The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 5 May, 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**		J Ord	To Note	9.30
3.	**Announcements**		J Ord	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 7 April 2016	Enclosure 1	J Ord	To Approve	9.35
	4.2 Action Sheet 7 April 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 Clark	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 End of Life and Palliative Care Report	Enclosure 6	D Wulff	To Note	10.20
	7.4 Organ Donation Report	Enclosure 7	J Sonksen	To Note	10.30
	7.5 NED Lead Responsibilities Report	Enclosure 8	G Palethorpe	To Note	10.40
	7.6 Health and Safety Assurance Report	Enclosure 9	P Bytheway	To Note	10.45
	7.7 Complaints Report	Enclosure 10	G Palethorpe	To Note	10.55
	7.8 Black Country Alliance Report	Enclosure 11	P Clark	To Note	11.05
	7.9 Constitution Annual Review	Enclosure 12	G Palethorpe	To Note	11.15
8.	**Finance and Performance**				
	8.1 Finance and Performance Committee Exception report	Enclosure 13	J Fellows	To Note & Discuss	11.25
	8.2 Operational Plan Report	Enclosure 14	A Baines	To Note	11.35
	8.3 Cost Improvement Programme and Transformation Overview Report	Enclosure 15	A Baines	To Note	11.45

9.	**Any other Business**				11.55
10.	**Date of Next Board of Directors Meeting** 9.30am 2 June 2016 Clinical Education Centre		J Ord		11.55
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		11.55

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 7th April, 2016 at 9:00am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Paul Taylor, Director of Finance and Information
Julian Atkins, Non Executive Director
Paula Clark, Chief Executive
Paul Bytheway, Chief Operating Officer
Dawn Wardell, Chief Nurse
Doug Wulff, Non Executive Director
Ann Becke, Non Executive Director
Jonathan Fellows, Non Executive Director

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Communications and Patient Experience
Glen Palethorpe, Director of Governance/Board Secretary
Anne Baines, Director of Strategy and Performance
Teekai Beach, Business Manager (Item P16/041.5)

16/034 Note of Apologies and Welcome
9.04am

Apologies were received from Paul Harrison.

16/035 Declarations of Interest
9.05am

There were no declarations of interest.

16/036 Announcements
9.05am

No announcements made.

16/037 Minutes of the previous Board meeting held on 3rd March, 2016 (Enclosure 1)
9.05am

Mr Fellows, Non Executive Director, confirmed that his name was missing from the attendance list. With this amendment the minutes of the previous meeting were agreed by the Board as a true and correct record of the meeting's discussion and signed by the Chairman.

16/038 Action Sheet, 3rd March, 2016 (Enclosure 2)
9.06am

All items appearing on the action sheet were noted to be complete, for update at a future Board meeting or appeared on the Board agenda.

16/039 Patient Story
9.08am

Liz Abbiss, Head of Communications and Patient Experience, presented the patient story. The lady on the video was the main carer for her husband and was visually impaired. The lady praised the care of her husband during his stay but had some observations regarding her own experience whilst visiting the hospital.

Liz confirmed that the Trust was looking at providing ward based visual awareness training.

The Chief Operating Officer suggested that the Visual Liaison Officer could present at a future learning event.

Mr Fellows, Non Executive Director, suggested that the approach should be the same for all patients. The Chief Executive agreed that the communication approach from all Trust staff should be the same.

The Chief Nurse confirmed that she is meeting with the Visual Liaison Officer to look at options to improve awareness across the Trust. The Trust could also use the Customer Care video. The Chief Nurse had spoken to the Heads of Nursing around communicating with patients. The Board discussed Nursing leadership and commented that sometimes it is not clear to visitors and patients who the sisters are.

Dr Wulff, Non Executive Director, asked if Trust signs are in braille and added that the Trust should also look at providing braille media. Liz Abbiss confirmed that the Trust has a braille machine and can produce literature in braille for patients.

The Chief Nurse confirmed that she will meet with Liz Abbiss to pick up the communication issues.

The Director of Strategy and Performance raised the carers issue and confirmed that she had recently met with the Wyre Forest Public Engagement Group who had asked if the Trust had a Carers Strategy. She suggested that the Trust could extend the Strategy to remind staff that carers have disabilities and not just patients. Liz Abbiss confirmed that the Trust does not currently have a Carers' Strategy but the CCG have a Health Economy wide Strategy and there is also a Health Economy Carers' Co-ordinator.

Mrs Becke, Non Executive Director commented that the carer did not have enough information about what was happening to her husband and that has been heard before in patients' stories. She suggested that information on what carers could expect to be told could also be included in the Strategy. The Chairman commented that this could be difficult if patient has capacity, there are limitations to what information should be shared with carers. Dr Wulff, Non Executive Director, suggested that the Trust could share some practical information.

Mr Atkins, Non Executive Director, suggested that the Trust needs a broader approach to disabilities. Liz Abbiss confirmed that the Trust is fostering links with disability groups.

The Chairman and Board noted the patient story and the work being undertaken regarding communication and training. The Chairman asked that checks are made to ensure that all intelligence from the video is covered by the Trust's strategies. The Board noted that the Chief Nurse and Liz Abbiss will investigate the production of a Carers Strategy.

Chief Nurse and Liz Abbiss to investigate the production of a Carers' Strategy and to also address communication approaches.

16/040 Chief Executive's Overview Report (Enclosure 3)
9.29am

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

- **Friends and Family:** The Chief Executive commented that the report usually provides provisional scores for part months and this will change to reporting full months from the next Board meeting. The Trust continues to push response rates.

- **Freedom to Speak Up Guardian:** This had arisen following Francis and Morecambe Bay. The Chief Executive confirmed that there is an open culture at the Trust for staff to raise concerns. The Board noted that Carol Love Mecrow had been appointed as the Trust's Freedom to Speak Up Guardian. The Board approved this appointment. The Director of Governance/Board Secretary confirmed that a national policy on Whistleblowing had recently been published and this will link into the Trust Whistleblowing Policy.

- **Wyre Forest:** The Board noted that the first clinic had gone live the previous week.

- **Interventional Radiology:** The BCA service went live the previous week.

- **100,000 Genomes Project:** Dr Neilson had attended a recent Directors meeting. The Trust is signing up to the Genomes Project and Dr Neilson will be the lead. The Board noted that Dr Neilson will present on the Project to one of its meetings or one of the Board Committees. The Chairman asked about the benefit for individuals. The Chief Executive confirmed that individuals will receive feedback.

The Chairman and Board noted the report.

16/041 Patient Safety and Quality

16/041.1 Chief Nurse Report (Enclosure 4)
9.36am

The Chief Nurse presented her report given as Enclosure 4.

The Chief Nurse presented on the key issues relating to infection control, including:

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

C.Diff: 14 cases over total trajectory numbers. The Trust is now at 12 cases against the yearly trajectory of 29 cases of lapses in care. The trajectory for 2016/17 remains at 29 cases. The total number of cases for the year was 43.

Norovirus: No cases to note.

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

- Amber shifts (shortfall) had shown an increase to 76, due to additional capacity open and fill rates from bank and agency.
- Maternity saw a rise in amber shifts in February to 13.
- One red (serious shortfall) shift in the month but no safety issues identified with this or any of the other shortfall shifts that affected quality of care. Patient safety continues to be the Trust's highest priority.
- A benchmark review on fill rates provided by Unify had been carried out using local Trusts and Dudley was noted to be comparable.

The Board noted that the Trust Recruitment Team is flying to the Philippines the following week to interview 140 nurses.

A Maternity Open Day is taking place this month with a larger recruitment Open Day arranged for May. Mr Miner, Non Executive Director, asked if the Philippine nurses are exclusive to the Trust. The Chief Nurse confirmed that the Trust did have exclusivity but the nurses were open to national recruitment. The Trust Recruitment Team was taking Philippino nursing staff to talk about their perspective of Dudley. Maternity were interviewing 15 midviwes and the Chief Nurse confirmed that this was a very positive position.

The Chief Nurse raised Nursing Care Indicators and confirmed that there had been escalation in some areas and it was hoped that improvements would be experienced over the next 2 months.

The Chairman asked about projections going forward for safer staffing. The Chief Nurse confirmed that there had been a positive response to the Health Care Support Worker vacancies and this will offset the vacancy rate and improve the bank fill rate.

The Chief Operating Officer added that there were currently 100 delayed discharges and this was not helping the position as the Trust had contingency areas open. The Chief Executive confirmed that there were 28 Dudley patients waiting for a nursing home placement and this equates to a full ward. The Chief Executive confirmed that that the situation had been raised with the NHSE and will be discussed at SRG the following week. The Chairman asked if the Board could do anything to assist further. The Chief Executive confirmed that she would continue to apply pressure.

The Director of Finance and Information highlighted the financial risk around the capacity issues.

The Chairman asked about the escalation procedure for Nursing Care Indicators. The Chief Nurse confirmed that there are clear discussions taking place around actions and expectations at every level.

The Chairman and Board noted the report and the excellent performance around infection control and noted the safer staffing actions.

16/041.2 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 5)
9.54am

Mrs Becke, Non Executive Director, presented the Clinical Quality Safety Patient Experience Committee Exception Report, given as Enclosure 5. The Board noted the following key areas from the previous meeting:

- Assurances Received: Following the request for further assurance at the January meeting, Executive Management assurance was provided that the data reported in the months of November and December supporting the High Risk TIA Screening Indicator was correct showing there had been a dip in performance as reported.

  The Trust was taking a deep dive on secondary malignancies and this will be reported back to the Committee.

  Executive Management assurance was provided in respect of incident reporting. There had been a data upload in respect of providing information to the National Reporting and Learning System which whilst corrected triggered a data quality flag on the NRL system. Assurance was also provided that revised checking had taken place to ensure such errors if they occur will be dealt with more promptly allowing the revised data to be accepted for inclusion in the published data.

  The Committee had received assurance in respect of the outcome and action learning from internal Quality Safety Reviews, the work of the Falls Group and that the Sepsis CQUIN had been met for quarter 3.

- Decisions Made/Items Approved: The Committee noted the approval of 7 policies and 10 guidelines and gave approval to close 29 RCAs.

The Chairman and Board noted the report and the assurances received.

16/041.3 Charitable Funds Committee Summary (Enclosure 6)
9.57am

Mr Atkins, Committee Chair, presented the Charitable Funds Committee Summary Report, given as Enclosure 6. The Board noted the following key areas from the meeting on 25th February, 2016:

- The Total fund balance stood at just over £2.5m and general funds stood at £443k.

- Out of 90 funds, 26 funds had not incurred any expenditure in the financial year to date. A request had been made to the top 7 funds in value to present to the Committee on how they intend to spend the money. The Committee had also reminded the other main funds to spend money.

- The Committee received an update from the Charitable Fundraiser on the Will Fortnight which had raised £4,700 and the charity football match and dinner dance which had raised £11,884.

- The Committee discussed the development of the Charity Hub and consideration will be given to the extension and improvement of the facility.

- The Committee received 4 bids for expenditure against general funds, 3 bids were approved and 1 bid turned down.

The Chairman and Board noted the report and the efforts to spend money appropriately.

16/041.4 Audit Committee Highlights Report (Enclosure 7)
10.00am

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

The Board noted the following key areas:

- The Internal Audit Progress Report confirmed that the 2015/16 audit plan is on track. The Board noted the amber/red rating on disaster recovery. There had been a similar rating previously for data security.

- The 2015/16 Clinical Audit Programme was progressing within expected timescales.

- The Audit Committee noted that the Annual Governance Statement will be completed in time for the Trust's Financial Statements and Annual Report ahead of the external audit.

- The proposed Internal Audit Annual Report for 2015/16 is expected to be at the second highest opinion because of the IT issues. The IT Steering Group is picking up issues and actions and the Audit Committee and Mr Miner will be taking a keen interest in the outcome.

- The proposed external audit report contains an “except for” modification reflecting the breach of licence during the year.

The Chairman and Board noted the report and was pleased to note that the Committee continued to take an interest in IT disaster recovery and data security. The Chairman asked if this is sufficiently reflected in the risk register. The Director of Governance/Board Secretary confirmed that this had been discussed at Directors and the risk was being taken into account.

16/041.5 Medical Revalidation Update Report (Enclosure 8)
10.06am

The Business Manager for the Medical Director presented the Medical Revalidation Update Report, given as Enclosure 8.

The Board noted the following key areas:

- Revalidation updates are presented quarterly and annually to the Workforce Committee.

- Proposal to transfer the role of Responsible Officer from the Medical Director to the Deputy Medical Director. This had been agreed by the Board two years ago because of the expanding role of the Medical Director and potential conflict in roles. From 1st April, 2016, the Deputy Medical Director will undertake shadowing of the Medical Director as part of transition into the role. The Deputy Medical Director will focus on developing the quality appraisal systems in the coming financial year.

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- Appraisal performance remains good at 80 to 85%.

- Proposed independent verification visit from NHS England – 3rd February, 2016: This had been downgraded to a desktop exercise. There had been open dialogue and a good relationship built with the Midlands and East.

The Chairman and Board noted the report. The Chairman thanked Teekai for an excellent summary of the work.

16/041.6 Monitor Certification Report (Enclosure 9)
10.14am

The Director of Governance/Board Secretary presented the Monitor Certification Report, given as Enclosure 9.

The Board noted the following key areas:

- Required as a Board to make a number of declarations to Monitor, in respect of its annual plan. The following self certification is required:

  - Continuity of services – availability of resources
  - Declaration of interim and/or planned term support requirements

- Declaration of review of submitted data
- Control total and sustainability and transformation fund allocation.

The Board noted that there was no further information to add and the Trust had agreed to take the STP funding and conditions that apply.

The Board is also required to make a number of declarations to Monitor in respect of its Licence.

The report contained the detail of the declaration, its requirement, the Board's position and supporting rationale.

The Chairman and Board noted the report and key areas. The Board approved the intention to certify that the Trust had confirmed all of its obligations to Monitor.

The Director of Finance and Information highlighted the risk that the Trust was carrying around the STP fund and particularly around agency limits and the Board noted that the Trust does not know what the financial consequence will be at this time. The Chairman asked if the wording could be amended to caveat the risk. The Chief Executive agreed that this should be flagged to Monitor.

16/041.7 Corporate Assurance and Risk Registers Summary Report (Enclosure 10) 10.21am

The Director of Governance/Board Secretary presented the Corporate Assurance and Risk Registers Summary Report, given as Enclosure 10.

The Board noted the following key points:

- Looking at year just ended. Debated at Audit and Risk and Assurance Committee.

- The Trust is starting the Corporate Risk and Assurance summary for this year and will expect to see increased risks around the STP fund and staffing levels and increased risks around delivery of CIP and financial balance for next year.

- The summary will give 12-16 key risks and will have Committee Leads next to the risks to undertake deep dives.

The Chairman and Board noted the report and that it was expected to see a change in the nature of risks for some areas. The Chairman asked about broader strategic risks and if the Trust records broader system based and environmental risks. The Director of Governance/Board Secretary confirmed that risks need to be tangible and monitorable and within the Trust's control. The summary had been commended by the auditors for reflecting good practice and the Board thanked the Director of Governance/Board Secretary for his work.

16/042 Finance

16/042.1 Corporate Performance Report (Enclosure 11)
10.29am

Mr Fellows, Committee Chair, presented the Corporate Performance Report, given as Enclosure 11.

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

The Board noted the key highlights as follows:

- The forecast outturn position, based on 11 months financial performance continues to be £3.1m deficit in line with plan

- Discussions had taken place with the CCG regarding improvements to the UCC facility. The Board agreed that this should have no cost impact on the Trust.

- The budget for 2016/17 had been agreed with a small deficit of £ 0.7m.

- Contract structure had been finalised.

- The Board will review its operational annual plan in detail in the private session.

- The Board gave delegated authority to the Audit Committee to approve the Annual Accounts and respective papers at its meeting in May .

The Chairman and Board noted the report and key areas and the Board approval to delegate authority to the Audit Committee to approve the Annual Accounts.

16/042.2 Integrated Performance Report (Enclosure 12)
10.32am

The Director of Strategy and Performance presented the Integrated Performance Report given as Enclosure 12.

The report covered the Trust's performance to February 2016, and included the following highlights:

- Overall performance continues to be positive.

- Emergency Access element is a combined target but the hospital is under continued pressure although it was believed that it had delivered the quarter and year target.

- Concern was noted in relation to cancer services and the Trust had seen a dip in delivery of the target in February and March performance. Tracking is helping to manage the situation. The situation is complicated to performance manage for the division and corporately. The Trust will miss a key national requirement and had placed emphasis with the Division for improvement in Quarter 1 next year.

- Concern was noted around diagnostics, the target had been achieved but there was increasing pressure, particularly in Endoscopy and CT scanning and this impacts on cancer services. The issue was being addressed with the Divisions who were producing short and long term rectification plans. The Board noted that some investment may be required.

- The Trust had missed the target on VTE screening. The Trust had experienced excellent performance for some years. The target had been missed in February and this was being picked up with the division. The Board noted that the target for March may also have been missed. Updates will be reported through the Clinical Quality, Safety, Patient Experience Committee quality reporting system.

Dr Wulff, Non Executive Director, commented on cancer waits and pointed out that the tumor site detail was not provided.

The Director of Strategy and Performance confirmed that this was still predominately in Urology and confirmed that the Trust had slightly slipped in the management of the full pathway. The Chairman asked if the Trust was undertaking individual patient tracking. The Director of Strategy and Performance confirmed that it was and also undertaking RCAs to understand the issues.

The Chairman asked about the trajectories appended to the report and if there were any other areas where there are concerns around meeting trajectories. The Director of Strategy and Performance confirmed that Cancer for next year is the area where the Trust is still unsure that all key issues had been addressed. It was also not clear around the emergency access target.

The Chairman and Board noted the report and key issues. The Board was pleased to note the performance given the difficult winter and gave thanks to all operational staff for the commitment demonstrated. The Board recognised that it was a tricky balance to maintain service levels given the unprecedented demand.

16/042.3 Transformation and Cost Improvement Programme Summary Report (Enclosure 13)
10.43am

The Director of Strategy and Performance presented the Transformation and Cost Improvement Programme Summary Report, given as Enclosure 13.

The Board noted the high level position as follows:

- Delivered £16m CIP for the year. The Board was grateful for the work of staff in achieving this throughout the organisation.

- 2016/17 position not as positive with only £10m identified against the £12.5m target. Some of projects are income projects and may be impacted upon under the proposed contract arrangements. Numbers were currently moving around and the Executive Team were looking at the gap and options to address this through the Transformation Executive Committee. The first line of action is to meet with the Divisions to challenge for further schemes to meet the figure. For Transformation schemes there is a greater risk on delivery as this depends on transformational change.

- The Trust is anticipating it will have reduced the gap by the next Board meeting.

The Chairman and Board noted the report. The Board concurred with the good work on this year's plan and noted the endeavours for the year.

16/043 Any Other Business

10.48am

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

16/044 Date of Next Meeting

10.48am

The next Board meeting will be held on Thursday, 5th May, 2016, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

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

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
16/018	Chief Executive's Overview Report	Outcome of the review of TTOs to be referred to the Clinical, Quality, Safety and Patient Experience Committee.	PB	29/3/16	To April CQSPE
16/027.1	Chief Executive's Overview Report	Update on TTOs to the March Clinical Quality, Safety, Patient Experience Committee and April Board.	PB	5/5/16	In CQSPE Report to May Board – On Agenda
16/019.6	End of Life and Palliative Care Strategy Group Report	Further End of Life Care Update Report to be presented to the Board in April.	DWu	5/5/16	To May Board – On Agenda
15/124.8	Research and Development	Chief Nurse to resolve the Research Nurse identification issue.	DWa	2/6/16	
		Mr Miner and the Director of Governance/Board Secretary to meet to discuss R&D reporting format for Board and Audit Committee.	RM/GP	2/6/16	
16/027.2	Research and Development	The Research and Development Report to be presented to the June Board. The report will focus primarily on strategic issues.	JN	2/6/16	
16/039	Patient Story	Chief Nurse and Liz Abbiss to investigate the production of a Carers' Strategy and to also address communication approaches.	DWa/LA	2/6/16	
16/030.3	NHS Preparedness for a Major Incident	Sharon Walford to be invited to present on Emergency Preparedness at a future Board General Clinical Presentation.	PB	1/9/16	The date is as a result of the expectation that the standards will be available in July.

Enclosure 3

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Public Board Meeting – 5th May 2016

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

SUMMARY OF KEY ISSUES:

- Friends and Family
- Junior Doctors Contract Update

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

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

Decision	Approval	Discussion	Other

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

The Dudley Group NHS
NHS Foundation Trust

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

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

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

The Dudley Group NHS
NHS Foundation Trust

Chief Executive's Report – Public Board – May 2016

Patient Friends and Family Test:

Community FFT (March 2016)

Based on the latest published NHS figures (February 2016*)* the Trust met the quality priority target of monthly scores that are equal to or better than the national average for the percentage who would recommend the service to friends and family members.

Date range	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Community FFT percentage recommended	97%	98%	96%	96%	94%	93%	97%	95%	99%	97%	98%	95%
Total number of responses	36	55	116	90	82	125	126	92	256	258	286	262
National average percentage recommended	96%	95%	95%	95%	96%	95%	95%	95%	95%	95%	95%	*n/a**

**national data not published at time of writing this report*

Inpatient FFT (March 2016)

The Trust continues to achieve the quality priority target of monthly scores that are equal to or better than the national average for the percentage who would recommend the service to friends and family members.

Date range	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Inpatient FFT percentage recommended	96%	97%	98%	97%	99%	97%	97%	97%	99%	98%	97%	97%
Inpatient response rate	16%	16%	14%	15%	20%	20%	13%	20%	17%	17%	17%	16%
National average percentage recommended	95%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	n/a*

**national data not published at time of writing this report*

Key for inpatient RAG rating

% of footfall (response rate)	*<25%*	*25-30%*	*30-40% +*	*40%+*
FFT percentage recommended	*<95%*	*96%+*	*97%+*	
FFT scores based on national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*	

A&E FFT (March 2016)

The percentage of patients who would recommend the Trust's A&E to friends and family during March 2016 remained the same as February and still below the highest score achieved in year of 95%. The latest published NHS England figures (February 2016) show The Dudley Group scored 92% which is higher than the national average of 86%.

Date range	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
A&E FFT recommended percentage	90%	90%	92%	90%	95%	90%	95%	91%	88%	95%	92%	92%
A&E response rate	8%	15%	12%	7%	6%	3%	8%	6%	6%	5%	8%	3%
National average percentage recommended	88%	88%	88%	88%	88%	88%	87%	87%	87%	86%	85%	n/a*

**national data not published at time of writing this report*

Key for A&E RAG rating

% of footfall (response rate)	*<15%*	*15-20%*	*20%+*
FFT percentage recommended	*<94%*	*94%*	*95%+*
FFT scores based on national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*

The Dudley Group NHS
NHS Foundation Trust

Maternity FFT (March 2016)

The Trust remains in the top 20% of trusts nationally for those who say they are extremely likely or likely to recommend our maternity services to friends and family with the exception of the antenatal ward service. The scores for February 2016 across all maternity services are equal to or better than the national average for the percentage of patients who would recommend the service to friends and family member with the exception of the post natal community service.

Maternity Area	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Antenatal, percentage recommended	95%	96%	99%	93%	99%	97%	96%	98%	90%	98%	97%	98%
National average percentage recommended	95%	96%	96%	95%	95%	95%	96%	96%	95%	96%	95%	n/a*
Response rate	30%	39%	24%	37%	38%	36%	49%	26%	26%	23%	14%	28%
Birth, percentage recommended	100%	100%	100%	99%	99%	100%	99%	99%	100%	98%	99%	98%
National average percentage recommended	97%	97%	97%	97%	97%	97%	94%	96%	97%	97%	96%	n/a*
Response rate	26%	20%	14%	22%	25%	27%	30%	47%	18%	19%	27%	12%
Postnatal ward, percentage recommended	100%	100%	99%	99%	99%	100%	98%	98%	98%	98%	99%	98%
National average percentage recommended	94%	93%	93%	94%	94%	93%	95%	94%	94%	94%	94%	n/a*
Response rate	26%	20%	14%	21%	25%	28%	4%	47%	18%	19%	26%	12%
Postnatal community, percentage recommended	100%	100%	96%	94%	92%	100%	100%	100%	100%	91%	97%	100%
National average percentage recommended	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	n/a*
Response rate	8%	10%	12%	8%	4%	6%	30%	2%	10%	5%	11%	16%

national data not published at time of writing this report

Key for maternity RAG rating

% of footfall (response rate)	<15%	15%+	
aAntenatal	100%	96-99	<95
Birth	100%	97-99	<96
Postnatal ward	98+%	93-97	<92
Postnatal community	100%	97-99	<96

FFT scores based on national scores	Below top 30% of trusts	Top 30% of trusts	Top 20% trusts

Outpatients FFT (March 2016)

The percentage of those who would recommend the service in March increased to 89% compared to 84% for February 2016. The Trust has not met 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 members.

FFT Outpatients Services	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Outpatients recommended percentage	84%	82%	82%	88%	90%	89%	88%	84%	88%	90%	84%	89%
Number of respondents	49	93	82	66	67	742	721	403	553	530	365	352
National average percentage recommended	92%	92%	92%	92%	92%	92%	92%	92%	92%	93%	93%	n/a*

national data not published at time of writing this report.

The Dudley Group NHS
NHS Foundation Trust

Junior Doctors Contract Update:

This week saw the first full strike by junior doctors following their dispute with the Government on the new proposed contract and its imposition.

As a Board we have been approached by the junior doctors to debate the issues and our stance on the situation as it continues to evolve.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th May 2016 - PUBLIC

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

CORPORATE OBJECTIVE:
SO1 – Deliver a great patient experience
SO2 – Safe and caring services
SO3 – Drive service improvements, innovation and transformation
SO4 – Be the place people chose to work
SO6 – Plan for a viable future

SUMMARY OF KEY ISSUES:

Infection Control results for the month of April (as at 25/4/16)

- No post 48 hr MRSA bacteraemia cases since 27th September 2015
- No Norovirus
- As of this date, the Trust has had 1 case so far in April 2016. This has yet to be apportioned but we will be within trajectory for April as the ceiling is 3 cases associated with lapses in care.

Safer Staffing

- Amber shifts (shortfall) have shown a small decrease to 70, this level is still due to additional capacity open and fill rates from bank and agency.
- Maternity saw a rise in amber shifts in March to 20.
- The new RAG rating system has been trialled in C7 during March, three red (serious shortfall) shifts in the month no safety issues identified or on any of the amber shifts that affected the quality of care.
- A benchmark review on fill rates provided by Unify has been carried out using local trusts, the trust is comparable.

Nursing Care Indicators

- There have been 8 escalations to level 3 now in place. Improvement seen in other areas.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		√	

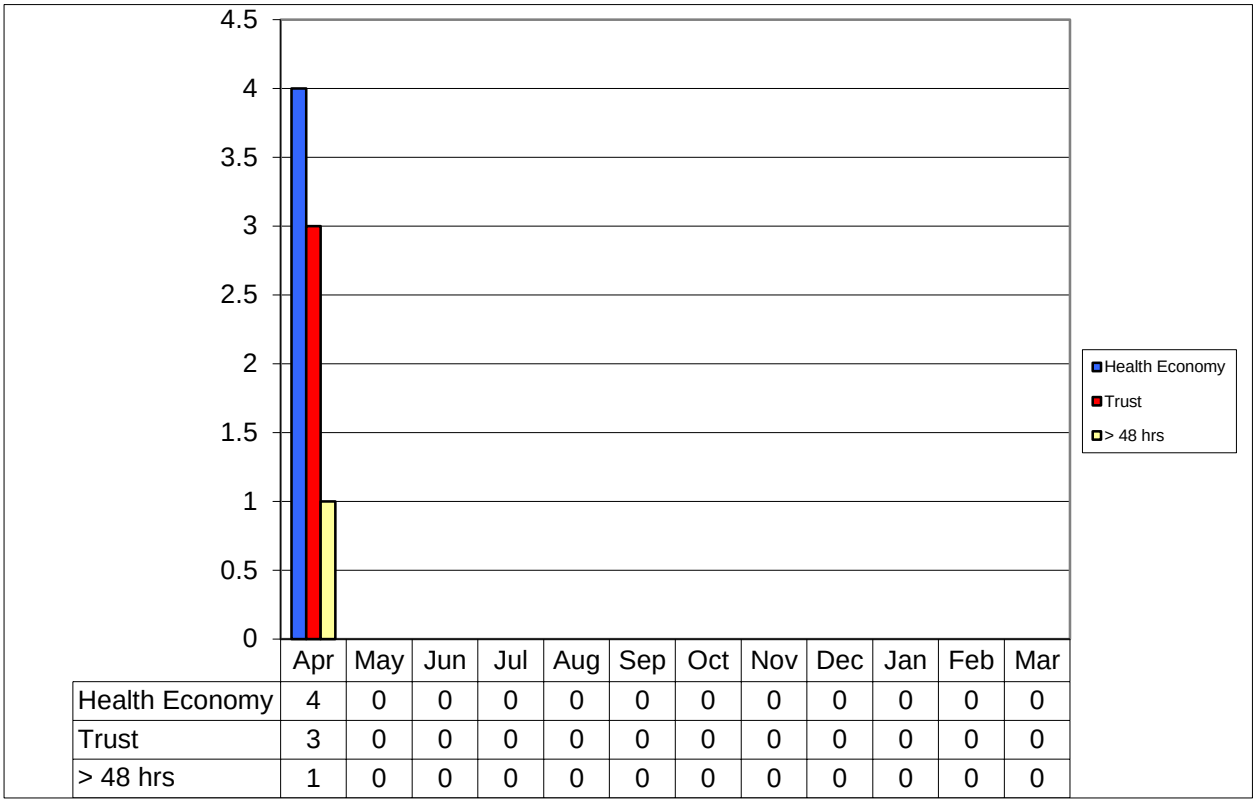
RECOMMENDATIONS FOR THE BOARD:
To receive the report and note the contents.

Chief Nurse Report

Infection Control

Clostridium Difficile – The target for 2016/17 is 29 cases associated with lapses in care, equivalent to 12.39 CDI cases per 100,000 bed days. At the time of writing (25.4.16) we have 1 post 48 hour case recorded in April 2016.

C. DIFFICILE CASES 2016/17



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	4	0	0	0	0	0	0	0	0	0	0	0
Trust	3	0	0	0	0	0	0	0	0	0	0	0
> 48 hrs	1	0	0	0	0	0	0	0	0	0	0	0

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. During the financial period 2015/16 of the 43 post 48 hour cases identified since 1st April 2015, 36 cases have so far been reviewed by the apportionment panel, all of which have had apportionment agreed and 13 of these were deemed as avoidable.

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

Norovirus - no further cases.

Reference

1. Clostridium difficile infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation, Public Health England.

Safer Staffing

Monthly Nurse/Midwife Staffing Position - March 2016

One of the requirements set out in the National Quality Board 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. This document is currently undergoing a review.

Following the discussion at the Board at the end of 2015, this paper outlines the staffing situation on the general wards in relation to the agreed transitional 1:10 requirement, except when there is a high acuity/dependency of patients or when the actual staff on duty is two or more less than the planned staff. The ratios for specialist areas, such as critical care, paediatrics, maternity etc. which all have specific, more intensive requirements continue as before.

The accompanying chart (Appendix B) includes the monthly results of the NCIs for each area which provides a quality of care comparator.

This paper therefore endeavours to give the Board a view of the frequency when Registered Nurse to patient ratios do not meet the ratio on general wards of 1:10 on day shifts (there is no recommended ratio for night shifts, although the 1:12 ratio is used as a benchmark) and also the number of occurrences when registered staffing levels have fallen below the planned levels by two or more. It should be noted that these occurrences will not necessarily have a negative impact on patient care.

From June 2015 following each shift, the nurse/midwife in charge completes a spreadsheet indicating the planned and actual numbers and, if the actual doesn't meet the planned, what actions have been taken, if any is needed, for the patients on that shift. Each month the completed spreadsheet is checked by the Matron then staff in the Nursing Division analyse the data and the attached charts are compiled. In addition, for consistency purposes the data from the spreadsheet is now used for the UNIFY return from which the fill rates are published on NHS Choices.

It can be seen from the accompanying chart 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).

This total figure for this month is 70 which is slightly down from last month, which had an increase from the previous two months (76, 39 and 46 in the three previous months) (see Table 1). When shortfalls have occurred, the reasons for the gaps and the actions being taken to address these in the future are outlined in Appendix A.

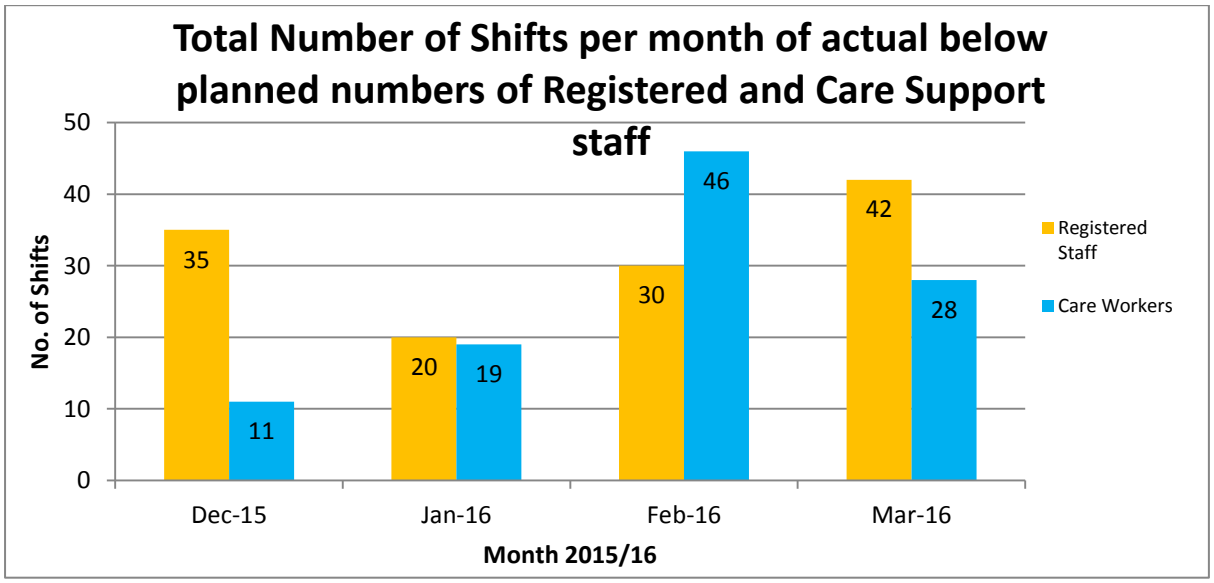
Although the overall number this month is similar to last month, there has been a reverse in the skill mix figures with a rise in qualified staff shortfalls (from 30 last month to 42) and a decrease in unqualified staff shortfalls (from 46 last month to 28). Other than maternity, the shortfalls are fairly evenly distributed across the wards. The maternity unit has vacancies, high volume cases and high workload. It accounts for just under a half (20, compared to 13 last month) of the total qualified and just over 60 per cent (17, compared to 22 last month) of

the unqualified shortfall shifts. There has been a sickness issue this month and active recruitment initiatives are in progress and further shortlisting has occurred for the care worker posts. Qualified Midwives have been recruited (7 WTE) across the maternity service, start dates to be agreed.

As indicated last month, for April figures onwards these reports will also include the new monitoring system of an explicit, consistent RAG (Red, Amber and Green) rating system of the overall workload status on the ward, which the lead clinical nurses undertake. This is being piloted this month on C7 hence the three red shifts appearing this month for that ward. This assessment is based not just on staffing numbers but also the dependency of the patients and other relevant factors. For two of the Red shifts on C7 this month there was a shortfall of one RN and for the third shift the actual staffing numbers were what was planned, but for all three shifts the overall workload due to the high dependent patients there on those days resulted in a heavy workload and some minor delays in providing care but overall safety being maintained.

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.

Table 1



Shift Fill Unify Data

This is collected by all hospitals and provided via UNIFY to the public website NHS Choices. Therefore it has been possible to do some local benchmarking to provide further assurance that the Trust is not an outlier with regard to fill rates.

	Qualified Days	Un Qual Days	Qualified Nights	Un Qual Nights
Trust Mar	95	97	97	100
Trust Feb	93	95	96	99
Trust A	88	112	88	135
Trust B	92	103	88	111
Trust C1	96	96	97	99
Trust C2	90	101	93	99
Trust D	95	100	91	99

What is interesting from the comparison is that it would seem that CSWs are being utilised to offset the Qualified Ratio/fill rate in a number of Trusts (A and B). This could however be a way of reporting differently as DGFT change the requirement if specials (1-1) are provided and so do not show as excess as it would seem occurs also at Trust C and D.

Finally, on the 22nd April NHS Improvement confirmed that Lord Carter's care hours per patient day (CHPPD) metric should be implemented from May 1st. This, as initially announced, is an aggregate result including a mix of registered nurses and healthcare assistants but will also now include a split between the two workforce groups and be publicly reported. The metric will replace the planned versus actual nurse staffing levels data reported monthly on the NHS Choices website. Ruth May, Executive Director of Nursing at NHSI has also announced that new specialty specific safe staffing guidance will be produced in the summer and autumn. An initial refresh of the 2013 National Quality Board guidance on nurse staffing is due out next month. She has said that NHSI will be developing a small number of nurse sensitive indicators reported at national level in quarter one of 2016-17, which will be used as a safeguard by both NHSI and the Care Quality Commission. These indicators would include pressure ulcers, falls with harm, the care hours metric and others. The Trust is presently assessing the implications of this announcement.

Recruitment and Retention

A team from the Trust went on a recruitment campaign to the Philippines on 9th April 2016. 108 Registered Nurses have been given conditional offers of employment. However, they still have to achieve (IELT) English testing to Level 7. This has proven challenging according to national feedback. Should they be successful it is expected that they would arrive in two cohorts during December 2016.

A local recruitment event is planned for 14th May and a communications campaign is underway to advertise this.

Over recruitment of Clinical Support Workers (CSW) is underway with initial interviews held week commencing 25th April 2016 with more planned in May. Nurse Bank recruitment for CSW has also been commenced to reduce the reliance on agency workers.

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	October 15 – Areas (Launch)	December 15 - Areas	January 16 - Areas	February 16 - Areas	March 16 - Areas	April 16- Areas
RED	15	4	3	7	6	3
AMBER	5	11	14	12	13	15
GREEN	4	9	9	8	8	9

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 April:

NCIs	
Level 1 Matron Level	4
Level 2 Head of Nursing Level	10
Level 3 Deputy Chief Nurse Level	8

Nutrition Audit	
Level 1 Matron Level	4
Level 2 Head of Nursing Level	2

Dawn Wardell - Chief Nurse - 27/04/16

Appendix A

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS MARCH 2016

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A2	3	CSW	Vacancy x 2 Sickness x1	Floating Band 6 nurse helped with patient care. No safety issues were identified.
B2H	1	CSW	Vacancy/Sickness	With the patients on the ward the nurse in charge assessed the ward as safe.
B3	2	RN	Staff sickness x 2	The bank was unable to fill and on one shift the booked agency nurse did not attend. On both occasions, assistance from B2 was given and lead nurse worked clinically on one of the shifts. No patient concerns were identified.
B4	3	RN	Maternity Leave x 1 Sickness x 1 Vacancy x 1	Bank/agency unable to fill. On one occasion a supernumerary nurse assisted. On the others, staff were reallocated duties appropriately. No safety issues occurred.
B5	3	RN	Vacancy x 3	The bank and agency were unable to fill. Patient flow co-ordinator supported ward on one occasion. Safety maintained on all three shifts with some delays in care on two occasions.
C1	2	CSW	Staff Sickness x 2	Nurse in charge assessed the situation and delegated staff appropriately to ensure patient safety.
C2	5	RN	Increased dependency and contingency beds open	Agency was unable to fill and on the one occasion it did the nurse did not attend. Nurse in charge assisted. All patients remained safe.
C4	1	CSW	Sickness	CSW on shift sent home sick. Bank unable to fill. Remaining staff undertook duties and safety maintained.
C6	1 1	RN CSW	Vacancy x 1 Sickness x1	On the RN shift, bank unable to fill. There were six empty beds and so the shift was managed with assistance from other wards. On the CSW shift, there were some delays in care. On both shifts safety maintained.
C7	4 2	RN CSW	Vacancy x 5 Workload x1	The bank was unable to fill. When available, lead nurse worked clinically and supernumerary nurse available for one shift. The remaining staff maintained safety.
CCU/PCCU	3	RN	Vacancy x 3	The bank was unable to fill. On one occasion an extra CSW was employed. Safety was maintained.
EAU	1	CSW	Sickness	Workload was redistributed to remaining staff. No safety concerns.
MHDU	1	RN	Sickness	Agency nurse cancelled late. Situation escalated, ITU unable to help. Due to patients in the unit that shift safety maintained. On one occasion two patients discharged to ward and agency nurse attended half way through the shift an on another a booked agency nurse did not attend. , Safety maintained in all three cases.
Maternity	20 17	RM CSW	Vacancy Maternity leave	Escalation policy enacted on all occasions. Bank unable to fill. On two occasions, midwives recalled from study days. On ten delayed inductions of labour. For CSW shifts: Bank unable to fill. Qualified staff undertook the roles. Active recruitment is occurring to these posts. No patient safety issues occurred.

Mar-16			SHIFT																																																												
	NCI		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		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	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	87	Reg																																																												
		Unreg																																																												
WARD A2	75	Reg																																																												
		Unreg									7/5																										7/5																				7/5					
WARD A3	97	Reg																																																												
		Unreg																																																												
WARD B1	88	Reg																																																												
		Unreg																																																												
WARD B2 HIP	98	Reg																																																												
		Unreg																															6/4																													
WARD B2 TRAUMA	100	Reg																																																												
		Unreg																																																												
WARD B3	83	Reg	5/4								6/4																																																			
		Unreg																																																												
WARD B4	82	Reg																			5/4										5/4																				5/4											
		Unreg																																																												
WARD B5	92	Reg							5/3																																								5/4													4/4
		Unreg																																																												
WARD B6		Reg																																																												
		Unreg																																																												
WARD C1	86	Reg																																																												
		Unreg																		9/7																																					10/8					
WARD C2***	94	Reg																																														9/5		9/5	8/5	8/5							8/6			
		Unreg																																																												
WARD C3	78	Reg																																																												
		Unreg																																																												
WARD C4	91	Reg																																																												
		Unreg																				3/1																																								
WARD C5	94	Reg																																																												
		Unreg																																																												
WARD C6	97	Reg																																						2/1																						
		Unreg																																													2/1															
WARD C7	87	Reg													6/5								6/5																	4/3									6/6													
		Unreg															5/3																													5/3																
WARD C8	77	Reg																																																												
		Unreg																																																												
CCU/PCCU	81	Reg																																			7/4														7/5				7/5							
		Unreg																																																												
EAU	99	Reg																																																												
		Unreg													6/4																																															
MHDU	100	Reg																																	3/3																											
		Unreg																																																												
CRITICAL CARE*	94	Reg																																																												
		Unreg																																																												
NEONATAL **	99	Reg																																																												
MATERNITY ****	98	Reg			18/16	17/17	18/15		18/14	17/12		17/15						17/15		17/16	18/15	17/15	18/15	17/12	18/15	17/15						17/14								17/15									18/15													17/17	18/17	17/15
		Unreg	8/4		8/6		8/5		8/6										8/4		8/6		8/6						8/5		8/5		8/6		8/5										8/5		8/6							5/3							8/5		8/6	5/3

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

The Dudley Grou
NHS Foundation Trust

Enclosure 5

Paper for submission to the Board on 5 May 2016

TITLE:	**26th April 2016 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

The Board ratify the decision of the Committee that its Chair, D Wulff, be the nominated Trust Non Executive member of the Quality Improvement Board.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

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

Declarations of Interest Made

None

Assurances received

- Operational Management assurance was provided on the performance in respect of key quality indicators including the strong performance in respect of preventing avoidable *C diff* cases. Whilst the Trust has had good performance in the area of apportioned *C diff* cases the two weekly meetings remain in place to keep the focus on the compliance with Trust processes in respect of infection prevention and control. In respect of the areas of poorer performance relating to specific Stroke Swallow Screen and Cancer 62 day Waits, assurance was provided that clinical care of patients, especially those were the cancer treatment whilst breaching the 62 days at the tertiary center, was not compromised and the Trust is pushing to have these patients seen as soon possible;
- Negative assurance was provided in respect of the Trust reviewing Polices in line with their planned review dates. Whilst extra Policy Group meetings are scheduled for May it is likely that some of the 37 Policies which are due for a review will not be completed in May, the Committee asked for a further update at its next meeting;
- Operational Management assurance was provided that the Trust has complied with the reporting requirement timescales in respect of SIs and 72 hour questions from the CCG;
- Executive Management assurance was provided in respect of progress being made against the initial 13 Trust recommendations made within the joint Serious Incident RCA Process Improvement plan with the CCG;
- Executive Management assurance was provided in respect of the Trust's continuing delivery of the Learning Disability Strategy and the Monitor required Learning Disability standards;
- The fourth quarter learning report provided assurance to the Committee that the Trust continues to disseminate learning out into the organisation;
- Executive Management assurance was provided in respect of the Trust's delivery of its Quality Priorities and the production of the Trust's Quality Account;

- Executive Management assurance was received via the Quality and Safety Group in respect of their agenda items including the positive outcome of the pharmacy license review by the Home Office; the outcome of the internal Quality Safety Reviews and the work of the Falls Group;
- Executive Management assurance was received via the Internal Safeguarding Board in respect of their agenda items, including the focus on the need for CAMHS Tier 4 beds which has seen an increased risk being reflected by the Trust within the Corporate Risk Register. More positive assurance was received via the Board in respect of the continued focus on Safeguarding Training, Mental Health Act Training and Learning Disability Training. The Internal Safeguarding Board are awaiting the feedback from the Local Authority report prepared as a result of the recent Ofstead Children's Safeguarding Inspection report, which once received will be reported to the Committee;
- Assurance was received via the update from the Internal Safeguarding Board coupled with the provision of the report to the Committee on the Trust's assessment against the Southern Health review recommendations;
- Executive Management assurance was received via the Patient Experience Group in particular in respect of the progress being made against the Maternity Survey 2015 action plan (an item the Committee had asked the Group to follow up on). The Group had also looked at the Friends and Family Test results and the Dementia Care Group reviews of the Dementia Careers Survey and the further planned action in this area; and
- Operational Management Assurance was provided in respect of the TTO review undertaken at the request of the Board. The Committee asked for the detailed action plan to come back to the next meeting along with in its preparation that consideration be given to ensuring that changes in one part of the system do not cause a problem elsewhere in the system (see action coming back to Committee).

Decisions Made / Items Approved

- Approval of 3 policies and 9 guidelines / procedures that had all been considered by Policy Group; and
- Approval to close 28 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, actions plans completed had been evidenced.

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

- Policies that are due for review but have not been reviewed within their expected timescales;
- Continued progress against the joint RCA Process Improvement Action plan with the CCG;
- Information on the performance against the Stroke and 62 Day Cancer specific indicators;

- The detailed action plan resulting from the TTO audit review to come back to the next meeting whilst in its preparation consideration is given to ensuring that changes in one part of the system do not cause a problem elsewhere in the system; and
- The National In-Patient Survey results which are due on the 8th June after their consideration at the Patient Experience Group.

Items referred to the Board for decision or action

The Board ratify the decision of the Committee that its Chair, D Wulff, be the nominated Trust Non Executive member of the Quality Improvement Board.

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 5 May 2016

TITLE:	**12th April 2016 End of Life and Palliative Care Group Summary**		
AUTHOR:	**Doug Wulff – Group Chair**	**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 Committee and the action the Committee is seeking the Board to take.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

To note the items referred to Board.

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
End of Life and Palliative Care Group	12 April 2016	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- Priorities for care – assurances received on progress of pilot on Ward C8 at Russells Hall Hospital which will run until end of June 2016. During June the process will be launched with education seasons that will incorporate learning from the pilot with view to roll out from 1 July 2016.
- Priorities for care – community provision of clinically assisted nutrition and hydration being monitored as implementation hampered by lack of workforce resources.
- Rapid discharge – negative assurance received due to continuing confusion between rapid discharge and fast track funding processes. The flow chart audit not complete as the Palliative Care Team not receiving all the paperwork.
- AMBER – assurances received that education going well with good engagement from consultants and patients being managed on the bundle.
- Macmillan Specialist Care at Home – assurance received regarding the extension of funding for a further year. During the next phase all parties will provide business cases for main streaming the services.
- Advance Care Planning – assurance received regarding progress. Dr Jane Reynolds now taking over leadership of this work stream and working to implementing ACP conversations in Out Patients. Recording of ACP on EMIS web now increasing.
- Education – positive assurance on move forward to develop an e-learning package funded by a charitable donation. Funding has been received from Health Education England to re-launch the End of Life Champions in the community teams.
- EPaCCS – negative assurance received as still awaiting decision on funding following CCG value proposition discussion. Should this prove positive then discussions with Dudley IT to take forward.
- Bereavement – negative assurance received as there is currently no clear action plan. Proposal for 4 clear actions plans to be developed to take this work stream forward. A key area is work on the existing documentation.
- VOICES – assurance receive that this is on-going and report will come back to Group later in year.

- End of Life Event – negative assurance in that event of 2 March 2016 had to be cancelled at short notice. Currently investigating potential for either champions or members event as well as combining with Dying Matters or Hospice Awareness weeks.

Decisions Made / Items Approved

- The End of Life and Palliative Care Strategy was approved.
- Agreed that End of Life and Palliative Care logo to be used on all documents relating to the subject across the health and social care community.
- Agreed to invite Public Health Consultant to attend and confirm the member from Dudley Metropolitan Borough Council.

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

- Mortality case reviews and morbidly and mortality reviews to come to July meeting for purpose of learning and improvement.
- Joint implementation plan based on agreed strategy to come to July meeting.

Items referred to the Board for decision or action

- Board to note the approval of End of Life and Palliative Care Strategy as set out in the attached document.
- Board to note and recognise the risk of failure of interoperability of IT systems in the implementation of EPaCCS.

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board Meeting on 5th May 2016

TITLE:	Organ Donation Committee Report to Board		
AUTHOR:	**Dr Julian Sonksen** **Miss Rebecca Timmins**	**PRESENTER**	**Dr Julian Sonksen**
CORPORATE OBJECTIVE: SO1,SO2,SO3			
SUMMARY OF KEY ISSUES: • Section 1: Report Trust Organ Donation data and activity • Section 2: Report progress with Trust Organ Donation Plan 2014-17 • Section 3: Report Trust contribution to Regional and National targets			
IMPLICATIONS OF PAPER:			
RISK		**Risk Description:**	
	Risk Register:	**Risk Score:**	
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Details: RESPONSIVE,CARING,EFFECTIVE**	
	Monitor	**Details:**	
	Other	**Details: NICE CG135**	

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

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

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

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

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

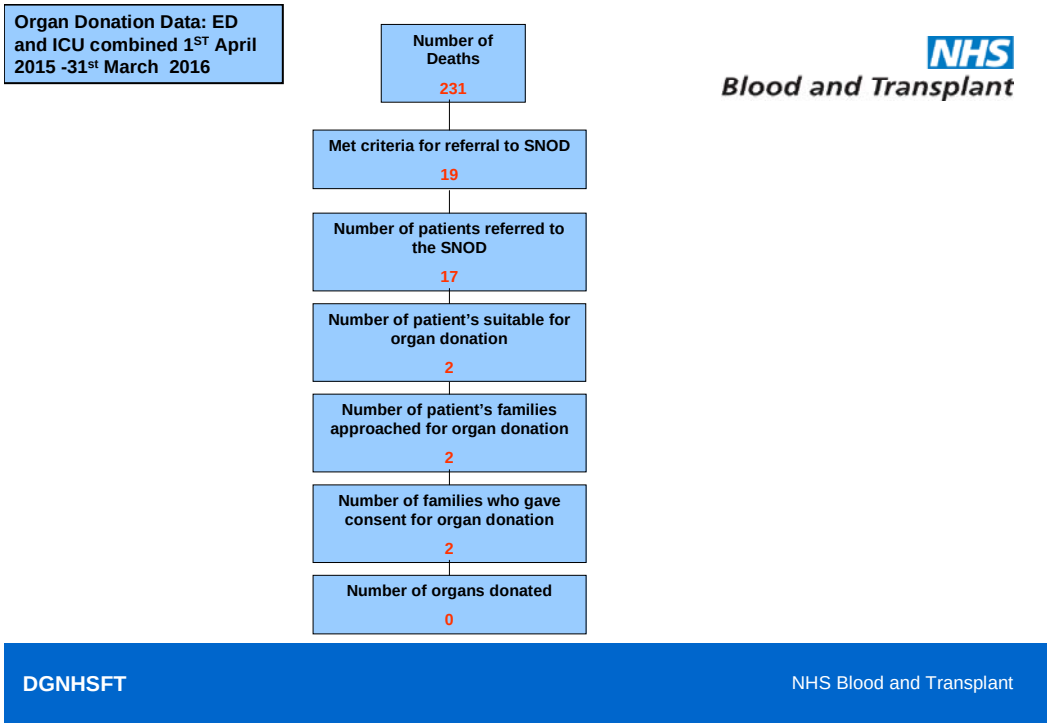
Section 1: Report Trust organ donation data and activity

The potential donor audit (PDA) is a national audit carried out by NHS Blood and Transplant staff in both the Emergency Departments and Critical Care Units. It audits all patient deaths under the age of 80 years and reports organ donation potential.

However as the upper age limit to donate solid organs is 85 years, the Organ Donation Committee have historically reported supplementary data to capture patients up to 85 years of age. This section of the Board Report therefore reports;

- Organ Donation Audit data
- All potential organ donation activity up to the age of 85 years
- Potential Donor Audit Data (Age 0-80years) and Trust Board Reports from NHS Blood and Transplant
- Adherence to standards approved by the Organ Donation Committee (previous CQUINS in 2011/12)

Organ Donation Audit data 1st April 2015 - 31st March 2016 including patients up to the age of 85 years

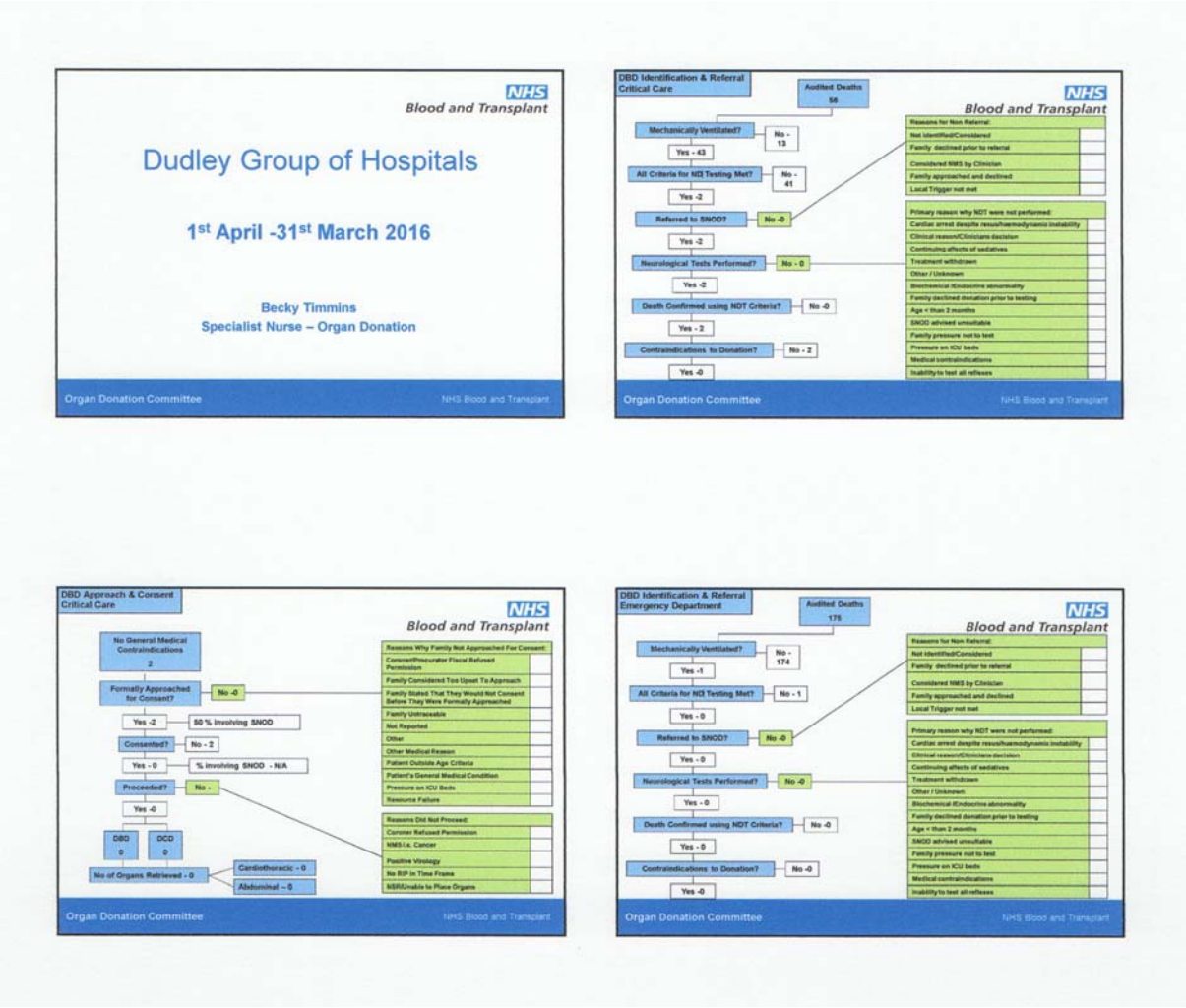


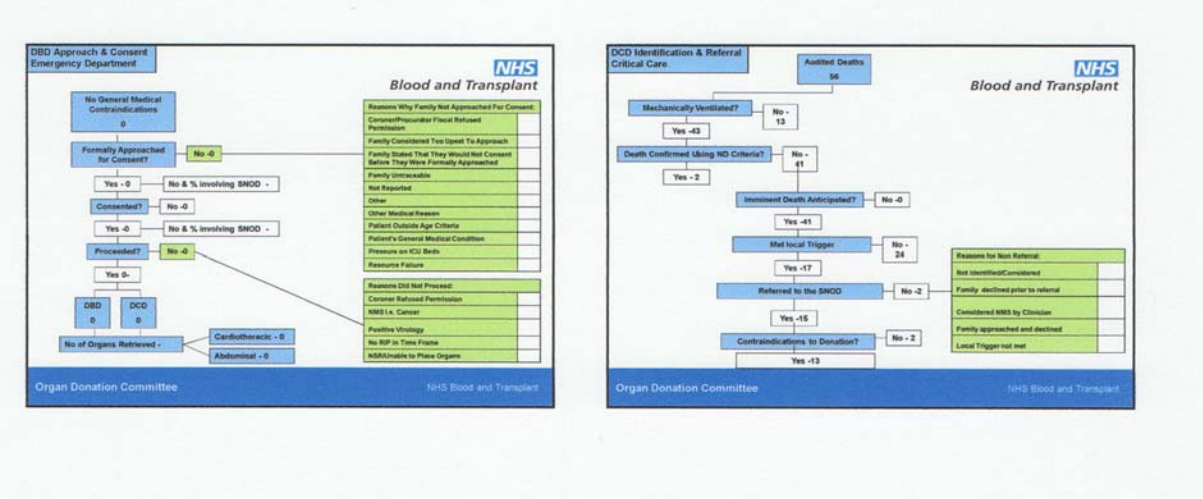
- 231 deaths were audited in the Emergency Department and Critical Care at Russell's Hall Hospital during this timeframe.
- 19 patients met the criteria for referral to the Specialist Nurse-Organ Donation (SN-OD)

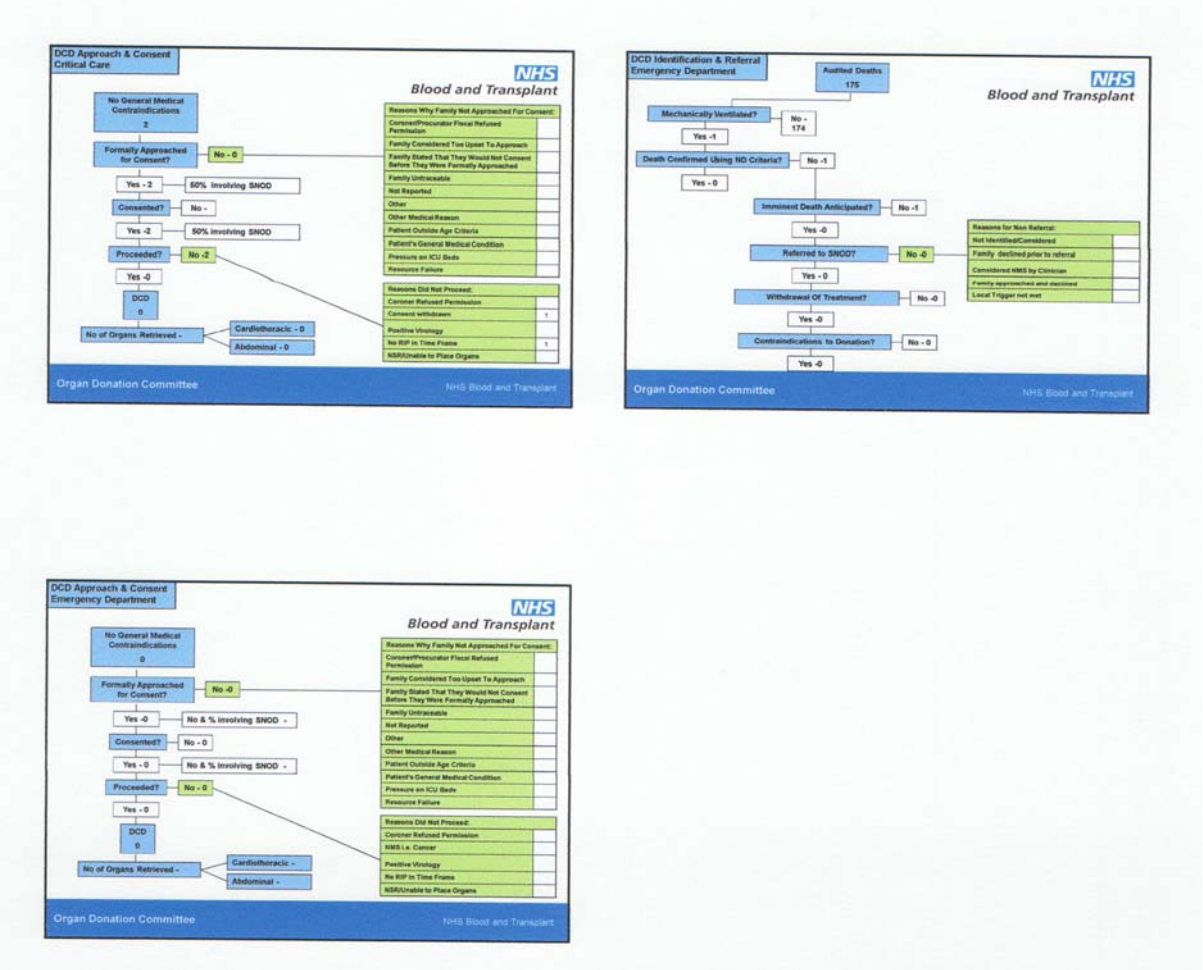
- 17 patients were referred to the SN-OD for either Donation after Brain Death(DBD) or Donation after Cardiac Death (DCD) donation , combined referral rate 89%
- Consent for Organ Donation occurred on 2 occasions (DCD Donation)
- There were 0 organs donated from the Trust.

<u>All potential organ donation activity up to the age of 85 years</u>

A more detailed breakdown of Organ Donation Data is presented here. The data shows activity by each department and for each method of donation: Donation after Brain Death (DBD) and Donation after Cardiac Death (DCD).







Donation after Brain Death (DBD) Data narrative

- There were 2 occasions where Neurological Death was suspected and on both occasions Neurological Death Testing (NDT) was performed. The Trust has a 100% Neurological Death Testing rate, National Neurological Death Testing rate is 85%.
- Referral to the SN-OD for patients who have had Neurological Death testing confirmed for Donation after Brain Death is 100%, National referral to the SNOD for DBD donation is 97%.

- Where DBD donation was possible (there were no absolute contraindications to organ donation) the family were approached on 100% of occasions, National approach rate is 90%.
- The SN-OD was involved in 50% of the initial approaches to the family for organ donation, National SNOD involvement in the approach for DBD is 90%.
- Consent was not obtained for DBD donation. 1 patient had registered to donate via the Organ Donor Register. Consent rate 0%, National DBD consent rate is 69%.

Donation after Cardiac Death (DCD) Data narrative

- There were 17 patients who met the Minimum Notification Criteria (MNC)/Local trigger referral to the SNOD
- 15 of these patients were referred to the SNOD, referral rate to the SNOD for DCD donation is 88%, National DCD referral rate is 82%.
- 2 patients were suitable for DCD donation, both patients families were approached for organ donation, approach rate 100%.
- The SNOD was involved in 50% of the initial approach to the family for organ donation. National SNOD involvement for DCD approaches is 75%.
- Consent was given on 100% of occasions, National DCD consent rate is 53%.
- There were 0 organs donated from the Trust. This was because where consent was given, on 1 occasion consent was revoked, on 1 occasion prolong time to asystole (PTA).

Potential Donor Audit Data/Trust Board Reports 2015-16

Reports will be issued to Trust Boards from NHS Blood and Transplant containing data from the Potential Donor Audit (Age 0-80years), and performance during May 2016.

Adherence to standards approved by the Organ Donation Committee

These standards were agreed by the Organ Donation Committee as indicators of good practice and therefore to be monitored and reported. These standards were also previously adopted by the Trust as Commissioning for Quality and Innovation (CQUINS) in 2011-12.

DGNHSFT Standards approved by ODC Trust data to date

N1; No of deaths where the diagnosis of ND was suspected and patient met criteria for ND Testing and had ND tests performed	Target set 80%	Achieving 100%
N2; Number of cases where ND testing was planned and the SNOD was informed	Target set 90%	Achieving 100%
N3; Number of cases where there was a decision to WOT in a patient with a catastrophic Neuro Injury and the SNOD was informed before WOT	Target set 50%	Achieving 100%
N4; Number of cases where ND was confirmed or a decision to WOT as per N3, and an approach was made to the family for organ donation	Target set 65%	Achieving 100%
N5; Number of times that donation activity if formally considered by committee and progress with annual plan	At least quarterly	Met once 2015-16

Section 2: Report progress with Trust Organ Donation Plan 2014-17

Action Plan	Progress	Outstanding actions
To monitor DGNHSFT organ donation performance indicators: • To achieve 100% Neurological Death Testing rate in ED/ICU Combined when Neurological Death is suspected.	• 100% NDT rate is achieved	• Staff Training to be rolled out on DCD/DBD policy and updates
• To achieve 100% referral to the SNOD of patients where Neurological Death is suspected	• 100% referral to the SNOD when ND had been confirmed by NDT.	• Nursing and Medical Staff to undertake E Learning mandatory training on Organ Donation which incorporates approaching the family for donation with the SNOD present.
• To achieve 100% SNOD involvement in the approach to the family for DBD donation (once ND confirmed).	• 50% SNOD involvement in the approach for DBD is achieved.	
• To achieve 100% referral to the SNOD of patients who meet the MNC for DCD donation and have a neurological injury.	• 100% referral achieved of this patient group.	
• To achieve at least 70% referral to the SNOD of patients who meet the MNC for DCD donation and do not have a neurological injury.	• 88% referral achieved of this patient group.	
• To achieve 100% SNOD involvement in the approach for DCD donation and the patient has a	• SNOD was involved in 50% of approaches to this patient group.	

neurological injury • To achieve at least 100% SNOD involvement in the approach for DCD donation and the patient does not have a neurological injury	• No activity to report.	
Dudley Group NHS Foundation Trust (DGNHFT) will deliver a Donor recognition project in line with recommendation 12 of the Organ Donation Taskforce Recommendations 2008, and NHSBT 2020 strategy to increase societies support for organ donation.	• Wonderful day had by all on the 8th October 2014 when the "Gift of Life" sculpture was unveiled by HRH Duke of Gloucester • Action Plan achieved	
Annual E Learning package will be developed and implemented for DGNHSFT staff working on ICU and on organ donation	• Funding secured for project Charitable Funds • Supplier of package identified	• E Learning content being developed with supplier. ICU Sister Kate Kemp to develop package if given some non clinical time whilst Rebecca Timmins (SNOD) on Maternity Leave. • E Learning pack is still to be developed

Areas for improvement and actions to be taken:

- Improve SNOD involvement in approaches to the family for Organ Donation.
- Telephone call from on Regional SNOD's to Critical Care when embedded SNOD is not on site (Actioned).
- Datix and investigate approaches where SNOD not involved in initial approach (In progress)
- National development of SNOD requestors (NHSBT to action and in progress)

- DBD/DCD Trust Policy to be rolled out and trained to all staff
- dates to be confirmed to enable training (await PDS team to confirm training dates)

- E learning pack to be developed
- Revisit costing and development with previous supplier (to be actioned)

- Review and evaluate any other Trust organ donation E Learning package (to meet with Sandwell and City NHS Trust SNOD and their package)

- Organ Donation Committee dates to be undertaken quarterly

- ODC have met in April 2016 and quarterly dates arranged and planned.

Section 3: Report Trust contribution to Regional and National targets

NHS Blood and Transplant 2020 Strategy aims to enable the UK to match world class Organ Donation and Transplantation performance.

The strategy has 4 Outcomes at which Regions are asked to support or deliver core and region specific actions. This report will share the Midlands Organ Donation Services actions that are relevant to Dudley Group NHS Foundation Trust.

Outcome 1 – Action by society and individuals will mean that the UK's organ donation record is amongst the best in the world and people donate when and if they can

Action	Owner	Due Date	RAG Status	Priority
Achieve at least 166 Deceased Donors During 2015/16.	Susan Richards Dr Nilesh Parekh Dr Jonathan Thompson	31st March 2016		1
Achieve an overall 64% Consent Rate.	Regional Collaborative	31st March 2016		1
Achieve a 72.5% DBD Consent Rate.	Regional Collaborative	31st March 2016		1
Achieve a 58.5% DCD Consent Rate.	Regional Collaborative	31st March 2016		1
Maintain a 96% DBD Referral Rate.	Regional Collaborative	31st March 2016		1
Achieve a 79% DCD Referral Rate.	Regional Collaborative	31st March 2016		1
Maintain a 93.5% DBD Approach Rate.	Regional Collaborative	31st March 2016		2
Maintain a 47% DCD Approach Rate.	Regional Collaborative	31st March 2016		3
Ensure that each organ donation committee has a Trust profile about organ donation during transplant week.	Emma Avery	30th July 2015		Complete

Outcome 2 – Action by NHS hospitals and staff will mean that the NHS routinely provides excellent care in support of organ donation and every effort is made to ensure that each donor can give as many organs as possible

Discussion to take place with Hospital	Alyson John	30th June		2

Trusts regarding daily unit phone calls from cluster SNODs to identify any donation potential.	Liz Armstrong Suzanne Roberts Claire Roberts Emma Lawson	2015		
Achieve an overall 80% SN-OD involvement rate.	Regional Collaborative	10th November 2015		2
Achieve a 87% DBD SN-OD involvement rate.	Regional Collaborative	10th November 2015		2
Achieve a 75% DCD SN-OD involvement rate.	Regional Collaborative	10th November 2015		2
Ensure all SN-ODs attend annual consent training.	Louise Hubner and Anne-Marie HIll	10th November 2015		1
Achieve an overall 69% SN-OD consent rate.	Regional Collaborative	10th November 2015		2
Achieve a 74% DBD SN-OD consent rate.	Regional Collaborative	10th November 2015		2
Achieve a 66.5% DCD SN-OD consent rate.	Regional Collaborative	10th November 2015		2

Outcome 3 – Action by NHS hospitals and staff will mean that more organs are usable and surgeons are better supported to transplant organs safely into the most appropriate recipient

Action	**Owner**	**Due Date**	**RAG Status (Q1, Q2, Q3, Q4)**	**Priority (1,2,3)**
Implement the donor optimisation care bundle.	Dr Nilesh Parekh Dr Jonathan Thompson	30th September 2015		complete
Support the scout pilot by ensuring completion of forms and access to donor hospitals.	MODST SNODs and Team Managers	30th June 2015		complete
Achieve 3.9 transplantable organs per DBD donor.	MODST SNODs and Team Managers NORs Transplant Centres	30th June 2015		3
Achieve 2.8 transplantable organs per DCD donor.	MODST SNODs and Team Managers NORs Transplant	30th June 2015		3

	Centres						
Ensure monthly attendance at NORS audit meetings.	MODST SNODs and Team Managers	30th June 2015					2
All hospitals within Midlands Region to utilise the Midlands Care Pathway (donor optimisation care bundle is incorporated in to the pathway).	Regional Collaborative	30th June 2015					1

Outcome 4 – Action by NHSBT and Commissioners means that better support systems and processes will be in place to enable more donations and transplant operations to happen

Action	Owner	Due Date	RAG Status (Q1, Q2, Q3, Q4)				Priority (1,2,3)
Ensure the regional collaborative meets a minimum of twice per year.	Susan Richards Dr Nilesh Parekh Dr Jonathan Thompson	31st March 2016					1
Ensure the regional collaborative appoints an ODC Chair Lead from the existing or former ODC Chairs to co-lead the regional collaborative with the Regional Manager (RM) and Regional Clinical Lead for Organ Donation (R-CLOD).	Susan Richards Dr Nilesh Parekh Dr Jonathan Thompson	30th June 2015					3
ODC Chairs will be expected to attend each appropriate Regional Collaborative event. Target ODC Chair attendance is 60% at each regional collaborative.	ODC Chairs	31st March 2016					2
CLODs will be expected to attend each appropriate Regional Collaborative event. Target CLOD attendance is 75% at each regional collaborative.	All CLODs Dr Nilesh Parekh Dr Jonathan Thompson	31st March 2016					2
Every donation committee will be led by a Chair who is not an intensive care or emergency medicine health professional.	Dr Dale Gardiner	31st March 2016					3
Donation committees will meet a minimum of four times per year. Target 100%. (see narrative).	Trust ODCs	31st March 2016					3
Every ODC will monitor their hospital performance every three months and develop action plans for areas of poor performance.	Trust ODCs	30th September 2015					2
Every ODC will write an annual plan	Trust ODCs	30th June					2

which includes action points and these action points are reviewed for progress.	MODST SNODs	2015					
All CLODS to ensure their hospital has an up-to-date organ donation policy, which is in accordance with national guidance and policy, appropriately approved by the relevant internal hospital governance structures. 100% sign-off required.	All CLODs MODST SNODs	30th June 2015					2

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board
on 5 May 2016

TITLE:	Committee/Group Non-Executive Director allocations		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary

CORPORATE OBJECTIVES ALL

During the last few months the allocation of Non-Executive Director (NED) time to Board Committees, Sub Groups along with areas where NED leads have been identified by NHS England or regulators as useful has been reviewed.

The Table attached shows the outcome of this review and seeks to balance the skills of the NED against the time commitments required.

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 but particularly well led**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF GROUP

Decision	Approval	Discussion	Other
		Y	

ACTION FOR THE BOARD
To note the allocation of Non-Executive Resource

The Dudley Group NHS
NHS Foundation Trust

Committee Attendance mapping

	Nominated NED for	Board Committees							Council of Governors Committees								Trust Groups					Comp-any	Ext Boards				
		Board of Directors (M)	Appointments and Remuneration Committee (A)	Finance & Performance Committee (M)	Workforce and Staff Engagement (Q)	Clinical Quality, Safety & Patient Experience (M)	Charitable Funds Working Groups (Q)	Audit Committee (Q)	Council of Governors (Q)	Annual General Members Meeting	Appointments Committee (A)	Remuneration Committee (A)	Strategy Committee (Q)	Governance Committee (Q)	Engagement and experience Committee (Q)	Governor Development Group (Q)	Internal Complaints Review Group (Q)	Arts and Environment Group (BM)	Mortality and morbidly group	Mortality Group	IT Steering Group (M)	Dudley Clinical Services (A)	End of Life Steering Group (Q)	Internal Safeguarding Board (M)	Dudley Children & Young People's Alliance Board (Q)	Dudley Clinical Education Centre	Organ Donation (Q)
Jenni Ord		C	C		A				C	C	A	A				A			A								A
Jonathan Fellows	SID	A	A	C			A	A	A	A	A**	A**		A*		A											
Richard Miner	Security Mgt	A	A	A				C	A	A				A*								A	A				
Ann Becke	Safeguarding	A	A			A		A	A	A			A		A		A	A			C			#	A	A	
Doug Wulff	Whistleblowing	A	A		A	C	A		A	A					A					A		A	C				
Julian Atkins		A	A	A	C	A	C		A	A			A														

C = mtg Chair
A= member of the meeting

***** alternate attendance
** attends when Chair's performance is being discussed
# attends only if requested

M = monthly meeting
Q = quarterly meeting – note that Audit has a fifth meeting – so does CoG governance comm
A = adhoc
BM = bi monthly
TBA = to be determined

Committee/Group NED allocations

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board May 2016

TITLE:	**Health, Safety and Fire Assurance Report**		
AUTHOR:	**Helen Watkiss, Health and Safety Manager**	**PRESENTER**	**Paul Bytheway, Chief Operating Officer**

CORPORATE OBJECTIVE:

SO1, SO2, SO3, and SO4

SUMMARY OF KEY ISSUES:

- Incident Data
- H&S Meeting Structure
- H&S Training
- H&S Audits
- Fire Safety Overview

IMPLICATIONS OF PAPER:

RISK	**For Information only**		**Risk Description:**
	Risk Register:		**Risk Score: Low**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	X	**Details:** Safe and Well Led
	Monitor		**Details:**
	Other	X	**Details:** Health and Safety Executive

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD:
To **NOTE** the contents of the report.
To **NOTE** the changes to the Health and Safety meeting structure

The Dudley Group NHS
NHS Foundation Trust

OVERVIEW

This report is presented to the Board to give an overview of the reactive health and safety incident data for the period 2014-16. The report contains a brief overview of the gaps identified within the H&S management systems and the actions offered in order to ensure compliance.
An overview of fire safety current projects and actions is included to offer assurance that appropriate action is being taken to address any shortcomings.

BACKGROUND

The new Health and Safety Manager joined the Trust in December 2015. On review of the management systems that were place at that time, it was identified that there are areas in which additional work is required to ensure that the Trust maintains compliance within the Regulatory structure.
The main areas identified are:-

- Communication and Assurance
- Health and Safety Training
- Health and Safety Auditing

The report contains the actions to be taken by the Health and Safety Manager over the twelve month period, to ensure that the above gaps within the management systems are being addressed and offer assurance to the Board that appropriate measures are being taken.

The report also contains information on the current situation in respect to incident reporting and the categories of incidents that are being reported externally to the Health and Safety Executive.

HEALTH AND SAFETY

Incident Data April 15 – March 16

The table gives an overview of the total number of incidents affecting staff reported during 2014/15 and 2015/16.

Incident Category	Incidents during 2014/15	Incidents during 2015/16
Manual Handling	88	26
Needle sticks and Sharps	162	96
Exposure to hazardous substances	54	26
Slips, Trips and Falls	96	66
Collisions and Contacts	81	42
Total number of reported incidents	481	256

The figures indicate that there has been a reduction of 47% in the total number of incidents reported across the group.
The reason for the significant reduction is unclear, and could be a general reduction in reporting, or could be as a result of interventions made to improve staff safety.

The number of needle stick / sharps incidents has reduced by 41%, this could be as a result of the introduction and on-going works in respect to safer sharps.

ACTION:
Health and Safety Manager to monitor the trends over the coming twelve month period. Comparative data from similar industries to be considered, to determine if the Trust is in line with other Healthcare Industries. Continued review and implementation of safer sharps through the DPE Group, to ensure that the Trust is maintaining compliance with the Healthcare Sharps Regulations, and that the intervention is ensuring staff safety.

RIDDOR Data:

Incident Category	Incidents during 2014/15	Incidents during 2015/16
Over seven day injury	11	13
Dangerous Occurrence	6	2
Disease	0	1
Major Injury	1	1
Major Injury to Patients	27	17
Total number of RIDDOR Reports	45	34

During the year 2014/15 there were 45 reports submitted to the Health and Safety Executive under RIDDOR. During 2015/16 this number reduced by 24% with only 34 incidents reported.

The data shows that the number of major injury's sustained by patients whilst receiving NHS funded care has reduced by 37%, this may be as a result of the work being carried out by the clinical teams in respect to managing patients who are at risk of falls in a more pro-active manner. The RCA process and information sharing of the falls group may have also contributed to raising the awareness of measures available to support patients and staff.

In regards to incidents affecting staff this has only slightly reduced with 18 reports in 2014/15 compared to 17 during 2015/16.

ACTION:
Health and Safety Manager to carry out RCA investigations into all RIDDOR reportable incidents which affect staff to determine causation and consider effective control measures to prevent re-occurrence, with a view to reducing the number of externally reported incidents. Learning from investigations to be discussed at the Health, Safety and Fire meetings.

Health and Safety Meeting Structure

The current Health and Safety Meeting does not fulfil the criteria that would be expected of a senior level meeting. The purpose of a formal health and safety committee is to offer assurance to the Board that the Trust is in compliance with the Law, and to act as an escalation route for concerns or issues that cannot be resolved locally within the Directorate that require senior level intervention.

A new structure is being introduced that incorporates a Health, Safety and Fire Assurance Group which sits between the existing H&S group and the HR Workforce and Staff Engagement Committee. The purpose of the H&S Group will be to discuss the local issues and offer resolution to the departmental representatives, overview incidents data and investigations and review policy.
The assurance group will review incident data and actions moving forward, ensure compliance with actions arising from audits and inspections and offer final approval on policy before escalation through policy approval process.

Whilst it is noted that this introduces another quarterly meeting, the attendance at each group is different and so adds no additional time pressures to staff members.
The only persons required to attend both meetings are the Health and Safety and Fire Safety Managers

The meeting has also been changed to formally incorporate Fire Safety so that progress with fire related issues can be monitored through the group and assurance offered to the Board that the Trust is maintaining compliance with the Regulatory Reform Fire Order.

The new structure takes effect from June 2016.

ACTION:
Health and Safety Manager to implement the new structure and review in June 2017 for effectiveness.

Health and Safety Audits

In compliance with HSG65 the Trust should ensure that there is an audit process in place. to assess that the policy standards set are in conjunction with the Regulations, and that the policy is implemented effectively within the working areas.

Previously the Trust had an inspection plan in which the local compliance elements were considered; however this would not be accepted as a formal audit of the full management system.

The Trust is now registered under the RoSPA QSA scheme.

ACTION:
The Health and Safety Manager has developed a three year audit plan which initially reviews all H&S policies against the regulatory perspective. Each quarter a division or department will be subject to a full compliance audit carried out by the H&S Manager, a report and action plan will be completed following each audit and issued to the relevant Head of Service. Progress with the audit plan and subsequent action plans will be monitored through the H&S and Fire meeting structure.

Health and Safety Training

There is a significant lack of suitable health and safety training for staff that are expected to undertake H&S duties as part of their role.
It is understood that in approximately 2014 the lack of suitable training was placed on the risk register as a corporate risk to the Trust.

A training plan has now been developed and offers training for all staff and managers in the following areas:-

- Risk Assessment
- COSHH Assessment
- DSE Assessment
- Work Related Stress Assessment.

There is also a paper being presented to finance in order to support the implementation of formal Health and Safety training for Managers.

ACTION:
H&S Manager to progress the paper with finance to implement the IOSH Managing Safely qualification for all managers and supervisors within the Trust. Annual review of the training programmes and attendance to be undertaken to ensure the training is effective and sufficient levels of staff are attending.

FIRE SAFETY

The Fire Safety and Property Manager joined the Trust in February 2016.

Fire Risk Assessments

An external Consultant has been employed by the Trust and the fire risk assessments for Russell's Hall, Corbett and Guest have now been completed. The assessments have been handed to the Trust Fire Safety Manager for implementation and action.

ACTION:
The Trust Fire Policy and associated procedures are currently under review by the Fire Safety Manager as a result of the assessments. Community fire risk assessments are also due to be reviewed in conjunction with the Trust Fire Safety Manager and the Community responsible person.

Fire Safety Mandatory Training

Mandatory fire training has been updated in accordance with the Fire Safety Manager and the Learning and Development Team. In order to comply with the Regulatory Reform Fire Order staff are now required to attend face to face sessions every two years. The Trusts Fire Safety Manager has developed a training programme, all staff due to update their fire training must attend a scheduled training session. Dates and locations are available on the HUB.

ACTION:
Mandatory training programme to be delivered by the Fire Safety and Property Manager. Annual review of compliance to be undertaken.

Fire Service Audit

The Fire Service attended site on Thursday 21st April 2016 to carry out a full site inspection, They are scheduled to attend Corbett / Guest on 5th May.

A letter of findings for RHH has been received by the Trust and notes points of concern to be addressed.

ACTION:
Fire Safety Manager to ensure that the points of concern are addressed for RHH. Action findings from the inspection at Corbett / Guest when information becomes available.

CONCLUSION

The actions noted above are for implementation over this financial year, progress will be monitored through the Health, Safety and Fire Assurance Group.

Paper for submission to the Board

on 5 May 2016

TITLE:	**Complaints and claims report for quarter four 2016 and for the year end 31 March 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 year ending 31 March 2016

There has been a 7% decrease in activity during the year, when compared with year ending 31/3/15, although the complaints are more complex and required more input when providing responses. In addition, more than half of the complainants are accepting the offer of a meeting, which need careful preparation to ensure all concerns are adequately addressed. Data within [ ] refers to previous year, ending 31 March 2015

100% [100%] of complaints received during Q4 and the year were acknowledged within 3 working days

38% [61%] - although only 38% of complaints received and closed during the year were closed within 40 working days, this is due to complainants accepting the offer of a local resolution meeting and these then having to be arranged at a mutually agreed date. ***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.***

59% [46%] of complaints received and closed were upheld/partially upheld

11 [20] complainants expressed dissatisfaction with their response (received and investigated)

101 [71] local resolution meetings held with complainants

12 [18] Inquests held and closed

1 [1] rule 28 - reports on 'Action to Prevent Future Deaths' received from Senior Coroner

An analysis of the cases referred to the PHSO have again not identified any areas for us to learn / modify our current processes.

Claims - Q4

11 [5] CNST claims closed, of which only three were successful and settlements made

3 [6] Employer's liability claims closed, none of which were successful

1 [2] new Employer/Public liability claim received

10 [15] new CNST claims received

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	**Y**	**The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 No. 309**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS:

To note details of complaints and claims activity during year end 31 March 2016

Key Facts – Complaints, Inquests & Ombudsman

Key facts During qtr/year	Qtr 4 ending 31/03/15	Year ending 31/03/15	Qtr 1 ending 30/06/15	Qtr 2 ending 30/09/15	Qtr 3 ending 31/12/15	Qtr 4 ending 31/03/16	Year ending 31/03/16
Total number of complaints rec'd within qtr/year	**94** 4 - high 48 - med 42 - low	**313** 12 - high 179-med 122 - low	**70** 5 - high 32 - med 33 - low	**86** 3 – high 42 – med 41 – low	**72** 2 - high 35 - mod 35 - low	**66** 2 – high 37 – med 27 - low	**294** 12- high 146-med 136 -low
% Complaints ack'd within 3 working days	100%	100%	100%	100%	100%	100%	100%
% Complaints rec'd and replied within 40 working days	45%	61% "	44%	44%	**25**% ** [see note below]	**38%**** [see note below]	**38% **** [see note below]
Number of upheld/ partially upheld complaints replied within qtr/year	**20***	**143* (46%)**	**34***	**60***	**43***	**36***	**173* (59%)**
Complaints accepted for investigation by PHSO	2	9	0	2	0	2	4
Privacy/dignity incl as a concern in complaint	4	6	0	0	1	3	4
Complaints referring to shared accommodation	0	0	0	0	0	0	0
Complaints incl safeguarding issue	0	1	0	0	1	2	3
Number of meetings held with complainants (% of complaints rec'd)	15 (16%)	71 (23%)	19 (27%)	17 (20%)	28 (38%)	37 (56%)	101 (34%)
Total number and % of dissatisfied complaints rec'd	6	20 (6%)	6	1	2	2	11 (4%
Total CCG/CSU led complaints yr	3	8	3	0	1	3	7
New Coroner's cases opened	1	7	7	1	1	7	16
Coroner's Inquests held/closed	2	18	4	5	0	3	12
Coroner's Rule 28 (was rule 43)	0	1	1	0	0	0	1

Note

* Includes c/fwd from previous quarters

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

Category * [see note below]	Qtr 4 ending 31/3/15	Trust yr ending 31/3/15	National yr ending 31/3/15	Qtr 1 ending 30/6/15	Qtr 2 ending 30/9/15	Qtr 3 ending 31/12/15	Qtr 4 ending 31/3/16	Trust yr ending 31/3/16
Clinical Care (Assessment/Monitoring)	50 (53%)	**134 (43%)**	**45%**	38 (54%)	43 (50%)	23 (32%)	20 (31%)	**124 (42%)**
Diagnosis & Tests	20 (22%)	**56 (18%)**	NA	12 (17%)	7 (8%)	8 (11%)	3 (5%)	**30 (10%)**
Records, comms, Information or appts (incl delay)	1 (1%)	**17 (5%)**	**22%**	4 (6%)	17 (20%)	18 (25%)	17 (26%)	**56 (19%)**
Admission, discharge & transfers	6 (6%)	**33 (11%)**	**5%**	6 (9%)	7 (8%)	8 (11%)	6 (10%)	**27 (9%)**
Values & behaviour of staff (prev 'staff attitude')	6 (6%)	**20 (6%)**	**11%**	6 (9%)	2 (2%)	3 (4%)	4 (6%)	**15 (5%)**
Obstetrics	2 (2%)	**12 (4%)**	**3%**	3 (4%)	3 (4%)	3 (4%)	7 (11%)	**16 (5%)**
Nursing care (District Nurses)	0	**2 1%)**	NA	0	0	1 (1%)	1 (1%)	**2 (1%)**
Medication	1 (1%)	**13 (4%)**	NA	0	3 (4%)	0 (1%)	4 (6%)	**7 (2%)**
Patient Falls, Injuries or Accidents	2 (2%)	**5 (1%)**	NA	1 (1%)	2 (2%)	2 (3%)	0	**5 (2%)**
Aids, appliances, equipment,	0	**4 (1%)**	**1%**	0	0	3 (4%)	1	**4 (1%)**
Safeguarding	0	**1 (1%)**	NA	0	0	1 (1%)	0	**1 (1%)**
Theatres	1 (1%)	**4 (1%)**	NA	0	0	0	1 (1%)	**1 (1%)**
Privacy & dignity	4 (5%)	**6 (1%)**	1%	0	0	1 (1%)	1 (1%)	**2 (1%)**
Pressure ulcer	0	**2 (1%)**	NA	0	0	0	0	**0**
Violence, aggression	1 (1%)	**2 (1%)**	NA	0	0	0	0	**0**
Other (security, workforce)	0	**2 (1%)**	**4%**	0	2 (2%)	1 (1%)	1 (1%)	**4 (1%)**
Total:	**94**	**313**		**70**	**86**	**72**	**66**	**294**

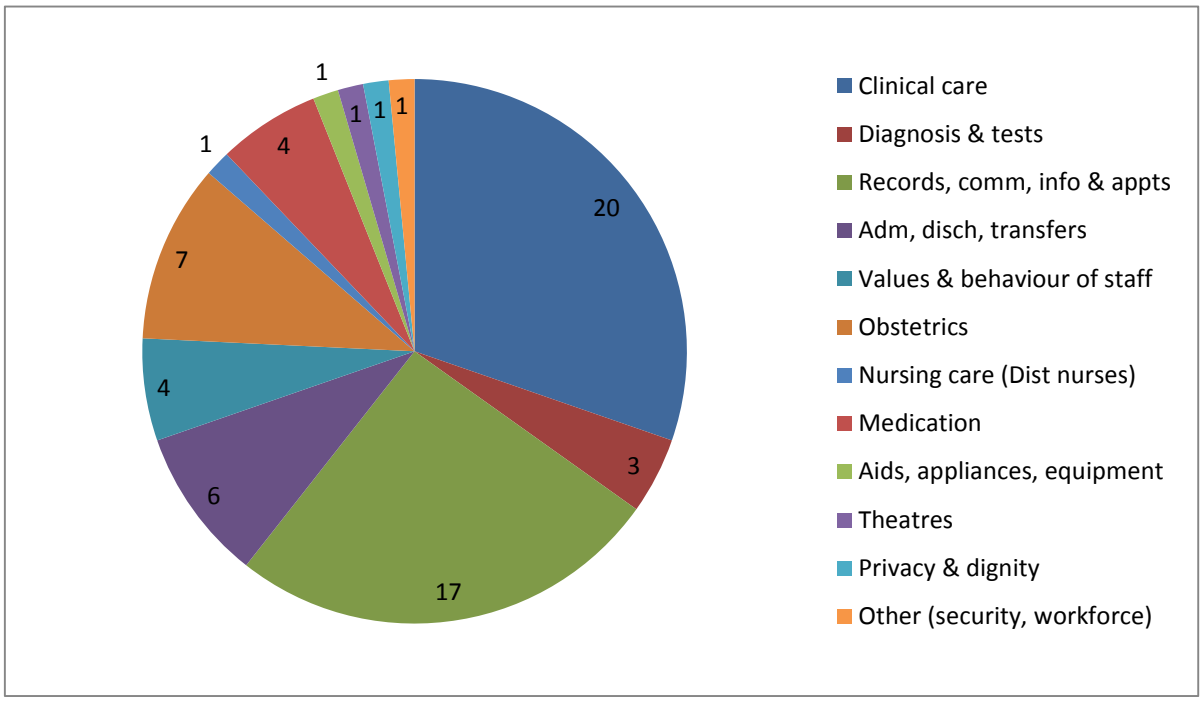
The message about 'Care, Respect and Responsibility' is included in the Chief Executive's briefings, which all staff are required to attend.

Quarter 3 report continues to reflect the downward trend in 'values and behaviour of staff' (including staff attitude), which compares favourably with national data.

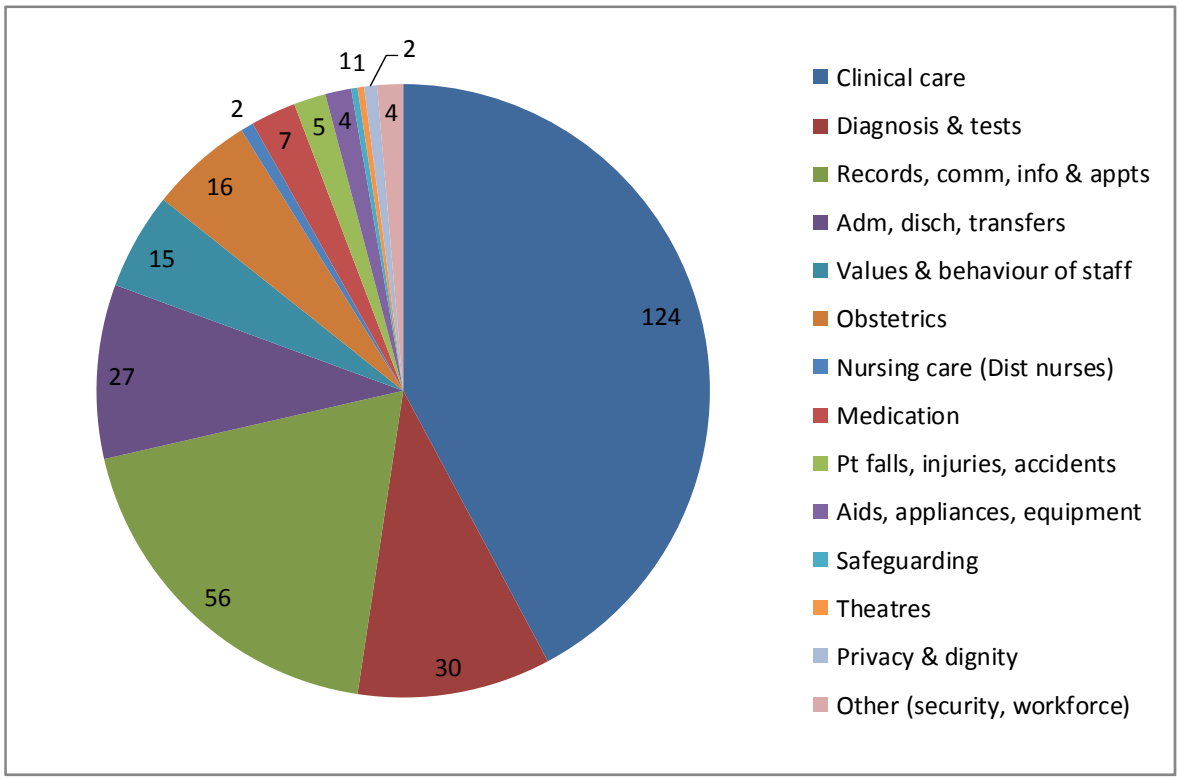
Note

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

Analysis of complaints received by category – Q4



Analysis of complaints received by category – yr ending 31/3/16

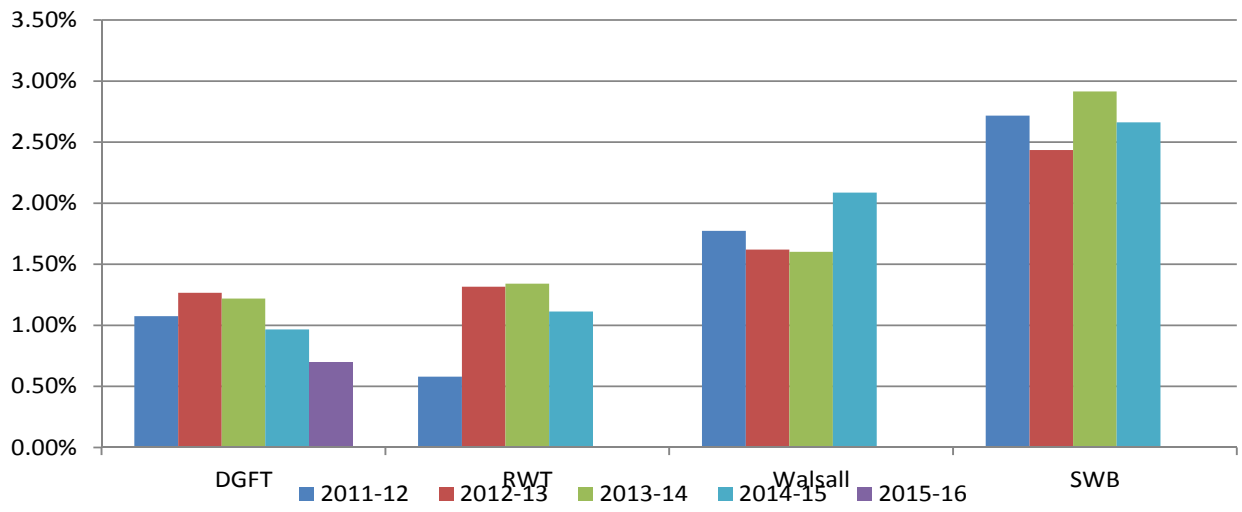


Benchmarking
– Birmingham & Black Country – Year ending 31/3/2015 (2016 not yet available)

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

- Complaints as percentage of admissions

Below is an analysis of our position relative to our nearest acute trust neighbours



% of complaints received against total hospital activity

ACTIVITY	Total qtr 4 ending 31/3/15	TOTAL year ending 31/3/15	Total qtr 1 ending 30/06/15	Total qtr 2 ending 30/9/15	Total qtr 3 ending 31/12/15	Total qtr 4 ending 31/3/16	TOTAL year ending 31/3/16
Total patient activity	183574	736,510	189260	181895	185460	188840	745455
% Complaints against activity	0.05%	0.04%	0.03%	0.04%	0.03%	0.03%	0.03%

Compliments received

1677 compliments received during Q4
7581 compliments received during year ending 31 March 2016 which is **4%** of total patient activity

Senior Coroner – Inquests

Q4

3 inquests held

Year ending 30 March 2016

12 inquests were held

1 rule 28 (formerly rule 43) 'preventing future deaths' letter was received from the Coroner. The action plan resulting from this has been formulated and implemented with the improvements made by the Trust reported to Clinical Quality, Safety and Patient Experience Committee, staff and our commissioners within our learning report.

Parliamentary & Health Service Ombudsman (PHSO)

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

Each of these referrals was reviewed and it was confirmed that there were no significant common themes identifying failings within the Trust's complaints process.

CLAIMS

Clinical negligence claims closed during Q4

Eight of the 11 claims closed/settled during the quarter resulted in no costs being made against the Trust.

Employer liability claims closed during Q4

All three of the Employer's liability claims closed were done so with no costs awarded against the Trust.

TRIALS AT BIRMINGHAM COUNTY COURT – QUARTER 4

During February 2016, Counsel acting on behalf of the NHSLA/Trust successfully defended three claims, which were all discontinued. This more forceful stance is very positive and shows that pursuing action to the point of trial is worthwhile when there more than a 51% chance of success and expert witness evidence is largely supportive of the care provided.

One claim was discontinued at the end of the second day of a four-day trial, with the Claimant's solicitors having to pay the NHSLA's total costs. We are awaiting confirmation from the NHSLA that we can close this claim.

The second claim was discontinued as the trial was about to commence, with the NHSLA's Counsel/solicitors making an application against the Claimant's solicitor for their costs (due to be heard by a Judge in May). This claim has been closed in the quarter at no cost.

The third claim was discontinued the day before the trial was due to commence. We are awaiting confirmation from the NHSLA that we can close this claim.

Year ending 30 March 2016

Clinical negligence claims during the year

There were 32 clinical negligence claims closed during year ending 31/3/16. 20 of these claims, including the eight in quarter 4 above, were closed/settled during the year resulted in no costs being made against the Trust

Employer's liability claims closed

There were nine employer's liability claims closed during year ending 31/3/16. Seven of these claims, including the three in quarter 4 above, were closed/settled during the year resulted in no costs being made against the Trust.

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th May 2016

TITLE:	**Black Country Alliance Report**		
AUTHOR:	**Terry Whalley, BCA Programme Director**	**PRESENTER**	**Paula Clark, Chief Executive**

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:

No issues arising.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details: None**
	Monitor	**N**	**Details: None**
	Other	**N**	**Details: None**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note this report from BCA Programme Director and ask any questions that may arise

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 Black Country Alliance

Programme Director's Update – April 2016

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 Phase 1 Project updates

2.1 Urology

The Urology Steering Group met on 17th March for the first time under executive sponsorship of Dawn Wardell. The group shared early draft on production of sub-speciality map which will enable more granular discussion of opportunity for collaboration that improves patient health outcomes, healthcare experience and better use of the resources we collectively have. Examples that are emerging where changes may be beneficial include making better use of Embryology, Penile and laser treatments. The group will meet again on 21st April to try to land the specialism map, agree some next steps and bring forward early examples of patient benefits already enabled through the collaboration now happening.

2.2 Interventional Radiology

The pilot of the non-vascular 7-day Interventional Radiology service was launched as planned on Saturday 2nd April. This is an exciting example of the potential for the Black Country Alliance to enable 7 day services to be better enabled through collaboration. All provisions were in place for service; however there were no referrals into the service. This is not unexpected, given the low volumes forecast when planning the pilot. Urology consultants will be contacted to ensure there were no patients missed who might have benefited from the service.

Regular updates on the pilot will be included each month in this report.

3. Phase 2 Project Updates

At March's BCA Board, the BCA Board agreed the scope of work for the Black Country Alliance in 2016/17 and added a number of phase 2 items to this scope. This included a handful of larger projects which will mobilise during April and May, plus a small number of rapid initiatives which the Board believes have the potential to

deliver results by the summer with the right support. The following sections focus on providing an update on those potential 'quick win' initiatives.

3.1 FINCH

Project Team			
	DGFT	**SWBH**	**WHC**
Trust Sponsor	Paul Bytheway	Mr Edward Harper	Mr Amir Khan
Clinical Lead	Mr Anthony Kawesha Ms Shalagh Macleod	Kelly Stackhouse Elizabeth Clarson,	Mr Robert Church Ms Sarah Addison Elaine Swan
Management Lead	Ned Hobbs	Shinade Coughlan	Nicola Sheard Rachel Benson

This aims to replicate SWBH's award winning Foetal Incontinence and Constipation Healthcare (FINCH) across the Black Country and beyond. For patients that suffer with bowel dysfunction, a thorough pelvic floor assessment, investigation, treatment and discharge will, based on experience, improve Quality Of Life by at least 50%. There is a range of treatments available and the current SWBH service is one of few centres specialised to do this in England.

Dudley Group now refers patients to the SWBH service. There will be more rigour and formality to form a pilot on which we might better measure improvements to our triple aim; improving health outcomes, healthcare experience and making better use of resources. A meeting took place on 22nd March with SWBH clinical leads which resulted in a defined current state and a draft future state model to aid a walk through with WHC and DGFT leads at a workshop session with all three partners.

Next Steps:

1. A pilot study based on current DGFT referral pathways to identify benefits and outputs.
2. A workshop session with all three partner leads in April.
3. Draft and agree project mandate with all three partner leads, to be completed in April

3.2 Complex TB

The project team formed			
	DGFT	**SWBH**	**WHC**
Clinical Lead	Dr Doherty Julie Webster	Dr Imtiaz Ahmed, Dr Guy Hagan, Dr Nazim Nathani Tracey Morrod Anne Lowe	Dr Viswanatha Balagopal Joanne Ellison
Operational Lead	Joanne Taylor	Casper Fons	**To be identified**

Sometimes patients with complex tuberculosis (TB), including multi drug resistant (MDR) cases, are referred outside of the Black Country for their treatment. SWBH have expertise built up over some years and could act via a larger clinical network allowing patients to be seen and treated more locally with care closer to home.

A meeting for clinical and nursing colleagues has been arranged for 15th April to explore this. The key focus will be to establish a common understanding of current 'as is' patient pathways for complex TB and MDR cases in Sandwell, City, Walsall and DGFT and define future state 'to be' pathways, possibly repatriating cases currently being sent outside the BCA.

The SWBH leads have discussed the above aims with their counterparts at partnering Trusts. WHC are supportive of the idea. DGFT are supportive of the principle but has mentioned that DGFT are already part of a TB clinical network with Wolverhampton. This will need to be considered further.

Next Steps:

1. A kick off meeting with all three partners on 15th April.
2. Reconfirm appetite at DGFT to consider SWBH service as well as or as an alternative to Wolverhampton service.
3. A project mandate with all three partner leads to be agreed by end of April.

3.3 Haemoglobinopathy

Project Team yet to be formed			
	DGFT	**SWBH**	**WHC**
Clinical Lead	Dr Rupert Hipkins	Dr Shivan Pancham	Dr Vinayak Tandon

There is an agreed protocol in place with DGFT team, whereby they manage straightforward patients at Dudley and complicated patients are referred to the SWBH team. SWBH have also helped DGFT with guidelines for the management of Haemoglobinopathy patients.

Walsall has arrangements with Wolverhampton and currently their view is that complex Haemoglobinopathy patients continue to be reviewed at New Cross in line with the other level 2 patients.

Next Steps:

1. BCA Board to confirm if there is a requirement to review option of moving complex cases from Wolverhampton to SWBH
2. Mobilise or close this project depending on step 1.

3.4 Endoscopic Colon Tumour Resection

Project Team			
	DGFT	**SWBH**	**WHC**
Trust Sponsor	Paul Bytheway	Dr Roger Stedman	Dr Amir Khan
Clinical Lead	Prof. Sauid Ishaq Mr Anthony Kawesha	Mr Vijay Thumbe to be confirmed	Mr Rob Church Ms Sarah Addison
Group Manager	Ned Hobbs		

This project will explore the opportunity for scaling up and replicating novel techniques, such as Novel Full thickness resection of colonic tumour endoscopically, currently being delivered in only 3 places in England (one being DGFT) to create a national centre of excellence.

In addition to specific sub-specialisms, there is an opportunity to jointly consider what a world class Endoscopy service might look like across the Black Country. Together we will consider further sub specialisms, translation of research into medical practice, closing the gap on 7 day services, reducing demands for out of hours on call rotas on individuals and reducing unwarranted variations in outcomes.

A meeting with DGFT Clinical Leads took place on 22nd March, which resulted in defining current state and drafting a proposed 'Endoscopic Full Thickness Resection' (EFTR) pathway. A three way meeting is currently being planned to discuss extending the current EFTR service to BCA Trusts.

Next Steps:

1. A meeting with all three partner leads in mid-April.
2. Draft and agreed project mandate with all three partner leads to be produced in April

3.5 Back Office Support Services - Phase 1

3.5.1 Contract Management in Estates & Facilities

Project Team			
	DGFT	**SWBH**	**WHC**
Trust Lead	Chris Walker	Alan Kenny	Mark Sinclair

All three Trusts operate PFIs. There is an extensive team at SWBH and changes in the team at Walsall. There is considerable collective knowledge of contract management. This review will examine both KPIs, processes for monitoring, and opportunities to operate similar review structures**.** Dates in April have been circulated to facilitate a three way meeting with the aim of examining current key performance measures

and indicators, processes for monitoring and to identify those opportunities to operate similar review structures across all three Trusts.

Next Steps:

1. A workshop session with all three partner leads in mid-April.
2. Draft an agreed project mandate with all three Trusts leads

3.5.2 Research Management & Governance

Project Team			
	DGFT	**SWBH**	**WHC**
Trust Leads	Jeff Neilson	Karim Raza	James Halpern
RM&G Management Leads	Margaret Marriott	Jocelyn Bell	Louise Jones

All 3 Trusts operate offices which examine, price, and approve studies. These 3 operate to common regional and national standards. The duplication may have value, but all three face periodic capacity pressures, and there may be benefit to developing a single process with common charging standards to enable open participation in studies.

The project leads have met and have begun the identification of studies where one site could act as a Participant Identification Centre (PIC) site for the other and coordinating / streamlining PIC site approvals. Secondly, a coordinated approach to quality assurance including study audits etc. The project team discussed the roll out of HRA approval processes requiring site specific capacity and capability assessment, which would be difficult to do at on a cross-Trust (level) basis.

Next Steps:

1. A three way meeting session with RM&G management on 8th April
2. Draft and agreed project mandate with all three Trusts leads

3.5.3 Legal Services

Project Team			
	DGFT	**SWBH**	**WHC**
Governance Leads	Glen Palethorpe	Kam Dhami	Linda Storey
Legal Services Lead	Glen Palethorpe	Allison Binns	Linda Storey

A meeting took on the 1st April to discuss Legal Services at each Trust and what benefit a BCA approach could have. The team had good discussions about some of the services and agreed to obtain more information within their own Trust. The team plans to meet again and discuss at the end of April.

Next Steps:

1. A three way meeting end of April to agree scope and plans
2. Draft and agreed project mandate with Trust leads

3.5.4 Information Governance

Project Team			
	DGFT	**SWBH**	**WHC**
Trust Leads	Glen Palethorpe	Kam Dhami	Linda Storey
IG Lead	Glen Palethorpe	Allison Binns	Linda Storey

All 3 Trusts operate small teams to advise Caldicott guardians and staff on issues of legal compliance. There may be merit in pooling that expertise to create good coverage across the three organisations, improved resilience and peer support in isolating roles.

A meeting took place on 1st April, which discussed Information Governance (IG) and the leads agreed to ask each of the Trust (IG) Managers to get together and propose a way to ensure IG resilience across the three sites. The IG managers generally have good networking and would need to discuss the scope of this piece of work.

Next Steps:

1. All three IG managers to arrange a meeting
2. Trust Leads to review IG Lead proposals and agree options for resilience

3.5.5 Temp Staffing Admin / Rates

Project Team			
	DGFT	**SWBH**	**WHC**
Trust Sponsor	Julie Lamb	Raffaela Goodby	Mark Sinclair
Trust Lead	Rachel Ingham-Jones	Glynis Fenner	Gaynor Farmer Justin Westwood

This review will explore immediately rates and terms being put in common. This will report back by July. Beyond that we will explore whether a single bank and bank system would add bandwidth and value.

There will be a clearer view on the way forward by mid-April, when the Trust Bank Managers have met together.

Next Steps:

1. A three way meeting sometime in mid-April
2. Draft and agreed project mandate with Trust leads

3.5.6 ESR Admin

Project Team			
	DGFT	**SWBH**	**WHC**
Trust Sponsor	Julie Lamb	Raffaela Goodby	Mark Sinclair
Management Lead	Rachel Andrew Julie Black (ESR expert)	Andrew Harding	Emma Peabody

We operate different ESR systems across the 3 Trusts. We want to collaboratively map our processes associated with using these systems. This may illustrate opportunities to improve our approaches – sharing best practice and removing unwarranted variation, and will provide a knowledge base in examining the future of all 3 ESR systems.

A group has now been formed and a meeting is in progress to collaboratively map out processes associated with ESR systems.

Next Steps:

1. A three way meeting sometime in mid-April
2. Draft and agreed project mandate with Trust leads

3.5.7 Coding

Project Team			
	DGFT	**SWBH**	**WH**
Trust Sponsor	Paul Taylor	Rachel Barlow	Russell Caldicott
Clinical Coding Lead	Andy Troth	TBC	Russell Caldicott

SWBH have yet to confirm their nominated lead. When this is known the team will begin discussions around banding structures of coders, best practice including home coding in line with clinical coding standards and examine leadership and training structures.

Next Steps:

1. Arrange a three way meeting in mid-April
2. Draft and agreed project mandate with Trust leads

3.5.8 Procurement

The 3 trusts have mobilised a joint procurement programme of work. A combination of short term tactical procurement projects, and longer term transformational change, this will be a key part of our collective response to Lord Carter's review of hospital efficiency. This review suggested that SWBH could make savings in the region of £50.9m when compared to the National mean, Dudley Group around £29.5m and Walsall Healthcare around £23.6m. With a theoretic opportunity that

appears to be in the region of £100m, we will need to be bold in our approach to enable the kind of change required to realise those efficiencies. This is covered in some more detail in a separate paper at April's BCA Board.

4. The Ask of the Black Country Alliance Board

The Black Country Alliance Board is invited to receive and comment on the above update.

The Black Country Alliance CAN – April 2016

Welcome to the latest edition of the Black Country Alliance CAN newsletter. Here you will find a brief update on the current projects being undertaken within the Black Country Alliance together with a roundup of other news items. This follows the BCA Board meeting, held for the first time in public on 13th April 2016.

Next Board date will be 11th May 2016 @11.30am in the Nurses Training Room, Ground Floor, Trust HQ, Sandwell Hospital. The BCA Board meetings are now open to the public and you would be most welcome to attend.

You can find papers from the public BCA Board on www.blackcountryalliance.org . Minutes of the meeting will also be published.

Interventional Radiology (IR)

The pilot of the non-vascular 7-day Interventional Radiology service was launched as planned on Saturday 2nd April. Whilst all provisions were in place for the service there we no referrals into the service. This however, is not unexpected as low volumes were forecast when planning the pilot.. The Steering Group will continue to monitor this pilot, and will consider the criteria by which we may extend the pilot to include procedures other than nephrostomies.

This is an exciting example of the Black Country Alliance collaborating to introduce a 7 day service together, and further updates about this service will follow as the pilot progresses.

A reminder of the rota is below .

Week	Non-Vascular On-call	Location for Non-Vascular
w/e 2nd April	DGFT	DGFT
w/e 9th April	DGFT	DGFT
w/e 16th April	RWHT	RWHT
w/e 23rd April	RWHT	RWHT
w/e 30th April(includes bank holiday provision)	SWBH	SWBH
w/e 6th May	SWBH	SWBH

Anne Baines, Director of Strategy, Performance and Transformation at DGFT, can provide further details of the pilot **(anne.baines@dgh.nhs.uk).**

Urology

The Urology Steering Group met on 17th March to share an early draft of a pan Black Country Urology sub-speciality map. This was to enable a more granular discussion of the opportunity for collaboration that both improve patient health outcomes/ healthcare experience and which enables a better use of collective resources. Some examples which emerged from the meeting, which was led by Chief Nurse at Dudley, Dawn Wardell, include better use of Embryology, Penile and laser treatments.

Next steering-group meeting will be 21st April and the outcomes will be reported in the next edition.

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

Rheumatology

The Board received a presentation from Dr Deva Situnayake (SWBH) and Dr Nicky Erb (DG), clinical leads in the Rheumatology Project group.

Work continues on the provision of a shared BCA Rheumatology Service to deliver a safe and sustainable service locally. The ambition of which is to be offer a "world class service" which will hopefully attract and retain new talent and strengthen the team to deliver service at Walsall. Some of the benefits of this work will also help us to secure more trials and attract patients to these trials.

Both Dr Situnayake and Dr Erb have taken the lead in identifying appropriate candidates for recruitment. Locums are also invited to apply and will do so through the formal governance process. This will be supported through the appointment of a Service Manager from SWBH who will be responsible for supporting SWBH rheumatology service and working across boundaries with BCA partners to develop the provider led model.

There has also been agreement from June that a Senior Nurse Specialist from SWBH will spend 3 days in Walsall per week to provide specialist care.

Dr Roger Stedman, Medical Director at SWBH can provide further details (roger.stedman@nhs.net).

Histopathology

On Thursday 31st March the BCA Cellular Pathology work stream hosted an engagement event. This was attended by clinical, technical and managerial representatives from all three Trusts. The group focused on integration of the service into wider clinical pathways and the development of an identity for the service. It was noted that there was an opportunity to standardise the service specification across the three Trusts and to repatriate tests which are currently outsourced. There are clear gaps in the workforce profile across the BCA. In the short term SWBH and The Dudley Group are working up an Service Level Agreement to support the current pressures at Russell's Hall Laboratory. In the moderate to longer term there are opportunities to standardise and design a modern workforce with a BCA development programme for non-qualified staff to support the consultant structures. The larger pool of staff was seen as a benefit in both recruitment and supporting Multi Disciplinary Teams.

Procurement

The BCA Board received a report from the Procurement Steering Group in respect of progress made so far. The group had been asked to identify opportunities for buying better together and also, how we might respond better together to the findings of Lord Carters' report into Hospital efficiency. The BCA Board have approved the establishment of a BCA Clinical Reference Group in the belief that securing and engaging medical, nursing and allied health professionals in the business of how we make better use of the resources we have together would enable us to achieve benefits together.

For further information on this work stream, please contact Daren Fradgley, Director of Strategy & Planning at daren.fradgley@walsallhealthcare.nhs.uk

Communications & Engagement

Senior Operational Managers at each Trust have been invited to an event to hear about the BCA current and future programmes of work, share experiences and ideas and network together. If you would like more information about the event, which is being held at Sandwell, please contact Sue Astley at susan.astely1@nhs.net

The first stakeholder reference group will take place week commencing 23 May 2016. Attendees such as local Health watch and CCG from each location will gather for an engagement session with the BCA Board to discuss how they can work together collaboratively to support the work of the Black Country Alliance.

In addition the outcomes of the LIA activites undertaken at the February Clinical Conference have been distributed to HR and Comms Directors at all three Trusts who will formulate action plans for each area.

Highlights of this and the Stakeholder Reference Group will be discussed at Board and an update given in the June version of BCA CAN.

For more information about this please contact Ruth Wilkin (ruth.wilkin@nhs.net), Director of Communications, SWBH.

Other Priorities for 2016/17 We have started to make good progress on some of the new projects approved by the BCA Board last month. Colleagues in a number of areas across all three trusts have been identified and are beginning to discuss how best to take forward their pieces of work. The BCA Board has asked that each of these bring back initial thoughts in the form of a 'Mandate' to May's BCA Board. This will ensure we maintain focus on quick progress, clarity on what is being asked and an early sight of the kind of support that may be required. Watch this space for more details on the progress these projects make in the coming months .The BCA Board spent a good amount of time exploring how best we identify, track and manage the realisation of Public Value benefits. These benefits are described at the highest level by our Triple Aim;

1. Improving Health Outcomes for people in the Black Country
2. Improving the experience of Health Care, both as a patient receiving but also as an employee helping to deliver
3. Making the best use of our resources to meet the rising demands of people as they live longer and with more long term, complex conditions.

The BCA Board approved a set of principles and some detailed methods that will allow us to be clear about the benefits,.

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

Paula Clark
Chief Executive
The Dudley Group

Toby Lewis
Chief Executive
Sandwell and West Birmingham

Richard Kirby
Chief Executive
Walsall Healthcare

Enclosure 12

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the meeting of the Board of Directors
Thursday 5th May 2016

TITLE:	**Trust Constitution Annual Review**		
AUTHOR:	**Mrs Helen Board, Patient and Governor Engagement Lead**	**PRESENTER**	**Mr Glen Palethorpe, Director of Governance / Board Secretary**

CORPORATE OBJECTIVE: SO 5 Make the best of what we have

SUMMARY OF KEY ISSUES:

Each year the Trust Constitution is subject to review and is updated to reflect any changes required. Changes to the Trust's Constitution can only take effect when amendments are approved by more than half of the voting members of the Trust Board of Directors and more than half of the Council of Governors.

As part of this year's review there is one small change proposed this relates to incorporating within the constitution the ability to consider and use where appropriate (initially likely to be for staff groups) electronic voting methods

Constitution Review 2016

Item number	Page number	Existing Text	Proposed text		Reason for change
25. Ballot paper envelope and covering	28	None	**25.1**	**E-voting systems**	Adoption of electronic voting methods
			25.1.1	If internet voting is a method of polling for the relevant election then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").	
			25.1.2	If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").	
			25.1.3	If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").	
			25.1.4	The returning officer shall ensure	

				that the polling website and internet voting system provided will: (a) require a voter to: (i) enter his or her voter ID number; and (ii) where the election is for a public or patient constituency, make a declaration of identity; in order to be able to cast his or her vote; (b) specify: (i) the name of the corporation, (ii) the constituency, or class within a constituency, for which the election is being held, (iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency, (iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates, (v) instructions on how to vote and how to make a declaration of identity, (vi) the date and time of the close of the poll, and (vii) the contact details of the returning officer; (c) prevent a voter from voting for more candidates than he or she is entitled to at the	

				election; (d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of- (i) the voter's voter ID number; (ii) the voter's declaration of identity (where required); (iii) the candidate or candidates for whom the voter has voted; and (iv) the date and time of the voter's vote, (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and (f) prevent any voter from voting after the close of poll.	
				25.1.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will: (a) require a voter to (i) enter his or her voter ID number in order to be able to cast his or her vote; and (ii) where the election is for a public or patient constituency, make a declaration of identity; (b) specify: (i) the name of the corporation, (ii) the constituency, or class within a constituency, for which the election is being held, (iii) the number of	

				members of the council of governors to be elected from that constituency, or class within that constituency, (iv) instructions on how to vote and how to make a declaration of identity, (v) the date and time of the close of the poll, and (vi) the contact details of the returning officer; (c) prevent a voter from voting for more candidates than he or she is entitled to at the election; (d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of: (i) the voter's voter ID number; (ii) the voter's declaration of identity (where required); (iii) the candidate or candidates for whom the voter has voted; and (iv) the date and time of the voter's vote (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; (f) prevent any voter from voting after the close of poll.	
				25.1.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will: (a) require a voter to:	

			(i) provide his or her voter ID number; and (ii) where the election is for a public or patient constituency, make a declaration of identity; in order to be able to cast his or her vote; (b) prevent a voter from voting for more candidates than he or she is entitled to at the election; (d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of: (i) the voter's voter ID number; (ii) the voter's declaration of identity (where required); (ii) the candidate or candidates for whom the voter has voted; and (iii) the date and time of the voter's vote (e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; (f) prevent any voter from voting after the close of poll.		

IMPLICATIONS OF PAPER:

RISK	**No**		**Risk Description:**
	Risk Register: No		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**No**	**Details:**
	Monitor	**Yes**	**Details: compliance with Code of Governance Framework**
	Other	**No**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD

To approve the amendments to the Trust Constitution

Enclosure 13

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 4 May 2016

TITLE	Corporate Performance Report – March 2016 (Month 12)		
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 28 April 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	
			yes	no
Finance & Performance Committee	28 April 2016	Jonathan Fellows	yes	

Declarations of Interest Made

None

Assurances Received

- The plan for the 62 day cancer waits was discussed and approved
- Progress on the EPR business case was discussed, and agreed that ways of securing external capital and identifying cash saving benefits would be essential in the successful resolution of this issue
- The year-end financial position was within the existing forecast at £2.95m deficit – see Appendix 1
- There was an improved cash and balance sheet position at the year-end
- That national performance targets for March 2016 were met apart from in Cancer 62 day waits – see Appendix 2
- That the CIP for 2015-16 was achieved at an unprecedented level of £16.66m
- The Monitor Compliance Framework assessment at March 2016 was a rating of 2 consistent with the plan, and that the Board anticipates that the Trust will maintain a rating of 3 for all of 2016-17.

Decisions Made / Items Approved

- Approved the accounting treatment of the Impairment of the Intangible asset
- Approved that the Trust remains a “going concern”

Actions to come back to Committee

- The remedial plan for the VTE Assessment Indictor to be presented to the meeting on 26 May 2016
- The shortfall in the CIP for 2016-17 of £1.9m is curremntly being addressed with all budget holders and that a plan to bridge the shortfall would be presented to the 26 May 2016 meeting

Items referred to the Board for decision or action

- The Committee confirmed that it would recommend for Board approval the Hybrid Business Case subject to finding the available capital finance. Further work was requested on the steps to be taken to secure additional income, and a 5 year financial profile showing scenarios to be developed for the Board Development session on 12th May 2016.

THE DUDLEY GROUP NHS FOUNDATION TRUST

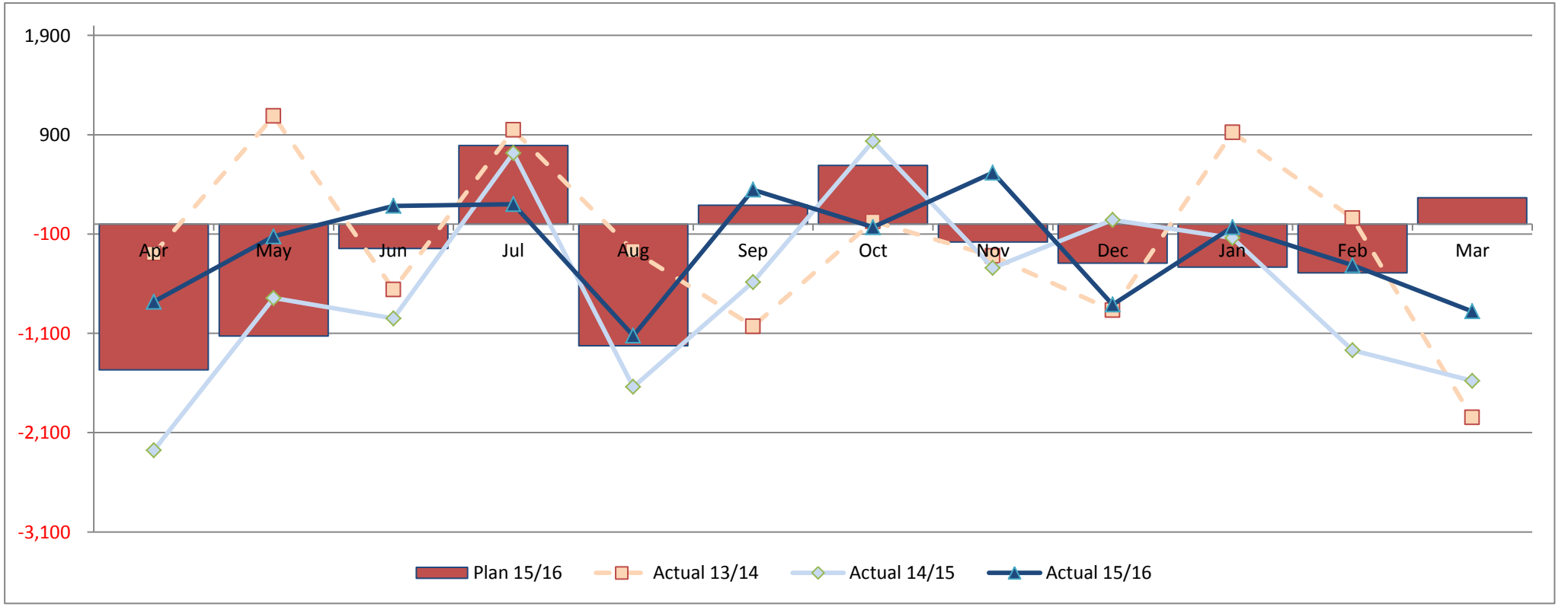
FINANCIAL SUMMARY **MARCH 2016**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£27,447	£28,760	£1,313
PAY	-£15,908	-£17,310	-£1,402
NON PAY	-£9,313	-£7,914	£1,398
EBITDA	**£2,226**	**£3,535**	**£1,309**
OTHER	-£1,961	-£4,414	-£2,453
NET	**£266**	**-£878**	**-£1,144**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£323,027	£325,835	£2,808
PAY	-£192,014	-£191,458	£556
NON PAY	-£111,404	-£111,550	-£146
EBITDA	**£19,609**	**£22,827**	**£3,218**
OTHER	-£23,327	-£25,772	-£2,445
NET	**-£3,718**	**-£2,945**	**£773**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£323,027	£325,835	£2,808
PAY	-£192,014	-£191,458	£556
NON PAY	-£111,404	-£111,550	-£146
EBITDA	**£19,609**	**£22,827**	**£3,218**
OTHER	-£23,327	-£25,772	-£2,445
NET	**-£3,718**	**-£2,945**	**£773**

NET SURPLUS/(DEFICIT) 15/16 PLAN & ACTUAL **MARCH 2016**



Appendix 2

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - March 2016

Quality & Risk			2015									2016				
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
Friends & Family – Community – Footfall			0%	0%	1%	1%	1%	1%	1%	1%	2%	2%	2%	2%	1%	
Friends & Family – Community – Recommended %			97%	98%	96%	96%	94%	93%	97%	95%	99%	97%	98%	95%	96%	
Friends & Family – ED – Footfall		20%	8%	15%	12%	7%	6%	3%	7%	6%	6%	5%	7%	6%	8%	
Friends & Family – ED – Recommended %		89%	90%	90%	92%	90%	95%	91%	96%	93%	88%	96%	93%	98%	92%	
Friends & Family – Maternity – Footfall		23%	23%	22%	21%	20%	22%	23%	25%	32%	18%	17%	20%	16%	22%	
Friends & Family – Maternity – Recommended %		99%	99%	99%	99%	97%	99%	99%	98%	98%	97%	98%	98%	98%	98%	
Friends & Family – Outpatients – Recommended %			84%	82%	82%	88%	90%	89%	88%	84%	88%	90%	84%	89%	88%	
Friends & Family – Ward – Footfall		32%	38%	33%	33%	31%	31%	30%	23%	23%	17%	17%	18%	18%	26%	
Friends & Family – Ward – Recommended %		98%	98%	97%	98%	97%	98%	96%	97%	97%	99%	96%	96%	94%	97%	
HCAI – Post 48 hour Clostridium Difficile		38	3	3	2	2	5	5	5	5	8	4	1	0	43	
HCAI – Post 48 hour MRSA		0	0	0	0	0	0	2	0	0	0	0	0	0	2	
Incidents - Patient Falls, Injuries or Accidents			127	116	116	103	97	119	111	118	114	129				
Incidents - Pressure Ulcer		2,091	187	163	182	150	120	132	125	141	172	187	242	246	2,047	
Mixed Sex Sleeping Accommodation Breaches		0	0	0	0	0	0	0	0	2	0	2	0	0	4	
Never Events		1	0	0	0	0	0	1	0	0	0	0	0	0	1	
Serious Incidents – Not Pressure Ulcer		108	6	9	9	10	7	11	11	11	10	9	4	7	104	
Serious Incidents - Pressure Ulcer		197	21	20	21	17	17	10	18	17	30	26	12	19	228	
Stroke - Suspected TIA Scanned < 24hrs of Presentation		85.47%	95%	100%	91.3%	88.89%	92.31%	85%	92.31%	50%	52.63%	85.71%	66.67%	60%	83.87%	
Stroke Admissions : Swallowing Screen		78.46%	81.25%	83.33%	72.09%	80%	74.07%	75%	78.38%	88.89%	87.88%	83.78%	76.32%	76.6%	79.49%	

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - March 2016

Quality & Risk			2015									2016				
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
Stroke Admissions to Thrombolysis Time		80%	69.23%	61.54%	42.86%	75%	61.54%	75%	37.5%	71.43%	33.33%	45.45%	37.5%	71.43%	71.43%	
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		88.84%	94.23%	92%	92.86%	94.34%	88.24%	92.68%	88.68%	88.68%	90.91%	92.68%	84.09%	63.89%	89.11%	
VTE Assessment Indicator (CQN01)		95.33%	96.32%	95.61%	96.74%	96.78%	96.42%	96.19%	96.1%	96.67%	96.47%	95.4%	94.43%	94.46%	95.96%	

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

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - March 2016

Finance			2015													
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
Budgetary Performance		(£2,722)k	£685k	£1,003k	£428k	(£592)k	£100k	£156k	(£623)k	£699k	(£418)k	£402k	£77k	(£1,144)k	£773k	
Capital v Forecast		87.8%	100%	98.6%	99.7%	93.7%	74.5%	66.2%	96.6%	90.8%	82.1%	78.6%	70.3%	69.5%	69.5%	
Cash v Forecast		109%	97.9%	104.9%	108.1%	87%	93.5%	94.8%	97.2%	89.2%	68.4%	88.4%	79.1%	122.3%	122.3%	
CIP - Actual Performance			£1,773k	£1,218k	£1,298k	£1,516k	£1,743k	£1,002k	£1,370k	£1,452k	£1,329k	£1,289k	£1,291k			
Debt Service Cover		0.85	0.72	0.93	1.05	1.13	1.01	1.08	1.09	1.15	1.1	1.11	1.09	1.18	1.18	
EBITDA		£15,817k	£1,138k	£1,814k	£2,079k	£2,145k	£829k	£2,283k	£1,909k	£2,449k	£1,141k	£2,012k	£1,492k	£1,169k	£20,460k	
I&E (After Financing)		(£8,033)k	(£783)k	(£123)k	£183k	£201k	(£1,124)k	£346k	(£31)k	£518k	(£811)k	(£30)k	(£413)k	(£878)k	(£2,945)k	
Liquidity		7.22	6.1	5.76	5.41	6.28	5.16	6.03	5.78	6.27	5.25	5.45	5.16	7.07	7.07	
SLA Performance		£6,271k	£1,023k	£506k	£497k	(£723)k	(£401)k	(£429)k	(£146)k	(£10)k	(£12)k	£358k	£632k	(£263)k	£1,031k	
SLR Performance		(£8,032)k	(£782)k	(£123)k	£184k	£201k	(£1,124)k	£344k	(£31)k	£518k	(£810)k	(£30)k	(£413)k	(£878)k	(£2,945)k	

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

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - March 2016

Performance			2015									2016				
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
A&E - A&E Attendances Seen Within 4 Hours (%)		94.7%	98.6%	98.8%	99.1%	99.3%	98.5%	97.6%	98.9%	97.5%	97.1%	91.8%	92.7%	92.4%	96.9%	
Activity - A&E Attendances		99,928	7,895	7,940	8,138	8,052	7,700	8,003	8,099	7,900	7,754	8,088	7,946	8,626	96,141	
Activity - Community Attendances		415,662	34,397	33,050	35,066	36,362	32,417	35,088	36,008	34,642	33,385	33,694	32,322	30,817	407,248	
Activity - Elective Day Case Spells		44,639	3,660	3,445	4,013	3,951	3,413	3,675	3,952	3,757	3,719	3,677	3,938	3,820	45,020	
Activity - Elective Inpatients Spells		6,953	482	525	580	580	508	537	572	580	481	500	515	534	6,394	
Activity - Emergency Inpatient Spells		50,876	4,426	4,282	4,183	4,205	4,077	4,105	4,296	4,265	4,552	4,573	4,359	4,714	52,037	
Activity - Outpatient First Attendances		125,382	10,391	10,059	11,359	11,488	9,298	10,758	10,712	11,159	10,604	11,304	11,569	12,255	130,956	
Activity - Outpatient Follow Up Attendances		320,876	26,142	24,480	28,055	27,442	23,254	26,290	25,988	27,022	25,643	26,438	26,699	26,435	313,888	
Activity - Outpatient Procedure Attendances		57,196	4,308	3,956	4,833	4,527	4,042	4,553	4,864	4,968	4,268	4,117	4,691	3,324	52,451	
RTT - Admitted Pathways within 18 weeks %		91.6%	95.2%	95.3%	96.1%	95.6%	96.1%	94.3%	92.5%	93.3%	93.4%	94.4%	92.8%	91.5%	94.2%	
RTT - Incomplete Waits within 18 weeks %		95.4%	95%	95.2%	95.2%	95.6%	94.9%	95.1%	94.6%	94.4%	94.9%	95%	95.6%	95.4%	95.1%	
RTT - Non-Admitted Pathways within 18 weeks %		98.7%	97.7%	97%	98%	98.3%	98.1%	98.3%	97.5%	97.8%	97.8%	97.3%	97.4%	96.7%	97.7%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		97.75%	98.69%	99.27%	99.47%	99.34%	98.35%	98.41%	97.87%	98.85%	99.29%	99.52%	99.53%	99.03%	98.97%	

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

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - March 2016

Staff/HR			2015									2016				
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
Appraisals		87.2%	88%	80.6%	81.5%	80.8%	80.3%	80.1%	78.4%	75.6%	80.4%	80%	79.2%	77.6%	77.6%	
Mandatory Training (Substantive)		80.68%	81.53%	82.13%	82.8%	82.35%	83.51%	83.16%	84.11%	84.8%	85.16%	83.97%	83.31%	83.39%	83.39%	
Sickness Rate (Performance Dashboard)		3.81%	3.49%	3.70%	3.65%	3.51%	3.22%	3.28%	3.83%	3.79%	4.06%	4.57%	4.37%	4.11%	3.80%	
Staff In Post (Contracted WTE)		4,181.19	4,090.77	4,073.22	4,045.78	4,019.79	4,018.55	4,039.04	4,075.01	4,069.24	4,064.03	4,087.57	4,125.26	4,116.31	4,116.31	
Vacancy Rate		9.42%	8.42%	8.81%	9.51%	10.11%	10.33%	9.92%	9.93%	10.31%	10.59%	10.05%	9.24%	9.41%	9.41%	

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

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - March 2016

Cancer Wait Times			2015									2016				
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
Cancer - 14 day - Urgent Cancer GP Referral to date first seen			97.7%	96.4%	95.5%	95.4%	94%	94.1%	94.2%	95.1%	95.1%	97.1%	96.9%	96.8%	95.7%	
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen			100%	98.7%	100%	97%	96.8%	95.9%	98.5%	99.3%	98.2%	98%	100%	97.1%	98.3%	
Cancer - 31 day - from diagnosis to treatment for all cancers			100%	100%	100%	100%	100%	99.3%	98.6%	100%	100%	100%	100%	100%	99.8%	
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments			100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery			100%	100%	100%	100%	100%	100%	100%	100%	100%	97.1%	100%	100%	99.5%	
Cancer - 31 Day For Subsequent Treatment From Decision To Treat			100%	100%	100%	100%	100%	100%	100%	100%	100%	98.8%	100%	100%	99.8%	
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade			95.8%	92.9%	92%	95.5%	100%	98.7%	98.8%	99%	100%	97.5%	94.3%	95.2%	96.7%	
Cancer - 62 day - From Referral for Treatment following national screening referral			82.4%	91.3%	95.2%	100%	93.3%	96.3%	100%	100%	100%	100%	100%	95.5%	96.2%	
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers			83.6%	81.9%	88.5%	83.8%	84.8%	83.5%	88.3%	86.6%	87.7%	81.7%	83.5%	75.2%	84.3%	

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

The Dudley Group NHS
NHS Foundation Trust

Integrated Performance Report - March 2016

Description	Target	All Tumour Sites	Brain	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Paediatric	Skin	Upper GI	Urology	Total
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	93%	-	100%	96.9%	94.9%	100%	100%	98.7%	100%	100%	95.6%	93.7%	100%	**96.8%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	-	97.1%	-	-	-	-	-	-	-	-	-	**97.1%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	-	100%	100%	100%	100%	100%	100%	-	100%	100%	100%	**100%**
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%	-	-	-	85.7%	100%	100%	100%	100%	-	100%	66.7%	100%	**95.2%**
Cancer - 62 day - From Referral for Treatment following national screening referral	90%	-	-	95%	100%	-	-	-	-	-	-	-	-	**95.5%**
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85%	-	-	85.7%	66.7%	75%	0%	0%	75%	-	100%	66.7%	82.1%	**75.2%**

Cancer – 62 Day – From Urgent GP Referral to Treatment performed below target for the third month with March at 75.2% (Provisional figure). This means that the target has not been achieved for Q4 2015/16 with a provisional performance of 80.3%. Continual validation is underway. Weekly performance monitoring continues with the Divisions providing forecasts based on planned activity and PTL analysis for the rest of the year.

62 DAY PTL 104 DAY Breaches

2015-16

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

Sustainability and Transformation Fund Trajectories 2016/17

Diagnostics

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	5,627	5,676	5,725	5,774	5,824	5,873	5,922	5,971	6,020	6,069	6,118	6,168	6,217
Patients Waiting < 6 weeks	5,566	5,620	5,668	5,717	5,766	5,815	5,863	5,912	5,960	6,009	6,057	6,107	6,155
Patients Waiting > 6 weeks	61	56	57	57	58	58	59	59	60	60	61	61	62
Performance	98.92%	99.01%	99.00%	99.01%	99.00%	99.01%	99.00%	99.01%	99.00%	99.01%	99.00%	99.01%	99.00%

Assumptions

Baseline = average of April 15 to January 16 performance

Growth of 5.7% factored in (based on historic growth for modalities included within DM01)

Cancer

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	83.7	77.0	78.0	79.0	84.0	86.0	88.0	88.0	86.0	84.0	78.0	78.0	78.0
Treated within 62 days	71.2	65.5	66.5	67.5	72.0	74.0	76.0	76.0	74.0	72.0	66.5	66.5	66.5
Breaches	12.5	11.5	11.5	11.5	12.0	12.0	12.0	12.0	12.0	12.0	11.5	11.5	11.5
Performance	85.07%	85.06%	85.26%	85.44%	85.71%	86.05%	86.36%	86.36%	86.05%	85.71%	85.26%	85.26%	85.26%

Baseline = average of April 15 to January 16 performance

Growth/Phasing based on historic performance

Appendix 2 (contd.): Sustainability and Transformation Fund Trajectories 2016/17

A&E Type 1

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	7,968	8,144	8,144	8,404	8,286	7,945	8,269	8,351	8,148	8,014	8,364	7,649	8,287
Treated within 4 hours	7,783	8,027	8,044	8,331	8,230	7,759	8,111	8,259	7,917	7,790	7,696	7,471	8,095
Breaches	185	117	100	73	56	186	158	92	231	224	668	178	192
Performance	97.68%	98.56%	98.77%	99.13%	99.32%	97.66%	98.09%	98.90%	97.16%	97.20%	92.01%	97.67%	97.68%

A&E Type 3

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	6,242	6,156	6,361	6,156	6,361	6,361	6,156	6,361	6,156	6,361	6,361	5,749	6,361
Treated within 4 hours	6,242	6,156	6,361	6,156	6,361	6,361	6,156	6,361	6,156	6,361	6,361	5,749	6,361
Breaches	0	0	0	0	0	0	0	0	0	0	0	0	0
Performance	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Combined

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	14,210	14,300	14,505	14,560	14,647	14,306	14,425	14,712	14,304	14,375	14,725	13,398	14,648
Treated within 4 hours	14,025	14,183	14,405	14,487	14,591	14,120	14,267	14,620	14,073	14,151	14,057	13,220	14,456
Breaches	185	117	100	73	56	186	158	92	231	224	668	178	192
Performance	98.70%	99.18%	99.31%	99.50%	99.62%	98.70%	98.90%	99.37%	98.39%	98.44%	95.46%	98.67%	98.69%

Baseline = average of April 15 to January 16 performance
Growth of 3% factored in
Includes both Type 1 and Type 3

RTT

	Baseline	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Patients Waiting	13,776	14,149	14,118	14,106	14,142	14,190	14,165	13,977	13,883	14,137	14,210	14,168	14,027
Treated within 18 weeks	13,005	13,357	13,329	13,318	13,350	13,395	13,372	13,195	13,106	13,345	13,414	13,374	13,242
Breaches	771	792	789	788	792	795	793	782	777	792	796	794	785
Performance	94.40%	94.40%	94.41%	94.41%	94.40%	94.40%	94.40%	94.41%	94.40%	94.40%	94.40%	94.40%	94.40%

Baseline = average of October 15 to January 16 performance
Growth of 2.0% factored into figures in line with contract proposal

Enclosure 14

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th May 2016

TITLE:	**Operational Plan 2015/16** **Q4 and year end progress against the annual goals**		
AUTHOR:	Karen Morrey	**PRESENTER**	Anne Baines Director of Strategy & Performance
CORPORATE OBJECTIVE: All			

SUMMARY OF KEY ISSUES:

The attached table identifies the progress of both Q4 and the year-end position against the annual goals identified in this year's Operational Plan.

The operational plan reporting was subject to an audit review. The conclusion was: "Overall, the Trust has designed one of the best report formats we have seen to date for the reporting of performance against the Operational Plan. That being said, there should be further focus on improving the clarity of metrics to remove some of the subjective reporting, clarity over what constitutes Red, Amber and Green performance and improved commentary re remedial action plans in order that assurance can be provided to the Board".
In response to this, for this Q4 report the presentation of the table has been modified to separate the measures of achievement onto different lines, and the RAG rating reviewed.

The summary of the Q4 position is indicated below:

Strategic Objective	RAG rating		
	Red	Amber	Green
Deliver a Great patient experience	1		5
Deliver safe and caring services	1	1	11
Drive service improvement, innovation and transformation		3	4
Be the place people choose to work	1	2	4
Make the best use of what we have			6
Plan for a viable future	1	2	2
Total	4	8	32

Where there is slippage identified the lead Executive has outlined the mitigating actions being undertaken.

There are red rated actions:

- Cancer treatment standards for 62 day target, action plans are in place to bring back the performance for 2016/17
- Delivery of quality improvements, in the achievement of improvement trajectory in nutritional audits. The Nutrition Group have an action plan and will monitor progress.
- Appraisals, which has significantly fallen in Q4. The requirement for improvement has been escalated through the clinical divisions by the Chief Executive
- Review Clinical Strategy has been deferred due to STP, and will be re-visited in Q2 2016/17.

The final ratings for the year are assessed to be:

Strategic Objective	RAG rating		
	Red	Amber	Green
Deliver a Great patient experience	1		5
Deliver safe and caring services	2	1	10
Drive service improvement, innovation and transformation		3	4
Be the place people choose to work		3	4
Make the best use of what we have			6
Plan for a viable future	1	2	2
Total	4	9	31

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

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	x	x	

RECOMMENDATIONS FOR THE BOARD:

- The progress against each of the goals is noted
- Assurance that remedial actions are being taken where appropriate

The Dudley Group NHS
NHS Foundation Trust

Operational Plan 2015/16:
Q4 and year-end progress against the Annual Goals

Annual Goal	Measures of Achievement	Timescale	Lead	Q4 Performance	RAG Q4	RAG 2015/16	Remedial Action
Deliver a great patient experience							
➢ Achieve good FFT results/patients survey	✓ Monthly scores equal or better than national average	Monthly	Chief Executive	Maintained equal to or better scores than the national average in all areas apart from outpatients and postnatal community	G	G	Continue to work with local managers to support performance
➢ Ensure patients, carers and public fully engaged and involved	✓ Improved National Patient Survey results	Annual	Chief Executive	The Picker results of the 2015 national inpatient survey published in February identified 36 questions that had improved compared to the 2014 results. The Trust scored about the same on 17 questions and worse on 13 questions. National survey results published on 8th June 2016.	G	G	'Improvement Group' established and developed actions to address areas identified for improvement.
	✓ Demonstrate engagement through feedback	On-going		The Trust employs a range of communication and engagement mechanisms to inform staff and patients of improvements made as a result of the feedback received.	G	G	
➢ Achieve key performance standards	✓ 95% emergency access standard	Monthly	Chief Operating Officer	Trust delivered 96.7% for the year 2015/2016.	G	G	

	✓ 18 weeks RTT	Monthly		On-going delivery of 18 week RTT maintained and delivered annually	G	G	
	✓ Cancer treatment standards	Monthly		Q4 was not delivered for the 62 day target.	R	R	Appropriate actions are in place to improve performance
Deliver safe and caring services							
➢ Deliver quality improvements	✓ Achievement of nursing care indicators ✓	Quarterly	Chief Nurse	Not all areas achieved a Green rating following the changes in the audit tool in Sept/October and the elevation of the tolerance levels in the RAG rating.	A	A	Escalation in place for those not achieving standards. Level 3 in place and timescales for delivery agreed.
	✓ Zero avoidable stage 4 pressure ulcers ✓	Monthly		Currently compliant with trajectory but not all have been agreed with CCG on avoidable harm.	G	G	
	✓ Reduction in stage 3 pressure ulcers from 14/15 ✓	March 2016		As above	G	G	
	✓ Zero post 48 hour MRSA cases ✓	March 2016		Green for Quarter 4 as no further cases but did not achieve at year end.	G	R	Infection prevention focus to be continued into 16/17
	✓ No more than 29 post 48 hour clostridium difficile Lapses in care ✓	March2016		Green for Quarter 4 Overall lapses in care not exceeding 29 cases in the year	G	G	Infection prevention focus to be continued into 16/17
	✓ Achievement of improvement trajectory in nutritional audit ending year in all wards green (93%)	Monthly/March 2016		Three wards did not achieve 93%. All were above 90%. Continue with Nutrition as a quality priority going forward	R	R	Nutrition group have action plan and will continue to monitor progress
➢ Deliver agreed CQUIN requirements	✓ Deliver CQUINs schemes	On-going	Director of Strategy & Performance	Approximately 95% of CQUIN schemes income has been achieved.	G	G	

➢ Maintain good mortality performance	✓ SHMI/HSMR within expected range	On-going	Medical Director	The latest SHMI published for the period October 2014- September 2015 is 1.02 and is within the expected range.	G	G	
	✓ 85% of in hospital deaths have multidisciplinary review within 12 weeks	On-going		The 15/16 target is 90% of deaths to be reviewed, where applicable, within 12 weeks by March 2016 The Trust is on target to achieve this with the latest results (Year to date) at 90.4%.	G	G	
➢ Improved risk management	✓ Reconfiguration of DATIX system	March 2016	Director of Governance	Datix was re-launched on the 1st February as planned.	G	G	Complete
➢ Deliver requirements from key quality inspections	✓ Deliver CQC action plan	See action plan	Chief Executive	Complete, further report to Board was made in the Board meeting on 7th Jan 2016.	G	G	Closed/Monitored through CQSPE
	✓ Deliver WMQRS action plans	See action plans		For 2016/17 a regular report will be provided to CQSPE on all external reviews including WMQRS reviews and this report will show progress on agreed actions for each review.	G	G	Closed/Monitored through CQSPE
➢ Safe staffing levels	✓ Deliver safe staffing levels	Monthly	Chief Nurse	Small number of Red shifts in Q4. Vacancies stabilised. % safer staffing appears favourable compared to local trusts. RAG rating of shifts introduced in Q4.	G	G	Recruitment retention programme. RAG rating tool to be reviewed.

Drive service improvement, innovation & transformation							
➢ Develop integrated services and redesigned community provision	✓ Integrated services across acute and community in place	Dec 2015	Director of Strategy and Performance/	New Division developed and workstreams in place to further develop integrated services. Strategy developed.	G	G	
	✓ Redesigned community services in line with Vanguard proposals	March 2016	Chief Operating Officer	Integral core divisions continue to work with Vanguard. All 3 locality managers are now in post and support our locally based teams.	G	G	
➢ Increase access to 7 day services	✓ 7 day services in place in diagnostics	TBA	Chief Operating Officer	Submission to National audit in April. Results to be published in May	A	A	
➢ Continued improvement in key services	✓ Improvements in service performance delivered Stroke	Review quarterly	Chief Operating Officer	Stroke services continue to maintain most of the performance standards. There are areas of concern noted and these are being worked through to improve performance.	A	A	
	✓ Renal			Continues to make progress against improved efficiency also tender discussions taking place in relation to satellite provision	G	G	
	✓ Care of the Elderly			On-going review with increased focus on frailty and front door provision	G	G	
➢ Expand Research & Development / Academic Health Sciences Network role	✓ Demonstrate greater involvement and engagement	On-going	Medical Director	Expanded Engagement with universities within the West Midlands and nationally. Expanded portfolio of studies across new specialties including Ophthalmology and Paediatrics Developing 2016/2017 Goal to increase Third Sector engagement through bids for third sector commissioned studies. Bids submitted in Q4.	G	G	

Be the place people choose to work							
➢ Continued implementation of Listening into action	✓ Regular events in place	June 2015	Chief Executive	Children's LD LiA held with successful feedback from parents. Key actions delivered and fed back to parents.	G	G	
➢ Enhance colleague engagement	✓ Improved scores in National staff Survey	Annually	Chief Executive	BCA LiA held in Feb actions being used to help plan future developments	G	G	
	✓ Wider engagement developed	On-going		Staff survey results received and communicated highlights to staff. Further CE briefings in diary to deliver 2016/17 plan in new financial year.	G	G	
➢ Improve workforce performance in sickness, mandatory training, appraisal	✓ Sickness a target 3.5%	Monthly	Chief Executive	Year end out-turn is 3.8%. Work has been undertaken during Q4 to support return to work for those with musculoskeletal issues.	A	A	
	✓ Mandatory training and appraisal target of 90%	Monthly		End of year for Mandatory Training is 83.39% (Amber)	A	A	
	✓ Appraisal target of 90%	Monthly		Appraisals 77.57% (red).	R	A	
➢ Leadership development/ OD	✓ To develop the measure in year	Quarterly	Chief Executive	The new leadership programme is continuing and is well subscribed. A bespoke programme and learning set was made available for the new Directorate Manager appointees.	G	G	
Make the best use of what we have							
➢ Develop IT Strategy /EPR	✓ Strategy and plan in place	December 2015	Chief Executive	EPR procurement plan approved and published to the Market under OJEU	G	G	
➢ Match capacity to demand	✓ Initial improvement achieved	Quarterly	Chief Operating Officer	Trust format being formally developed	G	G	
➢ Deliver financial	✓ Effective plans in place and monitored	Monthly	Director Finance and IT	Annual accounts showing £2.9m deficit (in line with plans) currently being audited	G	G	

(recovery) plan	✓ Financial plans delivered in line with plans	Monthly		Actuals delivered in line with plans in 2015-16	G	G	
➢ Delivery Monitor financial requirements	✓ Deliver plan i.e. Deficit of £4.2m, rating of 2	Monthly	Director of Finance and IT	Plan for new financial year agreed with £0.730m deficit (before Sustainability and Transformation Fund)	G	G	
➢ Deliver the CIP	✓ Deliver CIP and financial target	Monthly	Director Strategy and Performance	£16.7m CIP delivered.	G	G	
Plan for a viable future							
➢ Revise the current 5 year plan	✓ Revised plans in place	June 2015	Director of Strategy and Performance	Completed & submitted to Monitor.	G	G	
➢ Review the Clinical Strategy	✓ Revised plans in place	June 2015 Revised January 2016	Director of Strategy and Performance	Work deferred due to capacity and assessment of STP implications.	R	R	Capacity in place from June 2016.
➢ Develop an economy wide plan with CCG and other providers in Dudley	✓ Play a full part in this work	July 2015	CEO/ Director of Strategy and Performance	Attendance at Partnership Board and New Care Models implementation in place.	A	A	
➢ Play a part in the development of the Black Country Alliance	✓ Plan and Programme in place across alliance	July 2015	CEO	The 2015/16 Plan and programme are in place	G	G	Completed
➢ Dudley Partnership	✓ Vanguard	TBA	CEO/DSP	Attendance at Partnership Board and New Care Models implementation in place.	A	A	

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 5th May 2016

TITLE:	**TITLE:** **Transformation and Cost Improvement Programme (CIP) Summary Report – April 2016**		
AUTHOR:	Alex Claybrook Interim Head of Service Improvement and Programme Management	**PRESENTER**	**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: Plan for a viable future

SUMMARY OF KEY ISSUES:

Transformation Executive Committee (TEC) met on 21st April 2016 to review the 2015/16 CIP status and CIP planning for 2016/17.

The Trust has achieved £16.655m CIP against a full year plan of £16.701m in 2015/16.

The Trust has revisited its 2016/17 budget and, as a result, the 2016/17 CIP target is £11,908k. The Trust has identified 42 projects for delivery in 2016/17 totalling £10,064k (85%) against this target.

TEC has agreed a series of actions that will be undertaken to address the shortfall, including:

- Operational Divisions will assess their 2016/17 budget proposals and CIP plans alongside the Lord Carter benchmarking portal to identify additional service and cost improvement opportunities.
- A CIP shortfall meeting will be arranged to take place as soon as possible to assess opportunities in Nursing Division budgets.
- Executive Directors to undertake a review of all Corporate budgets.

These assessments will be undertaken and fed back to the Executive Team in week commencing 2nd May 2016. The outcomes of this discussion will then be reported to TEC in May 2016.

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 Capacity to deliver Programme of work Change in Executive Lead
	Risk Register: **Y**		**Risk Score:** 12, 6, 12, 10 (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 the final outturn of the 2015/16 CIP plan.

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 Transformation and PMO Update

5th May 2016

Executive Summary

The Trust had an overall Cost Improvement Programme (CIP) target of £16,701k in 2015/16. To support this, the Trust developed 30 projects to deliver the required savings in 2015/16.

The projects were split into four ambitious programmes to deliver the changes and benefits required. These programmes were:

- Value for Money
- Delivering Efficiency & Productivity
- Keeping People Closer to Home
- Workforce

Year end 2015/16 CIP performance is provided below (with supporting detail overleaf):

CIP Project Plans	Full Year Plan	YTD Plan	YTD Actual	YTD Variance	Y/E FOT	Y/E FOT Variance
TOTAL	£16,701k	£16,701k	£16,655k	-£46k	£16,655k	-£46k

As a result, the Trust has delivered a slight under performance of **£46k** against the full year plan and delivered **99.7%** against the **£16,701k** CIP plan.

The Trust has revisited its 2016/17 budget and, as a result, the 2016/17 CIP target is **£11,908k.** The Trust has identified 42 projects for delivery in 2016/17 totalling **£10,064k** against this target and the Trust agreed a series of Executive actions to address the shortfall.

2015/16 CIP Summary

Figures reported in £000's

	Planned	Actual	Forecast	Variance
FYE	£16,701	£16,655	£16,655	-£46
YTD	£16,701	£16,655	£16,655	-£46

Exec Lead : Paul Taylor				Click for Details
Planned Recurrent	£3,357	Planned Non Recurrent	£645	
Forecast Recurrent	£4,492	Forecast Non Recurrent	£645	

Value for money Infrastructure

	Planned	Actual	Forecast	Variance against Plan
FYE	£4,002	£5,136	£5,136	£1,134
YTD	£4,002	£5,136	£5,136	£1,134

Exec Lead : Anne Baines				Click for Details
Planned Recurrent	£0	Planned Non Recurrent	£0	
Forecast Recurrent	£0	Forecast Non Recurrent	£0	

Keeping People Closer to Home

	Planned	Actual	Forecast	Variance against Plan
FYE	£0	£28	£28	£28
YTD	£0	£28	£28	£28

Exec Lead : Paul Bytheway				Click for Details
Planned Recurrent	£2,873	Planned Non Recurrent	£300	
Forecast Recurrent	£3,604	Forecast Non Recurrent	£300	

Delivering Efficiency and Productivity

	Planned	Actual	Forecast	Variance against Plan
FYE	£3,173	£3,972	£3,972	£799
YTD	£3,173	£3,972	£3,972	£799

Exec Lead : Julie Bacon				Click for Details
Planned Recurrent	£9,331	Planned Non Recurrent	£125	
Forecast Recurrent	£7,519	Forecast Non Recurrent	£0	

Workforce

	Planned	Actual	Forecast	Variance against Plan
FYE	£9,526	£7,519	£7,519	-£2,008
YTD	£9,526	£7,519	£7,519	-£2,008

2015/16 Forecast Non Recurrent	£945k	% of Total CIP Forecast as Non Recurrent	5.68%