The Dudley Group NHS Foundation Trust

Board of Directors
Thursday 6 July, 2017 at 9.30am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	9.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	9.30
3.	**Announcements**		J Ord	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 1 June 2017	Enclosure 1	J Ord	To Approve	9.30
	4.2 Action Sheet 1 June 2017	Enclosure 2	J Ord	To Action	9.35
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Harrison	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 4	D Wulff	To note assurances & discuss any actions	10.00
	7.2 Chief Nurse Report	Enclosure 5	S Jordan	To note assurances & discuss any actions	10.10
	7.3 Nurse/Midwife Staffing Report	Enclosure 6	S Jordan	To note assurances & discuss any actions	10.20
	7.4 Workforce Committee Exception Report	Enclosure 7	J Atkins	To note assurances & discuss any actions	10.30
	7.5 Mortality Report	Enclosure 8	R Callender	To discuss	10.40

	7.6 Health and Safety Assurance Report	Enclosure 9	P Bytheway	To discuss and note assurances	10.50
	7.7 Charitable Funds Exception Report	Enclosure 10	J Atkins	To note assurances and discuss any actions	11.00
8.	**Finance and Performance**				
	8.1 Finance and Performance Committee Exception report	Enclosure 11	J Fellows	To note assurances & discuss any actions	11.10
	8.2 Performance Report	Enclosure 12	P Bytheway	To note assurances & discuss any actions	11.20
	8.3 Cost Improvement Programme and Transformation Overview Report	Enclosure 13	A Gaston	To note assurances & discuss any actions	11.30
9.	**Any other Business**		J Ord		11.40
10.	**Date of Next Board of Directors Meeting** 9.30am 7 September 2017 Clinical Education Centre		J Ord		11.40
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		11.40

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 1st June, 2017 at 9:30am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Julian Atkins, Non Executive Director
Doug Wulff, Non Executive Director
Diane Wake, Chief Executive
Paul Harrison, Medical Director
Siobhan Jordan, Interim Chief Nurse
Paul Taylor, Director of Finance and Information
Ann Becke, Non Executive Director

In Attendance:

Helen Forrester, EA
Glen Palethorpe, Director of Governance/Board Secretary
Andrew McMenemy, Director of HR
Mark Stanton, Chief Information Officer
Dr Mark Hopkin, Associate Non Executive Director
Joanne Newens, Divisional Director of Operations (for Chief Operating Officer)
Jackie Dietrich, Communications Manager (Item 17/061)
Lisa Peaty, Deputy Director of Strategy and Performance (Item 17/063.6)
Amanda Gaston, Head of Service Improvement (Item 17/064.1)
Jeff Neilson, Director of Research and Development (Item 17/063.3)
Babar Elahi, Guardian of Safeworking (Item 17/063.5)
Raj Uppal, Organ Donation Lead (Item 17/063.9)
Rebecca Evans, Organ Donation Nurse (Item 17/063.9)
Emma Lawton, NHSBT (Item 17/063.9)

17/056 Note of Apologies and Welcome
9.36am

Paul Bytheway, Chief Operating Officer, Liz Abbiss, Head of Communications and Patient Experience and Jonathan Fellows, Non Executive Director had sent apologies.

17/057 Declarations of Interest
9.36am

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

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

There were no other declarations of interest.

17/058 Announcements
9.36am

The Board noted that Mr Fred Allen had been appointed as Lead Governor. Rob Johnson, current Lead Governor will continue in post until December 2017.

17/059 Minutes of the previous Board meeting held on 4th May, 2017 (Enclosure 1)
9.37am

The minutes were amended at page 6 to read "Complaints as a % of the total patient activity in the Trust remain at 0.03% over the year and there was **0.8%** of the activity related to compliments made."

The minutes were amended at page 8 to read "The Chairman asked that broad themes **be taken up through the Workforce Committee**".

The minutes were amended at page 9 to read "A Smoke Free report will be provided to the June **Private** Board."

The minutes were amended at page 9 to read "The Trust had been allocated a further **£1.5m** additional STF funds as a result of exceeding the 2016/17 control total.

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

17/060 Action Sheet, 4th May, 2017 (Enclosure 2)
9.40am

17/060.1 Urgent Care Centre Build

The Director of Finance confirmed that the Chief Operating Officer had arranged a Project Board meeting for the following week. The Divisional Director, confirmed that she had met with the architect the previous week and the revised timescale was achievable but extremely tight. Work would commence at the end of August and be completed by 1st November. Concerns had been expressed around the ability to secure a provider to deliver the work within these timescales but Trust was engaging with the PFI provider to enable this.

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

17/061 Staff Story
9.44am

Jackie Dietrich, Communications Manager, presented the staff story. This featured a Physiotherapist based at the Corbett Outpatients Centre.

The story was positive with a few general concerns in relation to Allied Health Professionals (AHPs) and in particular, clinic appointments, MCP concerns, staff retention, staff engagement and staff pressures.

The Chief Nurse confirmed that she had attended a positive meeting with the Lead AHPs the previous week. A Listening into Action Event had been held the previous year and few actions had been progressed since the event. This would now be progressed with AHPs in the lead. A report will be produced on the role of the AHPs.

Mrs Becke, Non Executive Director, commented that there is a morale issue in the Community, for understandable reasons and a review into this area would be welcomed.

The Director of HR stated that there has been a focus on nursing recruitment and a lesser focus had been given to AHPs. He was pleased to have the story heard at Board and this should be welcomed by this group of staff showing that their voice is being heard. The Chairman asked that actions in respect of this cohort of staff are progressed through the Workforce Committee.

The Divisional Director confirmed that monthly pathway review meetings are being held with Community teams and leadership issues had been highlighted.

Dr Hopkin, Associate Non Executive Director, commented on the concerns regarding the MCP and that staff groups should see the MCP as an opportunity. The Medical Director confirmed that the issue is around the uncertainty in employment.

The Chairman and Board noted the story and asked Jackie Dietrich to ensure that comments are communicated back to the member of staff in respect of the support of the Board to this cohort of staff. The Director of HR and Chief Nurse would meet to discuss further and a paper provided to the Workforce Committee about AHPs.

Actions in relation to AHPs to be progressed through the Workforce Committee.

17/062 Chief Executive's Overview Report (Enclosure 3)
10.08am

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

- Caring Profession Event – positive feedback had been received from the organisation about the day.

- Interviews for the Director of Strategy and Business Planning – An offer had been made to the successful candidate and recruitment checks were underway.

- Andy Williams had been appointed substantively as STP Lead for the Black Country.

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

17/063 Patient Safety and Quality

17/063.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
10.11am

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

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

- The Committee continues to monitor the Trust's compliance with the recent NPSA alert on Naso Gastric Tube placements: The Committee had requested continued reporting of audits until it is satisfied that compliance is embeded.

- Reports on maternity performance: These are to be presented back to the Committee on a regular basis to ensure improvement plan actions are undertaken.

- Plain Film Reporting: A further report on the action plan to come back to the Committee in August to provide assurance over actions identified and taken.

- Evergreen: Further information to the presented back to the Committee in July on this ward and its performance.

The Board noted the assurances received and requested that the Executive Team maintain the focus on learning and improvements from Quality and Safety Reviews. The Board supported the follow up request on risk assessments by respective Divisions especially the need for the updating of standard operating procedures.

The Chairman and Board noted the report, assurances received and decisions made at Committee.

17/063.2 Audit Committee Summary Report including the Audit Committee Annual Report (Enclosure 5)
10.15am

Mr Miner, Committee Chair, presented the Audit Committee Summary Report including the Audit Committee Annual Report, given as Enclosure 5.

The Board noted the following key issues:

- The previous Audit Committee meeting had largely focussed on accepting the year end reports and approving the accounts under the delegated authority from the May Board meeting.

- Improvements had been seen by the Trust as reflected by the external audit report which now had a 'clean' opinion on the Trust's use of resources. The Internal Audit Opinion gave the 2nd highest level of confidence on the Trust's adequate and effective framework on risk management, governance and internal control.

- The Quality Report received two "except for" opinions – one for the ED 4 hour wait indicator and one for the 18 week RTT target. The Chairman confirmed that the ED issue had been picked up with PWC (external auditors) directly to that they provided a rounded narrative within their report over the Trust's processes. The Board acknowledged the system would not be changed as the Trust recorded actual handover times for ambulance arrivals which were not subject to any delays. Changes to national guidance were potentially required, given the lack of clarity in the procedures. The RTT issue reflected within the auditors opinion was for a limited period, and that had been rectified by the Trust during the previous year.

- The Annual Audit Report identified good Committee attendance and summarised the work done throughout the year. Counter fraud and cyber crime were noted as top risks and the Trust had taken action to mitigate these throughout the year.

The Audit Committee Chair noted the thanks for the work and effectiveness of the Committee.

Mr Fellows, Non Executive Director, asked about the areas where assurance was not provided or was insufficient in some of the audit reports. Mr Miner confirmed that these areas are followed up, with a number of these reported by the year end showing that agreed actions had been taken. Those reports where action is planned for the first quarter of the new year would be followed up and reported to the next Audit Committee meeting.

The Chairman and Board noted the Committee report and Annual Audit Report and endorsed the actions taken by the Committee on behalf of the Board.

17/063.3 Research and Development Report (Enclosure 6)
10.28am

The Director of Research and Development, presented the Research and Development Report (R&D), given as Enclosure 6. The Board noted the following key areas:

- R&D is facing challenges because wider health system delivery expectations.

- The Trust was undertaking locally developed studies and this was now showing positive outcomes for the Trust as well as our patients.

- R&D were paying attention to their commercial portfolio but it may not in itself meet the shortfall in income from other sources and they may need support to maintain staffing to support the portfolio of studies.

- Gaps in specialties not undertaking research was provided in the table as requested at a previous Board meeting.

- Funds had been received from the Clinical Research Network for reproductive child health and this requires full engagement from Obstetrics and Gynaecology for this study to be successful.

- The Trust needs to look to normalise research into 'business as usual' going forward and to recognise research more formally within SPA activity for Consultants.

- There is new evidence that patient outcomes are improved by participation in research studies.

- Since April the full complement of R&D senior team has been in place and some focus will be placed on AHP research opportunities.

The Medical Director agreed about improved outcomes from participation in research and the need to look at the medical and Consultant workforce with this activity to be included within relevant job plans.

Dr Wulff, Non Executive Director asked whether the Trust looking at opportunities for research in Community services. Dr Neilson confirmed that Primary Care research is accounted for separately. Dr Wulff stated that it was possible to separate this out and have any remaining community activity counted for the benefit of the Trust.

The Chief Executive asked if the Trust had an R&D Strategy. Dr Neilson confirmed that there was no written strategy but agreed that there was a need to pull one together with key milestones for the year.

Mr Miner, Non Executive Director requested that the Strategy should be reported to the Board with risks reported to the Audit Committee as now.

The Chairman asked that the R&D newsletter is published on the Hub and marketed to Community staff.

The Chairman and Board noted the report and the points regarding the potential to develop Community research work and the requirement to produce a Strategy for the Board to approve.

Research and Development Strategy to be produced and presented to Board.
R&D newsletter to be made available to Community staff.

17/063.4 Freedom to Speak Up Guardian Report (Enclosure 7)
11.06am

The Chief Nurse presented the Freedom to Speak Up Guardian's Report, given as Enclosure 7. The Board noted the following key issues:

- The Guardian had been in place for 12 months and was taking an active role in supporting staff to raise concerns and give them confidence that such concerns will be looked into.

- 21 concerns had been raised, 12 closed and the Trust was examining those still open.

- Carol Love-Mecrow, now a Deputy Chief Nurse, would be handing over to the two new Guardians after training had taken place in June.

The Director of HR raised total activity between May 2016 and May 2017 and noted that there had been only two concerns raised from February to May 2017.

The Director of HR will meet with the new Guardians when they are in post to ensure that continued good working relationships were maintained between HR and the new staff, enabling all relevant concerns to be registered.

Dr Wulff, Non Executive Director, asked what time commitment is given for the Guardians to undertake this work. The Chief Nurse stated that two had been appointed to give greater capacity but they had not been given time over and above their current roles. The Chief Nurse added that she will monitor the time requirements placed on these staff. Dr Wulff stated that he would be concerned if they did not receive dedicated allocated time and that they need to undertake proactive, not just reactive work for the Trust.

The Chairman confirmed that Dr Wulff is the allocated Non Executive Director supporting the Guardian role and that he will continue to meet with the guardians to make sure they were being appropriately supported.

The Chairman and Board noted the report and actions discussed and that both the Chief Nurse and the nominated NED would monitor the transition of the role to the new guardians. The Chairman also expressed the Boards thanks to Ms Love Mecrow who had developed the role from its inception.

17/063.5 Guardian of Safe Working Report (Enclosure 8)
10.43am

Dr Elahi, Guardian of Safe Working, presented his report, given as Enclosure 8. Dr Elahi outlined the role of the Guardian for the Board.

The Board noted the following key issues:

- This quarterly report is written to provide assurance to the Board.

- The report contained information by exception on identified gaps in the medical rotas, actions taken and that none identified significant safety concerns.

- The Board noted that 61 junior doctors were on the new contract. There were 199 juniors in total and there would be a bigger change in August, 2017.

- Engagement with junior doctors was working well and Dr Elahi updated the Board on the junior doctor forum he undertakes regularly.

- Consultants' involvement with educational supervisors on issues raised remained a challenge. The Medical Director confirmed that there were discussions at JLNC the previous day and actions would be put in place to improve this engagement. The Chief Executive stated that the Trust should use the Divisional structure and asked Dr Elahi to produce some guidance for the Divisional managers and that the Chief Executive be copied into emails if responses are not forthcoming as she would support Dr Elahi.

The Chairman asked whether IT could look at the efficiency of the payment mechanism to enable speedier redress. The Director of HR confirmed that the issue was not around the process but on accountability for dealing with the request for information in respect of each exception.

Dr Elahi confirmed that we were still performing better than other Trusts in respect of good level of engagement across the Trust and Executive support.

Mr Miner, Non Executive Director, asked about the national picture for Consultant job planning. The Medical Director confirmed that we are undertaking work on benchmarking our capacity to ensure all NHS additional tasks could be accommodated.

The Chairman and Board noted the report and asked for agreement to be reached on the exception reporting process with clinical supervisors. Dr Elahi, the Director of HR, Divisional Managers and Dr Banks, Operational Medical Director to meet and provide assurance to the Board in 3 months time. The Chief Executive expressed disappointment around the lack of action to engage with reported exceptions by the consultants.

Assurance to be presented to the Board around the exception reporting process in 3 months time.

17/063.6 Trust Annual Plan Objectives 2017-18 (Enclosure 9)
11.12am

The Deputy Director of Strategy and Business Planning presented the Trust Annual Plan Objectives 2017-18, given as Enclosure 9.

The Board noted the following key issues:

- There had been a thorough review of last year's Plan and delivery.

- The Trust had incorporated the requirements of the 5 Year Forward View within this document.

- The Plan had been discussed by the Executive Team, at the Board Workshop and by Governors at their Strategy Committee.

- Activity and goals were aligned under the respective Trust objectives.

- There will be a formal quarterly monitoring report to Board as in previous years.

Mr Miner, Non Executive Director, asked about EPR as this was a major transformation opportunity and this was not reflected in report. The Deputy Director of Strategy confirmed that it was included within the section under the Trust objective 'Making the Best Use of What we Have'.

With respect to the delivery of improvements in maternity care there was no real context of this within the plan. The Deputy Director of Strategy and Business Planning stated that there are maternity key milestones from the 5 Year Forward View and are not specific to Dudley. The Chief Nurse stated that this needed to be reworded to meet or reduce Dudley adverse incidents to that of the national target.

The Chairman asked about the milestones for the MCP. It was noted that there was a need to change the wording in relation to the outcome of the procurement process.

The Trust was working on a plan on a page and this will be published on the hub and intranet.

The Chairman and Board noted the report and actions identified.

Appropriate maternity elements specific to Dudley to be included in the Annual Plan. Text regarding the MCP to be amended in light of timescales.

17/063.7 Chief Nurse Report – Infection Prevention and Control Update (Enclosure 10) 11.20am

The Chief Nurse presented her report, given as Enclosure 10.

Report detailed infection prevention and control issues, including the following key highlights:

- MRSA: The Trust continued to see none prevalent in the Trust. The Board noted the positive performance in this area.

- CDiff: The Trust continues to do well. One positive case had been identified that week. The Trust is looking at environmental issues for any learning from this incident.

- TB: There had been a number of meetings and actions. The normal processes were being followed for this type of occurrence and 36 patients had been contact traced and there were no immediate concerns. There had been media contact and the

case is being investigated as an incident to ensure there is a structure to consider any learning and if necessary make changes to our processes.

- Infections in the organisation: There had been a few cases of Endobacteremia in the Neonatal Unit and further detail will be provided in the next report. The Trust had screened all babies in the Unit and contacted NHSI who will offer any wider thoughts the Trust can use within its infection control processes.

The Chief Executive stated that we must review our cleaning guidelines and need a systematic process to be assured these are appropriate for every area of the Trust.

The Chief Nurse confirmed that we need to undertake more regular audits to provide this level of assurance.

The Chairman and Board noted the report and the actions being taken in relation to the Neonatal Unit and the media interest in the TB case. The Board noted the positive performance in relation to MRSA and C-Diff.

Chief Nurse Report for the July Board to give more detail about infection control on the Neonatal Unit.

17/063.8 Monthly Nurse/Midwife Staffing Report (Enclosure 11)
11.30am

The Chief Nurse, presented the monthly Nurse/Midwife Staffing Report given as Enclosure 11.

The Board noted the following key issues:

- Progress on the nurse/midwife staffing review continues .
- Shift fill rates were nearly at 100%.
- The Trust was looking at the Model Hospital data to understand its workforce mix. The Trust had slightly fewer qualified staff and significantly more CSWs than the model hospital data
- New comparative information had been included in the paper so that the Board can understand the context for Dudley performance.
- The safer staffing summary was attached as an Appendix to the report. The Board noted the new format and agreed this was an improvement on the past presentation format.

The Director of HR asked if the report reflected the increase in 1:1s requested by Dudley wards. The Chief Nurse stated that it excludes these as the Trust does not know how other

Trusts are counting 1:1s. The reality is the Dudley ward staffing rates will be higher where these additional staff have been authorised.

The Chairman and Board noted the report and confirmed that the safer staffing summary was an improvement on that presented previously.

17/063.9 Organ Donation Committee Report (Enclosure 12)
11.39am

Raj Uppal and Rebecca Evans, presented the Organ Donation Committee Report given as Enclosure 12.

The Board noted the following key issues:

- Performance for 2016-17: 100% BSDT rate and 100% family approach rate, 66% for DBD collaborative approach and 83% DCD approach. The Trust has an excellent 97% referral rate.

Consent Rates:

- 6 patients were identified as BSD last year: all families were approached. One consent was later withdrawn by the family for wholly understandable reasons. No BSD donors.

- 6 DCDs occurred and all families approached. 4 families provided consent to progress with the donation process. 2 patients did not go forward as not medically suitable for donation.

- Donation summary: 2 DCD donors – these donated 1 kidney, and 1 kidney, liver and corneas successfully transplanted.

- Outcome – saved one 50 year old with left kidney, one 54 year old with right kidney, one 48 year old with liver and restored the sight of two 70 year olds.

- The Year Ahead: Blood and Transplant Authority has set a stretch goal for 2017 around the number of consents achieved.

- Dudley Group: The Trust has consent and awareness as a continued improvement goal.

Dr Wulff, Non Executive Director asked how the Trust undertakes benchmarking as rates for Dudley appeared low. Ms Evans confirmed that the Trust is a level 4 hospital and the other level 4 hospital in the cluster is performing at the same level as Dudley Group. It is very difficult to compare direct numbers as they are low so are sensitive to small changes.

The Chief Executive stated that the Trust needs to look at other opportunities such as tissue donation and the Trust was performing well for a small/medium acute hospital. The Chief Nurse asked if she could join the Donation Committee to help support the expansion of awareness of donations.

The Board noted that tissue donation is a responsibility of a separate external team and NHSBT do not capture tissue collection data. It was agreed they would facilitate contact so the Trust could promote tissue donation opportunities appropriately.

The Chief Executive stated that the Trust should include all donation data in its annual report in the future.

The Chairman suggested that the Chief Nurse joins the Donation Committee and that the next meeting was in November. The Chief Nurses confirmed that the group needs to link in to the End of Life Committee which she was now Chairing as this will help with community engagement.

The Board were informed that there is an Organ Donation awareness week in September. Dr Hopkin, Associate Non Executive Director asked that the Trust looks to involve General Practice in this event and make it a health economy week.

The Chairman and Board noted the report and actions identified including collecting tissue donation data and that General Practice and the wider community be included in the Organ Donation week. The Board noted the stretch targets going forward and that the Trust is replicating these in its annual aims for this aspect of its work.

Tissue and organ donation data to be included in future Annual Reports. General Practice to be included in the Organ Donation week arrangements for September. The Chief Nurse to join the Organ Donation Committee. NHSBT to facilitate contacts with the Tissue Donation team.

17/064 Finance and Performance

17/064.1 Cost Improvement Programme and Transformation Overview Report (Enclosure 13)
11.57am

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

The Board noted the following key highlights:

- A good start to the year was noted and the Trust had over-achieved against plan at month one.

- The Trust had developed a programme of schemes to deliver £12.7m against a £12.5m target for the year.

- Slide 3 shows the trajectory for the remainder of the year and the challenges this poses.

- For the year to date, 3% of schemes are non-recurrent.

- Three quarters of the schemes have been through the clinical quality approval stage.

Mr Miner, Non Executive Director, commented on slide 3 and that “forecast shortfall” was an incorrect heading as in effect the programme was showing a forecast positive variance

The Chairman and Board noted the report and the effective performance at month one.

17/064.2 Finance and Performance Committee Exception Report (Enclosure 14)
12.02am

The Director of Finance and Information presented the Finance and Performance Committee Exception Report, given as Enclosure 14 in the absence of the Committee Chair.

The Board noted the following key issues:

- Staffing review highlighted and that this was central to the Trust’s ability to achieve its agency targets and expenditure cap.

- For April 2017 the financial position achieved showed a slightly bigger deficit than forecast for the month and the Trust was looking to May’s position to make some recovery but the position was tight.

- There had been substantial discussions on Estates management performance within the PFI provision.

- The performance on certain key targets looked to be challenging in the year ahead.

The Chairman and Board noted the report the actions underway and the risks to delivering forecasts and performance.

17/065 Any Other Business
12.08am

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

17/066 Date of Next Meeting
12.10am

The next Board meeting will be held on Thursday, 6th July, 2017, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 1 June 2017

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/061	Staff Story	Actions in relation to AHPs to be progressed through the Workforce Committee.	AMcM/JA	27/6/17	Done
17/041.7	Corporate Risk Register and Assurance Report	The Executive Team to consider the inclusion of the new Apprenticeship levy on the Risk Register.	ET	6/7/17	Corporate Risk Register Report to be presented at the next Board.
17/063.7	Chief Nurse Report – Infection Prevention and Control Update	Chief Nurse Report for the July Board to give more detail about infection control on the Neonatal Unit.	SJ	6/7/17	In report.
17/052.3	Complaints and Claims Report	Future reports to contain correlation with incidents and examples of learning.	GP	7/9/17	
17/063.5	Guardian of Safe Working Report	Assurance to be presented to the Board around the exception reporting process in 3 months time.	BE	7/9/17	
17/063.6	Trust Annual Plan Objectives 2017-18	Appropriate maternity elements specific to Dudley to be included in the Annual Plan. Text regarding the MCP to be amended in light of timescales.	LP	7/9/17	
17/063.3	Research and Development Report	Research and Development Strategy to be produced and presented to Board. R&D newsletter to be made available to Community staff.	JN JN	7/12/17 7/12/17	
17/063.9	Organ Donation Report	Tissue and organ donation data to be included in future OD Annual Reports. General Practice to be included in the Organ Donation week arrangements for September. The Chief Nurse to join the Organ Donation Committee. NHSBT to facilitate contacts with the Tissue Donation team.	JN/RE/RU SJ	7/12/17 Sept 17 November Meeting	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 6th July 2017

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

SUMMARY OF KEY ISSUES:

- Friends and Family Test (FFT)
- Visits and Events
- Falls Prevention Week
- Introducing our Advanced Clinical Practitioners (ACPs) and Advanced Nurse Practitioners (ANPs)
- Fellow of the Royal Pharmaceutical Society
- World Continence Awareness Week
- Clinical Fellow Placements for Pharmacy Staff
- National Breastfeeding Celebration Week

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

Decision	Approval	Discussion	Other
		Y	**Y**

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

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – July 2017

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and a highlight a number of items of interest.

Items below are not reported in any order of priority.

Friends and Family Test (FFT)

Response rates:

The table below provides the FFT response rates for May 2017. Whilst it is disappointing to note that the Emergency Department has seen a decrease from 15.4% in April to 13.6% in May the response rate is now maintained above the national average 12.5% (April '17).
It is pleasing to see response rates for inpatient areas have increased from 28.7% (April '17) to 30.8% (May '17).

Table 1 – Response rates over time

Area	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Emergency Department	1.6%	8.4%	10.7%	5.0%	5.0%	3.7%	4.3%	13.1%	15.4%	18.6%	15.4%	13.6%
Inpatients (inc. day case)	13.9%	17.9%	18.6%	20.5%	19.2%	19.2%	17%	17.9%	18.1%	18.3%	28.7%	30.8%
Community	1.5%	1.1%	1.3%	1.1%	0.6%	1.3%	1.3%	1.5%	1.2%	1.2%	1.1%	0.9%
Outpatients	1.0%	1.7%	1.5%	1.4%	1.5%	2.5%	1.5%	2.4%	1.9%	1.7%	1.5%	1.9%

Actions to improve response rates will include the expansion of the FFT SMS messaging solution in the coming months to ward areas, community and outpatients.

Recommended percentage rates:

In May 2017, all areas achieved a recommended percentage that was equal to or better than the national average with the exception of ED who achieved 75% compared to the national average of 87% (April '17) and Inpatients who achieved 95.6% compared to the national average of 96% (April '17).

Outpatients have continued to maintain a percentage recommended score equal to or better than the national average score for eight months in a row from October 2016 to May 2017.

Table 2 –Recommended percentage rates over time

Description	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Community – Recommended %	94.7%	94.4%	97.3%	96.1%	96.1%	95.1%	95.5%	94.0%	94.4%	97.8%	97.3%	94.0%	96.0%
ED – Recommended %	91.3%	88.2%	91.7%	91.8%	91.9%	93.8%	93.1%	90.1%	75.3%	76.0%	81.0%	75.0%	76.6%
Inpatients – Recommended %	96.7%	97.0%	94.6%	96.6%	96.6%	97.9%	95.0%	97.9%	95.8%	97.3%	97.3%	96.4%	95.6%
Maternity – Recommended %	97.3%	98.9%	96.0%	98.6%	98.8%	98.8%	99.5%	99.4%	97.6%	98.2%	99.0%	98.8%	97.8%
Outpatients – Recommended %	82.2%	93.1%	91.7%	92.4%	92.4%	93.2%	94.9%	93.1%	95.0%	94.1%	96.2%	95.3%	95.2%

Visits and Events

5th June:	Visit to Ward A2, C3, ED, EAU, AEC
6th June:	Visit to Moss Grove Surgery
7th June:	Visit to Community Continence Team
	MCP Meeting
9th June:	NHSE Provider Chief Executive's Meeting
14th & 15th June:	NHS Confederation Conference
21st June:	NHSE Midlands and East Chief Executive's Networking Event
26th June:	STP Transformation Partnership Meeting
	MCP Events
28th June:	Partnership Board

MCP

Dudley CCQ issued the Pre-Qualification Questionnaire for their proposed £4bn 15 year procurement of primary and community care services on 9th June 2017. Dudley Group and Birmingham Community Healthcare NHS Foundation Trusts have been selected by Dudley GPs to prepare a joint submission to the PQQ by 13th July 2017.

A requirement of the PQQ is for the bidder to be in consortium with GP practices in Dudley of at least 100,000 patients, and the GP Collaborative has told us that they are not looking to bid with any other consortia. It is unclear though, whether 100% of Dudley GPs have signed up to our consortia, but we believe it to be the vast majority. It is our expectation, at the moment, that ours will be the only consortium selected for the next stages of negotiation and then final tender submission.

Four Eyes Update

Four Eyes are supporting the Trust with its transformation of services agenda. They are looking at several areas that include the 18 week pathway, Theatre utilisation along with continuing the work that supports patient access and Out Patient experience.

Data

Working with Directorate and as of 22nd June, now have a full set of data for the Trust for Theatres, Outpatients and Patient flow.

Theatres Dashboard

Now produced the Theatres dashboard for the Trust, this has not yet been fully validated with the Operational and Clinical teams but it is demonstrating that the Trust have a theatres opportunity which needs to be validated

Theatres

Carried out observations in main theatres. A further day of activity provisionally planned for 5th July to complete Theatre observations and patient walkthroughs in Day case theatres.

Outpatients

Carried out observations and meetings in Outpatients on 26th and 27th June, with key members of the team. Four Eyes business intelligence unit is currently finalising the Outpatient analysis, will be in a position to share this with teams for further validation from week commencing 3rd July, 2017.

Falls Prevention Week

The Trust's Falls Team kicked off Falls Prevention Week, as part of the national Sign up to Safety campaign, with a launch event on Monday 26th June, with a presentation on falls and a cake competition. The team spent the week visiting wards to give staff tips on preventing falls and, after taking part in NHS Improvement's National Falls Collaborative and presenting some pilot work at a recent conference, rolled out some key falls prevention resources this week including:

- 'Need it in a hurry?' grab bags for inpatient toilets so staff have all the essentials they need within reach.
- Bedside table pop-up encouraging inpatients to use their calls bells rather than struggle to mobilise alone.
- 1:1 badges for nursing staff so others know they cannot leave their patient alone.

Introducing our Advanced Clinical Practitioners (ACPs) and Advanced Nurse Practitioners (ANPs)

We recently welcomed Advanced Clinical Practitioners (ACPs) and Advanced Nurse Practitioners (ANPs) to our Emergency Department. Senior nursing and paramedic staff have undergone extensive advanced training and examinations in order to work in ED as independent practitioners with their own patient load. They are responsible for assessing, investigating, treating and observing their patients. The role is funded by the Trust and supported by Health Education England and the Royal College of Emergency Medicine as a valuable component of the emergency workforce.

Fellow of the Royal Pharmaceutical Society

Neurology Specialist Pharmacist Dr Janine Barnes has been awarded the title of Fellow of the Society for her outstanding contribution to the advancement of pharmaceutical knowledge by the Royal Pharmaceutical Society.

The honour recognises individuals who have attained distinction in their pharmacy career and is one of the highest honours that can be awarded to members. Janine is based at Stourbridge Health and Social Care Centre.

World Continence Awareness Week

To celebrate World Continence Awareness Week our Continence Team promoted their service to staff, patients and visitors on Tuesday 20th June, at the Health Hub in main reception at Russells Hall Hospital. The team is normally based at Brierley Hill Health and Social Care Centre and accepts self-referrals from anyone with a Dudley GP.

Clinical Fellow Placements for Pharmacy Staff

The Chief Pharmaceutical Officer of England, Keith Ridge, announced nine coveted Clinical Fellow placements to work in an apprenticeship model for 12 months with the most senior leaders across the NHS and healthcare related organisations. Two of our senior Pharmacists were selected for interview and appointed, Danielle Stacey who will take on a role at NHS Improvement and Graeme Hood who will work with Public Health England. Danielle and Graeme will work on key projects which contribute to national healthcare priorities around patient safety, medicines optimisation, transfer of care, digitalisation and Pharmacy workforce training.

National Breastfeeding Celebration Week

We celebrated National Breast Feeding Celebration Week (week commencing Monday 26th June) by encouraging mums to tell their stories of how people have supported them to breastfeed on social media using the hashtag **#bffriend17.** Visitors to the department also had the opportunity to take place in a breastfeeding wordsearch competition to be in with a chance of winning shopping vouchers.

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 6 July 2017

TITLE:	**27 June 2017 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe – Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

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

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

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

The Committee requests the Board to note the endorsement of the Chief Executives decision to secure more short term capacity in the area of ophthalmology.

The Committee requests that the Board ratify the revised terms of reference (enclosed as an appendix to this report).

The Committee recommends to the Board that the draft QIB report is received at the next CQSPE meeting in July and that the Committee extends an invite to the maternity and obstetric senior team to attend for this item.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	27 June 2017	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- The Committee received an audit of use of the "Estimated Discharge Date" data field on the patient record system. The Committee was updated on the current processes and the inherent weaknesses. The Committee was updated as to a wider project underway looking at bed utilisation which will illuminate where the process of planning for discharge is working well and areas where improvement is needed. The Committee asked that the recording, monitoring and use of estimated discharge dates be taken forward into the Digital Trust project to remove some of the inherent risks through the better design of the new patient record. The Committee agreed that the bed utilisation review will be the best place to assess what actions are needed to address better planning for discharge.
- The outcomes of the continued weekly audits on compliance with the National Patient Safety Agency Alert in respect of Naso Gastric Tube placements were received by the Committee. Insufficient assurance remained to change the frequency to quarterly audits and a report will be provided to the next meeting of this Committee. The Committee endorsed the proposed actions by management to expand the audit and to utilise the nutritional team to undertake future audits.
- The Committee received a report from the Surgery Division on three recent incidents within Ophthalmology. Whilst operational management assurance was provided in respect of the actions being delivered as a result of the investigations including the development of more capacity, the triaging and escalation of late appointments, the Committee endorsed the actions proposed by the Chief Executive Team to ensure that the short term capacity challenges are managed. The Committee agreed with the Chief Nurse's request that a more detailed action plan in respect of ophthalmology improvement be developed and brought back to this Committee for direct oversight.
- Executive Management assurance was provided on the quality aspects of the Trust's performance in respect of key quality indicators. The Committee was provided with an update on actions being taken and areas where future performance reporting to the Committee will be enhanced to allow a broader understanding of quality performance to be provided going forward.
- The serious incident report documented the Trust's continued focus on learning

and improvement however the Committee agreed that the learning detailed within the report did not adequately demonstrate the changes required as a result of the incidents and the changes actually made. The Committee required that this report be amended prior to any consideration by the Board. The report provided assurance that the Trust has complied with the reporting requirement timescales in respect of initially reporting of Serious Incidents (SIs) within two days. However, on conducting and closing 29 Pressure Ulcer SIs the two day reporting date was found to have been failed. The Trust did not close 4 of the investigations within the 60 day timescale this month, all related to pressure ulcers. The monthly report showed that the number of incident investigations being closed by the CCG with either no questions or just one set of queries was below the 100% target set by the Trust. There were 4 for the month of May where the CCG raised more than one set of queries. The relevant SI investigation lead director is made aware of these queries. The number of actions not being implemented in line with the agreed RCA action plans timescales has risen slightly this month to 4 (from the 3 last month), however for some to these actions the revised date is some two to three months later than the originally agreed date. The Serious Incident report also provided assurance regarding the Trust's engagement with families when a serious incident occurs through the reporting of the Trust's compliance with the duty of candour.

- The Committee received the update from the Quality and Safety Group Chair, the Chief Nurse, as requested at the last meeting. The Committee were updated on the issues the Group were focusing on including the level of infection prevention and control training taking place across the Trust and the follow up of incidents in relation to transfusions. The Group Chair had also engaged with the medics to ensure t that there is better attendance from this group of staff at Drugs and Therapeutics Group and the Quality and Safety Group.
- The Committee received a report on the qualitative aspects of the estates contract management processes in respect of both estates and facilities. The Committee received an update on the recent never event incident and the immediate actions taken by the Trust as a result.
- There are currently 3 policies under review that have exceeded their planned review date. The lead executive directors are aware of these instances. The Committee reiterated its stance that the review of Polices should be a priority. The report updated the Committee on the level of guidelines and standing operating procedures that are due for review.

Decisions Made/Items Approved

- The Committee requested the Serious Incident report be reviewed to ensure that it adequately documents the learning and changes made as result of individual incident investigations.
- The Committee supported the closure of 41 Root Cause Analyses (RCA) action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.
- The Committee approved 2 policies.
- The Committee agreed to recommend to the Board that the draft QIB report is received at CQPSE's next meeting in July and to extend an invite to the maternity

and obstetric senior team to attend this meeting for this item.

- The Committee approved its revised terms of reference reflecting the extended membership for this Committee. The Committee also agreed its cycle of business with a review of this document to take place after three months to ensure it is supporting it to deliver is terms of reference.

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

- The receipt of the outcome of the bed utilisation review, which would also incorporate information on the use of estimated discharge dates to the August Committee meeting.
- A more detailed action plan in respect of ophthalmology improvement be developed and brought back to this Committee for direct oversight.
- That the report on serious incidents is improved to detail the level of change made as a result of any incident investigation.
- The review in three months the Committee's cycle of business.

Items referred to the Board for decision or action

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

The Committee requests the Board to note the endorsement of the Chief Executives decision to secure more short term capacity in the area of ophthalmology.

The Committee requests that the Board ratify the revised terms of reference (enclosed as an appendix to this report).

The Committee recommends to the Board that the draft QIB report is received at the next CQSPE meeting in July and that the Committee extends an invite to the maternity and obstetric senior team to attend for this item.

The Dudley Group
NHS Foundation Trust

CLINICAL QUALITY, SAFETY AND PATIENT EXPERIENCE COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1 The Board of Directors resolves to establish a Committee of the Board to be known as the Clinical Quality, Safety and Patient Experience Committee. The Clinical Quality, Safety and Patient Experience Committee in its workings will be required to adhere to the Constitution of The Dudley Group NHS Foundation Trust, the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts. As a committee of the Board of Directors, the Standing Orders of the Trust shall apply to the conduct of the working of the Clinical Quality, Safety and Patient Experience Committee.

2. Membership

3x Non-Executive Directors
Chief Executive
Medical Director (or deputy)
Chief Nurse (or deputy)
Chief Operations Officer (or deputy)
Director of Human Resources (or deputy)
Chief of Medicine (or Director of Operations Medicine and Integrated Care)
Chief of Surgery (or Director of Operations Surgery and Women & Children)
Chief of Support Services (or Director of Support Services)
Chief Clinical Information Officer
Director of Governance (or deputy)
Associate Chief Nurse Medicine
Associate Chief Nurse Surgery
Chief Pharmacist
Head of Communications
Deputy Finance Director

The Board will appoint one of the Non-Executive Directors on the Committee as the Chairman of the Committee.

3. Attendance

3.1 In attendance
Deputy Chief Nurse

3.2 All other members of the Board shall be entitled to attend and receive papers to be considered by the Committee.

3.2 Other managers/staff may be required to attend meetings depending upon issues under discussion. The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as necessary and to commission input from external advisors as agreed by the Chair

3.3 The Board Secretary will ensure that an efficient secretariat service is provided to the Committee.

4. Quorum

4.1 A quorum will consist of three members including at least one Non-Executive Director and one Executive Director (voting or non-voting member) of the Trust Board

5. Frequency of Meetings

5.1 The Committee will normally meet monthly. It is expected that there will be at least 10 meetings a year and members will attend at least half of the meetings in the year. The Agenda will be circulated with papers 7 days before the meeting.

5.2 Additional meetings may be held at the discretion of the Chairman of the Committee.

6. Authority

6.1 The Committee is authorised by the Board to investigate any activity within its Terms of Reference and is expected to make recommendations to the full Board. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances and prior approval of the Board is required.

6.3 The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

7. Duties

7.1 The Committee will ensure that the Trust has appropriate and effective systems in place that cover all aspects of Clinical Quality, Clinical Effectiveness, Patient Safety and Experience. The duties of the Committee can be summarised as follows: -

- To undertake detailed scrutiny of regular reports, relating to Clinical Effectiveness, Patient Safety and Patient Experience utilising best practice metrics that provide robust clinical governance processes to deliver safe, high quality and patient centred care. Holding senior staff to account, to challenge assumptions and decisions as necessary, to monitor progress, and to provide assurance to the Board

- To approve, challenge as necessary and monitor progress of the Divisions' plans to drive an improvement culture to promote excellence in patient care across the organisation

- To set clear quality performance expectations and ensure the development of high quality care and continuous improvements through innovation and the use of levers such as CQUINS.

- To scrutinise and monitor progress against performance expectations, challenging progress where appropriate and managing actions where timeframes are breached.

- To identify and advise on quality improvement priorities of service areas, to receive exception reports and external reviews of provider services and ensure appropriate action is identified and monitored

- To ensure that the Trust fulfils its obligations with regard to the Health Act (2009) and NHSI in the production of an Annual Quality Account and Report.

- To monitor performance of all reporting groups; to review and challenge performance, assumptions and decisions as necessary with individual Clinical Units and Directorates. Ensuring robust remediation is implemented if appropriate and holding senior staff to account.

- To take a lead for Quality and Patient Safety within the organisation and provide assurance to the Board on the standards of care provided across the range of Trust services, including actions in place to drive improvements and mitigate risks.

- To take the lead for Patient Experience across the organisation and receive regular reports; challenge assumptions and decisions as necessary, and monitor progress to enable it to provide assurance to the Board on the arrangements in place to capture and report on Patient Experience and systems in place to drive improvements and learn from issues and complaints.

- Review and manage information from Complaints and Claims, receiving both quarterly and annual Complaints and Claims reports. Monitor the effectiveness of the Trust's systems for complaints handling, and reviewing trends and themes, monitoring the effectiveness of the Trust's system for advocacy and the encouragement of feedback from patients and relatives. Ensuring appropriate actions are identified and implementation of changes and improvements are implemented and progress monitored.

- Receive a quarterly claims report (incorporating an analysis of Solicitors Risk Management Reports) identifying trends and themes and lessons learned and ensuring Divisions have identified appropriate actions; that these are implemented within agreed timeframes and challenging assumptions and decisions as necessary.

8. Key Responsibilities

8.1 Monitor the adequacy and effectiveness of processes in place to meet national guidelines and safety standards; to ensure that robust systems are in place to monitor quality priority targets, challenge assumptions and decisions as necessary, comply with legal, professional, national and local guidance and hold senior staff to account.

Receive a summary of key issues and actions to address remediation as necessary arising from reporting groups at each meeting.

8.2 Review and monitor compliance with new and existing statutory and accreditation standards and legislative requirements (e.g. NICE (National Institute for Clinical Excellence)); consider, challenge and approve recommendations for the timely implementation of guidance.

8.3 Review assurances received on clinical practice and be advised of the progress of any major quality initiatives in the Trust.

8.4 Review the effectiveness of the Trust's arrangements for the systematic monitoring of mortality and other patient outcomes.

8.5 Receive a quarterly report on the Quality priority targets prior to reporting progress to the Trust Board.

8.6 Monitor the effectiveness of the Trust's systems for reporting and investigating Serious Incidents (SIs), Near Misses and other incidents.

8.7 Review the outcomes of investigations and external inspections, triangulating information from several sources to ensure that there is sufficient detail to enable systemic failings in patient care to be identified.

8.8 Receive, scrutinise and comment on action plans and progress reports proposed by management in response to SIs, Near Misses and other incidents; challenging responses where necessary. Ensuring there is identified learning and plans to implement changes and improvements.

8.9 Review, scrutinise and challenge Clinical unit compliance with national safety alerts (e.g. NPSA, MDA), receiving assurance that appropriate actions have been implemented within required timeframes.

8.10 Receive, and review the Trust Research and Development plans ensuring there is adequate linkage and relevance to the Trust quality priorities and evidence of developments and improvements in care.

8.11 Review Clinical audit plans to ensure that programmes are progressing as planned, providing challenge as necessary for any shortfalls in compliance with the plans and receive assurance of improvements in care as a result of the identified outcomes.

8.12 Review, scrutinise and challenge the Trust compliance with medicine management, investigate variances and review and approve proposed actions to remediate any shortfalls, holding senior staff to account.

8.13 Review, scrutinise, discuss and challenge where necessary the quality components of the PFI (Private Finance Initiative) estates contract compliance; including

- Cleaning
- Water safety
- Sterile services
- Security

8.14 Receive and discuss key risks relating to quality and safety practices; to consider, challenge as necessary and monitor plans for mitigation to maintain the risks at their lowest realistic level and advise the Board as appropriate.

9. Policies

9.1 The Committee will approve policies on subjects related to the committee terms of reference on recommendation from the Policy Group.

10. Reporting

10.1 The Clinical Quality, Safety and Patient Experience Committee reports to the Board of Directors. The Committee Chair shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities. The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed or where it has significant concerns.

10.2 The Committee receives assurance from the following working groups and will formally approve the Terms of Reference of these and receive appropriate assurance as determined by the Committee from each:

- Mortality Surveillance Group
- Patient Experience Group
- Quality and Safety Group
- Health and Safety Group (patient issues)

- New Interventions Group
- Internal Safeguarding Board

10.3 The minutes of the meetings of the Committee shall be received by Board members. The Committee shall carry out a self-assessment in relation to its own performance annually reporting the results to the Board of Directors

11. Review of Effectiveness

11.1 The Committee shall formally consider its effectiveness using any tools specified for the purpose by the Board of Directors on an annual basis.

11.2 The Terms of reference of the Committee shall be reviewed by the Board of Directors at least annually.

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 6th July 2017 - PUBLIC

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

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

SUMMARY OF KEY ISSUES:

For the month of June (as at 26.6.17)

- Two cases of post 48 hour C. difficile in June and five cases YTD.
- TB incident May 2017 – Investigation identified a number family and house hold contacts, and investigation continues.
- No post 48 hour MRSA bacteraemia cases since 27th September 2015.
- There have been 4 MSSA bacteraemia identified in the Trust of which 1 is post 48 hour case.
- There have been 23 E. coli bacteraemia identified in the Trust of which 5 are post 48 hour cases.
- The Enterobacter Neonatal episode has been closed.
- No Norovirus episodes in the month of June 2017.

IMPLICATIONS OF PAPER:

RISK	**Yes**		**Risk Description:** Failing to meet minimum standards
	Risk Register: Yes		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** Safe 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.

Clostridium Difficile

The target for 2017/18 is a maximum of 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. Penalties will be associated with exceeding 29 cases associated with lapses in care.

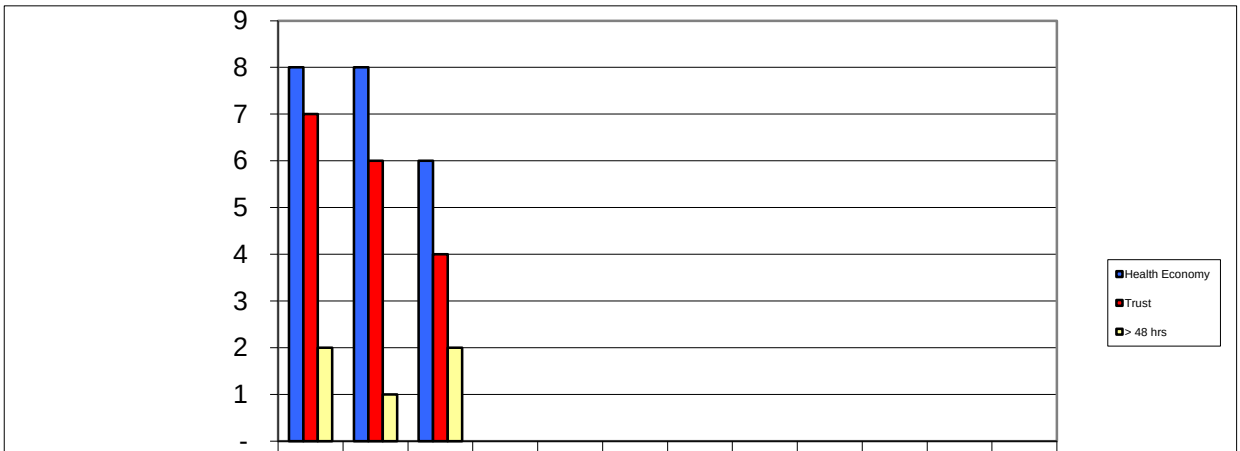
The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], continues.

For the financial period 2017/18 there has so far been 5 post 48 hour case identified since 1st April 2017. There are 2 cases for June 2017 to date. Of these 5 cases 2 are lapses in care and the remaining 3 are under review. Of the 2 apportioned cases the lapses in care associated are: failure by areas to meet their mandatory IC training targets, cleaning score below the required standard and failure to complete a stool chart on admission of the patient.

There is work on going to address the Infection Control Mandatory training to ensure all areas meet their target. Currently there are 2 face to face sessions available per month for ward staff, e learning is available at all times and the Infection Control Team proactively approaches wards to arrange local training.

There is a Trust wide 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.

C. DIFFICILE CASES 2017/18



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	8	6	-	-	-	-	-	-	-	-	-
Trust	7	6	4	-	-	-	-	-	-	-	-	-
> 48 hrs	2	1	2	-	-	-	-	-	-	-	-	-

TB Incident – In the community household and family contact tracing is nearing completion. Further work has been required in the Trust which is in progress.

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

MSSA bacteraemia (Post 48 hrs) – There has been 1 post 48 hour MSSA bacteraemia in the last month (there were 3 pre 48 hr cases). Review of the post 48 hr case shows association with an intravascular device. Work will be undergoing in that area to ensure all standards are met.

MRSA screening – The Trust screens emergency admissions as well as appropriate elective surgical cases. The percentage of emergency admissions for May is 93.6% (last complete set of data available). The information around the compliance with the elective surgical screening has demonstrated that the data collection cannot be verified and as a result a review of how the data is collected is ongoing with the intention of more accurate data being provided within the next month.

E. coli bacteraemia – For the post 48 hr cases an enhanced surveillance module has been commenced in April 2017 in order to ascertain themes and trends within the acute Trust to see where lessons may be learnt. There is a requirement for a larger number of cases to be reviewed which would include the pre 48 hr cases. There is a meeting at the beginning of July regionally to review the methodology and impact of the enhanced surveillance. Locally we have identified 11 post 48 hr E. coli bacteraemia since April 2017 and work is ongoing to see if we can identify any trends or themes. There is a quality premium agenda directed towards CCGs to ensure that there is a reduction in Gram negative blood stream infections with a target of a reduction of 10% in this calendar year.

Neonatal Unit – Results of the typing from the cases identified on the NNU in April/May do not demonstrate widespread transmission of enterobacters between individual babies. As a result the incident has been closed. The actions agreed as part of this episode were to clarify screening procedures for babies admitted from other Trusts, to ensure that the handwash basins available on the NNU meet the building regulations requirements, that the nursing staffing numbers meet national recommendations and that more trollies are purchased to ensure babies can be transferred within the unit on their own trolley.

Reference

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

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 6th July 2017

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

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

SUMMARY OF KEY ISSUES:

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

The ongoing staffing review being undertaken by the Interim Chief Nurse has nearly completed the surgical areas and some comparative CHPPD data from the National Model Hospital is included for those wards here. The comparative data must be interpreted with caution as areas may not be directly comparable. However, the data does suggest that there are a number of areas that are staffed overall and, in particular by qualified staff, lower than the regional and national medians. This is confirmed by the ongoing review that is being undertaken which is showing staff to patient ratios less than national standards.

The staffing review is using this information and other data from a wide variety of sources to gain a firm foundation to inform nursing and midwifery staffing at the Trust. The outcomes of the review will be reported, as agreed, to the Board of Directors in due course.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

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

Monthly Nurse/Midwife Staffing Position
July 2017 Report containing May 2017 data

The attached Safer Staffing Summary (Appendix1) shows the actual and planned hours for four categories of staff, qualified and unqualified staff for both day and night shifts, for each area of the Trust for May 2017 (B6 and A3 wards have been omitted as they were both closed part way through the month). As well as showing the actual and planned hours the report shows the fill rate for each of the four categories. The totals for the Trust are also indicated. In addition, the last four columns show the actual Care Hours Per Patient Day (CHPPD). We provide this information to NHS Improvement and part of it is utilised in the National Model Hospital dataset.

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

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

The chart below shows that the percentage fill rates have been improving over the year.

Table 1. Percentage fill rates January 2017 to the present

	Qualified Day	**Unqualified Day**	**Qualified Night**	**Unqualified Night**
Jan	94%	96%	94%	99%
Feb	93%	95%	96%	99%
Mar	95%	97%	97%	100%
Apr	97%	96%	98%	98%
May	97%	97%	99%	98%

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

Table 2. Care Hours Per Patient Day (CHPPD) – Overall Trust Regional Comparators

2017 Month	**TRUST** Nurse & Midwife	**Midlands & East Median**	**National Median**	**TRUST** Care Support Workers	**Midlands & East Median**	**National Median**	**TRUST** Total number	**Midlands & East Median**	**National Median**
January	4.30	4.7	4.7	3.50	2.9	2.9	7.8	7.7	7.6
February	4.34	N/A	N/A	3.63	N/A	N/A	7.97	N/A	N/A
March	4.44	N/A	N/A	3.74	N/A	N/A	8.18	N/A	N/A
April	4.55	N/A	N/A	3.73	N/A	N/A	8.28	N/A	N/A
May	4.38	N/A	N/A	3.83	N/A	N/A	8.22	N/A	N/A

N/A = Data not yet available

As part of the staffing review being undertaken the comparative data in the Model Hospital has been considered. The examples below are for surgery as the review has nearly been completed for these wards.

Table 3. Care Hours Per Patient Day (CHPPD) for Surgery – Trust and Regional and National Medians

Speciality/ Staffing Type					
T AND O	**B1**	**B2H**	**B2T**	**Peer Median**	**National Median**
Total	***5.65***	8.23	6.92	6.48	6.87
Registered	***3.21***	***2.78***	***2.59***	3.42	3.63
HCSW	***2.44***	5.45	4.32	3.05	3.08
SURGERY	**B3**	**B4**	**B5**	**Peer Median**	**National Median**
Total	6.71	***5.71***	***5.53***	6.52	7.00
Registered	***3.47***	***2.62***	***3.55***	3.79	4.17
HCSW	3.23	3.09	***1.98***	2.62	2.77
UROLOGY	**C6**			**Peer Median**	**National Median**
Total	***5.78***			6.11	6.36
Registered	***3.22***			3.45	3.52
HCSW	2.56			2.69	2.50
PAEDIATRICS	**C2**	**NEONATAL**		**Peer Median**	**National Median**
Total	***8.41***	***8.98***		10.99	12.01
Registered	***6.76***	8.98		8.56	9.97
HCSW	***1.65***	0		2.26	2.25

(Peer Median is for NHSI Region) (These figures from January 2017 are the latest available)

Again, it has to be stressed that these figures need to be interpreted with caution. For instance, the Model Hospital has only a single median figure for both paediatrics and neonates and one would expect these to be different based on the different nature of a specialist unit compared to a general paediatric ward. Also, with regards to trauma and orthopaedics the median figures are for all of these wards, the majority of which will be general T&O wards like B1 while comparing these median figures is less applicable to, say, B2 hip suite a specialised area having many elderly and patients with dementia.

All Trust figures that are less than both the peer and national median have been put into bold and italics and it can be seen that the majority of the qualified staffing and many of the total staffing figures are less than both medians. This is confirmed by the ongoing review that is being undertaken which is showing staff to patient ratios less than national standards.

The Trust is just starting to use this comparative data and this will continue and become more refined as time progresses. A visit from NHSI specialists on both nurse staffing and this data is being arranged.

Conclusion

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

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

APPENDIX 1

Safer Staffing Summary **May** Days in Month 31

Ward	Day RN Day RM Plan	Day RN Day RM Actual	Day CSW Day MSW Plan	Day CSW Day MSW Actual	Night RN Night RM Plan	Night RN Night RM Actual	Night CSW Night MSW Plan	Night CSW Night MSW Actual	Qual Day	UnQual Day	Qual N	UnQual N
Evergreen	117	117	261	252	117	117	229	222	100%	96%	100%	97%
A2	248	245	217	206	155	154	186	182	99%	95%	99%	98%
A3												
A4												
B1	122	122	68	66	71	72	67	68	100%	97%	101%	101%
B2(H)	124	115	199	193	93	91	162	158	93%	97%	98%	98%
B2(T)	93	93	167	163	62	62	135	135	100%	97%	100%	100%
B3	194	190	174	168	161	159	139	138	98%	97%	99%	99%
B4	186	178	233	218	155	149	175	169	96%	94%	96%	97%
B5	186	176	124	121	155	155	95	93	95%	98%	100%	98%
B6												
C1	186	176	349	321	155	143	239	226	95%	92%	92%	95%
C2	192	220	72	64	183	181	42	41	115%	89%	99%	98%
C3	198	186	406	399	173	162	415	414	94%	98%	94%	100%
C4	155	137	80	79	93	92	103	100	88%	99%	99%	97%
C5	186	167	252	266	155	137	191	199	90%	106%	88%	104%
C6	93	91	62	61	62	62	66	66	98%	98%	100%	100%
C7	186	183	133	132	124	123	134	130	98%	99%	99%	97%
C8	217	201	260	261	186	184	266	268	93%	100%	99%	101%
CCU_PCCU	217	180	35	35	155	153	-	-	83%	100%	99%	
Critical Care	297	293	57	56	295	294	-	-	99%	98%	100%	
EAU	186	185	155	150	155	155	155	151	99%	97%	100%	97%
Maternity	550	545	217	204	527	521	155	148	99%	94%	99%	95%
MHDU	120	117	42	39	121	122	15	13	98%	93%	101%	87%
NNU	155	184	-	-	151	186	-	-	119%		123%	
TOTAL	**4,207**	**4,099**	**3,563**	**3,453**	**3,504**	**3,474**	**2,969**	**2,921**	**97%**	**97%**	**99%**	**98%**

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 6th July 2017

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

CORPORATE OBJECTIVES

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

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: COR105, COR109, COR 083, COR102, COR110 & COR 119.**
	Risk Register: Y		**Risk Score: 20, 20, 16, 16, 15 & 12.**
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		Y

RECOMMENDATIONS FOR THE BOARD

To note the assurances received via the Committee and the decisions taken in accordance with the Committee's terms of reference.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	27th June 2017	Julian Atkins	**yes**	**no**
			Yes	

Declarations of Interest Made

No declarations registered.

Assurances received

Workforce Governance

1. The Committee received a new version of the corporate workforce associated risks including their description, RAG rating alongside controls and mitigations. The Committee were assured that the descriptions represented the main risks associated to workforce. However, it was clear that some risks had been written from the perspective of a single staff group when it should represent a number of staff groups. In addition, some of the risks required to be updated in terms of the controls and mitigations.
2. The Committee were provided with assurance that policies were either compliant or in the process of being reviewed in order that they would be compliant within the required timescales.
3. The revised terms of reference for the Committee were presented and discussed. The main changes were described as the inclusion of Divisional Management representation as members of the Committee as well as having the Staff Side Convener as an attendee of the Committee. The Committee agreed that the revised terms of reference should be recommended to the Trust Board for implementation and ratification. (Appendix One)

Workforce Education

4. An update of EDS2 was provided which developed into a wider discussion regarding the provisions at the Trust to support the Equality & Diversity agenda for both patient care and staff. This included the proposal being presented to the Executive Team to provide a shared resource between ourselves and Walsall Healthcare to provide Equality & Diversity provision to support staffing as well as service/patient matters.
5. An update was provided on progress and plans to support the optimum use of the apprenticeship levy. We were advised that the Levy contributions took effect from 1st April 2017 and equate to a figure around £900,000 (based on the total Pay Bill), (deducted monthly). The funding remains available for 2 years from the date it enters the account and money can only be spent on approved providers of

apprenticeships. A range of qualifications are available and they vary in value depending on type and level. In order to utilise as much of the Trusts' contribution as possible, a range of apprenticeships will need to be offered including higher value degree-level qualifications. A recent event took place with managers at the Trust where the regional lead on apprenticeships provided specific advice on opportunities to utilise the levy. It is also expected that the workforce KPIs will be developed to indicate progress alongside the use of the levy by Division and staff group.

6. The finance team had provided some costs associated to Learning & Education following a request at the previous Committee meeting. However, this requires further consideration around the cost and also the budget setting mechanisms to provide greater levels of clarity around current and future proposed costs for training and developing our staff.

Workforce Performance

7. The Workforce Key Performance Indicators were presented with the Committee pleased with the level of detail provided. The discussion focused on the new format of the report and the information associated with the new performance indicators for occupational health and recruitment. The main areas of concern for recruitment of staff is the time taken to approve vacancies and shortlist. In May 2017 there were only 11% of occasions where recruiting managers shortlisted within the target timescale of 16 days. In terms of Occupational Health, in only 21% of occasions staff were provided an appointment following a management referral within 14 days of receipt of the referral. It is proposed that the new KPIs are now highlighted at the monthly Divisional Performance meetings for confirm and challenge.

Workforce Strategy

8. The Committee received an update on the Workforce Business Plan that gave assurance that agreed objectives are on track at this time.

9. The Committee received an update regarding the Staff Survey actions. This provided assurance that actions following feedback are being undertaken and that additional pulse surveys are being supported within the FFT framework.

Workforce Change

10. The Committee were provided confirmation that the MTI recruitment process has now been initiated alongside our colleagues in Pakistan for 5 SHO and 5 SpR level doctors.

11. There were changes to Annual Leave that were raised at Committee for ratification and information. First of all the annual leave policies had been revised to provide a clear understanding that all annual leave should be taken in the leave year and without carry over of leave. In addition, and for information, the Committee were advised that a new scheme was to be initiated from July allowing staff to purchase annual leave. The Committee agreed that the purchase scheme would be reviewed to determine its success.

Decisions Made / Items Approved
The Committee ratified the following policies: • Fire Safety Policy • Annual Leave Policy • Senior Medical Leave Policy • Consultant Job Planning Policy
Actions to come back to Committee (items the Committee is keeping an eye on)
1. The Committee requires further feedback regarding progress on the implementation of the following: • Further costs associated training & development of staff; • Learning & Development Strategy; • Annual Leave Purchase Scheme; • Confirmation of Equality & Diversity provision at the Trust.
Items referred to the Board for decision or action
The Committee is asking the Trust Board to ratify the attached revised Terms of Reference for the Workforce & Staff Engagement Committee.

Enclosure 8

The Dudley Group
NHS Foundation Trust

Annual Mortality Report to Board on 6th July 2017

TITLE:	**Hospital Mortality Report July 2017**		
AUTHORS:	**Andy Troth Head of Informatics and Roger Callender Deputy Medical Director**	**PRESENTER**	**Roger Callender Deputy Medical Director**

CORPORATE OBJECTIVE:

SO1: **Deliver a great patient experience**
SO2: **Safe and Caring Services**
SO4: **Be the place people choose to work**
SO5: **Make the best use of what we have**

SUMMARY OF KEY ISSUES:

Attached is the Hospital Mortality Update report for the period to December 2016 (Latest SHMI Published)

Standardised Mortality Indicators: Both HSMR and SHMI are within expected range with the latest HSMR position 101 (Mar 16 to Feb 17), just above national average; and SHMI (Jan 16 to Dec 16) at 0.97, below national average. National guidance however seems to be moving towards an increased emphasis on "Learning from Deaths" rather than scrutinising these indices (see below).

Condition Groups / Exceptions: Septicaemia continues to flag a high index with SHMI (1.286) and HSMR (138.1). However, our investigations to date have not found any systematic care issues and CQC does not see it as an issue (Letter from CQC Appendix 1). Other condition groups of note are shown in the report

Mortality Tracker and Audit: At December 2016 98% of all deaths had been validated by the consultant in charge of the case. 95% have been audited in departmental mortality meetings and there has been a substantial improvement in the percentage of these audits taking place within 12 weeks (80.09%). A small number of specialties continue to record poorer percentages of timely audit on the tracker, but this is often due to a delay in submitting the audit to the tracker rather than a delay in performing the review. Going forward, we will require this to be addressed in departmental reports.

National Guidance on Learning from Deaths
A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care (March 2017):
We need to update our policies and procedures for reviewing deaths in the Trust to take this guidance into account, as discussed in the report.

The latest report on perinatal deaths is now included Appendix 1. Please note: the author has used the percentage sign in error instead of writing "per thousand".

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL	**CQC**	**Y**	**Responsive Safe Well Led**
	Monitor	**Y**	**Details:** Poor performance would result in the Trust being in breach of licence

REQUIREMENTS	Other	N	Details:

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
x		X	

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the contents of the Annual Mortality Report, including the proposals under "National Guidance on Learning from Deaths".

ANNUAL HOSPITAL MORTALITY UPDATE
JULY 2017

Contents

ANNUAL HOSPITAL MORTALITY UPDATE
JULY 2017

1. MORTALITY INDICATORS

1.1 Mortality indices have been proposed as indicators of Trusts' safety, though more recently the evidence for this is being questioned. Nevertheless we continue to report the two indices remaining in common use; HSMR and SHMI. HSMR is an index that looks at 56 key diagnoses associated with 80% of in-hospital deaths. SHMI looks at all deaths in hospital regardless of diagnosis, plus all deaths for patients who died in the 30 days following discharge from hospital. SHMI does not adjust for patients who were discharged from hospital with palliative care support in their own home, or a hospice, nor is there a requirement for the patient's death to be related to their previous hospital admission, whilst HSMR does.

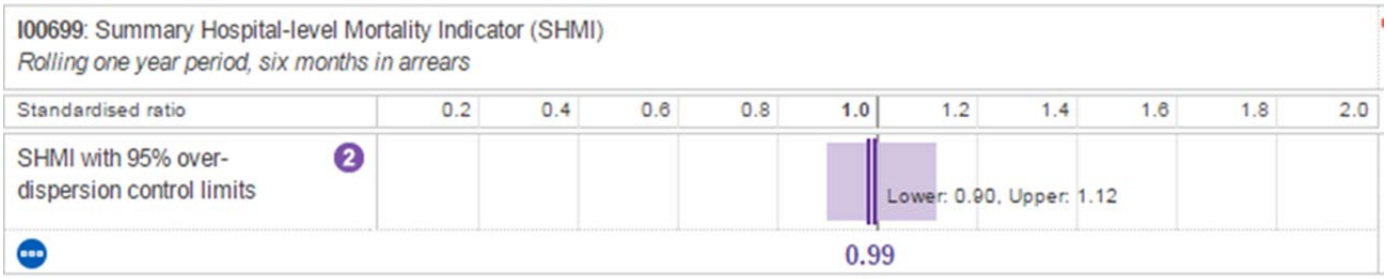
1.2 SHMI seems to be the favoured index, though we need to move towards the requirements of "Learning from Deaths" now.

1.3 DGNHSFT MORTALITY INDICATORS

1.3.1 SHMI – NHS Digital

The latest SHMI published by NHS Digital is for the period January 2016 to December 2016 gives a value of 0.98 which is below the national average and shows the continuing improvement by the Trust against this indicator.

Summary Hospital-level Mortality Indicator (SHMI) • January 2016 - December 2016



1.3.2 <u>SHMI – HED</u>

The HED benchmarking tool allows us to view SHMI at a slightly more up to date period. However, it must be noted there may be a slight difference between this value and any finally NHS Digital published value due to rebasing and other data cleansing via HES and is therefore indicative only.

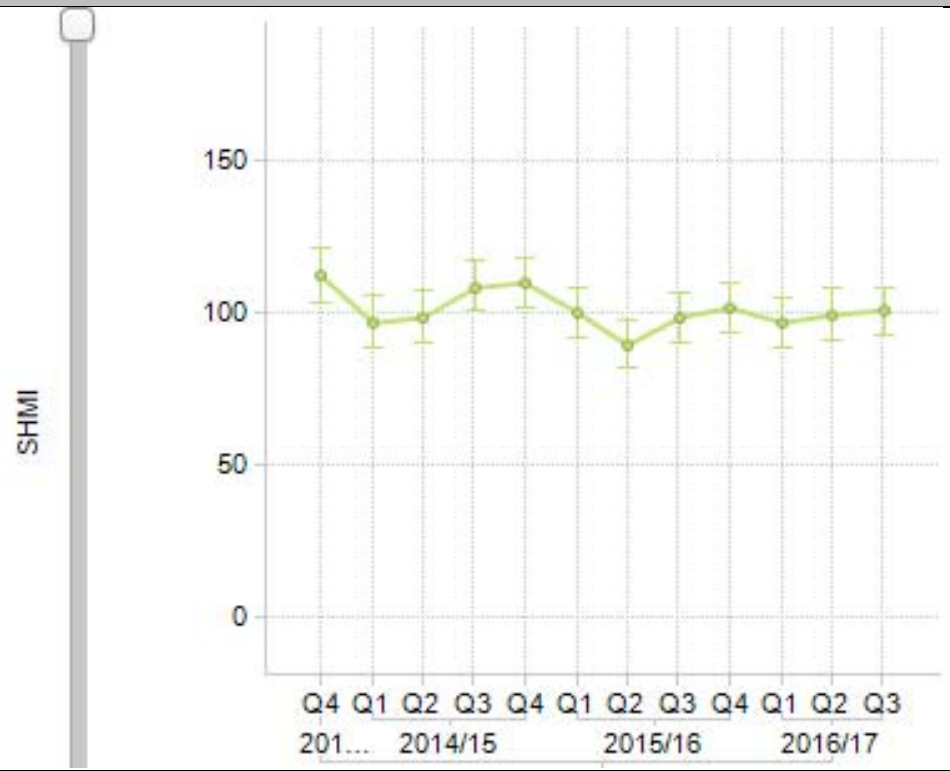
For the period March 2016 to February 2017 the SHMI value is 1.00, placing the trust 56th best performing out of 136 acute Trusts, and 2nd out of 14 Trusts in our regional peer group.

1.3.3 <u>HSMR – HED</u>

For the period 2016 to February 2017 the HSMR value for the Trust is 101, just above the national average, placing us 66th of 136 acute Trusts, and 6th out of 14 Trusts in our regional peer group.

Note: We report these placings for interest; there is no scientific basis for comparing care in Trusts using these indices.

SHMI CURRENT POSITION



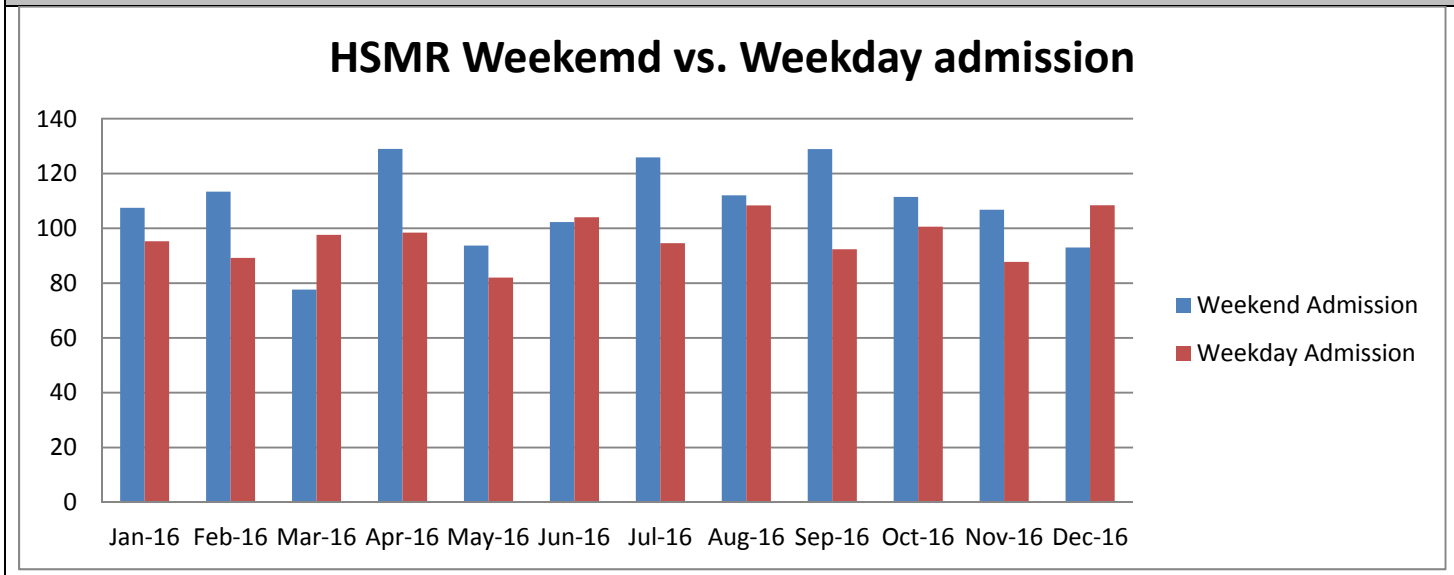
SHMI Compared to Peers Latest Publication Period	
Peers	**SHMI**
HEFT	0..98
THE DUDLEY GROUP	0.99
BURTON	1.00
SHREWSBURY AND TELFORD	1.01
UNIVERSITY HOSPITALS NORTH STAFFS	1.01
SANDWELL AND WEST BIRMINGHAM	1.03
WALSALL	1.04
UNIVERSITY HOSPITAL BIRMINGHAM	1.04
WORCESTERSHIRE ACUTE	1.08
SOUTHWARWICKSHIRE	1.08
GEORGE ELIOT	1.11
UNVERSITY HOSPITALS COVENTRY AND WARWICK	1.12
ROYAL WOLVERHAMPTON	1.12
WYE VALLEY NHS TRUST	1.20

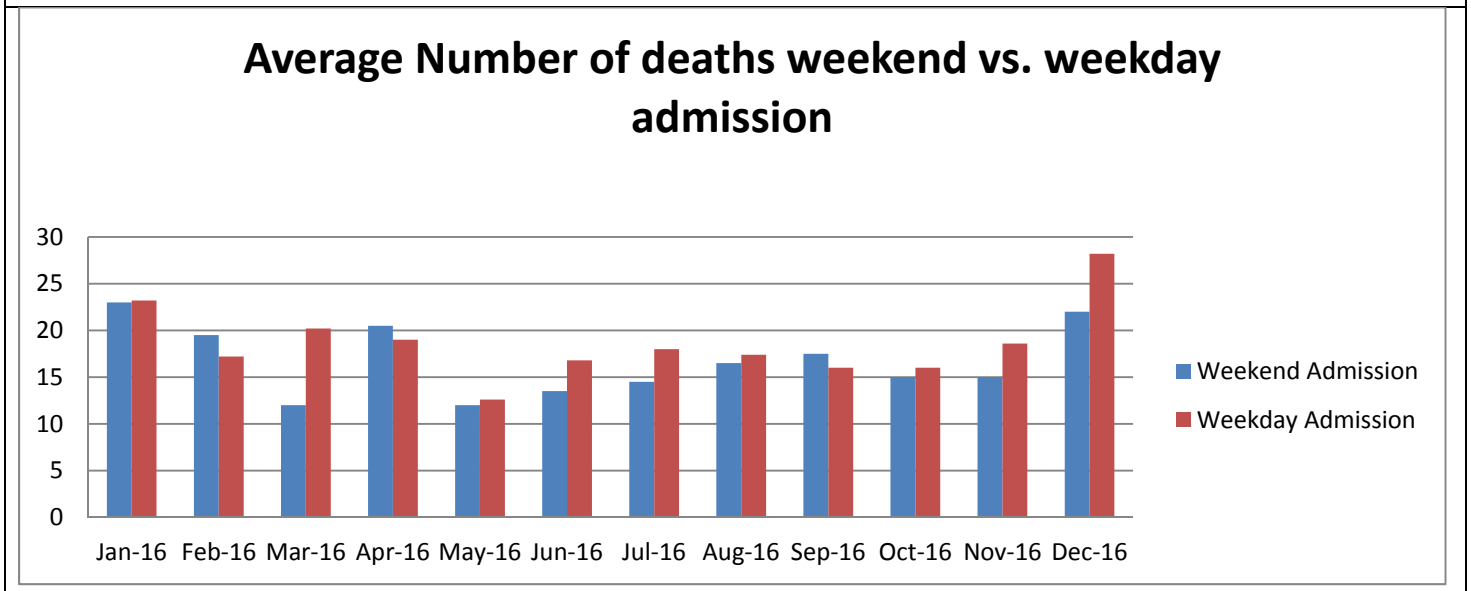
NHS Digital SHMI is taken from HES data and subsequently linked to ONS data for out of hospital mortality and is published as a rolling 12 months figure, quarterly and at least 6 months in arrears.

DGH SHMI has been decreasing over a series of reporting periods over the last 3 years. For the last reporting period 70.85% of deaths are identified as occurring in hospital, as compared to 70.42% in the last report.

Source: HED Monthly SHMI

WEEKEND MORTALITY





Weekend mortality is recognised as a contentious issue give Seven Day Services.

Mortality data demonstrates that there does not appear a consistent variance between mortality for patients admitted on weekends or weekdays, however in the majority it is lower for weekdays.

Month	Weekend HSMR	Weekday HSMR
Jan-16	107.5	95.25
Feb-16	113.41	89.22
Mar-16	77.63	97.64
Apr-16	128.95	98.41
May-16	93.73	82.01
Jun-16	102.27	104.05
Jul-16	125.86	94.6
Aug-16	112.03	108.36
Sep-16	128.9	92.34
Oct-16	111.45	100.6
Nov-16	106.79	87.72
Dec-16	92.99	108.4

The graph opposite (average deaths weekend vs. weekday) shows the total number of deaths for patients admitted on weekends and weekdays divided by the appropriate number of days to give a comparative average (i.e. deaths per month for weekday admitted patients divided by 5 days)

1.3.4 Additional observations from the list of Diagnosis Groups: Top 10
(Period January 2016 to December 2016)

Diagnostic Group (SHMI)	Spells	Expected Deaths	Observed Deaths	Excess	SHMI
Septicaemia (except in labour), Shock	491	107.79	139	31.21	128.96
Fluid and electrolyte disorders	479	38.09	54	15.91	141.77
Liver disease; alcohol-related	113	15.9	29	13.1	182.35
Acute cerebrovascular disease	684	112.67	124	11.33	110.06
Gastrointestinal haemorrhage	564	35.06	46	10.94	131.21
Secondary malignancies	183	41.19	51	9.81	123.81
Pleurisy; pneumothorax; pulmonary collapse	232	16.76	26	9.24	155.12
Congestive heart failure; non-hypertensive	674	98.03	106	7.97	108.13
Deficiency and other anaemia, 60 - Acute post-haemorrhagic anaemia	327	13.06	21	7.94	160.8
Fracture of neck of femur (hip)	532	46.09	53	6.91	115

Septicaemia: The CQC has notified us recently that it requires no further action following our reviews last year. Both the coding and diagnosis of septicaemia are changing and we need these changes to work through before seeing whether we need to specifically re-address this group. Letter from CQC Appendix 3.

Fluid and electrolyte disorders: An extensive review in 2016 revealed that this was indeed a common primary diagnosis of acute admissions. It usually indicated dehydration/frailty and was associated with multiple comorbidities. The actual fluid and electrolyte disorder was normally promptly treated and not the primary cause of death.

Acute Cerebrovascular Disease: Includes conditions other than Stroke as reported to SSNAPP

Liver Disease; Alcohol related: This condition group has been the subjects of previous alerts and will be monitored monthly.

Pleurisy; pneumothorax; pulmonary collapse; Twenty three of these cases have been reviewed in detail by two respiratory consultants. The primary diagnosis is misleading as to the cause of death. 12 metastatic cancers, 7 pneumonia/emphysema, 2 primary cardiac problems, 1 C *diff* and CRF, 1 neutropenic sepsis.

#NOF: This is also monitored at Surgical Division Performance monthly meetings and the trend is significantly down in recent months beyond this reporting period.

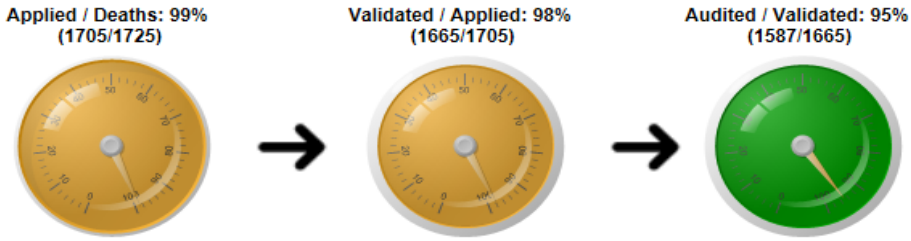
1.3.5 Crude Mortality Monitoring by Month:

NOTE: Crude Rate (Deaths/Discharges) is No. Deaths/Total No. of discharged spells (excl. Well Babies)

Month	Performance			
	Discharges	Hospital Inpatient Deaths	Per 1000 discharges	Crude Rate (Deaths/ Discharges)
Jan-15	11531	241	20.90	2.09%
Feb-15	10384	127	12.23	1.21%
Mar-15	11490	178	15.49	1.55%
Apr-15	11232	178	15.85	1.58%
May-15	11026	156	14.15	1.41%
Jun-15	11633	125	10.75	1.07%
Jul-15	11647	95	8.16	0.82%
Aug-15	10807	117	10.83	1.08%
Sep-15	11065	141	12.74	1.27%
Oct-15	11600	137	11.81	1.18%
Nov-15	11253	141	12.53	1.25%
Dec-15	11533	135	11.71	1.17%
Jan-16	11480	178	15.51	1.54%
Feb-16	11429	138	12.07	1.21%
Mar-16	11794	143	12.12	1.21%
Apr-16	11273	164	14.55	1.45%
May-16	11524	108	9.37	0.94%
Jun-16	11527	122	10.58	1.06%
Jul-16	11434	137	11.98	1.20%
Aug-16	11287	139	12.32	1.23%
Sep-16	11280	133	11.79	1.18%
Oct-16	11313	129	11.40	1.14%
Nov-16	11473	144	12.55	1.26%
Dec-16	12319	180	14.61	1.46%

2. MORTALITY TRACKER SYSTEM

Mortality Tracker reports for the period January 2016 to December 2016



2.1 Mortality Audits

Overall performance for the Trust was 95% of all deaths validated have been audited. Many specialties are performing well with between 90% and 100% audited. However, some specialities, especially those with cross trust working are struggling to achieve satisfactory levels, but note that audit of the case may have been carried out without the tracker audit being completed.

2.2 Audit within 12 Weeks

The Trust has a target that 85% of deaths should be audited within 12 weeks of the coding validation date. For the period the overall Trust performance was 81.6%%, below target but a slight improvement on the previous report at 80.09%

Specialty Description	Validated	Audited within 12 weeks	Percentage Audited within 12 weeks
Rehabilitation	2	2	100.0%
Diabetes	5	5	100.0%
Geriatric Medicine	338	338	100.0%
T&O Rehabilitation	21	21	100.0%
Cardiology	60	58	96.7%
Trauma & Orthopaedics	42	40	95.2%
Endocrinology	9	8	88.9%
Gastroenterology	135	118	87.4%
Renal	66	57	86.4%
Respiratory	246	211	85.8%
General Medicine	148	118	79.7%
Stroke Rehabilitation	32	25	78.1%
General Surgery	112	87	77.7%
Medical Assessment	242	177	73.1%
Urology	11	8	72.7%

Stroke Medicine	73	53	72.6%
Accident & Emergency	2	1	50.0%
Neonate	4	2	50.0%
Paediatrics	2	1	50.0%
Haematology	17	8	47.1%
Vascular Surgery	41	15	36.6%
Haematology (Clinical)	16	4	25.0%
Endoscopy	1	0	0.0%
Clinical Oncology	25	0	0.0%
Medical Oncology	10	0	0.0%
Gynaecology	3	0	0.0%

Going forward, we shall request a brief report from departments falling below 80% on this measure both for assurance and to check whether there are fixable problems using the tracker.

2.3. Overall View of Responses, Level One (Departmental) Reviews

Mortality Questions Summary Created on 19/06/2017 14:51:25. Deaths Between 01/01/2016 and 31/12/2016 for specialty 'ALL SPECIALTIES'

Question (Audit Form v3)	Yes	No	None	Total
1) Is it clear from the notes that a plan of care was made on admission by a doctor of sufficient seniority?	1589	5	0	1594
2) Was there a delay in any investigation, procedure, operation or referral, or failure to respond to a result or report which affected outcome?	26	1568	0	1594
3) Were there any identifiable actions taken that could have contributed to death?	10	1584	0	1594
4) In your judgement, is there some evidence that the patients death was avoidable?	1	1593	0	1594
4.1) Has it been reported on Datix?	3	1	1590	1594
4.2) Is the RCA available?	1	2	1591	1594
5) In the opinion of the review team, was there a perceived deficiency of care from another department which may have contributed to death?	11	1583	0	1594
5.1) Is evidence available that it has been reviewed with the department involved?	3	10	1581	1594
6) Was the patient admitted <24hrs before death from a care home? (Please note care home in free text)	72	1522	0	1594
7) Was the patients' ward location appropriate?	1571	23	0	1594
8) Have any/all learning points from the review of this death been shared throughout your department?	1010	584	0	1594
9) Are there any learning points which should be shared more widely?	47	1547	0	1594
9.1) Has your department taken action to share these learning points more widely?	39	5	1550	1594
10) Was appropriate end of life care provided; this includes appropriately noted discussion with patient/family, noted treatment limitations and appropriate adherence to treatment limitations.	1578	16	0	1594
TOTAL	**5961**	**10043**	**6312**	**22316**

2.4 Work is proceeding to integrate the review process for paediatric and ED deaths into the Tracker. Paediatrics already uses the Tracker questionnaire, though not the adult level 2 escalation. ED deaths are not “inpatient deaths”, though they are all reviewed by the department. A structured review appropriate for these is in consideration by the College of Emergency Medicine.

3. Response to National Guidance on Learning from Deaths

3.1 Because the Trust has been using the Mortality Tracking System for some years now we are well placed to develop fully all the obligations therein. For instance one of the earlier suggestions is that Trusts need to develop a process for deciding which deaths to review, whereas we already review all inpatient deaths.

Nevertheless, the processes listed below will require some development to embed them properly and we will need to learn and adjust along the way.

3.2 Particular attention to deaths of patients with Learning Disability:

Patients known to have LD are flagged on OASIS. The LD nurse will automatically be informed. As well as the standard audit, the LD nurse will review the notes and the case will automatically be subject to a level 2 review.

The LD nurse is already reviewing all such deaths and there have been 7 in the last year.

3.3 Bereaved relatives should have the opportunity to voice any remaining concerns and that any review should take such concerns into account. (This is in addition to the statutory Duty of Candour)

We are liaising with the bereavement group, PALS and Comms to consider placing within the Trust booklet "For you in your loss" (already given to all bereaved relatives) the information that the Trust reviews all deaths and that we would welcome expressions of any concern relating to treatment and will respond.

We have discussed writing to relatives if, for instance, the audit triggers a level 2 review. Obviously this would need a sensitive approach, particularly because a level 2 review does not necessarily imply any failings in care. If we do this we need to appreciate the resource that will be needed to respond appropriately to expressions of concern that may result.

3.4 We should note that the title specifies learning from deaths and acknowledge that there will often be learning even when care has been good. Report from the Tracker for 2016 shows:

- Have any/all learning points from the review of this death been shared throughout your department?
    - Yes 1010/1594
- Are there any learning points which should be shared more widely?
    - Yes 47/1594
- Has your department taken action to share learning points more widely?
    - Yes 39/1594

Specific learning from any case revived at level 2 is captured in detail on the Tracker though specifics are harder to identify in detail from the first level audit. It is planned to further develop the Tracker to record specific learning points identified by departments even if the case is not escalated to level 2 review.

Women and Children's Perinatal Mortality Report Q4:
1st January 2017 to 31stMarch 2017

1. Definitions

Terminations of pregnancy: The deliberate ending of a pregnancy, normally carried out before the embryo or fetus is capable of independent life.

Late fetal death: A baby delivered between 22+0 and 23+6 weeks gestational age showing no signs of life, irrespective of when the death occurred.

Stillbirths: A baby delivered at or after 24+0 weeks gestational age showing no signs of life, irrespective of when the death occurred.

Neonatal death A live born baby (born at 20+0 weeks gestational age or later, or with a Birth weight of 400g or more where an accurate estimate of gestation is not available) who died *before* 28 completed days after birth

- **Early neonatal death**: live born baby (born at 20+0 weeks gestational age or later, or with a birth weight of 400g or more where an accurate estimate of gestation is not available) who died *before* 7 completed days after birth.
- **Late neonatal death**: live born baby (born at 20+0 weeks gestational age or later, or with a birth weight of 400g or more where an accurate estimate of gestation is not available) who died *from* 7 completed days but *before* 28 completed days after birth.

2. Rates

Rates in this report relate to women who received care from the maternity services at the Dudley Group NHS Foundation Trust (DGFT). The total number of births is provided by the Trust Information Officer.

Calculations: All rates are expressed as per 1000 births which is the nationally recognised and expected methodology.

Crude stillbirth rates: Calculated from the total number of stillbirths for the period divided by number of births within the period multiplied by 1,000.

Adjusted stillbirth rates: Calculated from the total number stillbirths for the period less: Multiple pregnancy when one or more fetus has demised preterm but delivered post 24 weeks gestation, Fetal anomalies (incompatible with life) where termination of pregnancy has been declined but delivered a stillbirth. Then divided by number of babies born for the period and multiplied by 1,000

Crude neonatal death rates – Calculated from the total number of neonatal deaths divided by number of live births multiplied by 1,000.

Adjusted neonatal death rates- Calculated from the total number of neonatal deaths less: Babies delivered prior to 24 weeks gestation or with known congenital anomalies, then divided by the number of live births for the period and multiplied by 1,000.

Combined perinatal mortality rates – Calculated by adding the total number of stillbirths and the total number or neonatal deaths for the period, divided by the total number of births within the period multiplied by 1,000.

3. **Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) across the UK Perinatal Surveillance Report of perinatal deaths for births from January to December 2014 (MBRRACE 2016) rates per 1,000 births.**

   MBBRACE within the 2014 report have reported for 2 groups of clinical and administrative organisations relevant to Dudley, the UK rates and Network Trust of Sandwell are included for comparison.

   - **Mortality rates by NHS organisation responsible for population based care commissioning**

   - **Mortality rates for individual Trusts and Health Boards**

2014	Crude stillbirth rate	Adjusted stillbirth rate
UK	4.16%	No adjusted figures for UK available on MBRRACE
Sandwell & West Birmingham	6.34%	4.67%
Dudley Organisation (Russells Hall hospital)	3.88%	3.81%
Dudley Clinical Commissioning Group	3.45%	3.92%

The above rates were launched by MBRRACE in the Perinatal Surveillance report 2014, published May 2016; there is no recent data available.

4. **Dudley Group NHS Foundation Trust rolling annual stillbirth rate for babies born within the organisation of Russell Hall hospital**

   Births for this period = **4497**

Rolling annual period 01/04/16 to 31/03/17	Crude total	Crude annual rate	Adjusted total	Adjusted rate
Stillbirths	16	3.56%	13	2.89%
Twin death	1			
Fetal anomaly but declined TOP	2			
Undiagnosed congenital anomaly	0			

Dudley Group NHS Foundation Trust Quarter 4 stillbirth rates

Births for this period = **1064**

Quarterly 4 period 01/01/17 – 31/03/17	Crude total number	Crude stillbirth rate for period	Adjusted total number	Adjusted stillbirth rate for period
Stillbirths	5	4.70%	3	2.82%
Twin death	1			
Fetal anomalies but declined TOP	1			
Undiagnosed congenital anomaly	0			

Analysis of stillbirths in this quarter:

There were 5 stillbirths during this quarter including:

INC 15518
Woman admitted to delivery suite with confirmed IUD. Scan performed at BWH 10/2/16. 38+2 weeks gestation and previously booked at RHH. Care was transferred to BWH at 34 weeks gestation due to Cardiac anomaly (Ebstein's Anomaly).

Level 1 investigation undertaken as agreed at maternity MDT meeting. IOL and SB on 10/02/17 38+3. MDT agreed all care appropriate, no care or service delivery issues identified.

Learning identified: No Care, service or delivery issues identified at maternity MDT meeting.

Post mortem –declined
A post mortem has been declined. This case is scheduled to be presented at the Women and Children's Perinatal Audit Meeting for shared learning 13th June 2017.

INC 15983
IUD found during planned ANC appointment, admitted to delivery suite with confirmed IUD, the woman had attended diabetic clinic earlier in day where no FHR was audible. IUD confirmed at 38+1 weeks gestation P0. Type 1 Diabetic, smoker. Induction of Labour commenced as per protocol. Patient declined Mifepristone.

Level 2 investigation as agreed by MDT. Poor controlled Diabetic, HBA1C result 77 the day before admission. The woman DNA several diabetes appt. Declined

CGMS monitoring on 2 occasions. Birth weight plotted above 90th Centile consistent with poorly controlled diabetes. MDT agreed appropriate care provided. No care, service or delivery issues identified.

Learning Identified No care, service or delivery issues identified no learning identified.

Post mortem –declined

A post mortem has been declined. This case is scheduled to be presented at the Women and Children's Perinatal Audit Meeting for shared learning 13th June 2017 .

INC16087

Attended DAU at 27+3 with DFM confirmed IUD by two sonographers. Breech stillbirth.

Level 1 investigation as agreed by MDT at SIRS. Appropriate care provided no care, service or delivery issues identified.

Learning Identified No Care, service or delivery issues identified at maternity MDT meeting.

Post mortem –declined

A post mortem has been declined, however placenta sent to BWH for histology. This case is scheduled to be presented at the Women and Children's Perinatal Audit Meeting for shared learning on 13th June 2017

INC 16826

A twin pregnancy, delivered on 08/03/17 at 34/40. Twin 1 was a confirmed IUD at 27+5 by scan, booked for elective LSCS however admitted in spontaneous labour progressing rapidly and transferred to theatre for EMCS. Twin 1 Still Birth delivered at 13.34. (Twin II NVD delivered at 13.37 and required basic resuscitation. The baby was transfer to NNU due to gestation).

Level 1 investigation undertaken as agreed at the maternity MDT meeting. MDT agreed all care appropriate, no care or service delivery issues identified.

Learning identified: No Care, service or delivery issues identified.

Post mortem – Accepted

A post mortem has been accepted. This case is scheduled to be presented at the Women and Children's Perinatal Audit Meeting for shared learning 13th June 2017.

INC 17607

34+1 IUD woman attended triage with ? SROM and DFM since the previous evening. No fetal heart present therefore USS performed and IUD confirmed. Admitted to HDU for observations due raised BP.

Level 2 investigation undertaken as agreed at the maternity MDT meeting. MDT agreed all care appropriate, no care or service delivery issues identified.

Learning identified: No Care, service or delivery issues identified. However incidential findings - second USS was booked for 36/40 Obstetric Consultant stated a USS at 32 or 34 weeks gestation would have been more appropriate. This may have indicated reduced growth however this is unknown

Post mortem – Accepted

A post mortem has been accepted. This case is scheduled to be presented at the Women and Children's Perinatal Audit Meeting for shared learning 13th June 2017

5. Reporting and escalation

Monthly stillbirth rates are reported on the maternity clinical dashboard which is reviewed within the monthly Maternity Governance Meeting and Maternity Quality and Governance Meeting.

All stillbirths and neonatal deaths are reported through the Trust Datix platform. These incidents are reviewed at a weekly Serious Incident Review meeting where the case notes are reviewed by the multidisciplinary team to determine any, care delivery or service issues that have caused harm.

If harm is identified the incident is reported to the NHS Midlands and East via the Strategic Executive Information System (STEIS). The RCA is submitted via Trust Governance to the Central Support Unit (CSU), who receives these on behalf of the Clinical Commissioning Group (CCG). A Supervisor of Midwives review is undertaken for all cases. An external expert review is commissioned proactively bi-annually and when there is any significant trend or rise in rate is noted.

Where no harm is identified gestation determines the level of investigation performed and subsequent escalation pathway:

24-28 weeks gestation:	Review by MDT at SIRS Meeting Complete a Level 1 Datix investigation Reviewed at Maternity Risk Meeting Reviewed by a Supervisor of Midwives Reported to MBRRACE Presented at Maternity Clinical Governance Meeting
28 weeks to Term gestation:	Review by MDT at SIRS Meeting Complete a Level 2 investigation Reviewed at Maternity Risk Meeting Reviewed by a Supervisor of Midwives Reported to MBRRACE Presented at Maternity Clinical Governance Meeting
If Harm is identified:	Complete Level 3 Investigation (complete RCA) Perform Duty of Candour with 10 days of the incident Reviewed by a Supervisor of Midwives Reported to MBRRACE Reviewed at Maternity Risk Meeting Presented at Maternity Clinical Governance Meeting

6. Neonatal deaths (early 0-7 days of age)

Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) across the UK Perinatal Surveillance Report of Perinatal deaths for births from January to December 2014 (MBRRACE 2016) rates per 1,000 births.

MBBRACE within the 2014 report have reported for 2 groups of clinical and administrative organisations relevant to Dudley, the UK rates and Network Trust of Sandwell are included for comparison.

2014	Neonatal death rates	Adjusted neonatal death rates
UK	1.77%	No adjusted figures for UK available on MBRRACE
Sandwell & West Birmingham	2.35%	1.52%
Dudley Organisation (Russells Hall hospital)	1.83%	1.35%
Dudley Clinical Commissioning Group	2.39%	1.87%

The above rates were published by MBRRACE in the Perinatal Surveillance report 2014, published May 2016.

7. Dudley Group NHS Foundation Trust Rolling Annual Neonatal Death (early) rates for babies born within the organisation of Russell Hall hospital

Total live births for the period: 4491

1st April 2016 to 31st March 2017	**Crude neonatal death rate**	**Adjusted neonatal death rate**
Dudley Organisation (Russells Hall hospital)	1.34% (6)	0.22%(1)

8. Dudley Group NHS Foundation Trust Quarter 4 Neonatal Death rates (early).

Total live births for this period = **1059**

Quarterly period 1/01/17 – 31/03/16	Total for period	Crude Neonatal Death Rate	Adjusted Neonatal Death Rate
Neonatal Deaths	2	1.89%	0.94%

There were 2 neonatal deaths during this quarter:

INC15112
26+5 week gestation Neonatal Death at I hour and 41 minutes of age. Primiparous 14 year old, booked consultant led care, self-referred to triage with APH, admitted to delivery suite. Delivery expedited by EMCS Cat 1.
Level 2 investigation as agreed at maternity MDT meeting. No care or service delivery issues identified. All care considered appropriate.

Learning identified: No Care, service or delivery issues identified at maternity MDT meeting.

Post mortem –declined
A post mortem has been declined. This case is scheduled to be presented at the Women and Children's Perinatal Audit Meeting for shared learning June 2017.

INC15112
33+6 week gestation Neonatal Death at 60 minutes of age following spontaneous labour.
Level 1 investigation completed.
Major congenital abnormalities detected through screening at mid t scan including: Contralateral renal agenesis, Anhydramnios, Dolichocephaly. Termination of pregnancy was offered however declined by the parents.
Learning identified: No Care, service or delivery issues identified.

Post mortem –declined
A post mortem has been declined; this case has been presented at the Women and Children's Perinatal Audit Meeting for shared learning and no further learning has been identified when reviewed by the wider MDT.

9. MBRRACE 2014 Perinatal Mortality Rates as published (May2016).

2014	Crude mortality rate	Adjusted mortality rate
UK	5.38%	No adjusted figures for UK available on MBRRACE
Sandwell & West Birmingham	8.43%	5.73%
Dudley Organisation (Russells Hall hospital)	5.71%	5.15%
Dudley Clinical Commissioning Group	5.83%	5.85%

The above rates were launched by MBRRACE in the Perinatal Surveillance report 2014, published May 2016.

10. Dudley Group NHS Foundation Trust Perinatal combined mortality rates (combined stillbirth and neonatal deaths).

	Total births for period	Crude mortality rate	Adjusted mortality rate
Rolling annual rate:1/4/16 - 31/3/17	4497	4.89%	3.11%
Quarter 1 rate: 1/04/16 – 30/06/16	1108	4.51%	3.61%
Quarter 2 rate: 1/07/16 – 30/09/16	1226	3.26%	2.45%
Quarter 3 rate: 1/10/16 – 31/12/16	1098	3.64%	3.64%
Quarter 4 rate: 1/01/16 – 31/03/17	1064	6.58%	3.76%

11. Conclusion

The Trust rolling annual crude still birth is 3.56% this is 0.6% lower than the UK 2014 rate published by MBRRACE in 2016.

The Quarter 4 crude stillbirth rate has been calculated at 4.70% which compares unfavourably to the UK rate of 4.16% reported through MBRRACE (2016). However the adjusted still birth rate of 2.82%. This is due to considerations of twin demise, cardiac anomaly and congenital abnormalities.

The Quarter 4 Trust rolling annual crude neonatal death rate is 1.89%. This is 0.12% higher than the UK reported rates. On review the Trust adjusted neonatal death rate is considerably lower than the UK rates at 0.94%. This is due to considerations of a known congenital abnormality and Pre-viable gestations.

The combined crude mortality rate for the rolling annual period is 4.89% this is favourably 0.49% below the UK rate. The adjusted combined mortality rate is 3.11%.

Quarter 4 combined crude mortality rate is 6.58% this compares unfavourably at 1.2% higher than the UK rate. The adjusted rate is 3.76%.

All cases of stillbirth and neonatal death are reported to Mothers and Babies Reducing Risk Through Audit and Confidential Enquiry (MBRRACE). This is a data collection system for the national surveillance of late fetal losses, stillbirths, infant deaths and maternal deaths

The crude stillbirth rate is a calculation of all stillbirths including termination of pregnancy, multiple pregnancies, where one fetus has died or where fetal anomaly has been diagnosed and a termination of pregnancy has been declined but a stillbirth ensues. The adjusted stillbirth rate gives a more meaningful rate than the crude stillbirth rate by excluding these factors.

There have been 5 stillbirths for this quarter, a trends analysis matrix is used to continually monitor, analyse and identify trends in care delivery or, service issues. No harm was identified with these cases and level 2 investigations were carried out in accordance with the Trust incident process. No trends have been identified to date.

All still births and neonatal deaths are reported through the Trust Datix platform. These incidents are reviewed at a weekly Serious Incident Review meeting where the case notes are reviewed by the multidisciplinary team to determine any care delivery or service issues that have caused harm.

If harm is identified the incident is reported to the NHS Midlands and East via the Strategic Executive Information System (STEIS). The RCA is submitted via Trust Governance to the Central Support Unit (CSU), who receives these on behalf of the Clinical Commissioning Group (CCG).

For all cases where harm has been identified an action plan is formulated and the completion of all actions are monitored through the weekly Maternity Governance Meeting and presented at the Women and Children's Perinatal Audit meeting to the multidisciplinary team to inform and share any learning outcomes.

The Trust contributes to the national 'Every Baby Counts' project, which is coordinated by the Royal College of Obstetricians, this initiative is designed to review all cases of intrapartum fetal loss and to learn from the analysis to reduce future risk and poor outcomes.

Report compiled by:
Tracy Archer and Sarah Gibbs
Specialist Midwife
Clinical Governance & Risk
Reviewed and endorsed at the Maternity Governance Meeting

OFFICIAL SENSITIVE

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Roger Callender, Deputy Medical Director
The Dudley Group NHS Foundation Trust
Trust Headquarters, Russells Hall Hospital
Pensnett Road
Dudley, West Midlands
DY1 2HQ

3 May 2017

Our reference: A867/TG, A981/TG and A1037/JC

Dear Mr Callender

Re: Imperial College Dr Foster mortality outlier alerts for 'septicaemia (except in labour)' at The Dudley Group NHS Foundation Trust

As you are aware, the Care Quality Commission has been notified on three separate occasions that data held by Imperial College has indicated significantly high mortality rates for patients admitted with 'septicaemia (except in labour)' at your trust. We wanted to be certain that the high mortality rates in this area had been recognised, explanations explored and appropriate actions taken by the trust in a timely manner to ensure the future safety of patients.

We previously wrote to you on 20 May 2015 (Our Ref: A867/TG) and 9 September 2016 (Our Ref: A981/TG) to inform you that these two outlier alerts had been passed to your local CQC inspection team who would follow up on your progress with implementing your planned actions. Your local inspector has now confirmed that they are satisfied that sufficient action has been taken to reduce the risks to patients in relation to issues identified by your reviews of the alerts. As a result, both of these outlier cases have now been closed.

We are also aware that you recently received a further letter from the Dr Foster Unit at Imperial College London, in January 2017, regarding mortality rates for patients admitted with 'septicaemia (except in labour)' at your trust (Our Ref: A1037/JC). We have concluded that we do not need to undertake further enquiries at this time and I can confirm that this outlier case is also now closed.

Should you become aware of any further issues relating to these alerts, we would ask you to let us know.

This letter will be shared with your Care Quality Commission local inspection team contacts, NHS England, NHS Improvement and your local Clinical Commissioning Group for their information.

If you would like to discuss the content of this letter in more detail, please contact Melissa Williams (Analyst Team Leader) on 020 7448 9321.

Yours sincerely

Hamish Young
Interim Head of Provider Analytics (Hospitals)
outliers@cqc.org.uk

cc: Diane Wake – Chief Executive – The Dudley Group NHS Foundation Trust
Kathleen Delholm – Inspector – Care Quality Commission
Angela Martin – Inspection Manager – Care Quality Commission
Tim Cooper – Head of Hospital Inspection (Central West) – Care Quality Commission
Dr Paul Watson – Regional Director (Midlands and East) – NHS England
Dr David Levy – Regional Medical Director (Midlands and East) – NHS England
Dr Lynne Wigens – Regional Chief Nurse (Midlands and East) – NHS England
Sylvia Knight – Deputy Chief Nurse (Midlands and East) – NHS England
Alison Tonge – Director of Commissioning Operations (West Midlands) – NHS England
Dr Kiran Patel – Medical Director (West Midlands) – NHS England
Rebecca Farmer – Delivery and Improvement Lead (Midlands and East) – NHS Improvement
Dr David Hegarty – Chair – NHS Dudley Clinical Commissioning Group

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board July 2017

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

CORPORATE OBJECTIVE:

SO1, SO2, SO3, and SO4

SUMMARY OF KEY ISSUES:

- Overview of actions from 2016 Annual Report
- Fire Safety Overview
- Medical Devices – Trust Compliance
- H&S Work plan 2017/18
- Fire Work plan 2017/18
- Incident Data

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 West Midlands Fire Service

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD:
To **NOTE** the contents of the report
To **APPROVE** the Health and Safety Work Plan for 2017/18
To **APPROVE** the Fire Safety Work Plan for 2017/18

OVERVIEW

This report is presented to the Board to give an overview of the actions completed during 2016/17 identified in the previous year's report and the work plan for Health and Safety and Fire for 2017/18. The report also contains a brief overview of the reactive health and safety incident data. .

Actions from 2016/17 Report

Health and Safety Meeting Structure

In July 2016 the Health and Safety Group structure was changed to incorporate fire as a standard agenda item, this is to ensure that there is a suitable forum for all issues relating to fire to be monitored.

The group has also been divided into two levels giving a consultation group for the departmental representatives and a senior group chaired by the COO, that requires assurance of compliance with H&S policies, escalation of concerns and issues and monitoring of the annual work plan.

Health and Safety Audits

During 2016/17 6 policies and 3 procedures were updated and 2 new policies developed following a Regulatory review.

Compliance reviews have been undertaken within the following areas and advice given to the H&S leads:-

C2
Neonates
Maternity
Centafile
Dermatology
Main Theatres

As the policies are still under review and there has been a significant change in the approach to the assessment process, the full management audits of the local areas will not be implemented until approximately 2018/19, this is to enable departments to implement the policy changes and bring documentation up to the relevant standard.

Health and Safety Training

The training calendar for 2016/17 was implemented at the beginning of April 2016 and during the course of the year the following numbers of people have been trained in H&S specific assessment processes:

Risk Assessment	34 people
Stress risk assessment	22 people
DSE assessment	3 people
COSHH assessment	4 people
FFP3 face fit testing	35 people

Following review of the feedback and attendance on the courses the following changes have been made for the forthcoming year 2017/18:

Stress	This course has been reduced from a full day to half a day's session
DSE	This course has now been designed as an e-learning package
COSHH	The number of courses has been reduced to 2 per annum

Management training was going to be delivered as IOSH standard, however review of the training package identified that there was little relevance to Healthcare. A training package has been developed that is aimed specifically at Managers / Leads that identifies the legal requirements and the policy standards, giving a more specific and tailored address as to what Managers are expected to achieve.

The training calendar for 2017/18 is now available on the Health and Safety page on the HUB.

Fire Safety Action Plan Update

Following the actions arising from the Fire Safety audit completed during February 2016 the following actions have been satisfied.

Risk Assessments
Fire risk assessments have all been reviewed and updated onto the HTM template. Review plan is in place and in progress.

Fire Training
Fire mandatory training has been reviewed and the new process has been implemented with effect from 1st April 2017.

Fire training for identified leads and site co-ordinators has been developed and implemented.

Emergency evacuations equipment training is available for relevant staff.

West Midlands Fire Service have approved a request for the Trust to implement competency based train the trainer training for staff, this will enable the Trust to have access to more resources for the delivery of fire training. The first training session is scheduled for May 2017.

Inspections / Audits
Monthly fire inspections have been updated and the SOP is due for presentation at the Policy Group in June for formal adoption.
Compliance will be monitored as part of the fire risk assessment process.

Policy / Procedure
Fire policy and procedures were updated as an interim measure during 2016 with full review currently in progress, these are due for presentation at Policy Group in June.

Fire Instruction Notices
These have been updated and MC is supporting the move to the new format throughout RHH, Corbett and Guest.

External fire audit.
Actions identified through the external audit completed by Fegus Fire have been satisfied and closed.

Medical Devices – Trust Compliance

A review of the Trust Medical Devices has been undertaken and it has been identified that there are currently 1910 devices that are outside of their service date.

These devices have been risk assessed and currently the Trust has identified that 85 of these devices present a high risk whilst 1789 present a medium risk and 39 low risk.

The high risk devices are within the Main Theatres and Day Surgery Unit, they are anaesthetic machines and gas modules, in which Siemens are targeting with a deadline of two weeks to ensure the equipment is serviced and the asset register updated. An out of hours visit is being scheduled to further assist with this equipment being serviced.

Immediate Action
The Medical Devices Manager and Siemens representative are visiting wards and departments to actively look for equipment which is out of service date, this is then logged for repair / service. Maintaining an action log of equipment and issues found and ensuring that all equipment has a service label and Siemens asset label attached. Siemens are sourcing additional engineering resources to address the issue.

Actions
The overall system will be changed moving forward to incorporate a follow up report being issued to the local departments two weeks after the initial service visit advising of the equipment that was not available. The Siemens engineer will be visiting the area after a further two weeks to actively search for the equipment. Following the audit equipment that is not located and has not been seen since 2015 with agreement

from the Lead Nurse for the area, the device will be changed to inactive on the asset inventory. If located at another time the device will be reactivated on the asset inventory.

Health and Safety Work Plan 2017/18

The HSE Strategy for 2017/18 is more of a focus on the effects of work on health. Within the Healthcare sector the two main key points are:-

- **Musculoskeletal – DSE**
- **Stress**

In addition to the above key topics; noted below are further points within HSE Strategy that will also be targets included within the work plan:-

- **Management of Dermatitis**
- **Management of Sharps Review**
- **Diathermy fume release through treatment**

Action – DSE
Departments to identify DSE Assessors to undergo the training Assessments to be completed for all relevant staff Compliance inspection to be undertaken

Action – Stress
Department to identify suitable assessors to undergo the training provided Assessments to be completed for all departments Compliance inspection to be undertaken

Action – Dermatitis
Risk register entry to be completed Identification of any other substances used within the Trust that causes or contributes to the disease Identification of sole supplier for hand wash, hand gel and moisturiser Moisturiser to be made available in all relevant areas Skin health surveillance to be undertaken Investigations to be completed for any reported and diagnosed cases of Occupational Dermatitis

Action – Safer Sharps
Ensure policy standards are still viable and achievable Inspection of practice being adopted operationally is in line with the requirements of the policy. Monthly review of incidents reported between SHW to ensure accurate and detailed reporting RIDDOR reportable dangerous occurrences to be investigated with clinical skills team to ensure compliance with training Review of trust wide risk assessment for safer sharps Identification of non-safe sharps in use and ensuring suitable and sufficient risk assessments are in place.

Action – Diathermy Fume
Review of the equipment used and the environmental controls Risk assessment to be completed under COSHH to identify extent of risk Control measures to be identified and implemented if viable

Fire Work Plan 2017/18

In addition to the maintenance of the training and assessment programme the four factors noted below will be the main focus of the work activity moving forward this financial year:

- **Identification of all compartmentation / change of use breach (Trust Responsibility)**
- **Community Fire Training**
- **Community Fire Inspections**
- **Fire Evacuation Drills**

Action – Compartmentation / Change of use breach
Identify all areas of breaches that have been caused by unauthorised changes of room use.

Obtain costs for the corrective works to be undertaken. Potential risk register entry to be raised Process to be developed Trust wide that prevents unauthorised changes of use from being undertaken.

Action – Community Fire Training
Identify the most suitable and sufficient method of delivering Fire training to the community teams whilst still maintaining compliance with Fire Code HTM series.

Action – Community Fire Inspections
Develop a community fire inspection checklist as a monitoring tool to ensure that measures are in place to ensure the safety of staff and patients.

Fire Evacuation Drills
Identification of the most suitable departments where evacuation exercises can by undertaken. Schedule to be agreed with the senior teams Implement schedule to audit the effectives of fire safety arrangements.

Incident Data April 16 – March 17

The table gives an overview of the total number of incidents affecting staff reported during 2014/15, 2015/16 and 2016/17.

Incident Category	Incidents during 2014/15	Incidents during 2015/16	Incidents during 2016/17
Manual Handling	88	26	26
Needle sticks and Sharps	162	96	116
Exposure to hazardous substances	54	26	54
Slips, Trips and Falls	96	66	84
Collisions and Contacts	81	42	42
Total number of reported incidents	481	256	322

The figures indicate that there has been an increase of 26% in the total number of incidents reported across the group in comparison to last year.
During the year 2016/17 there has been a targeted approach to ensuring all incidents are reported so that the information gathered by the Trust is a true reflection of the occurrences within the business. Therefore there is no concern in regards to the increase.

In comparison to last financial year there has been an increase in the following reported incidents:-

Needle Sticks	21% Increase
Exposure to Hazardous Substances	108% Increase
Slips, Trips and Falls	27% Increase

Collision and contact and manual handling incidents maintained across the year.

There has been no reduction in any category.

ACTION:
The work being implemented as part of the safer sharps focus will address the increase in needle sticks and exposure incidents. The interventions implemented as part of this project should instigate a reduction over the coming period.

RIDDOR Data:

Incident Category	Incidents during 2014/15	Incidents during 2015/16	Incidents during 2016/17
Over seven day injury	11	13	11
Dangerous Occurrence	6	2	4
Disease	0	1	0
Major Injury	1	1	1
Major Injury to Patients	27	17	20*
Total number of RIDDOR Reports	45	34	36

* At the time of compiling this report a further 2 RCA reports were outstanding to await determination of reporting requirement.

During the year 2016/17 there were 35 reports submitted to date to the Health and Safety Executive under RIDDOR. This is a slight increase of 6% as there were 2 additional reports; however it is noted that there are further incidents under review that may alter the final reported number.

The data shows that the number of major injury's sustained by patients whilst receiving NHS funded care has increased, the extent of the increase is yet unknown and as such cannot be quantified.
The introduction of the CQC Enforcement Policy and the changes under the Memorandum of Understanding is moving the focus of investigations from HSE to CQC.
As the guidance is clinically based in respect to the determination of reporting due to being based upon care planning, a discussion is currently underway to move the decision making process to report patient falls under RIDDOR to the Senior Nursing team.
The Trust has a focus on patient falls and a number of clinical interventions are being implemented to support the drive to gain a reduction on falls.

In regards to incidents affecting staff there has been a slight but continued decrease in the number of incidents relating to staff with a reduction of 1 totalling a 6% decrease.
There has been a decrease in the number of incidents reported following absence or restrictions for over seven days; however an increase in the numbers of dangerous occurrences which are needle stick and exposure related incidents.

ACTION:
With the focus on safer sharps and exposure incidents all RIDDOR reportable incidents relating to dangerous occurrences will be investigated to identify the root cause and to implement measures to reduce re-occurrences across the Trust.

CONCLUSION

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

Enclosure 10

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 6 July 2017

TITLE	**Charitable Funds Committee Summary**		
AUTHOR	**Julian Atkins** **Non-Executive Director**	**PRESENTER**	**Julian Atkins** **Non-Executive Director**

CORPORATE OBJECTIVE:

S01 – Deliver a great patient experience
S05 – Make the best use of what we have

SUMMARY OF KEY ISSUES:

Summary of key issues discussed and approved at the Charitable Funds Committee on 25 May 2017.

RISKS	**Risk Register N**	**Risk Score**	
COMPLIANCE	**CQC**	**N**	
	NHSLA	**N**	
	Monitor	**N**	
	Other	**Y**	**To comply with the Charity Commission**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

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

MATTERS ARISING FROM PREVIOUS MEETING

Mr Walker reported that he had spoken to Sandwell and West Birmingham to gather benchmarking information and that they have similar Charitable Fund targets to the Dudley Group.

Mr Atkins confirmed that he and Mr Taylor had met with Mrs Phillips to discuss her role and where her fundraising focus needed to be moving forward. Mrs Phillips line management has now moved to the Communications Team.

SPENDING PLAN PRESENTATION

Dr Rees presented her funds spending plans. These related to staff training events, course fees and new chairs for the staff rest room in Pathology.

FUNDRAISING UPDATE

Mrs Phillips reported that the focus of her role is now on obtaining grants and corporate support.

The 2016/17 fundraising plan ended the year with a £21,000 deficit. Mrs Phillips is however confident that following the changes to her role, the 2017/18 income and expenditure plan will be achieved.

She reported that the Trust's Dementia Campaign has been selected by the Midland Co-op as their Charity of the Year. She also informed the Committee that she is working with Dudley News to promote a wheelchair sponsorship campaign.

FINANCE UPDATE

Mr Walker presented the Finance update. He reported that the total fund balance stood at £2,390,899 whilst the general funds balance was £207,714.

Income for the year to date was reported as £36,211 whilst expenditure was £32,991.

FUNDRAISING REQUESTS

Four bids for income were approved.

- Two bed shoe weighing scales £4,000
- Fifty new wheelchairs £22,031
- Eight replacement monitoring machines, a computer station and printer £26,000
- Six patient observation machines £16,960

A bid to support the Trust moving to a smoke free site was deferred pending Board approval of the initiative.

CHARITY FINANCIAL STATEMENTS AND ANNUAL REPORT 2016/17

Mr Walker presented the Charitable funds financial statements and Annual Report for 2016/17.

ANNUAL REVIEW OF TERMS OF REFERENCE

No issues were raised during the self-assessment process and the Committee therefore approved the Terms of Reference.

Meeting	**Meeting Date**	**Chair**	**Quorate**	
Charitable Funds Committee	**25 May 2017**	**Julian Atkins**	**yes**	**no**
			Yes	
Declarations of Interest Made				
None				
Assurances Received				
Fundraising manager confident of achieving 2017/18 income and expenditure plan				
Decisions Made / Items Approved				
Four bids for income were approved				
Actions to come back to Committee				
Bid for resources to support Trust as a smoke free site				
Items referred to the Board for decision or action				
Decision on whether the Dudley Group should have smoke free sites				

Enclosure 11

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 6 July 2017

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	J Fellows Non-Executive Director
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: Summary reports from the Finance and Performance Committee meeting held on 29 June 2017.			

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

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

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**29 June 2017**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- An update on the Nursing and Midwifery Workforce was given including information on new agency controls and the forthcoming safer staffing review
- The Transformation Programme of £12.5m was discussed. At Month 2 it was reported that there was a forecast shortfall of £9,600, but this had been resolved in the last week so the programme was now "back on track"
- The Income and Expenditure position for 2017-18 was discussed at length. Whilst Income and Non-pay remained in line with plans, agency spend was not reducing as quickly as had been planned. Capacity reductions in B6 and Evergreen ward were debated, and the potential impact they may have on the year-end position. If unchecked it was noted that the Trust would exceed its year-end control total by £4.5m to £5m. It was noted that non-recurrent flexibility had now been completely consumed, and so the Trust was at risk of not achieving its Q1 STF allocation. A couple of potential in-month solutions were debated
- Cash flow continues to be strong but is very dependent upon ongoing receipt of STF funds in 2017-18
- Key performance target challenges in ED, Cancer, and Diagnostic waits were discussed together with actions being taken to improve. This included the opportunity to review and discuss divisional performance.
- The current financial implications of the MCP procurement process were discussed and the ISAP approval process noted
- The current contract discussions with Summit regarding the estates management element of the PFI contract were discussed and noted.

Decisions Made / Items Approved

- The Emergency Department business case was approved and is recommended for approval to the Board of Directors
- The accounts for Dudley Clinical Services Limited for 20161-7 were approved and the contribution to the Trust noted. It was noted that Mark Stanton had taken over from Anne Baines as a Director of the company
- The amendment to the Leased Car Policy was agreed

Actions to come back to Committee

- Quarterly report back to Committee required on the financial implications of the MCP

Performance Issues to be referred into Executive Performance Management Process

- No new performance issues – existing know issues noted

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

- Ensure that the Managed Service Contract risk is appropriately recorded in the Divisional Risk register

Items referred to the Board for decision or action

- The revised Terms of Reference for Finance and Performance Committee

- The current financial position of the Trust as noted in the assurance section, and the need for a significant improvement in agency spending and reduced bed capacity in order to meet the Trust's control total in 2017-18
- The Emergency Department business case is recommended for approval

THE DUDLEY GROUP NHS FOUNDATION TRUST

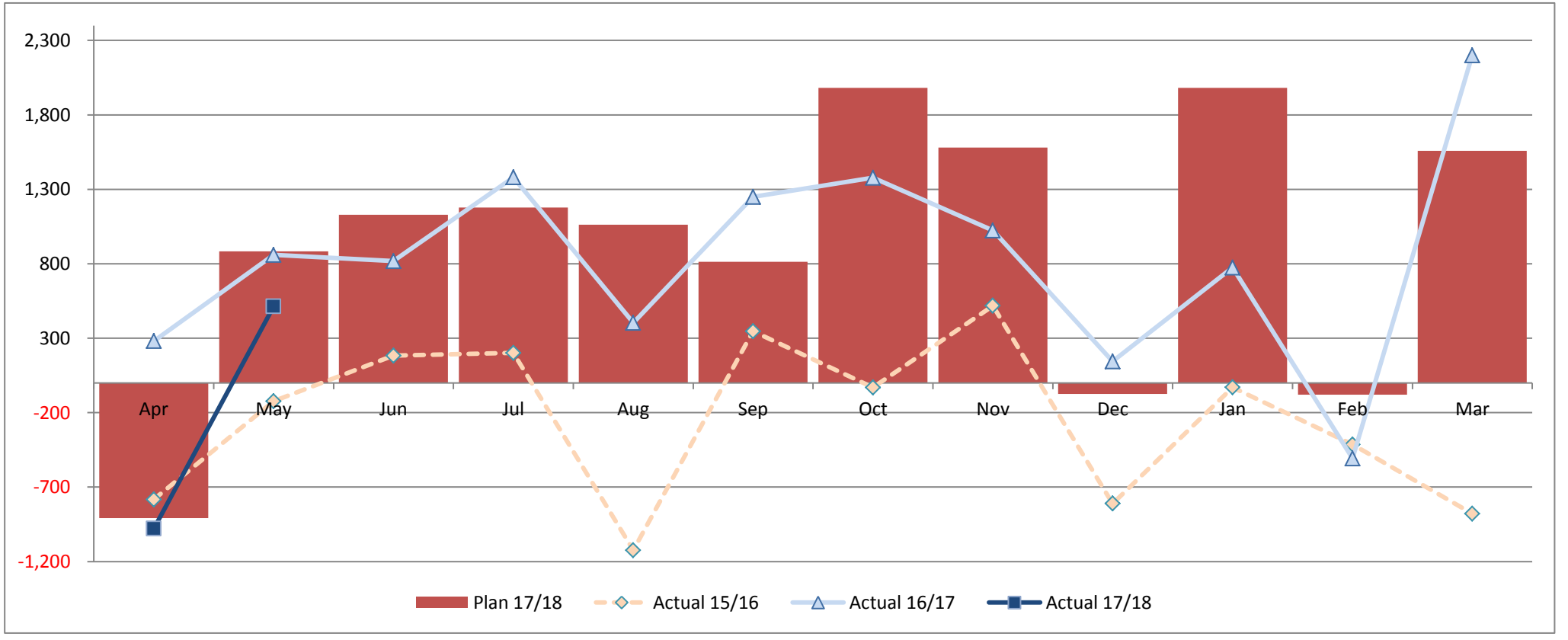
FINANCIAL SUMMARY **MAY 2017**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£29,942	£30,088	£146
PAY	-£17,394	-£17,866	-£472
NON PAY	-£9,701	-£9,842	-£141
EBITDA	**£2,846**	**£2,380**	**-£466**
OTHER	-£1,963	-£1,866	£98
NET	**£883**	**£514**	**-£369**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£57,345	£57,373	£28
PAY	-£34,347	-£34,972	-£625
NON PAY	-£19,218	-£19,150	£68
EBITDA	**£3,780**	**£3,251**	**-£529**
OTHER	-£3,805	-£3,717	£88
NET	**-£25**	**-£465**	**-£440**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£358,337	£358,703	£366
PAY	-£205,926	-£210,671	-£4,745
NON PAY	-£118,605	-£118,955	-£351
EBITDA	**£33,806**	**£29,076**	**-£4,730**
OTHER	-£22,702	-£22,702	£0
NET	**£11,104**	**£6,374**	**-£4,730**

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



The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - May 2017

Quality & Risk			2016							2017						
Description		LYO	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD	YEF
Friends & Family – Community – Footfall		1.2%	1.5%	1.1%	1.3%	1.1%	0.6%	1.3%	1.3%	1.5%	1.2%	1.2%	1.1%	0.9%	1%	
Friends & Family – Community – Recommended %		95.8%	94.4%	97.3%	96.1%	96.1%	95.1%	95.5%	94%	94.4%	97.8%	97.3%	94%	96%	95%	
Friends & Family – ED – Footfall		7.9%	1.6%	8.4%	10.7%	5%	5%	3.7%	4.3%	13.1%	15.4%	18.6%	15.4%	13.7%	14.5%	
Friends & Family – ED – Recommended %		85.1%	88.2%	91.7%	91.8%	91.9%	93.8%	93.1%	90.1%	75.3%	76%	81%	75%	76.1%	75.5%	
Friends & Family – Inpatients – Footfall		17.8%	13.9%	17.9%	18.6%	20.5%	19.2%	19.2%	17%	17.9%	18.1%	18.3%	28.7%	30.8%	29.9%	
Friends & Family – Inpatients – Recommended %		96.6%	97%	94.6%	96.6%	96.6%	97.9%	95%	97.9%	95.8%	97.3%	97.3%	96.4%	95.6%	96%	
Friends & Family – Maternity – Footfall		30.1%	16.6%	33.8%	32.7%	32.3%	27.6%	36.5%	33.9%	34.5%	29.5%	32.7%	30.9%	48.9%	40.1%	
Friends & Family – Maternity – Recommended %		98.3%	98.9%	96%	98.6%	98.8%	98.8%	99.5%	99.4%	97.6%	98.2%	99%	98.8%	97.8%	98.2%	
Friends & Family – Outpatients – Footfall		1.6%	1%	1.7%	1.5%	1.4%	1.5%	2.5%	1.5%	2.4%	1.9%	1.7%	1.5%	1.9%	1.7%	
Friends & Family – Outpatients – Recommended %		92.6%	93.1%	91.7%	92.4%	92.4%	93.2%	94.9%	93.1%	95%	94.1%	96.2%	95.3%	95.2%	95.2%	
HCAI – Post 48 hour MRSA		0	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI CDIFF – Total Number Of Cases		33	2	2	6	6	2	2	3	2	3	0	2	1	3	
Incidents - Pressure Ulcer		2,573	194	193	196	188	192	202	212	233	216	254	227	242	469	
Mixed Sex Sleeping Accommodation Breaches		62	0	0	0	0	4	4	7	26	14	7	5	3	8	
Never Events		1	0	0	1	0	0	0	0	0	0	0	0	0	0	
Serious Incidents – Not Pressure Ulcer		100	4	12	11	6	7	9	8	12	8	10	5	5	10	
Serious Incidents - Pressure Ulcer		150	8	10	17	16	14	8	9	19	10	17	12	11	23	
Stroke Admissions : Swallowing Screen		77.02%	85.11%	78.72%	73.91%	62.5%	75.68%	73.33%	77.55%	66.67%	67.31%	84.21%	72.73%	64.52%	67.92%	
Stroke Admissions to Thrombolysis Time		51.25%	83.33%	36.36%	54.55%	50%	66.67%	37.5%	30%	83.33%	33.33%	50%	100%	44.44%	58.33%	

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - May 2017

Quality & Risk			2016							2017						
Description		LYO	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD	YEF
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		87.56%	91.53%	90.2%	88.64%	89.36%	97.5%	86.54%	89.8%	79.03%	83.64%	85.71%	94.23%	90.16%	92.04%	
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation		79.31%	36.36%	63.64%	66.67%	83.33%	93.33%	80%	100%	66.67%	93.75%	91.67%	100%	100%	100%	
VTE Assessment Indicator (CQN01)		94.76%	95.09%	93.91%	94.5%	93.91%	95.65%	95.64%	94.64%	94.18%	92.84%	96.31%	92.3%	92.22%	92.26%	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - May 2017

Finance			2017			
Description		LYO	Apr	May	YTD	YEF
Budgetary Performance		£230k	(£72)k	(£369)k	(£440)k	
Capital v Forecast		63.7%	72.6%	52.7%	52.7%	
Cash v Forecast		65.6%	80%	74.9%	74.9%	
Debt Service Cover		1.77	0.57	1.06	1.06	
EBITDA		£32,776k	£871k	£2,380k	£3,251k	
I&E (After Financing)		£10,004k	(£980)k	£514k	(£465)k	
Liquidity		16.43	14.7	14.56	14.56	
SLA Performance		£1,937k	£45k	£155k	£200k	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - May 2017

Performance			2016							2017						
Description		LYO	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD	YEF
A&E - 4 Hour A&E Dept Only % (Type 1)		89.77%	94.48%	93.34%	92.97%	92.14%	92.3%	86.08%	82.86%	77.85%	86.3%	92.46%	84.94%	86.6%	85.79%	
A&E - 4 Hour UCC Dept Only % (Type 3)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99.97%	99.98%	
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)		94.16%	96.76%	96.21%	95.81%	95.29%	95.51%	91.97%	90.78%	87.7%	92.31%	95.59%	91.69%	92.05%	91.87%	
Activity - A&E Attendances		102,696	8,433	8,973	8,579	8,594	8,929	8,477	8,718	8,607	7,758	9,020	8,577	9,056	17,633	
Activity - Community Attendances		394,381	32,846	31,673	33,863	33,078	32,365	34,044	33,676	33,404	29,912	34,208	26,346	31,856	58,202	
Activity - Elective Day Case Spells		45,982	3,998	3,798	3,895	3,911	3,721	3,888	3,428	3,761	3,748	4,313	3,827	4,243	8,070	
Activity - Elective Inpatients Spells		6,029	549	561	482	506	540	518	454	414	440	528	473	508	981	
Activity - Emergency Inpatient Spells		60,748	5,077	5,054	5,002	4,933	5,038	5,119	5,171	5,107	4,765	5,412	4,972	5,253	10,225	
Activity - Outpatient First Attendances		125,869	10,560	9,890	10,006	10,799	10,445	11,007	9,158	10,610	10,450	12,172	9,721	12,498	22,219	
Activity - Outpatient Follow Up Attendances		310,607	26,893	25,084	25,384	26,492	25,427	27,159	23,292	26,406	24,567	26,804	21,873	26,327	48,200	
Activity - Outpatient Procedure Attendances		59,621	5,210	5,090	4,898	4,992	4,845	4,985	4,067	5,163	5,133	5,311	4,839	4,987	9,826	
RTT - Admitted Pathways within 18 weeks %		92.4%	94.2%	94.2%	95%	93.2%	93.9%	92.6%	92.9%	91.4%	88%	88.5%	86.3%	88.8%	87.6%	
RTT - Incomplete Waits within 18 weeks %		95.4%	97.1%	97.1%	96.6%	96.1%	95.6%	95%	94.5%	94.2%	93.3%	92.8%	94.2%	94.7%	94.4%	
RTT - Non-Admitted Pathways within 18 weeks %		96.5%	98.1%	98%	98.4%	97.1%	95.9%	96.3%	96.3%	94.2%	94.3%	95%	93.2%	94.5%	94%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		97.41%	99.16%	98.96%	97.69%	98.12%	98.59%	97.38%	93.5%	92.25%	97.09%	99.29%	95.99%	94.28%	95.12%	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - May 2017

Staff/HR			2016							2017						
Description		LYO	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	YTD	YEF
Appraisals		82.9%	81%	78.1%	78.3%	77.4%	77%	77.1%	73.9%	71.7%	75.9%	82.9%	81.9%	83.6%	83.6%	
Mandatory Training		83.9%	76.3%	77.4%	78.6%	77%	78.5%	79.6%	79.4%	78.6%	80.2%	83.9%	84.6%	84.8%	84.8%	
Sickness Rate		4.17%	4.04%	4.07%	3.73%	4.04%	4.38%	4.29%	4.30%	4.57%	4.37%	4.16%	3.44%	3.81%	3.63%	
Staff In Post (Contracted WTE)		4,278.19	4,083.01	4,083.49	4,112.05	4,146.74	4,199.22	4,236.4	4,230.95	4,240.77	4,280.54	4,278.19	4,309.81	4,301.72	4,301.72	
Vacancy Rate		7.90%	10.78%	10.75%	10.31%	9.61%	9.18%	9.09%	9.18%	8.77%	7.93%	7.90%	8.65%	8.62%	8.62%	

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

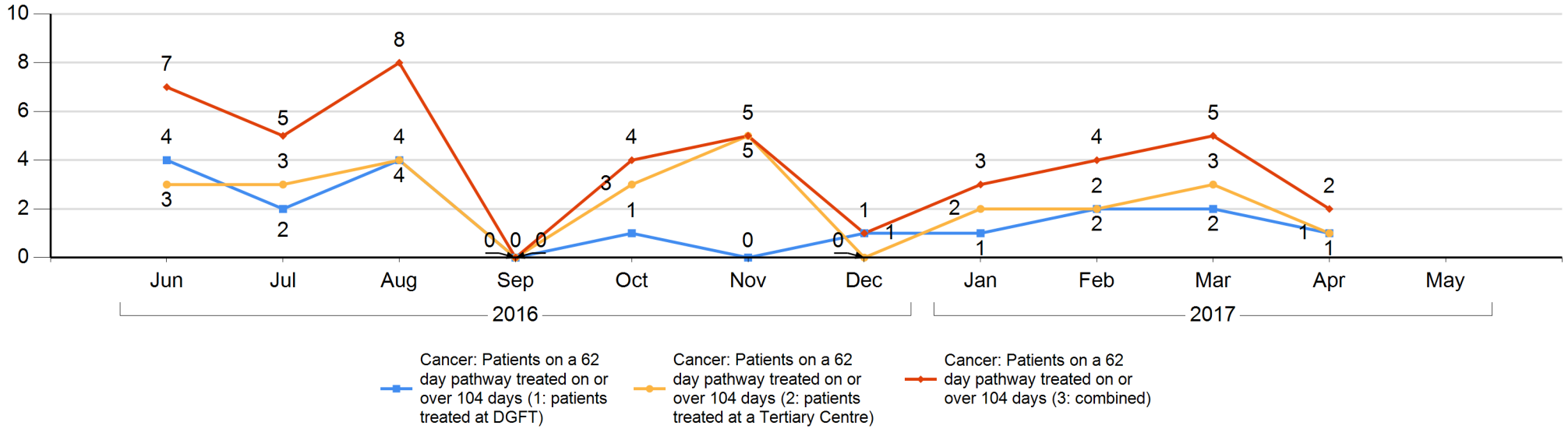
The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - May 2017

Description	Target	All Tumour Sites	Brain	Breast	Colorectal	CUP	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%	97.2%	96.5%	-	96.1%	91.7%	99.1%	78.8%	100%	99.4%	92.5%	97.9%	**96.7%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	-	97.2%	-	-	-	-	-	-	-	-	-	-	**97.2%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	-	100%	100%	100%	100%	100%	100%	100%	-	100%	100%	97.6%	**99.4%**
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	98%	92.3%	-	-	-	-	-	-	-	-	-	-	-	-	**92.3%**
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	94%	95%	-	-	-	-	-	-	-	-	-	-	-	-	**95%**
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	96%	93.9%	-	-	-	-	-	-	-	-	-	-	-	-	**93.9%**
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	85%	-	-	-	100%	-	83.3%	100%	0%	71.4%	-	100%	92.3%	72.2%	**87.2%**
Cancer - 62 day - From Referral for Treatment following national screening referral	90%	-	-	88.9%	100%	-	-	-	-	-	-	-	-	-	**92%**
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85%	-	-	84.6%	84.2%	-	46.2%	75%	33.3%	100%	-	93.3%	25%	79.3%	**78%**

The Dudley Group NHS
NHS Foundation Trust

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



The Dudley Group
NHS Foundation Trust

FINANCE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1 The Board of Directors resolves to establish a Committee of the Board to be known as the Finance and Performance Committee. The Finance and Performance Committee in its workings will be required to adhere to the Constitution of The Dudley Group NHS Foundation Trust, the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts. As a committee of the Board of Directors, the Standing Orders of the Trust shall apply to the conduct of the working of the Finance and Performance Committee.

2. Membership

3 Non-Executive Directors
Chief Executive
Director of Finance and Information (or deputy)
Chief Operating Officer (or deputy)
Director of Strategy and Business Planning (or deputy)
Director of Human Resources (or deputy)
Chief Nurse (or deputy)
Medical Director Operations
Director of Governance (or deputy)
Chief Information Officer
Deputy Director of Finance Strategy and Performance
Deputy Director of Finance Financial Reporting
Director of Operations Medicine and Integrated Care (or Chief of Medicine)
Director of Operations Surgery and Women & Children (or Chief of Surgery)
Director of Operations Support Services (or Chief of Support Services)
Head of Communications

In the absence of the Chair, the Committee will be chaired by a Non-Executive Director.

3. Attendance

3.1 All other members of the Board shall be entitled to attend and receive papers to be considered by the Committee.

3.2 Other managers/staff may be required to attend meetings depending upon issues under discussion. The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as necessary and to commission input from external advisors as agreed by the Chair

3.3 The Board Secretary will ensure that an efficient secretariat service is provided to the Committee.

4. Quorum

4.1 A quorum will consist of three members including at least one Non-Executive Director and one Executive Director (voting or non-voting member) of the Trust Board

5. Frequency of meetings

5.1 The Committee will meet monthly. It is expected that there will be at least 10 meetings a year and members will attend at least half of the meetings in the year. The Agenda will be circulated with papers 7 days before the meeting.

5.2 Ad hoc meetings may be called by the Committee Chair or as a result of a request from at least three members of the Committee, including at least one Non-Executive Director and one Executive Director. The request will be made to the Trust Chair.

5.3 Additional meetings may be held at the discretion of the Chairman of the Committee.

6. Authority

6.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference and is expected to make recommendations to the full Board. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

6.2 The Committee is authorised by the Board to obtain outside financial, legal or other independent professional advice and to secure the attendance of others from outside the Trust with relevant experience and expertise, if it considers it necessary. This authority will only be used in exceptional circumstances and prior approval of the Board is required.

6.3 The Committee is authorised by the Board of Directors to approve the monthly or quarterly monitoring returns and annual return to NHSI.

6.4 The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

7. Duties

The duties of the Committee can be categorised as follows:

7.1 Strategic and Business Planning

7.1.1 Undertake detailed scrutiny of processes for the preparation and the content of Strategic and Business Plans (including the local CCG (Clinical Commissioning Group) contract) and Annual Revenue and Capital Budgets, test the key assumptions, decisions and risks underpinning such plans and holding leaders to account.

7.1.2 Review, discuss and challenge where necessary the Trust Annual Plan and Annual Budgets before submission to the Board of Directors.

7.1.3 Monitor performance compared to the Annual Plan and Budgets; investigate variances and review and approve proposed actions to remediate any shortfalls, holding senior staff to account.

7.1.4 Consider and advise on financial aspects of Business Cases for significant revenue or capital expenditure, ensuring benefits realisation are detailed and appropriate as defined in the Trust's Standing Financial Instructions and Scheme of Delegation, prior to submission to the Board of Directors.

7.1.5 Undertake PIR (post implementation review) of all Business Cases for return on investment/benefits realisation.

7.1.6 Review opportunities for increasing activity/income from market intelligence analyses.

7.2 Performance Management

7.2.1 The Committee shall receive an update of all performance review meetings held by Directors of the Trust with Operational Divisions or Directorates ensuring appropriate challenge has been made and evidence of actions to manage variances in performance detailed

7.2.2 Monitor and where necessary challenge the financial performance of individual Operational Divisions and Directorates, ensuring there is evidence of actions to manage variances

7.2.3 Receive, the performance dashboard; review and challenge performance as necessary with individual Operational Divisions and Directorates, ensuring any necessary action to mitigate poor performance is appropriate

7.2.4 Consider performance against external performance targets set by the Care Quality Commission, NHSI and as agreed in legally binding contracts

7.2.5 Receive and undertake detailed scrutiny of the PFI contract performance with Summit, specifically receiving updates on performance evaluation of catering, cleaning services, estates, sterile services, security and medical device maintenance.

7.2.6 Receive, review and challenge reports in respect of Transformation and Cost Improvement Programmes to ensure proposals are realistic, financially sound and delivering as planned, addressing any shortfalls.

7.2.7 Review the Trust compliance with relevant financial and performance CQC standards, ensuring appropriate actions are in place to remediate any shortfalls

7.2.8 Develop, implement and maintain an effective service line accountability framework.

7.2.9 Review and approve local delivery plans (including CQUIN). Monitor compliance and ensure appropriate remediating actions have been identified where necessary

7.3 Financial Accounting

7.3.1 Consider the likely impact of technical changes to accounting policy or practices and agree significant changes to accounting practice in advance.

7.3.2 Consider and provide advice to the Board on detailed expenditure, cash flow and working capital plans and forecasts.

7.3.3 Consider and provide advice to the Board on regular financial performance reports and forecasts, focussing particularly on risks and assumptions.

7.3.4 Commission and consider various financial reports and analyses, as appropriate.

7.3.5 Consider other topics or matters, as directed by the Board of Directors.

7.4 Business Risks

7.4.1 Receive assurances from Executive Directors in respect of the organisations financial and performance risks, monitoring mitigating actions to maintain the risk at the lowest realistic level, ensuring the strategically significant risks are included in the Board's Assurance framework.

7.4.2 Consider and provide advice to the Board on the short to medium term impact on current performance of internal and external business risks.

7.4.3 Review NHSI's risk rating and instigate appropriate action.

7.4.4 Undertake detailed financial assessment of the Trust's strategic risks in conjunction with the Board of Directors and monitor trends and progress in reducing financial exposure.

8. Trust Subsidiary Companies

8.1 The Committee shall monitor the financial and operational performance of any subsidiary companies wholly or partly owned by the Trust.

8.2 The Committee shall receive an annual report on the activities and profitability of such companies and provide regular assurance on business effectiveness and profitability to the Board of Directors.

9. Policies

The Committee will approve policies on subjects relating to the committee terms of reference on recommendation from the Policy group.

10. Reporting

10.1 The Finance and Performance Committee reports to the Board of Directors. The Committee Chair shall report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities. The Committee shall make whatever recommendations to the Board it deems appropriate on any area within its remit where action or improvement is needed or where it has significant concerns.

10.2 The committee will receive a report covering any relevant areas from the:

- Estates Performance and Contracts groups

10.3 The minutes of the meetings of the Committee shall be received by Board members. The Committee shall carry out a self-assessment in relation to its own performance annually reporting the results to the Board of Directors

11. Review of Effectiveness

11.1 The Committee shall formally consider its effectiveness using any tools specified for the purpose by the Board of Directors on an annual basis.

11.2 The Terms of reference of the Committee shall be reviewed by the Board of Directors at least annually.

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board Committee on 6th July 2017

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

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

SUMMARY OF KEY ISSUES:

The Trust identified schemes totalling **£12.4m** against a Full Year (FY) target of **£12.5m**.

As at Month 2 the Trust achieved savings of £1,085k against a plan of £1,231k, and is forecasting to deliver £12,442k by the year end.

Of the 37 projects due to deliver savings in 2017/18, 32 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC).

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

Transformation Executive Committee (TEC) met on 22nd June to discuss:

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

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

IMPLICATIONS OF PAPER:

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

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

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

		Y	

RECOMMENDATIONS FOR THE COMMITTEE:
Note delivery of CIP to date and the current forecast outturn.

CORPORATE OBJECTIVES : ***(Please select for inclusion on front sheet)***
SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO3: Drive service improvements, innovation and transformation
SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: Deliver a viable future

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

The Dudley Group NHS
NHS Foundation Trust

Trust Board Committee

Programme Management Office

Summary Report

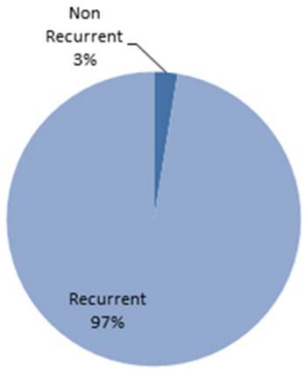
6th July 2017

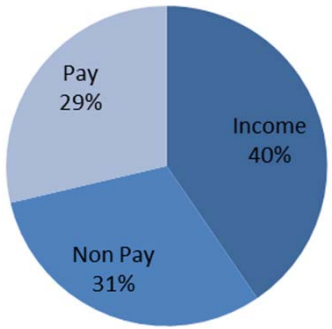
Executive Summary – 2017/18

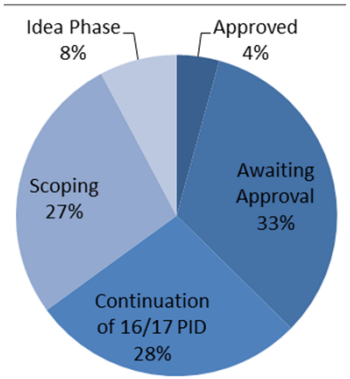
The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18. To support this, the Trust has identified 37 of 64 schemes currently on the work programme contribute to the £12.5m identified, and 3% of the CIP has currently been identified as non recurrent savings.

A summary of CIP performance as at Month 2 is provided below (with supporting detail overleaf):

	Full Year (FY)			YTD Performance against identified Plans			Y/E Forecast of identified Plans	
CIP Project Plans	FY Target	FY Identified	Shortfall against FY Target	YTD Plan (from identified schemes)	YTD Actual	YTD Variance (against identified schemes)	Y/E FYE of identified schemes	Y/E FYE Variance of identified schemes
TOTAL	£12.5m	£12.439m	-£51k	£1,231k	£1,085k	-£146k	£12,448k	£9.6k







Based on the Month 2 position, the Trust has identified schemes totalling **£12.43m** against a Full Year (FY) target of **£12.5m.**
As at Month 2 the Trust is forecasting to deliver £12,448k.

Of the 37 projects due to deliver savings in 2017/18, 32 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC).

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

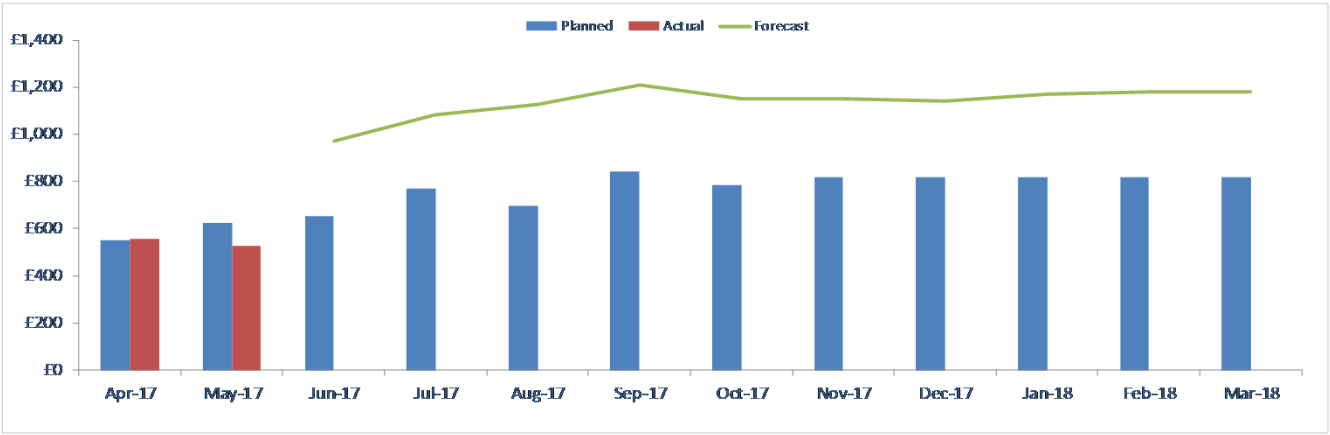
The Programme Risk Log is attached on page 21. An additional risk has been identified relating to non delivery of 2017/18 CIP work programme.

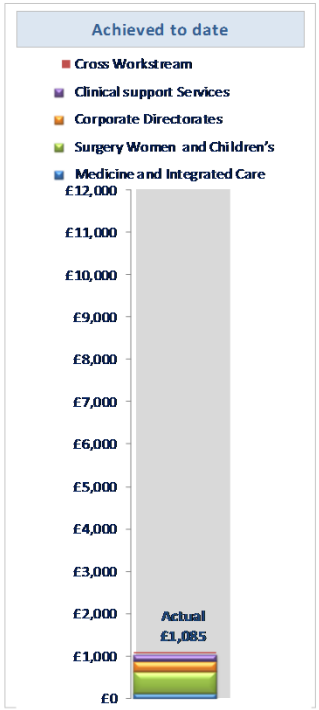
Executive Summary – 2017/18

	YTD	FYE
Planned	£1,231,440	
Actual	£1,085,320	
Forecast		£12,448,677
Variance	-£146,120	£9,671

	Submitted Plan
Identified	£12,439,005
Target	£12,500,000
	-£51,323

Programme (Click for details)	YTD Plan	YTD Actual	YTD Variance	FYE Plan	FYE Forecast	FYE Variance
Surgery Women and Children's	£548,725	£530,893	-£17,832	£3,292,348	£3,352,982	£60,634
Medicine and Integrated Care	£144,505	£138,474	-£6,031	£1,438,509	£1,456,005	£17,496
Clinical support Services	£148,121	£149,422	£1,301	£998,746	£1,078,346	£79,600
Corporate Directorates	£361,255	£245,494	-£115,761	£2,774,155	£2,619,476	-£154,679
Cross Workstream	£28,833	£21,037	-£7,796	£3,935,247	£3,941,868	£6,620
View all Projects	£1,231,440	£1,085,320	-£146,120	£12,439,005	£12,448,677	£9,671





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