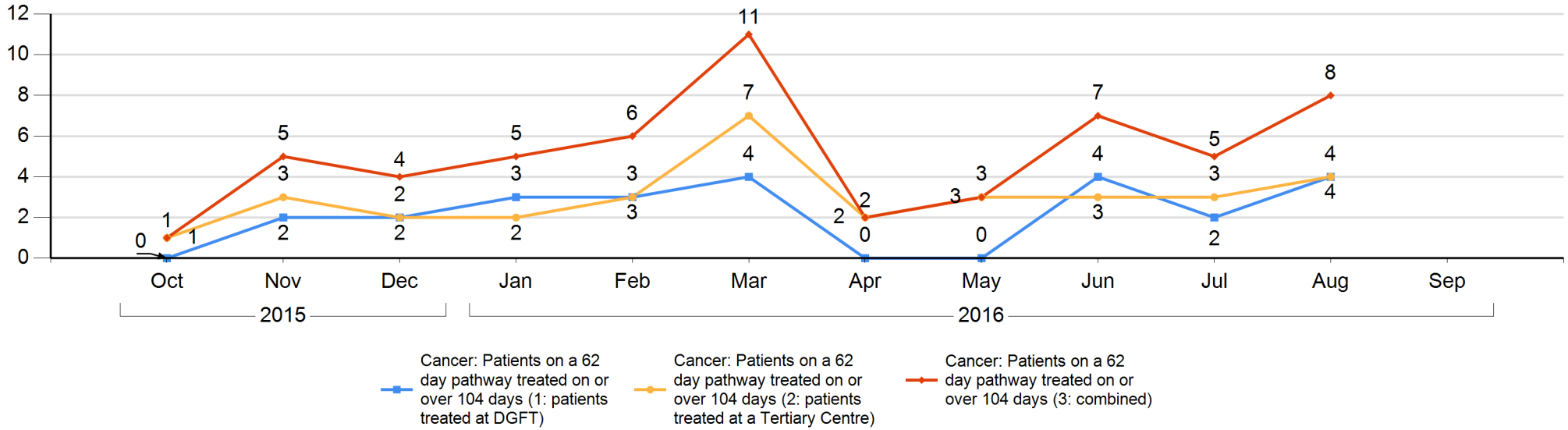
	2015			2016								
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Cancer: Patients on a 62 day pathway treated on or over 104 days (1: patients treated at DGFT)	0	2	2	3	3	4	0	0	4	2	4	
Cancer: Patients on a 62 day pathway treated on or over 104 days (2: patients treated at a Tertiary Centre)	1	3	2	2	3	7	2	3	3	3	4	
Cancer: Patients on a 62 day pathway treated on or over 104 days (3: combined)	1	5	4	5	6	11	2	3	7	5	8	



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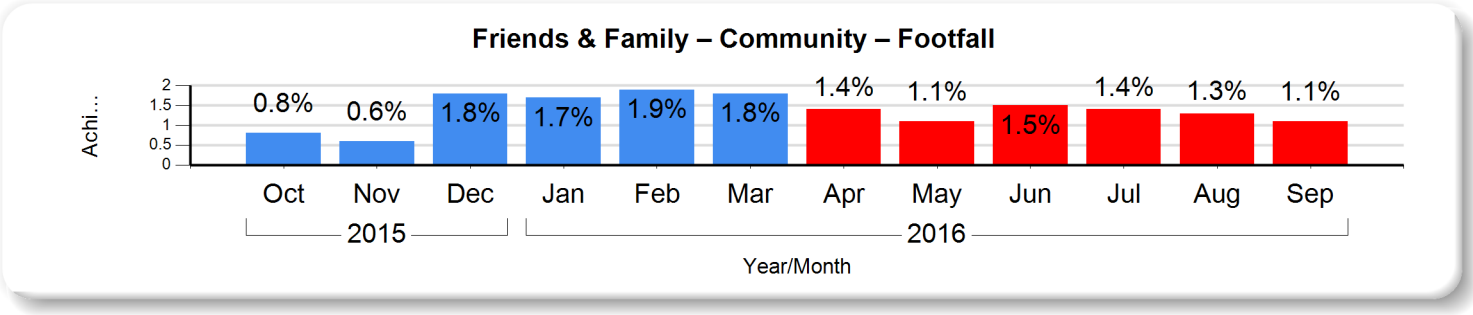
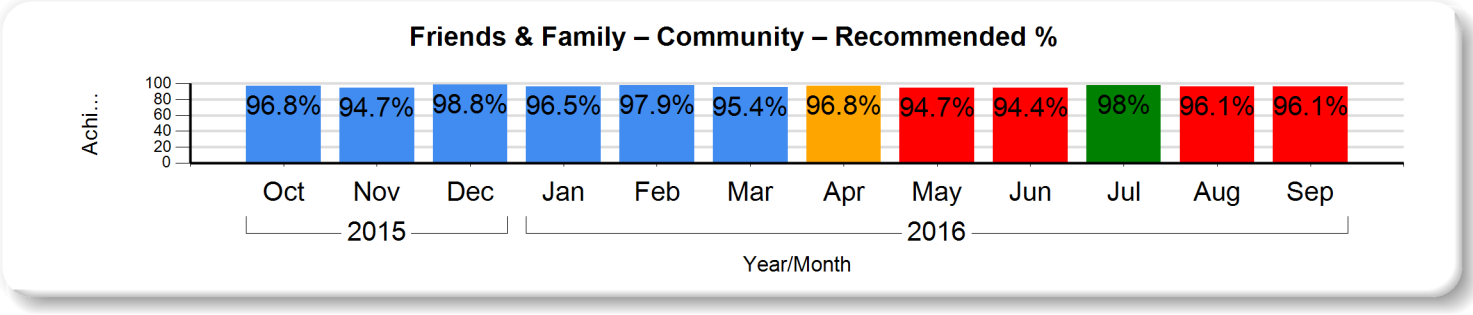
Quality & Risk Fails

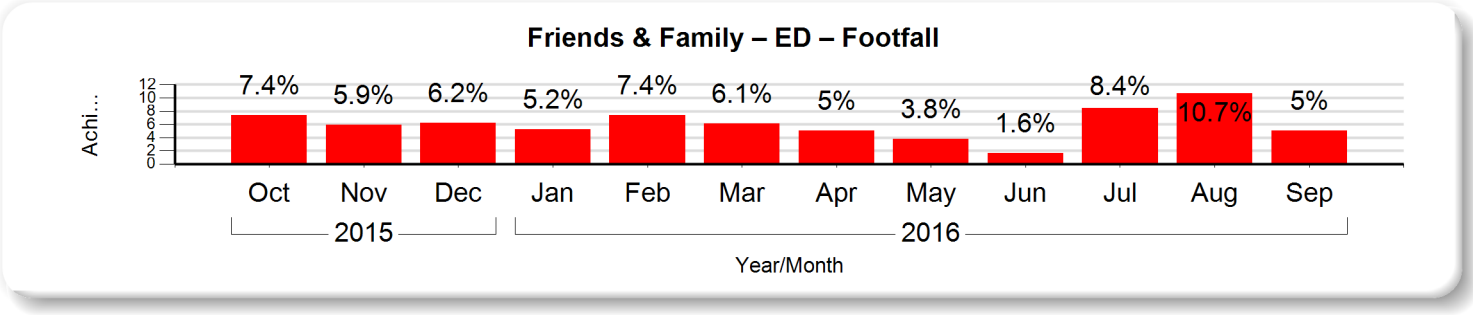
Friends & Family – Community – Footfall



Friends & Family – Community – Recommended %



Friends & Family – ED – Footfall



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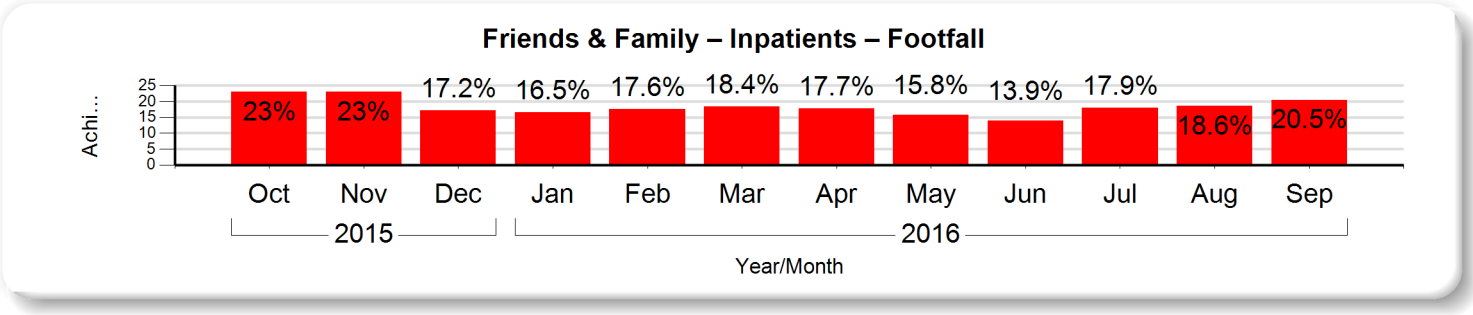
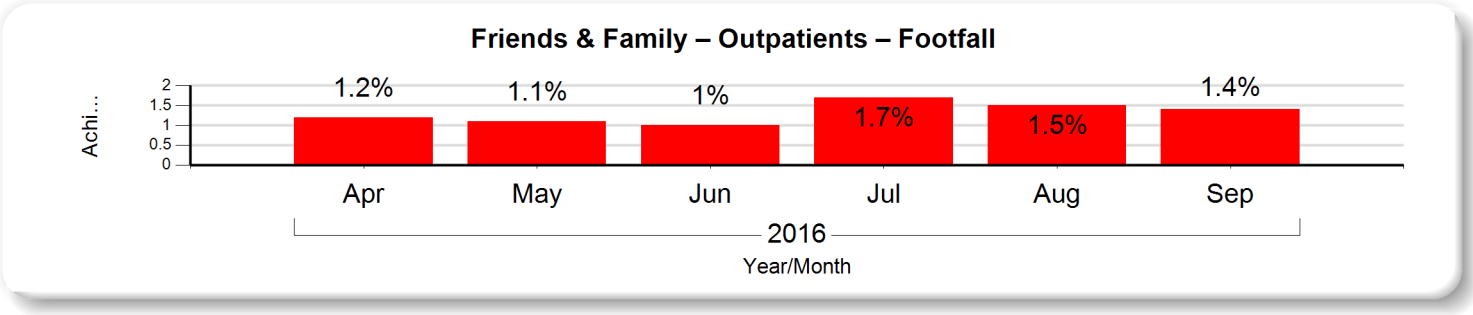
Quality & Risk Fails

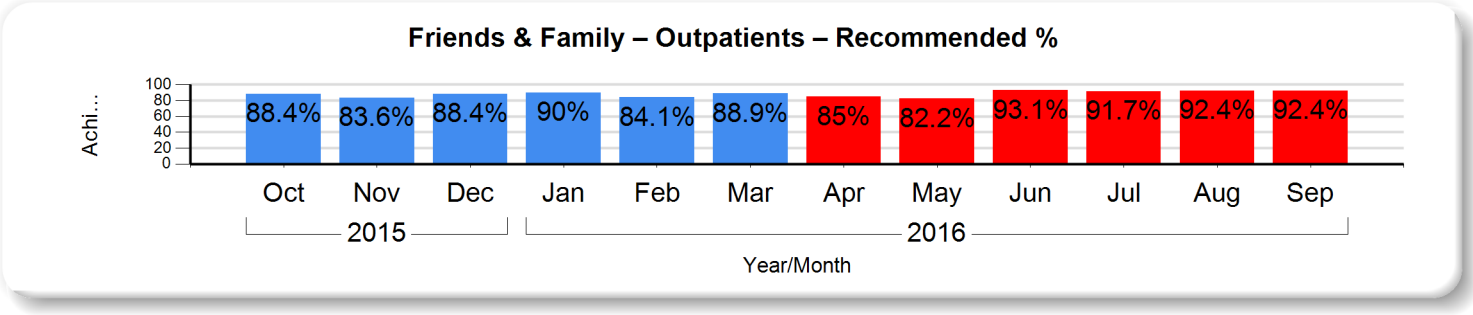
Friends & Family – Inpatients – Footfall



Friends & Family – Outpatients – Footfall



Friends & Family – Outpatients – Recommended %



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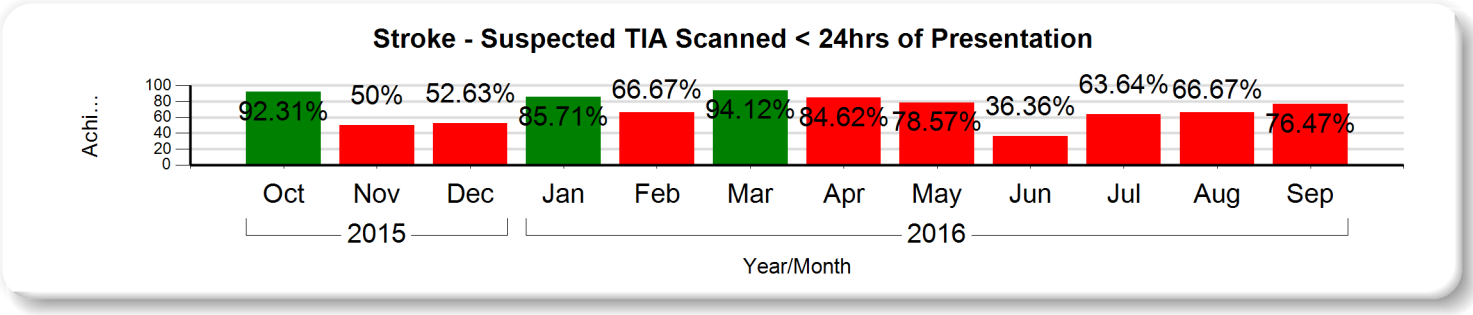
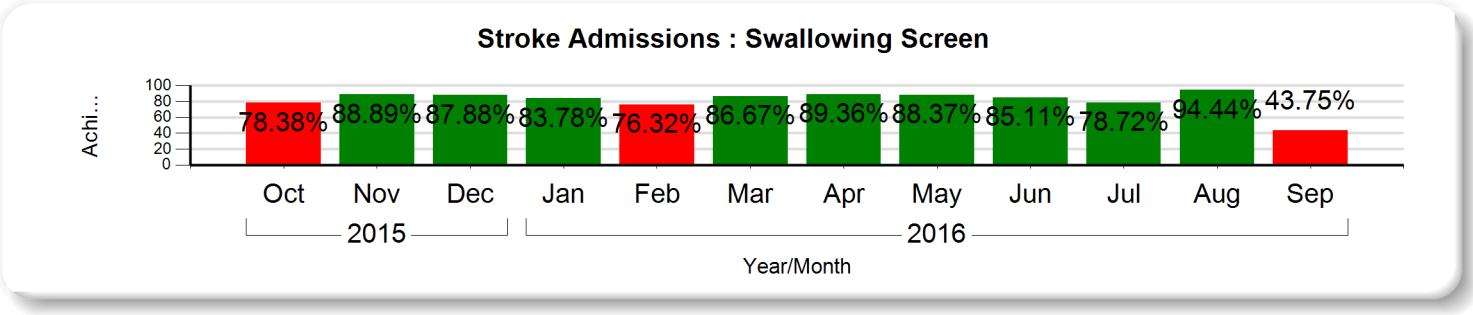
Quality & Risk Fails

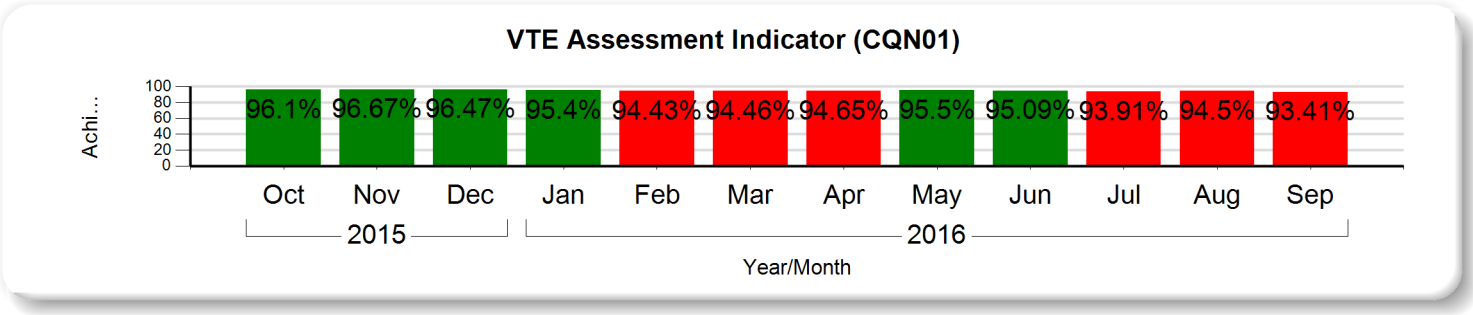
Stroke - Suspected TIA Scanned < 24hrs of Presentation



Stroke Admissions : Swallowing Screen



VTE Assessment Indicator (CQN01)



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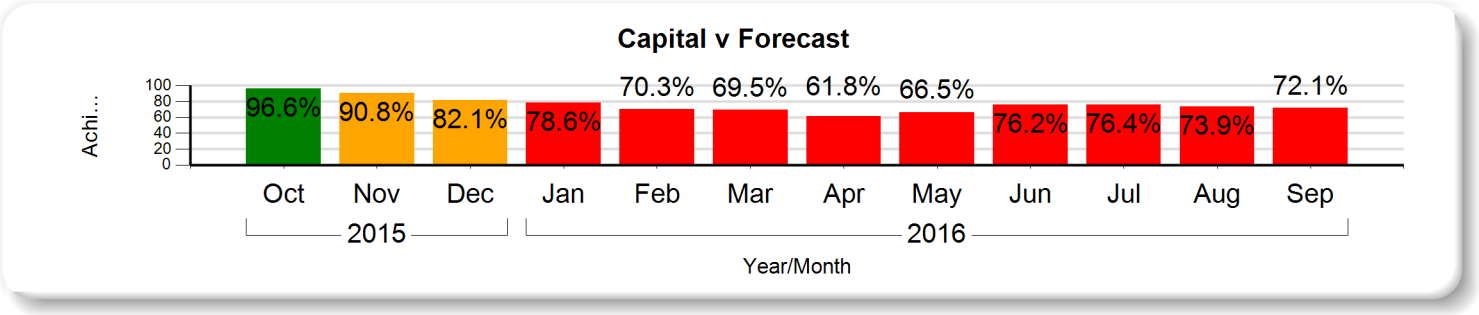
Finance Fails

Capital v Forecast



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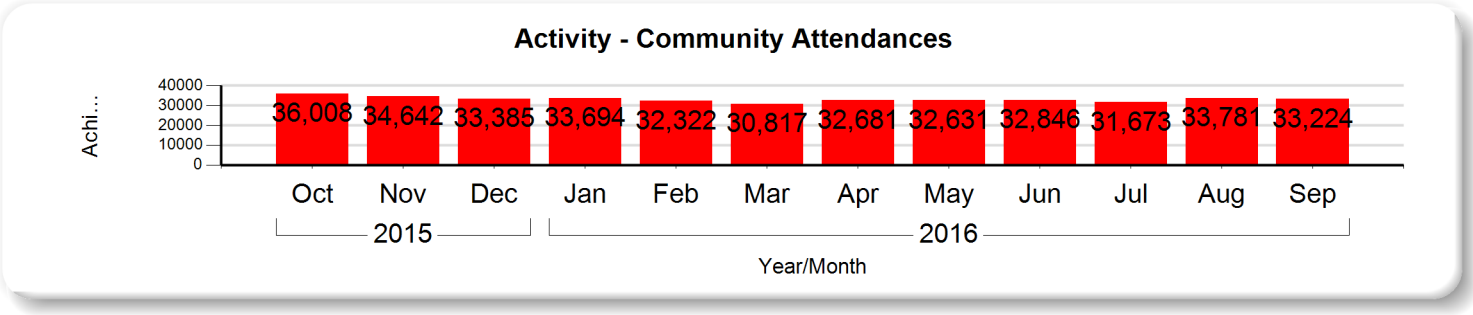
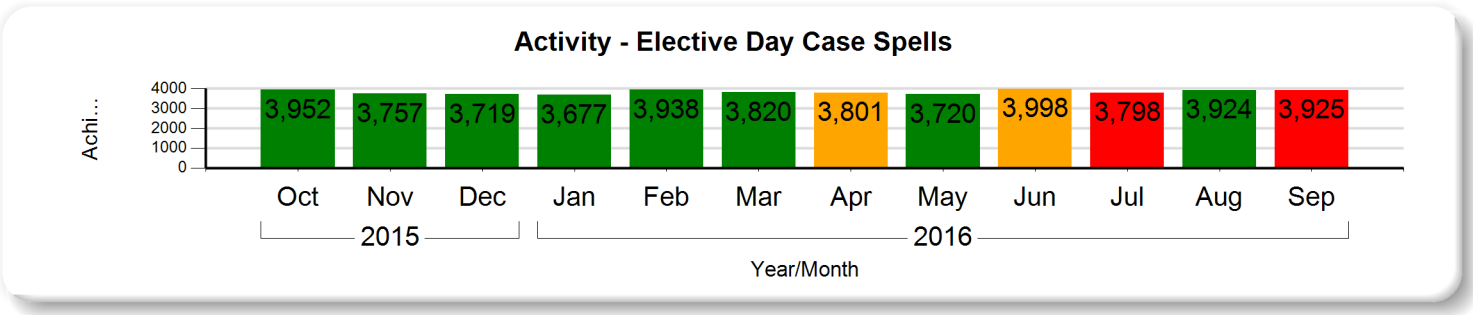
Performance Fails

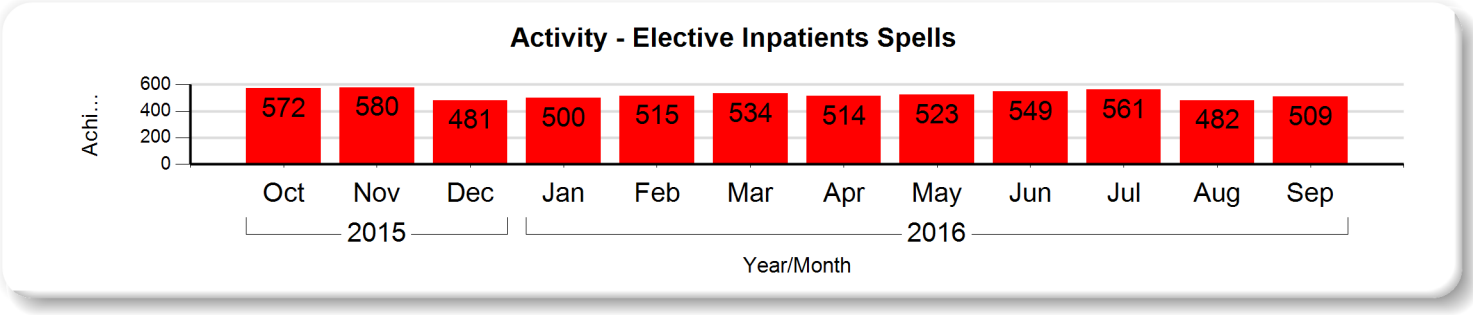
Activity - Community Attendances



Activity - Elective Day Case Spells



Activity - Elective Inpatients Spells



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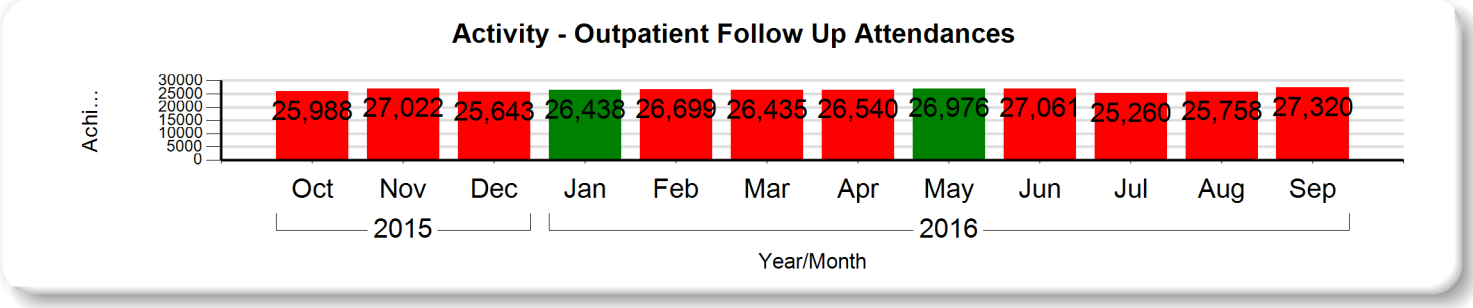
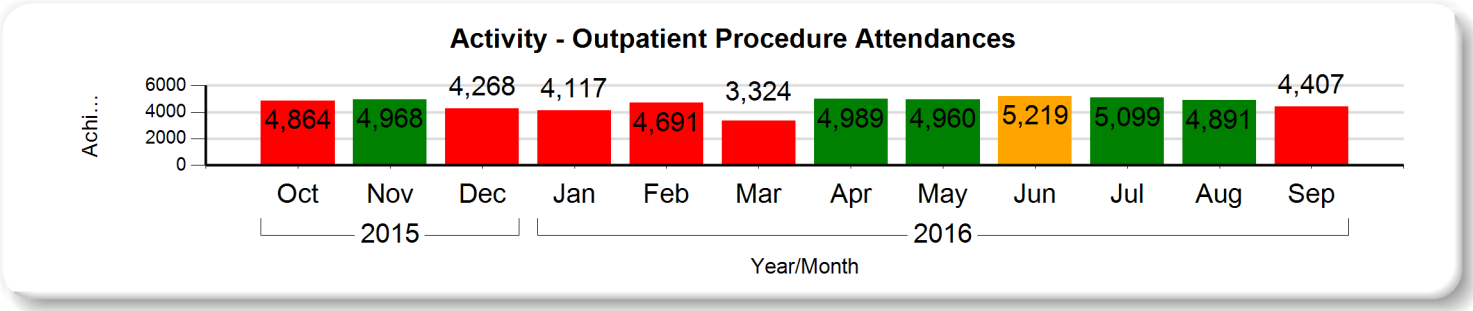
Performance Fails

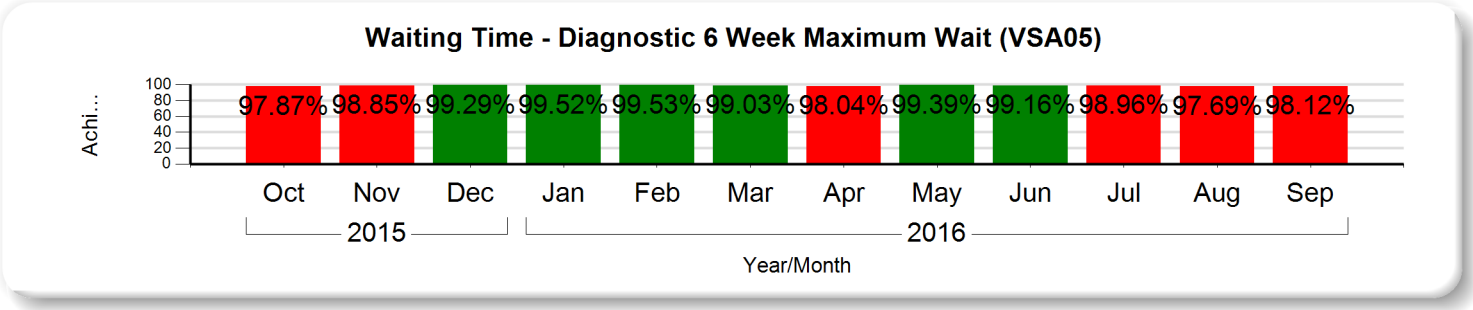
Activity - Outpatient Follow Up Attendances



Activity - Outpatient Procedure Attendances



Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)



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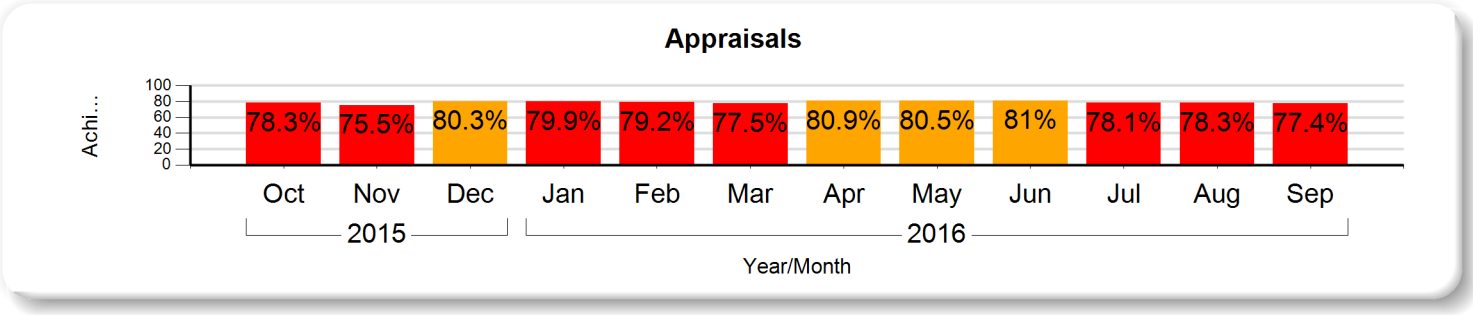
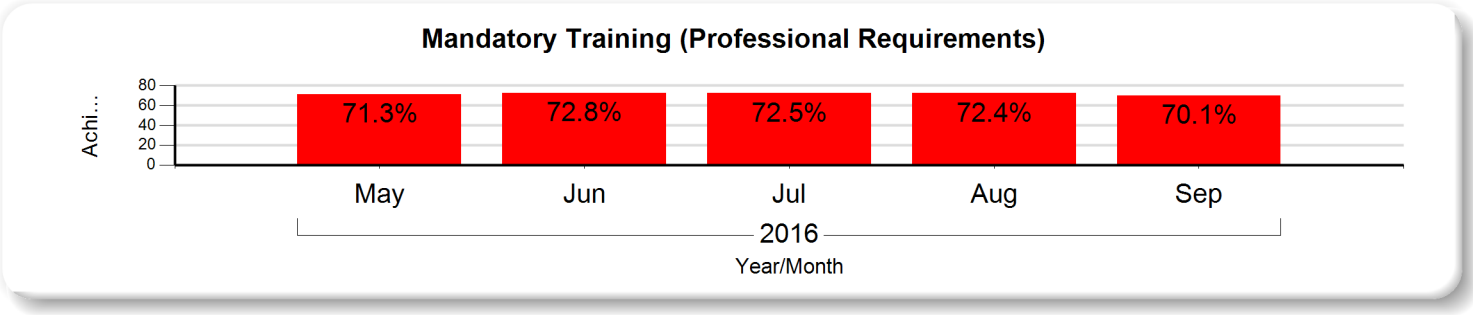
Staff/HR Fails

Appraisals



Mandatory Training (Professional Requirements)



Mandatory Training (Substantive)