The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 6 October, 2016 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	9.30
2.	**Declarations of Interest**		J Ord	To Note	9.30
3.	**Announcements**		J Ord	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 1 September 2016	Enclosure 1	J Ord	To Approve	9.30
	4.2 Action Sheet 1 September 2016	Enclosure 2	J Ord	To Action	9.35
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Harrison	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Organ Donation Annual Report	Enclosure 4	J Sonksen	To Note	10.00
	7.2 Chief Nurse Report	Enclosure 5	D Wardell	To Note & Discuss	10.10
	7.3 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 6	D Wulff	To Note & Discuss	10.20
	7.4 Audit Committee Exception Report	Enclosure 7	R Miner	To Note & Discuss	10.30
	7.5 Charitable Funds Committee Exception Report	Enclosure 8	J Atkins	To Note	10.40
	7.6 Medical Education Report	Enclosure 9	A Whallett	To Note	10.50
	7.7 Revalidation Report	Enclosure 10	P Stonelake	To Note	11.00
	7.8 Workforce Strategy Update Report	Enclosure 11	A McMenemy	To Note	11.10
	7.9 Speak Up Guardian Report	Enclosure 12	C L Mecrow	To Note	11.20
	7.10 Outpatients Transformation Programme Report	Enclosure 13	L Mcmahon	To Note	11.30
8.	**Finance and Performance**				
	8.1 Cost Improvement Programme and Transformation Overview Report	Enclosure 14	A Gaston	To Note	11.40
	8.2 Finance and Performance Committee Exception report	Enclosure 15	J Fellows	To Note & Discuss	11.50

9.	**Any other Business**		J Ord		12.00
10.	**Date of Next Board of Directors Meeting** 9.30am 3 November 2016 Clinical Education Centre		J Ord		12.00
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		12.00

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 1st September, 2016 at 9:00am in the Clinical Education Centre.

Present:

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

In Attendance:

Helen Forrester, EA
Glen Palethorpe, Director of Governance/Board Secretary
Andrew McMenemy, Director of HR Jackie Dietrich, Communications Manager
Amanda Gaston, Head of Service Improvement (Item 16/085.1)
Professor Judith Smith, University of Birmingham (observing the board as part of research study)

16/078 Note of Apologies and Welcome
9.02am

Apologies were received from Anne Baines and Liz Abbiss. The Board sent Anne their best wishes.

16/079 Declarations of Interest
9.04am

Dr Harrison reminded the Board that he was married to a local GP. The Board considered this declaration and agreed that there were no decisions that were planned to be made for which this may cause a potential for any conflict.

There were no other declarations of interest.

16/080 Announcements
9.04am

The Chairman confirmed that the Chief Executive, Director of Finance and Information and Medical Director would be leaving the meeting at 10am to attend a meeting in Birmingham with NHS England and NHS Improvement in respect of the Dudley MCP.

16/081 Minutes of the previous Board meeting held on 7th July, 2016 (Enclosure 1)
9.05am

The Board noted on page one of the minutes that the Director of HR commenced on 1st August, 2016. With this amendment the minutes of the previous meeting were agreed by the Board as a true and correct record of the meetings discussion and could be signed by the Chairman.

16/082 Action Sheet, 7th July, 2016 (Enclosure 2)
9.06am

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

16/083 Patient Story
9.07am

Jackie Dietrich, Communications Manager, presented the patient story. The patient was receiving care at home from the Community Nursing Team. The patient was extremely complimentary about the care provided and the Community Nursing Team members themselves.

The Chairman welcomed a story relating to Community nursing.

Mrs Becke, Non Executive Director, commented that it was also assuring to hear a positive story about pressure ulcer care.

The Chairman asked how the Trust will communicate the story. The Chief Nurse confirmed that a communication campaign was being planned.

The Chief Executive asked about the availability of equipment. The Chief Operating Officer confirmed that the CCG are working to improve provision in this area. Mrs Becke, Non Executive Director, commented that from previous experience it was a complicated process. Dr Wulff, Non Executive Director, agreed that the issue had been raised at the End of Life and Palliative Care meeting and he would welcome any improvements to the service the CCG could bring to bear from there work.

The Chairman asked about the equipment store. The Chief Operating Officer confirmed that there is no longer a main store and most items come directly from a supplier. The Chairman asked for additional information for the Board on this system so the Board Members could be better informed drawing out key issues especially in respect to anysupplier and process delays.

The Chief Operating Officer confirmed that he will also investigate the comments relating to the changes in nursing teams made by the Patient as continuity of care within community teams is a key element the service is striving to maintain.

The Chairman and Board noted the story and the issues raised.

The Chief Operating Officer to provide the Board with additional background on equipment storage, process, and provision.

The Chief Operating Officer to investigate comments relating to workforce changes in the Community Nursing team.

16/084 Chief Executive's Overview Report (Enclosure 3)
9.23am

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

- **Friends and Family:** The detailed report had been presented to the Finance and Performance Committee. The Chief Executive confirmed that the Trust is currently equal to or better than the national average in most areas. The Trust performs well for Maternity Friends and Family compared to other Black Country organisations. The Board noted that work continues to improve response rates.

- **Junior Doctors Contract:** The Chief Executive confirmed that a future five day strike had been announced the previous day. The Board noted that there was very little time to make preparations for the strike, with action planned to commence on Monday, 12th September, for 5 consecutive days. Mr Miner, Non Executive Director, asked about the length of the dispute and what strain it would put on the Trust especially senior consultants. The Medical Director confirmed that some of the senior doctors had already shown that they were not supportive of the junior doctors taking this length of action and confirmed that he was very anxious about the difficulties that will be encountered in covering this period of time. The Board noted that there will certainly be an affect on the level of performance. Mr Fellows, Non Executive Director, stated that the effect on performance could be a concern in relation to Trust retaining STP monies and asked if it might affect the Trust's contract income for the year. The Director of Finance and Information confirmed that having a block contract with Dudley CCG will help the impact on the Trust's contract income risk. The Chief Operating Officer stated that it will be impossible for the Trust to participate in the 7 day working audit whilst industrial action is taking place. The Chairman asked if there was any sense as to how many junior doctors will be taking action. The Director of HR confirmed that he will be speaking to the new Junior Doctors representative with regard to this but at this stage this was not clear. The Chairman asked about the start and finish times of the action and whether there will be resulting peaks in ED attendances. The Chief Operating Officer confirmed that during previous action ED had maintained a high level of support to ensure flow.

- **Jim Mackay Visit:** Jim Mackay, the Chief Executive of NHS Improvement, visited the Trust on Monday 8th August, 2016. The senior team spoke with Jim about the pressures facing the Trust, he then visited the award winning Day Surgery Unit. Jim later wrote to the Trust to thank them and confirmed that the visit was "one of the best and most impressive" visits he had undertaken.

- **Gill Morgan Visit:** Gill Morgan, Chair of NHS Providers, had visited the Trust the previous day. Gill and the senior team had talked about the wider challenges facing the NHS. Gill also visited the Day Surgery Unit.

The Chairman and Board noted the report and in particular the potential effect of extended industrial action on the Trust. The Chairman asked for an update to the Board on the position by the end of the following week in respect of the Trust's plans for dealing with the planned industrial action.

Update to Board members on planning for the industrial action by 9th September, 2016.

16/085 Finance and Performance

16/085.1 Cost Improvement Programme and Transformation Overview Report (Enclosure 4)
9.45am

Amanda Gaston, Service Improvement Manager, presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 4.

The Board noted the high level position as follows:

- CIP forecast gap remains. Overall shortfall of £1.3m. The Transformation Executive had met the previous week and discussed mitigation plans for the slippage.

- Two new workstreams are to be established to help reduce the gap.

- Workforce, Bank and Agency is now a separate workstream and there are some new mitigation plans for this area.

- Areas performing below plan continue be escalated with sponsoring Directors pushing for mitigating actions to be identified.

The Director of Finance and Information confirmed that the Trust it refining the work already commenced to reduce the slippage but noted that it was now unlikely to bridge the total gap in the financial year. The Trust is looking at further non recurrent schemes that can help with the gap.

Dr Wulff, Non Executive Director, asked about Quality Impact Assessments. Amanda confirmed that leads are being trained to help speed up the Quality Impact Assessment process and their quality. Dr Wulff asked for feedback from the actions to improve the process in particular those actions taken to reduce the potential time delay of a scheme starting due to a poor QIA not being able to be approved quickly. The Medical Director confirmed that he could assure the Board that the Trust had a very robust process in place and that they would not pass a QIA that had not undertaken robustly.

The Chairman and Board noted the report.

The Board to receive feedback on improvements to the Quality Impact Assessment process and report back to the next Board meeting.

16/085.2 Finance and Performance Committee Report (Enclosure 5)
9.53am

Mr Miner, Non Executive Director, presented the Finance and Performance Committee Report, given as Enclosure 5.

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

The Board noted the key highlights as follows:

- EPR Project: Currently on track and the various stages of the project plan will be presented to the Board over the coming months.

- Nursing Division: Some financial issues within the Nursing Division and also in relation to agency costs, the Committee will continue to monitor this closely but this has been escalated as a corporate risk.

- The Board noted the shortfall on CIP as discussed in the previous report. The Director of Finance and Information confirmed that the Trust's inability to close additional wards as planned is having a very detrimental effect of the Trust's financial position. The Chief Executive confirmed that the Trust is looking to put a blanket ban in place on agency Clinical Support Workers. The Chairman asked about the £1.3m gap forecast and how confident was the Trust that it will not see further slippage on the identified schemes. The Director of Finance and Information confirmed that the lead sponsors are working hard to maintain performance on schemes but he could not give absolute assurance that the Trust would be able to prevent any further slippage.

The Chairman and Board noted the report, risks and key areas. The Board noted the 4 key elements identified at the end of the report.

16/086 Patient Safety and Quality

16/086.1 Chief Nurse Report (Enclosure 6)
10.05am

The Chief Nurse presented the Chief Nurse Report given as Enclosure 6.

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

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

C.Diff: The Trust has had 12 cases to date in 2016/17. The determination as to any lapses in care has only been undertaken in two cases so far, and of the two cases one of these cases had been attributable to the Trust. A period in increased incidence had been identified on MHDU and RCAs are being undertaken to highlight any further learning the Trust may be able to take in the area of infection control.

Norovirus: No cases to note.

Dr Wulff, Non Executive Director, asked for the summary on the front page of the report to be made clearer especially in respect of the numbers apportioned and those where such an apportionment is still to be undertaken.

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

- Amber shifts (shortfall) total figure for July was 70 and 47 for June which is up from the preceding months (52 in May).

- Red (serious shortfall) shifts: no safety issues that could affected quality of care were identified in the red shifts nor had any been identified on any of the amber shifts.

- A local Red Amber Green rating system for wards to assess their shift shortfalls had been rolled out across 3 wards in June and 12 in July, no red shifts were identified utilising this methodology for that period.

- The Care Hours per Patient Day (CHPPD) had commenced collection of data since May and was reported in a limited way in the papers.

Mr Atkins, Non Executive Director, asked about the Trust's safe staffing risk mitigations. The Chief Nurse confirmed that Lead Nurses perform normal nursing duties during periods of increased pressure on Wards thus patient care is prioritised over their other lead nurse duties for that shift.

The Board discussed the recent capacity pressures on Neonatal cots, both within the Trust and regionally. The Board was assured by the actions taken to ensure safe staffing and care in this area.

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

- Improvement can be seen with the reduced number of areas in the red category and increases in those scoring green. 1 area is at a level 4 escalation and they have met with the Chief Nurse to discuss their rectification and improvement plan. More intensive support had been provided to wards which had seen the appropriate change in results presented in this month's report.

The Chief Nurse presented on Reforming of Healthcare Education funding. The Board noted the potential impact from the outcomes of the public consultation on the move from bursaries to student loans. The Chairman asked about Associate Nurses. The Chief Nurse confirmed that an Associate Nurse type programme had commenced at the Trust in February this year. The Black County Alliance had put forward a bid to become a pilot site for the Associate Nurse programme.

Mr Fellows, Non Executive Director, commented that it would be helpful to include a ward/specialty key within future reports.

The Chairman and Board noted the report and assurances around neonatal capacity.

Ward/Specialty list to be included in future Chief Nurse reports.

16/086.2 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 7)
10.19am

Dr Wulff, Committee Chair, presented the Clinical Quality, Safety and Patient Experience Committee Exception Report, given as Enclosure 7. The Board noted the following key areas from the previous two Committee meetings:

- There continues to be a lag in the reviewing of Trust policies within planned review timescales. There are 38 policies requiring review. The issue was discussed at the Risk and Standards Group and the Governance Team are producing a business case for an external policy management system. An update will be provided at the September meeting. The Director of Governance/Board Secretary confirmed that the policy review process had also changed and staff are notified 6 months in advance of the policy requiring review.

- Executive assurance was provided that the Ophthalmology capacity risk is on the Divisional Risk Register and that action had been taken in respect of the three SIs. The Committee had received a presentation on the SIs from the Divisional Medical Services Head, the Consultant, Directorate Manager and Divisonal Director of Operations with the details of the actions being taken and those that had been taken or are planned around service transformation to deal with the wider capacity challenges facing this service. An update will be presented to the Committee in 6 month's time.

- There were two areas of concern around operational Performance indicators, one for Stroke where a drastic reduction in the number of patients receiving TIA scans and the second in respect to the reduced VTE assessments being undertaken. The Committee noted that there had been some process changes in these areas and asked for further information to come to a subsequent committee meeting.

- In relation to progress on the accessible information standard the Board noted that the Trust was meeting the standard wherever possible. The Committee had discussed the sharing of electronic information between the Trust and primary care and this had been flagged for the new EPR system procurement process. The Chairman asked if this reflects the question and answer from the Annual Members Meeting. The Director of Governance/Board Secretary confirmed that it did and responses were included in the Council of Governors papers for the meeting that evening and will also be added to the Trust website.

- The Board were asked to note that 4 junior doctors (out of 40) had failed the prescribing test and will be unable to write prescriptions until they re-sit the assessment in November. This will place an extra burden on the doctors within their clinical areas. Work is being undertaken to clarify the prescribing role of Physicians Associates and an update will be brought back to the Committee.

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

16/086.3 NHS Preparedness for a Major Incident Report (Enclosure 8)
10.28am

The Chief Operating Officer presented the NHS Preparedness for a Major Incident Report given as Enclosure 8.

The Board noted the annual Core Standards response which had been more complex this year.

A Major Incident exercise will be taking place soon and this will include a multi-provider response.

An impact assessment on how long the Trust can continue to work without utility services had been requested following a recent audit report. The Board noted that there is still further work to do on our preparedness and learning from major incidents.

The Chairman asked about the Health Emergency Planning team being disbanded. The Chief Operating Officer confirmed that they want to be hosted by a provider organisation but no clear decisions had been made. Further discussions were taking place at the Provider Chief Executives meeting. The Chairman asked about the financial implications of moving the Decontamination Unit. The Chief Operating Officer confirmed that these were yet to be established and the Estates and Finance teams were working together in this respect.

The Chief Operating Officer confirmed that a presentation on emergency preparedness will be given to the Board in December, 2016.

The Chairman and Board noted the report and progress made.

Presentation on Emergency Preparedness to the December Board meeting.

16/086.4 Complaints and Claims Report (Enclosure 9)
10.34am

The Director of Governance/Board Secretary presented the Complaints and Claims Report, given as Enclosure 9.

The Board noted the following key issues from the first quarter of 2016:

- 81 complaints received and all acknowledged in 3 working days.
- 36 resolution meetings held in the quarter.
- The number of dissatisfied complainants had increased in the quarter and further analysis will be included in future reports as the quick analysis done on the 9 within this report identified that 7 were in effect asking more questions and it was not that they were dissatisfied with response initially given.
- There were a spread of issues but mainly related to records, communication or the appointment delays category.
- There had been no Coroner Rule 28 reports to prevent future harm.
- Comparative information is now included on page 6 of the report as requested and shows the Trust continues to have a significantly lower level of complaints to compliments and when complaints are considered as a percentage of our activity we are performing better than our neighbouring trusts within the Black Country.
- The analysis of referrals made to the ombudsman and their judgements showed no significant issues which required amendments to our processes to be made.
- Information on clinical negligence claims and personal injury claims confirmed that the Trust continues to work well with the NHS Litigation Authority in this area.

The Chairman commented on the correlation opportunities that could be gained from other sources such as PALS information that were available to demonstrate dissatisfaction. The Director of Governance/Board Secretary confirmed that information is mapped across from Datix into all areas but he would look to include patient experience and friends and family results within that analysis. More detail will be provided in the next report.

The Chairman and Board noted the comprehensive report and continuing actions.

Further analysis on dissatisfied complainants to be included in future reports, making use of friend and family and patient experience analysis where appropriate.

16/086.5 Board and Committee Meeting Calendar (Enclosure 10)
10.42am

The Director of Governance/Board Secretary presented the Board and Committee Meeting Calendar, given as Enclosure 10.

The Board noted that the May Audit Committee date is currently the 16th May, which is early in the month and may be subject to change.

Mr Atkins, Non Executive Director, confirmed that the Workforce Committee had voiced concern at only meeting four times per year, given the amount of work currently being discussed by the Committee. It was recommended that the Committee meets every 2 months. The Director of Governance/Board Secretary will amend the Calendar. Dr Wulff, Non Executive Director, commented that it would be helpful to try and link the Workforce Committee meeting dates to Clinical Quality, Safety, Patient Experience Committee dates as had happened in the previous year.

The Chairman and Board noted the report and the change to the Workforce meetings.

The Director of Governance/Board Secretary to update the Calendar with the amended Workforce Committee dates.

16/086.6 End of Life and Palliative Care Strategy Group Report (Enclosure 11)
10.45am

Dr Wullf, Non Executive Director, presented the End of Life and Palliative Care Strategy Group Report, given as Enclosure 11.

The Board noted the following key issues:

The final version of the End of Life and Palliative Care Implementation Plan will be presented to the Committee later in the year.

Dr Wulff confirmed that there was some degree of uncertainty around how the group feeds into other organisations across the economy and it had asked the CCG to confirm how they would like to see this group reporting across the economy if it is not reporting into the Partnership Board as initially envisaged.

Mrs Becke, Non Executive Director, commented on a recent Quality Review held on B4 and confirmed that the staff were excited by the work being piloted there. The Chairman recognised the work and suggested the potential of an award nomination.

The Chairman and Board noted the report and the excellent presentation at the Annual Member Meeting on End of Life Care and the visit by the Macmillan Chief Executive Officer to the Mary Stevens Hospice. During the visit she was noted to have raised concerns regarding the impact of the potential disaggregation of Community services and its transfer potentially to another provider

16/086.7 Six New Requirements in NHS Standard Contracts for Hospitals in Relation to Hospital/General Practice Report (Enclosure 12)
10.48am

The Chief Operating Officer presented the Six New Requirements in NHS Standard Contracts for Hospitals in Relation to Hospital/General Practice Report, given as Enclosure 12.

The Board noted that the Trust was working towards the best possible level of compliance. The Chief Operating Officer had met with senior consultants that morning to discuss ways of assisting primary care colleagues.

The Medical Director was meeting with Dr Bramble and Dr Love to see how the Trust can make a difference to Dudley GPs.

The Chairman asked about timing of this requirment, as contracts had already been signed. The Chief Operating Officer confirmed that this was being discussed by the Contracts Board.

Mrs Becke, Non Executive Director, expressed concern regarding the Trust's partial compliance assessment in some of these areas. The Chief Operating Officer confirmed that there are two specialities with an issue but most are compliant. There is a plan in place to work toward full compliance.

Dr Wulff, stated that the Trust needs to have a clear understanding with General Practice around receiving and dealing with routine investigations.

The Chairman asked when a further update will be provided to Board. The Chief Operating Officer confirmed that the next report will be presented to the Board in January 2017.

The Chairman and Board noted the report and position and update to the January Board.

Further update on NHS Standard Contracts in relation to Hospital/General Practice to the January 2017 Board meeting.

16/086.8 NHS Improvement National A&E Improvement Plan Report (Enclosure 13) 10.55am

The Chief Operating Officer presented the NHS Improvement National A&E Improvement Plan Report, given as Enclosure 13.

The Board noted that the Trust is required to undertake six actions by September and November. Each Trust is given a rating from one to four and Dudley is in Group 4, which needs the lowest level of further intervention.

The Chief Operating Officer confirmed that the red areas are due to the roll out process and Dudley was further ahead with actions than most Trusts.

The Chairman and Board noted the report and position and passed their thanks to the team for maintaining flow in such difficult circumstances.

16/086.9 Quarterly Safeguarding Report (Enclosure 14) 11.00am

The Chief Nurse presented the Quarterly Safeguarding Report, given as Enclosure 14.

The Board noted the following key areas:

The CQC Looked After Child Review took place in May and the formal report had now been received and the Trust was developing an internal action plan as part of the health economy action plan which will be presented to the next Internal Safeguarding Board and then to the Clinical Quality, Safety and Patient Experience Committee.

A number of actions had already been put in train from the verbal feedback received and the Board will be kept updated on progress.

The detailed Mazars Report had been provided to the CCG. A summary of the report was attached to the papers and details were also contained within the Learning Disability Strategy

Access to Tier 4 CAHMS beds continues to be an issue and is included on the Trust's Corporate Risk Register and the risk score had been increased this year. The Chairman suggested that the Trust contacts NHS Improvement for their support and involvement. The Board supported this approach.

With regard to Safeguarding Training compliance a recovery plan is in place and the Trust will monitor achievement.

The Chairman and Board noted the report.

The Trust to contact NHS Improvement for their support and involvement in the access to Tier 4 CAHMS beds issue.

16/086.10 Workforce and Staff Engagement Committee Meeting Summary Report (Enclosure 15)
11.10am

Mr Atkins, Committee Chair, presented the Workforce and Staff Engagement Committee Summary Report, given as Enclosure 15.

The Board noted the highlights from the August meeting as follows:

- The Committee received the latest figures from the staff Friends and Family survey and a slight improvement was noted.
- The Committed was briefed on the forthcoming staff satisfaction survey.
- The Committee received the People Plan. The Director of HR will review the document for the next meeting.
- The Committee received the Apprenticeship report. The HR department were encouraged to ensure that the levy is used wherever possible.
- An improvement in sickness, turnover and nurse retention KPIs was noted.
- The Committee debated actions around mandatory training.
- The Committee received the action plan for flu vaccinations and initiatives.
- The Committee received an update on nurse vacancies.

The Board noted that the People Plan, update on nurse vacancies and further analysis on the funded establishment figure will be presented back to the Committee.

The Committee referred to the frequency of the meetings to the Board as discussed earlier on the agenda.

The HR Director commented that the Trust needs to refocus on the People Plan and objectives and create an HR infrastructure that provides better support to the organisation.

Mr Miner, Non Executive Director asked if the People Plan will include what an outstanding Trust should look like and how the Trust will get to that ideal. The HR Director confirmed that it will focus on areas where the Trust knows it can do better.

Mr Miner commented that the Trust needs to look at the bigger picture. The HR Director confirmed that talent management and aspirations will be included along with real actions for achievement.

The Chairman stated that we must get staff engagement right as our staff are a vital part of the Trust.

Mr Miner, Non Executive Director commented that the new EPR will be a cultural change and will require real staff involvement.

Mrs Becke, Non Executive Director, added that staff engagement is undermined by using agency staff.

The Chairman and Board noted the report and the change to the number of meetings held per year.

16/087 Any Other Business
11.19am

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

16/088 Date of Next Meeting
11.19pm

The next Board meeting will be held on Thursday, 6th October, 2016, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 1 September 2016

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
16/084	Chief Executive's Overview Report	Update to Board members on planning for the industrial action by 9th September, 2016	PB	9/9/16	Action Postponed. Update in CEs Report (Enc 3)
16/064.2	Transformation and Cost Improvement Programme Summary Report	Presentation on the Outpatient Programme to be delivered to the Board in October 2016.	AB	6/10/16	On Agenda (Enc 13)
16/073	Chief Executive's Overview Report	Freedom to Speak Up Guardian Report to be presented to the October Board.	CLM	6/10/16	On Agenda (Enc 12)
16/083	Patient Story	The Chief Operating Officer to provide the Board with additional background on equipment storage, process and provision. The Chief Operating Officer to investigate comments relating to recent workforce changes in the Community Nursing team.	PB PB	6/10/16 6/10/16	In CE's Report (Enc 3) In CE's Report (Enc 3)
16/085	Cost Improvement Programme and Transformation Overview Report	The Board to receive feedback on improvements to the Quality Impact Assessment process and report back to the next meeting.	AG	6/10/16	On Agenda (Enc 14)
16/086.1	Chief Nurse Report	Ward/specialty list to be included in future Chief Nurse Reports.	DWa	6/10/16	On Agenda (Enc 5)
16/086.5	Board and Committee Meeting Calendar	The Director of Governance/Board Secretary to update the Calendar with the amended Workforce Committee dates.	GP	6/10/16	Done
16/086.9	Quarterly Safeguarding Report	The Trust to contact NHSI for their support and involvement in the access to Tier 4 CAHMS beds issue.	DWa	6/10/16	

16/086.4	Complaints and Claims Report	Further analysis on dissatisfied complainants to be included in future reports, including friends and family and patient experience.	GP	3/11/16	
16/030.3 & 16/086.3	NHS Preparedness for a Major Incident	Sharon Walford to be invited to present on Emergency Preparedness at a future Board General Clinical Presentation.	PB	1/12/16	This date is the next scheduled General Clinical Presentation.
16/086.7	Six New Requirements in NHS Standard Contracts for Hospitals in Relation to Hospital/General Practice Report	Further update on NHS Standard Contracts in relation to Hospital/General Practice to the January 2017 Board meeting.	PB	5/1/17	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 6th October 2016

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

SUMMARY OF KEY ISSUES:

- Friends and Family
- Industrial Action Assurance
- Update from September Patient Story

IMPLICATIONS OF PAPER:

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

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

Decision	Approval	Discussion	Other

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

The Dudley Group NHS
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CORPORATE OBJECTIVES : *(Please select for inclusion on front sheet)*

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

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

The Dudley Group NHS
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Chief Executive's Report – Public Board – October 2016

Patient Friends and Family Test:

Quality Priority - Patient Experience

Based on the latest published NHS figures (July 2016) all areas of the Trust continue to meet the quality priority target of monthly scores that are equal to or better than the national average for the percentage of patients who would recommend the service to friends and family, with the exception of Inpatients which saw a decrease in recommend score to 95.6% this is the first time it has been below the national average in over 12 months. Although Outpatients again scored highly with 92% of patients recommending our services it is just short of the national average of 93%.

The FFT response rate rectification plan continues to be implemented and has seen an incease in rates moving towards the national average.

Industrial Action Assurance:

In preparation for this round of industrial action, the Trust was asked to provide assurance to NHS England via the A&E Delivery Board submission. Most teams who were asked to contribute to this document confirmed that extra arrangements were in place for the proposed 7 days. The A&E Delivery Board assurance document was being completed as responses came in with ambers for UCC, social services and mental health as we are waiting for assurance in these areas. The divisions were preparing rota's to provide assurance that senior cover was available in all areas in preparation for the IA.

Update from September Patient Story

There is a community store and it is based in Pensnett, the store is operated by the local authority and there is a correct ordering procedure to allocate equipment from the stores, all of our community staff are trained to assess for equipment for community patients, the basic stores required equipment such as walking aids, toileting aids or basic pressure relieving equipment is kept in stock. In hours Monday to Friday this store is easily accessed by all community staff and same day delivery is available in some if not most circumstances.

Community services also hold a peripheral store at Brierley Hill Health and Social Care Centre for use out of hours for toileting equipment, walking aids and basic pressure relieving equipment. If stores do not have the more complex pressure relieving aids and beds The Trust uses a company called Parkhouse which is 24/7 service and has a 4 hour delivery window.

There is on-going work with the CCG to provide a more seamless cover from the stores out of hours.

The changes within community teams has been a long process and the Trust has integrated 23 teams into 5 teams. Continuity of care concerns should now have been addressed as we have invested a lot time into the teams to ensure that we have a good even skill mix for each locality.

Patients have now been clearly allocated within the caseloads and within a GP zone in each locality, this has addressed the continuity of care for nursing teams.

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on Thursday, 6th October, 2106

TITLE:	**Organ Donation Report**		
AUTHOR:	**Julian Sonksen**	**PRESENTER**	**Julian Sonksen OD Lead**
CORPORATE OBJECTIVE: S01/S02			
SUMMARY OF KEY ISSUES: **Organ Donation Annual Report from NHS Blood and Transplant**			

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			To Note

RECOMMENDATIONS FOR THE BOARD

To note contents of report.

The Dudley Group NHS
NHS Foundation Trust

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

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

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

Organ Donation Committee (ODC)

Trust Board Report

6th October 2016

Dr Julian Sonksen CL-OD (on behalf of the ODC)

The Dudley Group NHS
NHS Foundation Trust

Year April 2015-2016

- Donation activity
- NHSBT PDA Quality markers

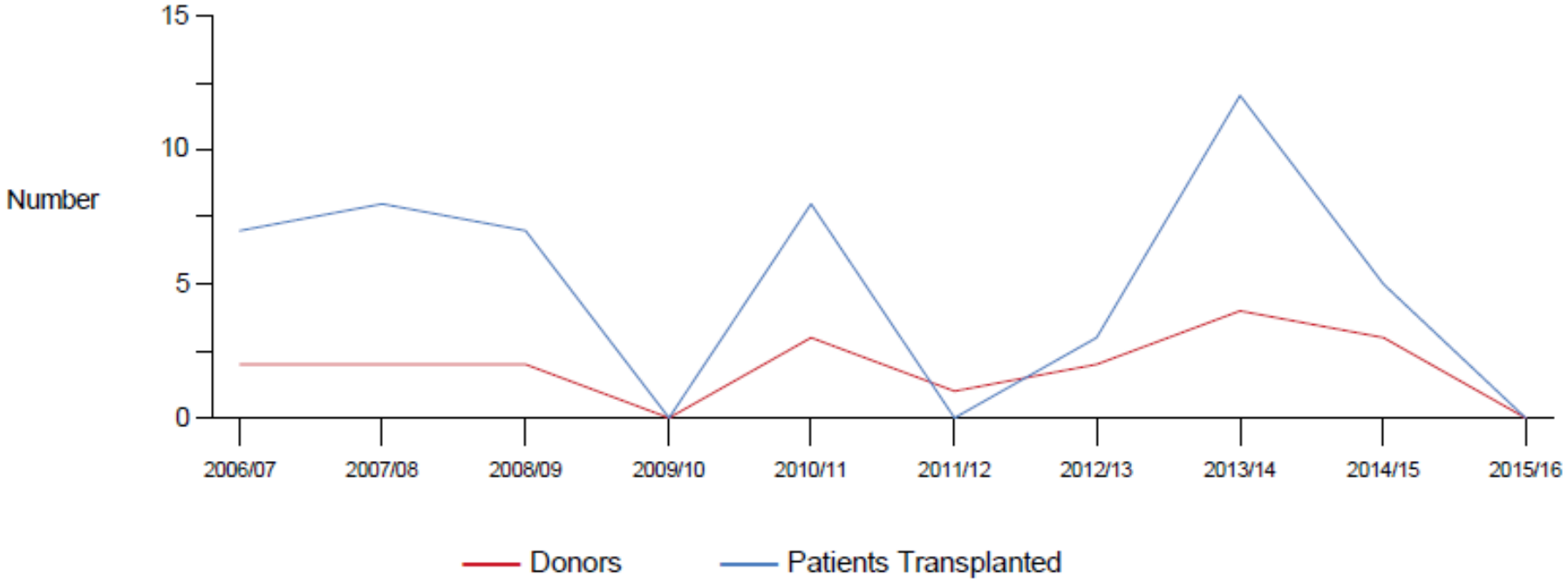
- Embedded Specialist Nurse-OD
- NHSBT response

- National Organ Donation & Transplantation Congress 2016
- ODC Plan for coming year

The Dudley Group NHS
NHS Foundation Trust

Donor Activity

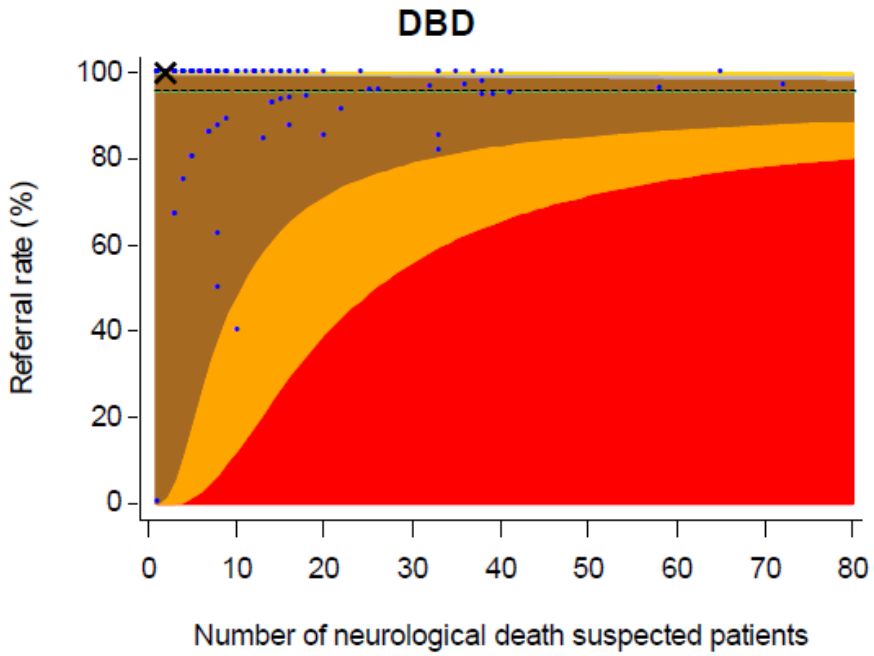
- Donors 0
- Patients Transplanted 0

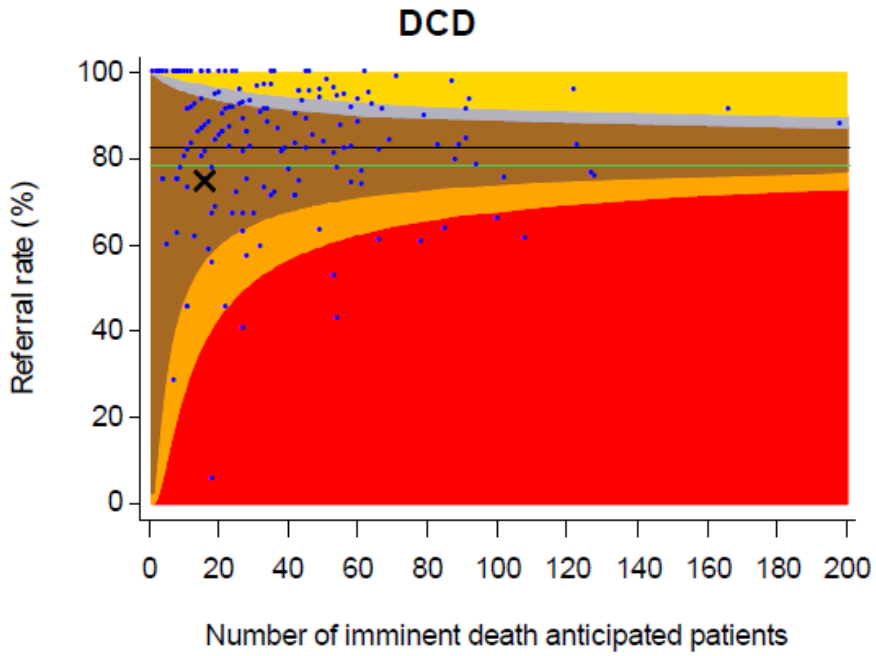


The Dudley Group NHS
NHS Foundation Trust

NHSBT PDA Quality markers

- Referral to Specialist Nurse (NHSBT)





The Dudley Group NHS
NHS Foundation Trust

NHSBT PDA Quality markers

- Formal approach to family

2/2 eligible, approached

3/13 eligible, approached

Table 3.5.1 Reasons given why family not formally approached, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Patient's general medical condition	-	-	5	50.0
Other	-	-	5	50.0
Total	**-**	**-**	**10**	**100.0**

If 'other', please contact your local SN-OD for more information, if required.

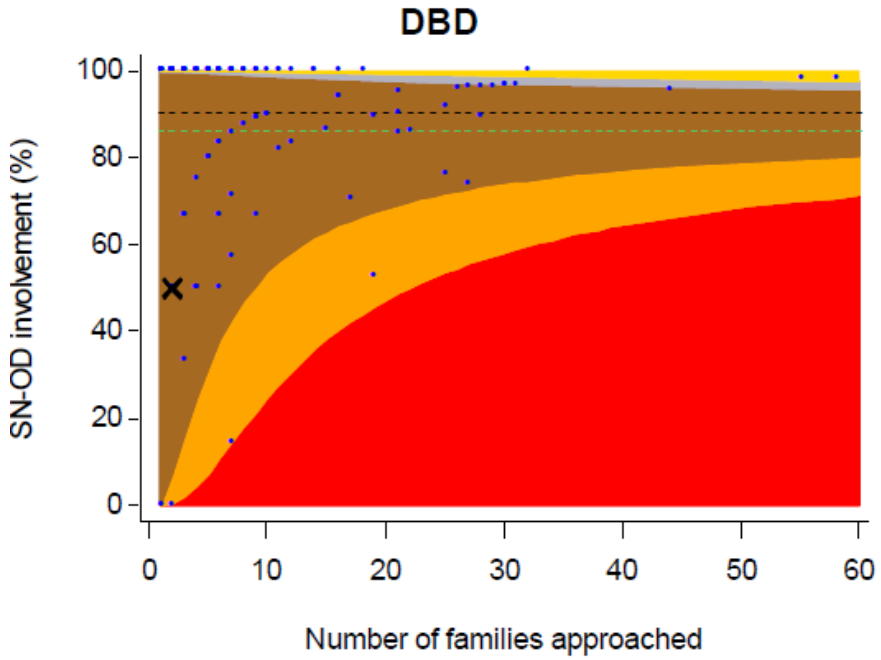
Number of eligible DBD

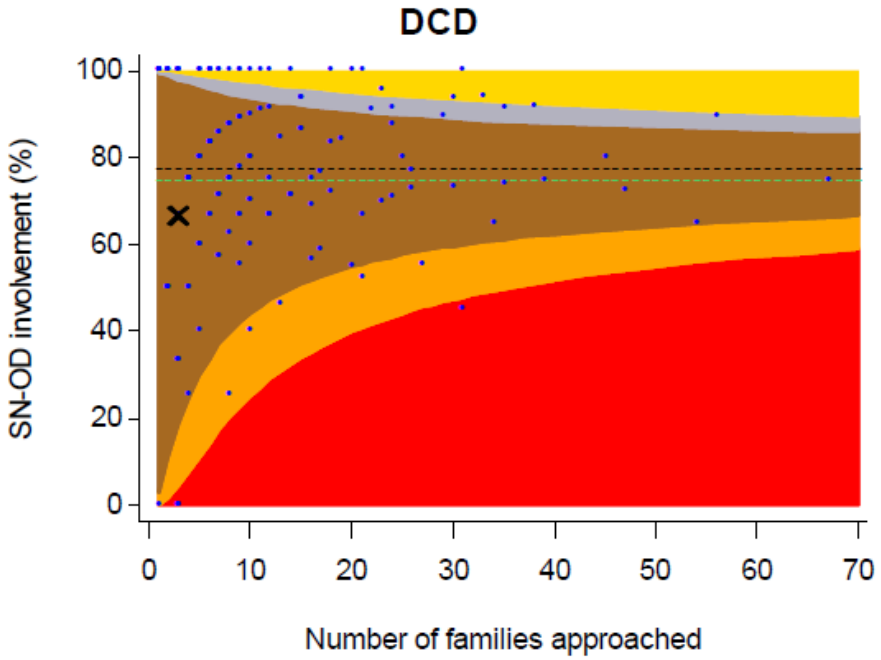
Number of eligible DCD

The Dudley Group NHS
NHS Foundation Trust

NHSBT PDA Quality markers

- SN-OD involved in approach





The Dudley Group NHS
NHS Foundation Trust

NHSBT PDA Quality markers

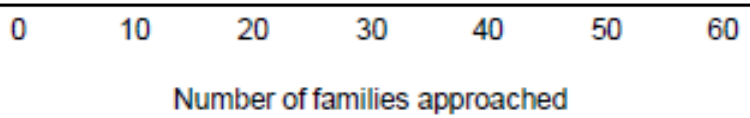
- Family Consent rate

DBD **DCD**

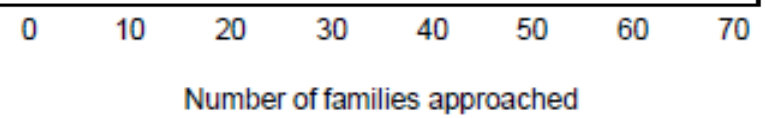
Table 3.7.1 Reasons given why family did not give consent, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	**%**	**N**	**%**
Family were not sure whether the patient would have agreed to donation	1	50.0	-	-
Other	1	50.0	-	-
Total	**2**	**100.0**	**-**	**-**

If 'other', please contact your local SN-OD for more information, if required.



Number of families approached



Number of families approached

The Dudley Group NHS
NHS Foundation Trust

NHSBT PDA Quality markers

- Proceed to donation

DBD	DCD
0/0 who consented	0/3 who consented

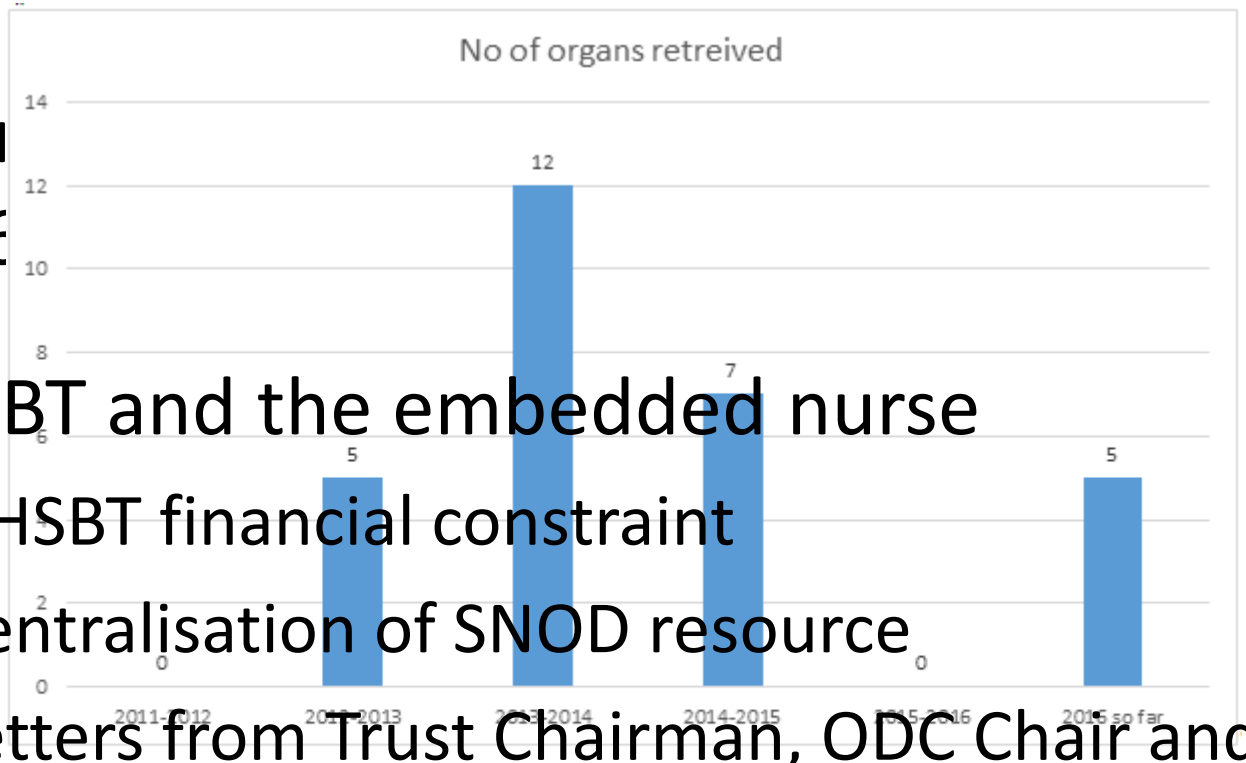
Table 3.8.1 Reasons why solid organ donation did not occur, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Family changed mind	-	-	1	33.3
Prolonged time to asystole	-	-	1	33.3
General instability	-	-	1	33.3
Total	**-**	**-**	**3**	**100.0**

If 'other', please contact your local SN-OD for more information, if required.

The Dudley Group NHS
NHS Foundation Trust

Embedded Specialist Nurse



- Retu Feb 2016
- NHSBT and the embedded nurse
  - NHSBT financial constraint
  - Centralisation of SNOD resource
  - Letters from Trust Chairman, ODC Chair and CL-OD
- Black Country resource

CARE RESPECT RESPONSIBILITY

The National Organ Donation and Transplantation Congress 2016

The Dudley Group NHS
NHS Foundation Trust

- Du
  pa
- Gi
  Pr
- Re

Dudley
Metropolitan Borough Council

The Dudley Group NHS
NHS Foundation Trust

Results

Dudley Borough	UK
– 31st March 2012	– 31st March 2012
• 57,135 on ODR	• 19 128 712 on ODR
– By 31st March 2016	– By 31st march 2016
• 72,357 on ODR	• 22 486 113 on ODR
• 27% relative increase	• 17% relative increase

Each year the percentage rise in Dudley greater than for UK

Data: *Statistics and Clinical Studies*, NHS Blood and Transplant, population estimates mid-2014

CARE RESPECT RESPONSIBILITY

WHERE PEOPLE MATTER dgnhs

ODC Plans 2016/2017

The Dudley Group NHS
NHS Foundation Trust

- Target
  - Formal approach
  - SN-OD involvement with approach
- Work with BC SNODs to secure on-site presence
- Project to work with local minority communities to improve understanding of Organ Donation and registrations on ODR

NHS
Blood and Transplant

Detailed Full Report

Actual and Potential Organ Donors

1 April 2015 - 31 March 2016

The Dudley Group Of Hospitals NHS Foundation Trust

Table of Contents

Further Information

- Appendix A.4 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA on 1 April 2013.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/odt/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2016 based on data reported at 9 May 2016.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated, obtained from the UK Transplant Registry

1.1 Donor outcomes

Between 1 April 2015 and 31 March 2016, The Dudley Group Of Hospitals NHS Foundation Trust had no deceased solid organ donors. If you would like further information, please contact your local Specialist Nurse - Organ Donation (SN-OD).

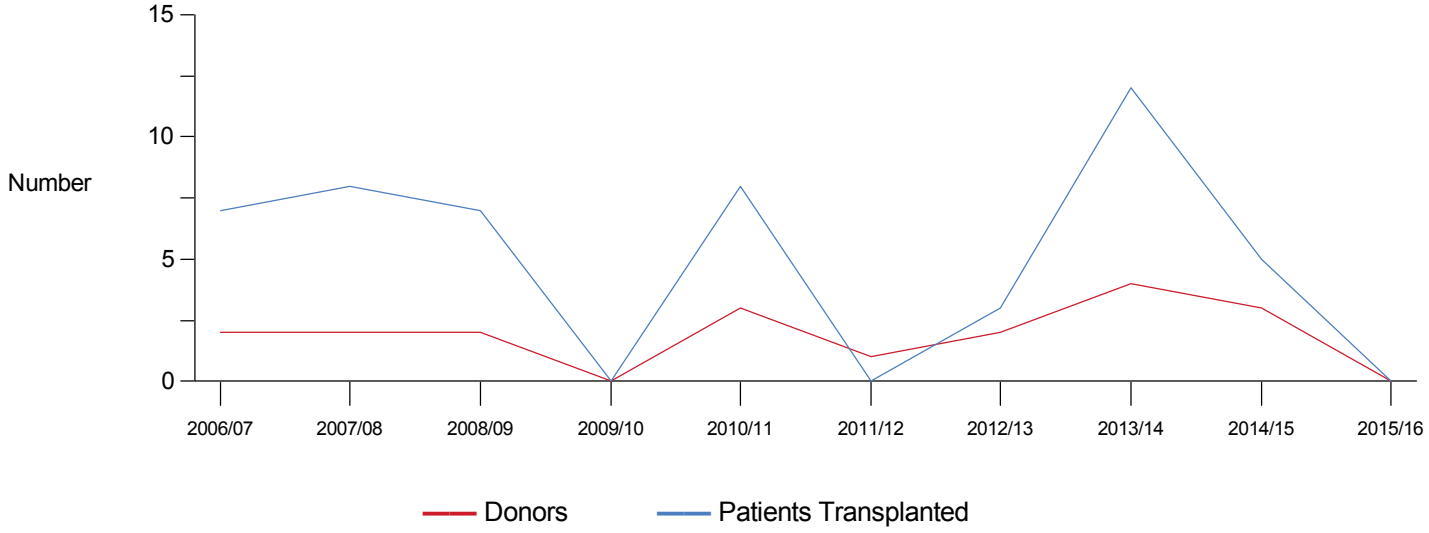
Table 1.1.1 Donors, patients transplanted and organs per donor, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		Average number of organs donated per donor UK	
DBD	0	(0)	0	(0)	-	(-)	3.9	(3.8)
DCD	0	(3)	0	(5)	-	(2.3)	2.8	(2.7)
DBD and DCD	0	(3)	0	(5)	-	(2.3)	3.4	(3.4)

Table 1.1.2 Organs transplanted by type, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)
DCD	0	(3)	0	(1)	0	(2)	0	(0)	0	(0)	0	(0)
DBD and DCD	0	(3)	0	(1)	0	(2)	0	(0)	0	(0)	0	(0)

Figure 1.1.1 Number of donors and patients transplanted each year



Data in this section have been obtained from the UK Transplant Registry. Section 2 onwards reports on data obtained from the national Potential Donor Audit (PDA).

2. Key Rates on Potential for Organ Donation

A summary of the key rates on the potential for organ donation, obtained from the national Potential Donor Audit (PDA)

2.1 Key rates

Two radar charts are displayed in Figure 2.1.1 showing specific percentage measures of potential donation activity in 2015/16 for The Dudley Group Of Hospitals NHS Foundation Trust compared with national data for the UK, and compared with 2014/15 activity. This information is displayed in an alternative format as bar charts in Appendix A.1. The funnel plots in Section 3 can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential.The colour of the rate label indicates the Trust performance as shown in the appropriate funnel plot using the gold, silver, bronze, amber, and red (GoSBAR) scheme. Figure 2.1.2 shows the trends in percentage meaures of potential donation activity from 1 April 2013.

Figure 2.1.1 Key rates on the potential for organ donation, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

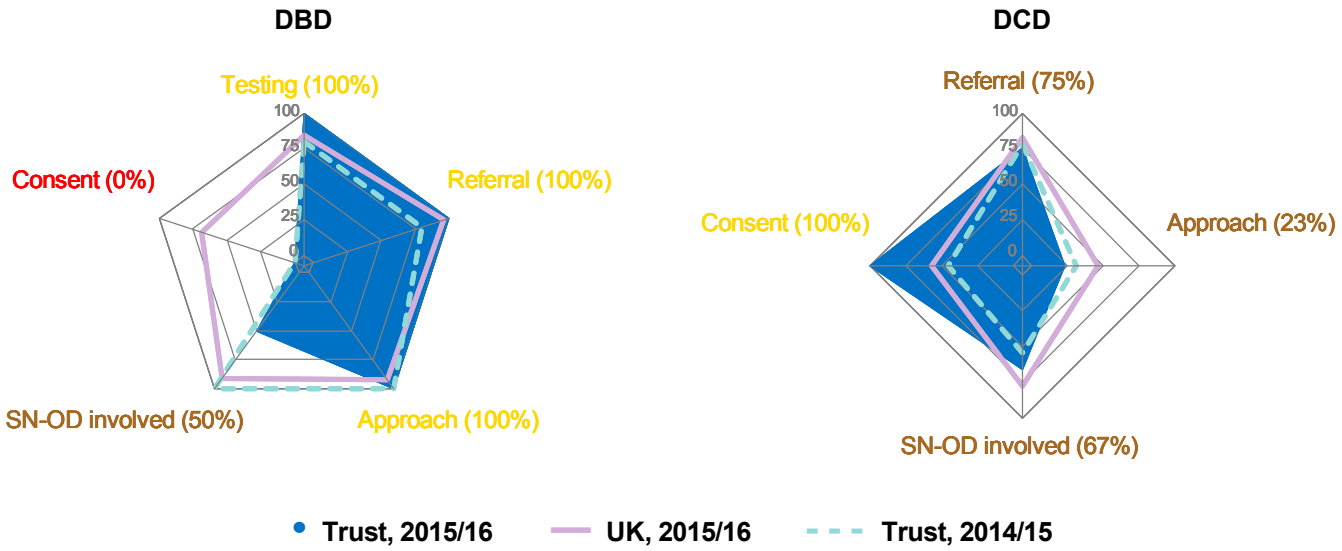
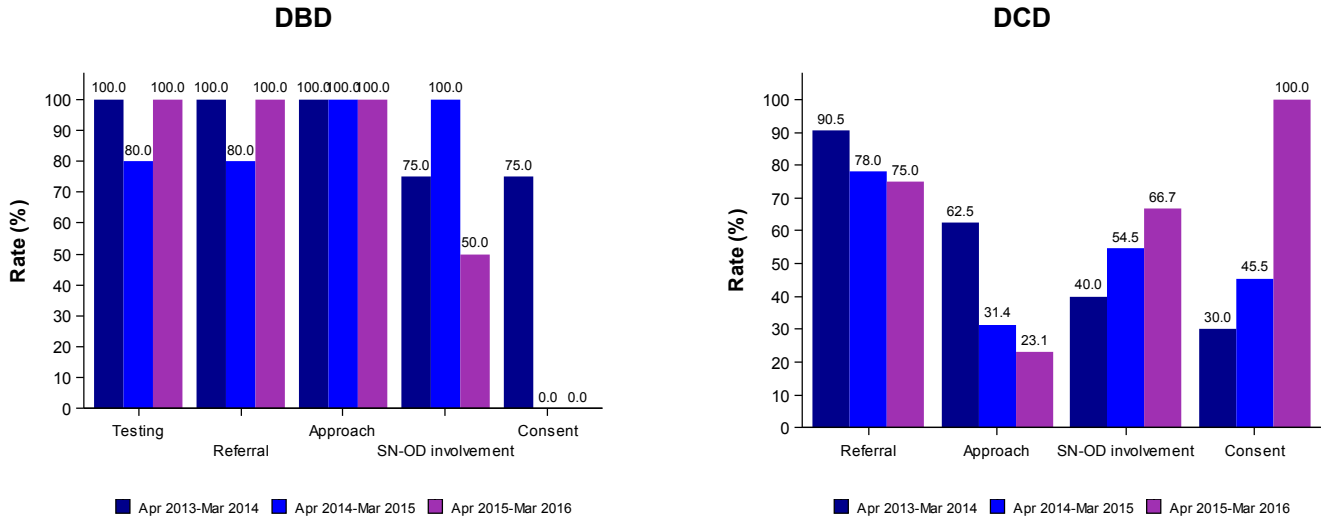


Figure 2.1.2 Key rates on the potential for organ donation, 1 April 2013 - 31 March 2016



2.2 Key numbers, rates and comparison with national targets

The percentages shown in Figure 2.1.1 are also shown in Table 2.2.1 along with the number of patients at each stage. A national comparison and a time period comparison are again provided. A comparison against funnel plot boundaries has been applied by highlighting the key rates for your Trust as gold, silver, bronze, amber, or red. See Appendix A.6 for ranges used. Note that caution should be applied when interpreting percentages based on small numbers.

Table 2.2.1 Key numbers, rates and comparison with national targets, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

	DBD						DCD				
		2015/16		2014/15			2015/16			2014/15	
	Target	Trust	UK	Trust	UK	Target	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]		2	1,742	5	1,734		16	6,502	41	6,755
Referred to SN-OD		2	1,679	4	1,671		12	5,399	32	5,154
Referral rate %	*96%*	G *100%*	*96%*	*80%*	*96%*	*79%*	B *75%*	*83%*	*78%*	*76%*
Neurological death tested		2	1,472	4	1,445					
Testing rate %	*82%*	G *100%*	*85%*	*80%*	*83%*					
Eligible donors[2]		2	1,399	1	1,373		13	4,204	35	4,284
Family approached		2	1,293	1	1,284		3	1,941	11	2,018
Approach rate %	*94%*	G *100%*	*92%*	*100%*	*94%*	*47%*	B *23%*	*46%*	*31%*	*47%*
Family approached and SN-OD involved		1	1,177	1	1,113		2	1,511	6	1,459
% of approaches where SN-OD involved	*87%*	B *50%*	*91%*	*100%*	*87%*	*75%*	B *67%*	*78%*	*55%*	*72%*
Consent given		0	888	0	859		3	1,112	5	1,046
Consent rate %	*73%*	R *0%*	*69%*	*0%*	*67%*	*59%*	G *100%*	*57%*	*45%*	*52%*
Expected consents based on ethnic mix		1		1			1		3	
Expected consent rate based on ethnic mix %		*74%*		*70%*			*61%*		*55%*	
Actual donors from each pathway		0	784	0	780		0	566	3	493
% of consented donors that became actual donors		*N/A*	*88%*	*N/A*	*91%*		*0%*	*51%*	*60%*	*47%*

Colour key - comparison with funnel plot confidence limits	G *Gold*	S *Silver*	B *Bronze*	
	A *Amber*	R *Red*		

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

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

3. Stages Where Opportunities were Lost

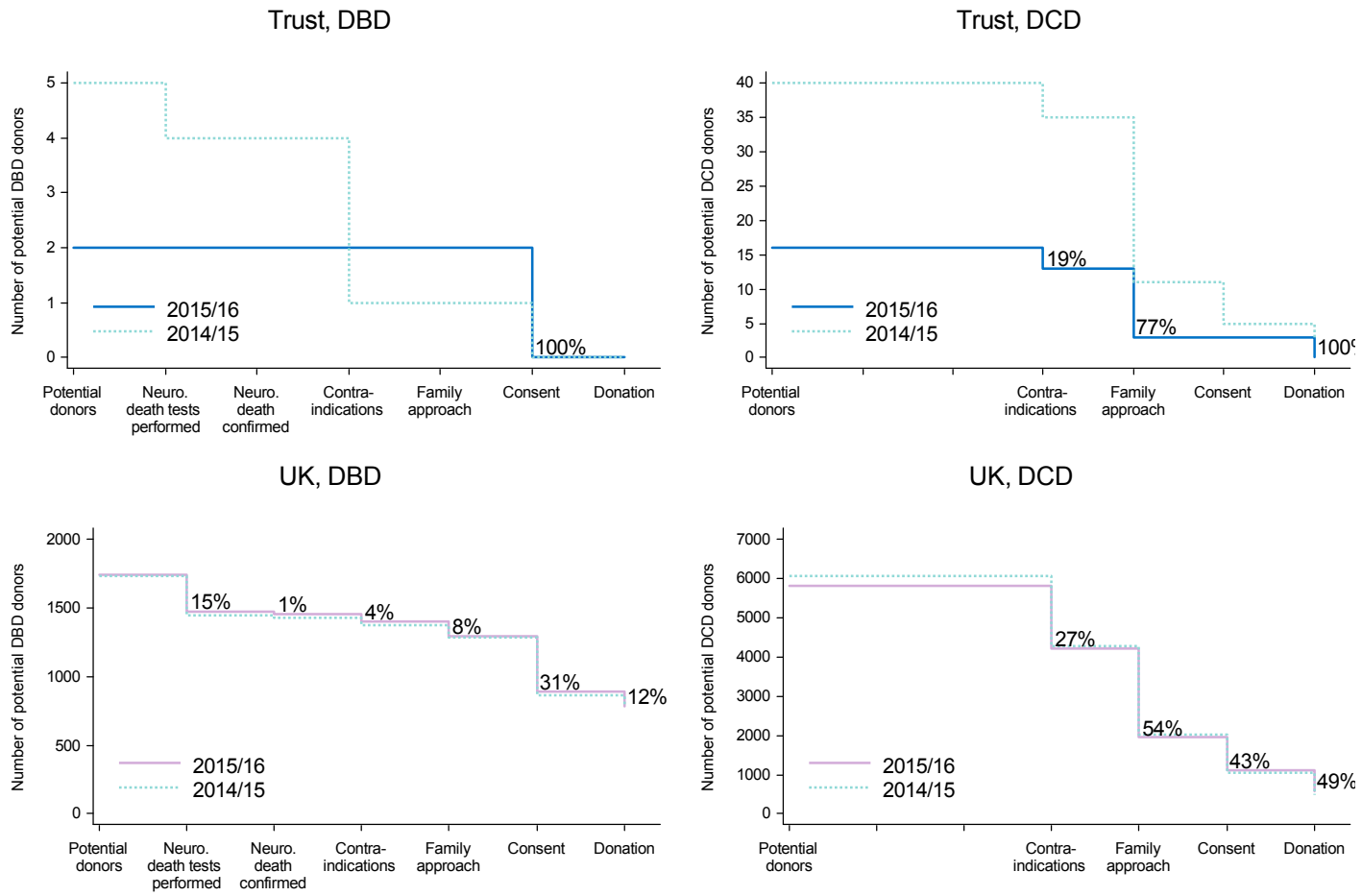
Stages at which potential donors lost the opportunity to become actual donors

3.1 Overview of lost opportunities

Neither of the potential DBD donors with suspected neurological death proceeded to donation. None of the 13 eligible DCD donors proceeded to donation.

Figure 3.1.1 gives an overview of the various stages where opportunities were lost. There are four charts showing DBD and DCD stages separately for The Dudley Group Of Hospitals NHS Foundation Trust and the UK, all of which contain a comparison with 2014/15. The number of potential donors is shown on the vertical axis for each chart and at each 'step' the proportion of potential donors lost at that stage is displayed. Caution should be applied when interpreting percentages based on small numbers. Further information is available for individual hospitals and units in Tables 4.1.1 and 4.1.2 in Section 4.

Figure 3.1.1 Stages at which potential donors lost the opportunity to become actual donors, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)



3.2 Neurological death testing

A funnel plot of neurological death testing rates is displayed in Figure 3.2.1. The national target for 2015/16 of 82% is also shown on the funnel plot, for information, but the goal is to ensure that neurological death tests are performed wherever possible. For information about how to interpret the funnel plots, please see Appendix A.6.

Figure 3.2.1 Funnel plot of neurological death testing rates, 1 April 2015 - 31 March 2016

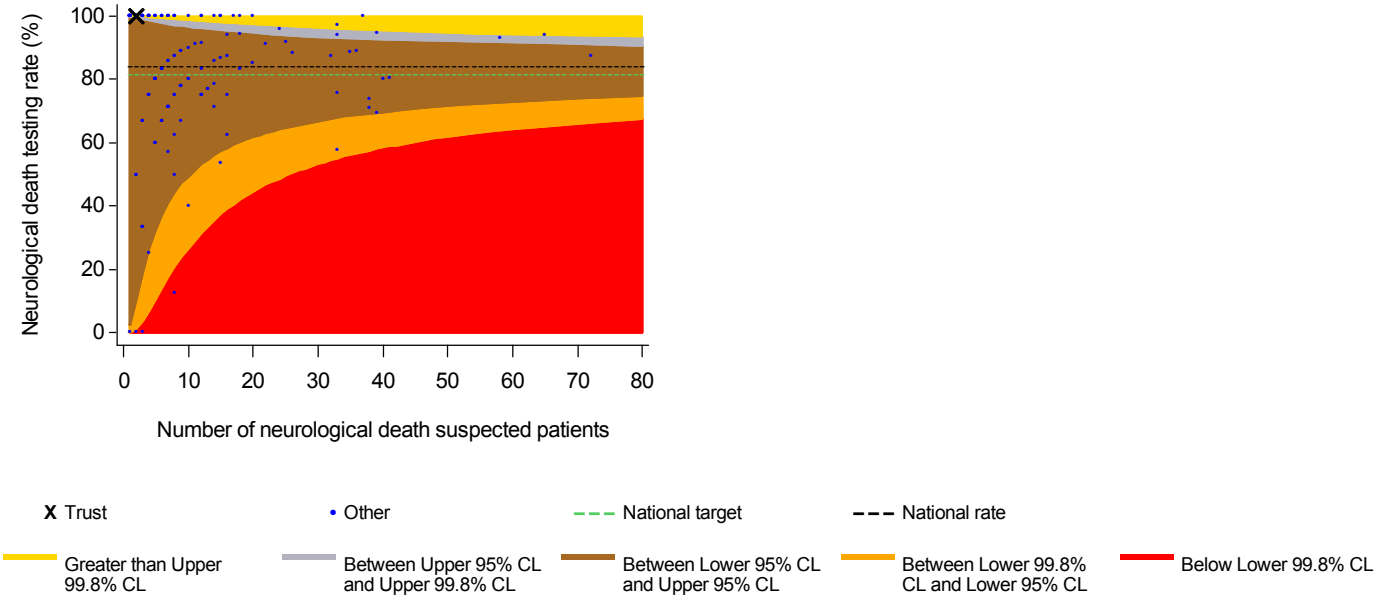


Table 3.2.1 shows the reasons why neurological death tests were not performed, if applicable, for your Trust. Patients for whom the reason for not performing neurolgical tests is given as 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', or 'neonates - less than 2 months post term' are now excluded from the calculation of the neurological death testing rate and Table 3.2.1.

Table 3.2.1 Reasons given for neurological death tests not being performed, 1 April 2015 - 31 March 2016

	N	%
All patients were tested or there were no patients with suspected neurological death	-	-

If 'other', please contact your local SN-OD for more information, if required.

3.3 Referral to Specialist Nurse - Organ Donation (SN-OD)

Funnel plots of DBD and DCD referral rates are displayed in Figure 3.3.1. The 2015/16 national targets of 96% and 79% for DBD and DCD, respectively, are also shown on the funnel plots, for information. Every patient who meets the referral criteria should be identified and referred to the SN-OD, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 3.3.1 Funnel plots of referral rates, 1 April 2015 - 31 March 2016

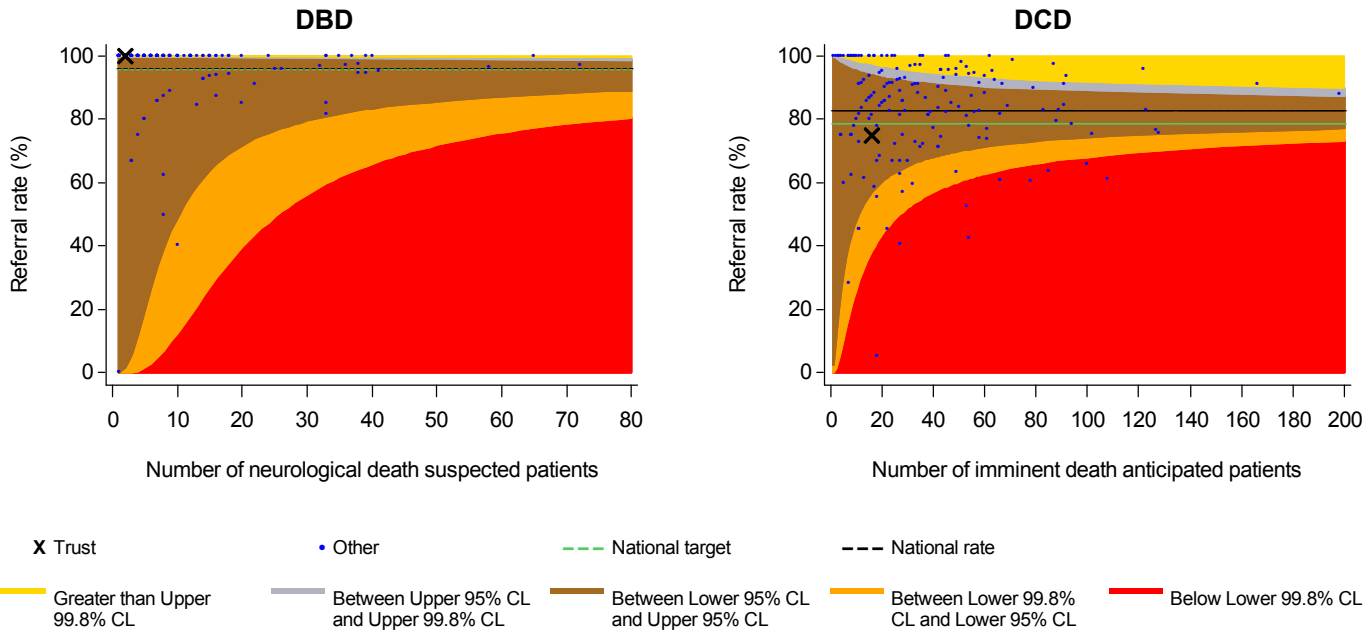


Table 3.3.1 shows the reasons why patients were not referred to a SN-OD, if applicable, for your Trust.

Table 3.3.1 Reasons given why patient not referred, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Medical contraindications	-	-	1	25.0
Other	-	-	3	75.0
Total	**-**	**-**	**4**	**100.0**

If 'other' or 'medical contraindications', please contact your local SN-OD for more information, if required. Please note that patients may appear in this table more than once if they met the referral criteria for both DBD and DCD donation.

Early referral to the SN-OD is important to enable the opportunity for donation to be maximised. Early referral triggers should be in place to ensure all donors are identified to the SN-OD to allow the family the option of organ donation. For patients who were referred, Table 3.3.2 shows the timing of the first contact with the SN-OD by the clinical staff. All patients meeting the referral criteria should be referred as early as possible to enable attendance of the SN-OD to assess suitability for donation and ensure that a planned approach for consent to the family is made in line with NICE CG135[1] and NHSBT Best Practice Guidance on approaching the families of potential organ donors[3].

Table 3.3.2 Timing of first contact with a SN-OD by clinical staff, for patients who were referred, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Before sedation stopped	-	0.0	-	0.0
Absence of one or more cranial nerve reflexes and GCS of 4 or less not explained by sedation	1	50.0	-	0.0
No sedation or after sedation stopped, decision made to carry out BSD tests, before 1st set of tests	1	50.0	1	8.3
After 1st set and before 2nd set of BSD tests	-	0.0	-	0.0
After neurological death confirmation	-	0.0	-	0.0
Clinical decision to withdraw life-sustaining treatment has been made, before treatment withdrawn	-	0.0	11	91.7
After treatment withdrawn	-	0.0	-	0.0
Not reported	-	0.0	-	0.0
Total	**2**	**100.0**	**12**	**100.0**

NB, 0 patients with suspected neurological death also went on to meet the referral criteria for DCD donation, and are therefore included twice.

[1] NICE, 2011. *NICE Clinical Guidelines - CG135* [online]. Available at: <http://publications.nice.org.uk/organ-donation-for-transplantation-improving-donor-identification-and-consent-rates-for-deceased-cg135/recommendations> [accessed 9 May 2016]

[2] NHS Blood and Transplant, 2012. *Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice* [online]. Available at: <http://www.odt.nhs.uk/pdf/timely-identification-and-referral-potential-donors.pdf> [accessed 9 May 2016]

[3] NHS Blood and Transplant, 2013. *Approaching the Families of Potential Organ Donors – Best Practice Guidance* [online]. Available at: <http://www.odt.nhs.uk/pdf/family_approach_best_practice_guide.pdf> [accessed 9 May 2016]

3.4 Contraindications

Table 3.4.1 shows the primary absolute medical contraindications to solid organ donation, if applicable, for potential DBD donors confirmed dead by neurological death tests and potential DCD donors in your Trust.

Table 3.4.1 Primary absolute medical contraindications to solid organ donation, 1 April 2015 - 31 March 2016

	DBD	DCD
Any cancer with evidence of spread outside affected organ (including lymph nodes) within 3 years	-	2
Active haematological malignancy (myeloma, lymphoma, leukaemia)	-	1
Total	**-**	**3**

3.5 Family approach

Funnel plots of DBD and DCD family approach rates are displayed in Figure 3.5.1. The 2015/16 national targets of 93.5% and 47% for DBD and DCD, respectively, are also shown on the plots, for information. All families of eligible donors should be formally approached for a decision about organ donation.

Figure 3.5.1 Funnel plots of approach rates, 1 April 2015 - 31 March 2016

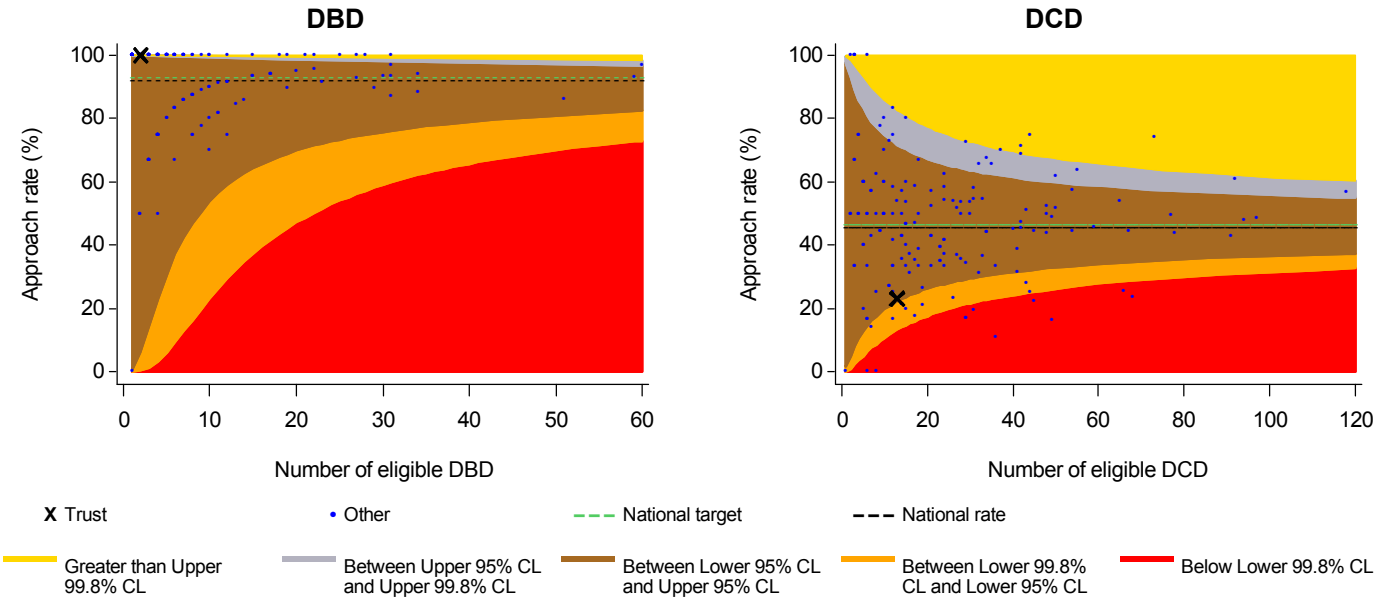


Table 3.5.1 shows the reasons why patients were not formally approached for a decision about organ donation, if applicable, for your Trust.

Table 3.5.1 Reasons given why family not formally approached, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	**%**	**N**	**%**
Patient's general medical condition	-	-	5	50.0
Other	-	-	5	50.0
Total	**-**	**-**	**10**	**100.0**

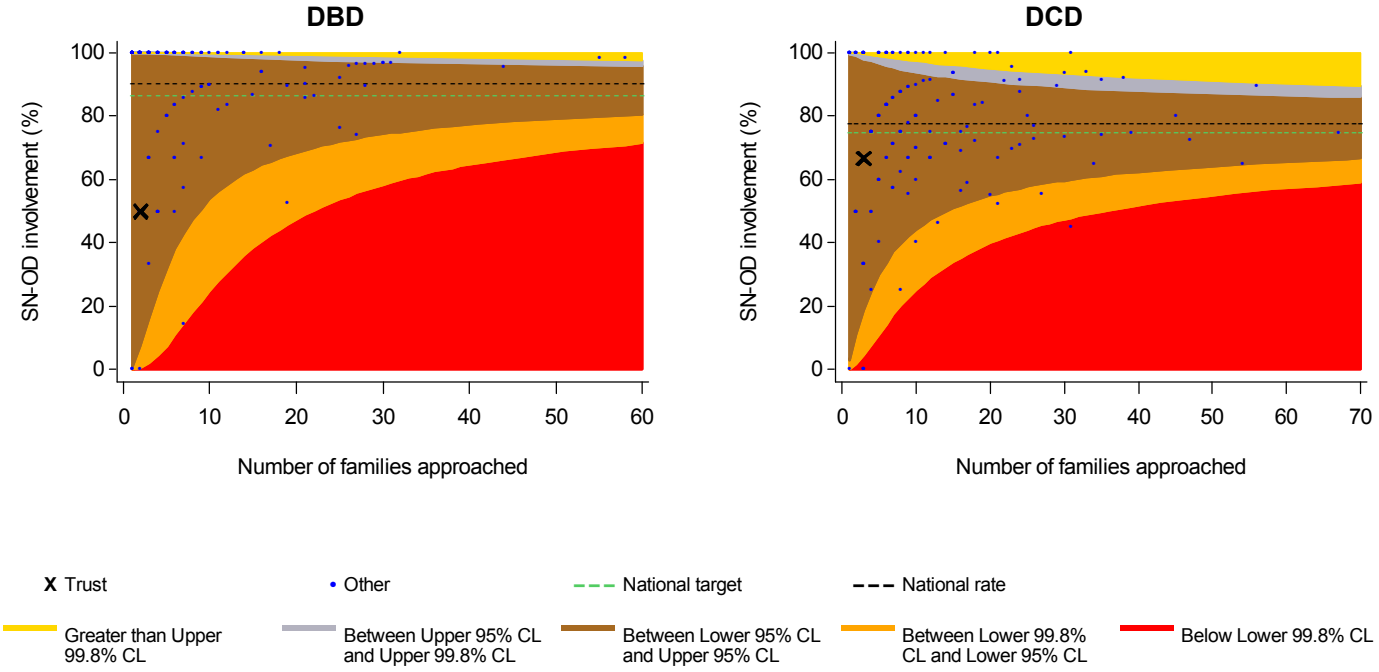
If 'other', please contact your local SN-OD for more information, if required.

3.6 Proportion of approaches involving a SN-OD

In the UK, in 2015/16, when a SN-OD was not involved in the approach to the family for a decision about organ donation, DBD and DCD consent rates were 51% and 24%, respectively, compared with DBD and DCD consent rates of 70% and 67%, respectively, when a SN-OD was involved. NICE CG135[1] and NHSBT Best Practice Guidance on approaching the families of potential organ donors[3] reinforces that every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SN-OD and should be clearly planned taking into account the known wishes of the patient. The Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Funnel plots of DBD and DCD SN-OD involvement rates are displayed in Figure 3.6.1. The 2015/16 national targets of 87% and 75% for DBD and DCD, respectively, are also shown, for information. A SN-OD should be actively involved in the formal approach to the family and an approach plan made and followed.

Figure 3.6.1 Funnel plots of SN-OD involvement rates, 1 April 2015 - 31 March 2016



3.7 Consent

Funnel plots of DBD and DCD consent rates are displayed in Figure 3.7.1. The 2015/16 national targets of 72.5% and 58.5% for DBD and DCD, respectively, are also shown, for information.

Figure 3.7.1 Funnel plot of consent rates, 1 April 2015 - 31 March 2016

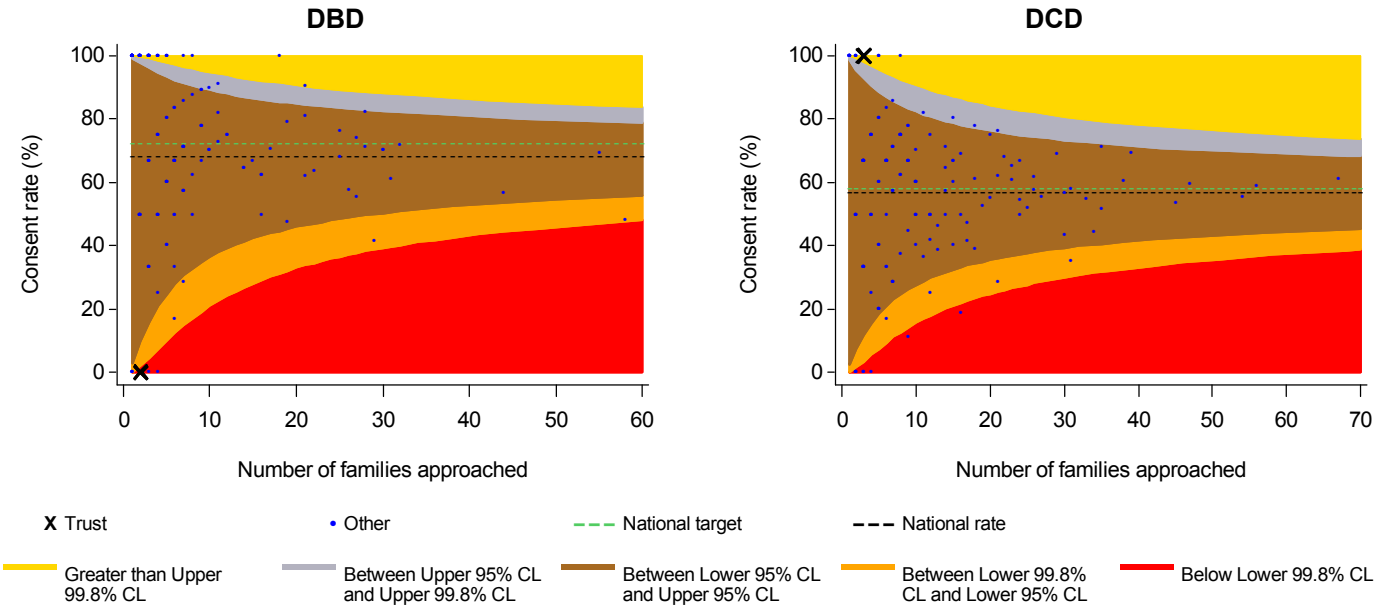


Table 3.7.1 shows the reasons why families did not give consent, if applicable, for your Trust.

Table 3.7.1 Reasons given why family did not give consent, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Family were not sure whether the patient would have agreed to donation	1	50.0	-	-
Other	1	50.0	-	-
Total	**2**	**100.0**	**-**	**-**

If 'other', please contact your local SN-OD for more information, if required.

3.8 Reasons why solid organ donation did not occur

Table 3.8.1 shows the reasons why solid organ donation did not occur, if applicable, for your Trust.

Table 3.8.1 Reasons why solid organ donation did not occur, 1 April 2015 - 31 March 2016

	DBD		DCD	
	N	%	N	%
Family changed mind	-	-	1	33.3
Prolonged time to asystole	-	-	1	33.3
General instability	-	-	1	33.3
Total	**-**	**-**	**3**	**100.0**

If 'other', please contact your local SN-OD for more information, if required.

4. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where the patient died

4.1 Key numbers and rates by unit where the patient died

Tables 4.1.1 and 4.1.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Caution should be applied when interpreting percentages based on small numbers. For each of the units tabulated in Tables 4.1.1 and 4.1.2, the national key rates from the PDA are displayed in Appendix A.2 to aid comparison with equivalent units. For example, neurosurgical ICUs can be compared against the average rates achieved nationally for neurosurgical ICUs.

Table 4.1.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

Unit where patient died	Patients where neurological death was suspected	Patients that were tested	Neurological death testing rate (%)	Patients where neurological death was suspected that were referred to SN-OD	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors (Death confirmed by neurological tests and no absolute contra-indications)	Eligible DBD donors whose family were approached	DBD approach rate (%)	Families consenting donation	DBD consent rate (%)	Actual DBD and DCD donors from eligible DBD donors	DBD SN-OD involvement rate (%)
1 April 2015 to 31 March 2016													
Dudley, Russells Hall Hospital													
General ICU	2	2	100	2	100	2	2	2	100	0	0	0	50
1 April 2014 to 31 March 2015													
Dudley, Russells Hall Hospital													
A&E	0	0	-	0	-	0	0	0	-	0	-	0	-
General ICU	5	4	80	4	80	4	1	1	100	0	0	0	100

Table 4.1.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2015 - 31 March 2016 (1 April 2014 - 31 March 2015 for comparison)

Unit where patient died	Patients for whom imminent death was anticipated	Patients for whom imminent death was anticipated that were referred to SN-OD	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors (Imminent death anticipated and treatment withdrawn with no absolute contra-indications)	Eligible DCD donors whose family were approached	DCD approach rate (%)	Families consenting donation	DCD consent rate (%)	Actual DCD donors from eligible DCD donors	DCD SN-OD involvement rate (%)
1 April 2015 to 31 March 2016											
Dudley, Russells Hall Hospital											
General ICU	16	12	75	16	13	3	23	3	100	0	67
1 April 2014 to 31 March 2015											
Dudley, Russells Hall Hospital											
A&E	4	1	25	4	3	0	0	0	-	0	-
General ICU	37	31	84	36	32	11	34	5	45	3	55

Tables 4.1.1 and 4.1.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total, for The Dudley Group Of Hospitals NHS Foundation Trust in 2015/16 there was one such patient.

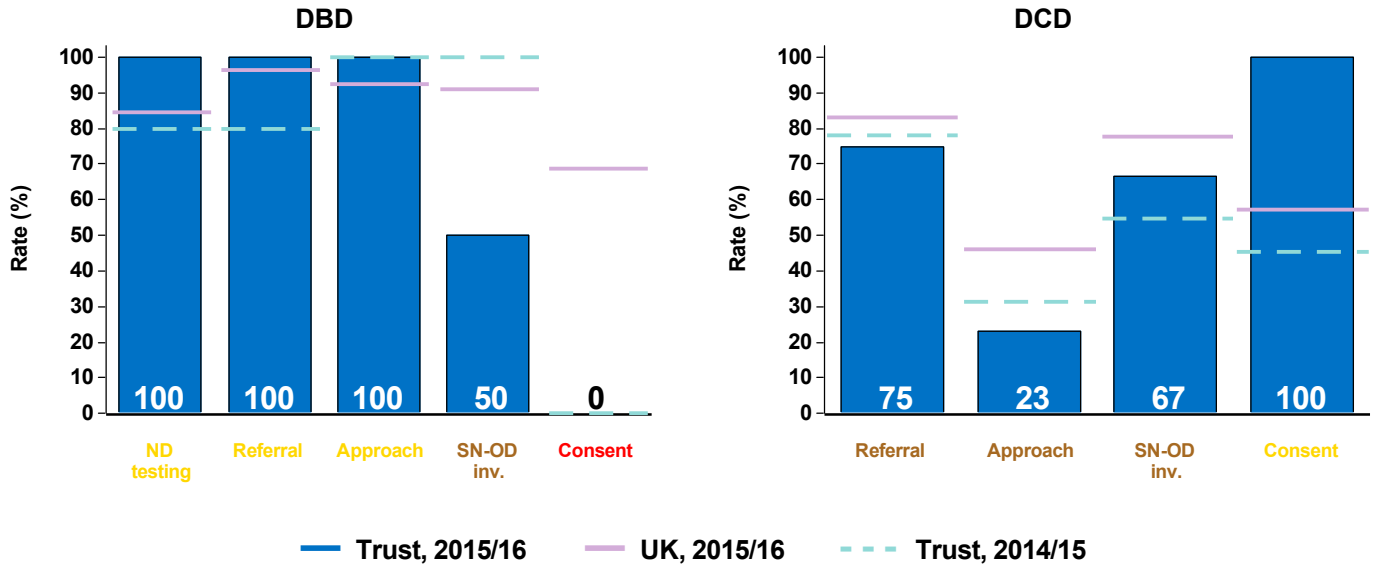
It is acknowledged that the PDA does not capture all activity. In total there was 1 patient referred in 2015/16 who are not included in Section 2 onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

Appendices

Appendix A.1 Bar charts of key rates

Figure A.1.1 shows the same information as the radar charts in Section 2 but in an alternative format. The bars show the latest rates for your Trust. Purple lines have been superimposed to provide a comparison with the UK and turquoise dashed lines show the rates achieved by your Trust in the equivalent period last year. The funnel plots in Section 3 can be used to identify the maximum rates currently being achieved by Trusts with similar donor potential. The colour of the rate label indicates the Trust performance as shown in the appropriate funnel plot using the gold, silver, bronze, amber, and red (GoSBAR) scheme.

Figure A.1.1 DBD and DCD key rates



Appendix A.2 National rates by unit type

For each of the units tabulated in Tables 4.1.1 and 4.1.2, the national key rates from the PDA are displayed in Tables A.2.1 and A.2.2 to aid comparison with equivalent units.

Table A.2.1 National DBD key numbers and rates by unit where the patient died, 1 April 2015 - 31 March 2016

Unit where the patient died	Patients where neurological death was suspected	Patients that were tested	Neurological death testing rate (%)	Patients where neurological death was suspected that were referred to SN-OD	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors (Death confirmed by neurological tests and no absolute contra-indications)	Eligible DBD donors whose family were approached	DBD approach rate (%)	Families consenting donation	DBD consent rate (%)	Actual DBD and DCD donors from eligible DBD donors	DBD SN-OD involvement rate (%)
General ICU[1]	1001	845	84	978	98	832	795	727	91	511	70	451	91
Neurosurgical ICU	306	288	94	303	99	288	277	263	95	189	72	171	93
General/Neuro ICU	212	179	84	207	98	178	175	168	96	103	61	90	91
Cardiothoracic ICU	48	43	90	46	96	43	42	38	90	29	76	24	82
Paediatric ICU[2]	91	59	65	75	82	56	55	45	82	28	62	23	84
Specialist ICU[3]	60	54	90	59	98	53	52	50	96	27	54	24	98
Accident and emergency	22	2	9	9	41	1	1	1	100	1	100	1	100

Table A.2.2 National DCD key numbers and rates by unit where the patient died, 1 April 2015 - 31 March 2016

Unit where the patient died	Patients for whom imminent death was anticipated	Patients for whom imminent death was anticipated that were referred to SN-OD	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors (Imminent death anticipated and treatment withdrawn with no absolute contra-indications)	Eligible DCD donors whose family were approached	DCD approach rate (%)	Families consenting donation	DCD consent rate (%)	Actual DCD donors from eligible DCD donors	DCD SN-OD involvement rate (%)
General ICU[1]	4630	3891	84	4060	2824	1206	43	710	59	344	78
Neurosurgical ICU	395	383	97	378	319	240	75	159	66	93	83
General/Neuro ICU	611	544	89	577	443	265	60	157	59	83	86
Cardiothoracic ICU	250	218	87	223	179	66	37	38	58	23	86
Paediatric ICU[2]	194	135	70	180	141	75	53	22	29	13	57
Specialist ICU[3]	75	65	87	59	44	23	52	12	52	6	87
Accident and emergency	325	143	44	297	237	55	23	9	16	1	40

[1] includes General ICU, HDU, General ICU/HDU/Coronary Care Unit, General ICU/HDU.
[2] includes Paediatric ICU, Neonatal ICU.
[3] includes Specialist ICU, Multiple Injuries Unit.

Further national comparisons can be made by viewing the PDA section of the Organ Donation and Transplantation Activity Report and the PDA Annual Report, both of which are available on the ODT website. See links on Page 2.

Appendix A.3 National rates by Trust/Board level

The Dudley Group Of Hospitals NHS Foundation Trust has been categorised as a level 3 Trust/Board. Tables A.3.1 and A.3.2 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid comparison with equivalent Trusts/Boards. Note that caution should be applied when interpreting percentages based on small numbers.

Table A.3.1 National DBD key numbers and rates by Trust/Board level, 1 April 2015 - 31 March 2016

	Patients where neurological death was suspected	Patients that were tested	Neurological death testing rate (%)	Patients where neurological death was suspected that were referred to SN-OD	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors (Death confirmed by neurological tests and no absolute contra-indications)	Eligible DBD donors whose family were approached	DBD approach rate (%)	Families consenting donation	DBD consent rate (%)	Actual DBD and DCD donors from eligible DBD donors	DBD SN-OD involvement rate (%)
Your Trust	2	2	100	2	100	2	2	2	100	0	0	0	50
Level 1*	987	841	85	949	96	834	803	752	94	501	67	448	92
Level 2	331	282	85	323	98	277	271	248	92	175	71	154	92
Level 3	294	234	80	279	95	227	214	192	90	137	71	118	89
Level 4	130	115	88	128	98	115	111	101	91	75	74	64	82

Table A.3.2 National DCD key numbers and rates by Trust/Board level, 1 April 2015 - 31 March 2016

	Patients for whom imminent death was anticipated	Patients for whom imminent death was anticipated that were referred to SN-OD	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors (Imminent death anticipated and treatment withdrawn with no absolute contra-indications)	Eligible DCD donors whose family were approached	DCD approach rate (%)	Families consenting donation	DCD consent rate (%)	Actual DCD donors from eligible DCD donors	DCD SN-OD involvement rate (%)
Your Trust	16	12	75	16	13	3	23	3	100	0	67
Level 1*	2818	2316	82	2565	1850	961	52	537	56	293	78
Level 2	1699	1455	86	1494	1144	453	40	259	57	122	80
Level 3	1462	1200	82	1286	907	394	43	241	61	113	77
Level 4	523	428	82	448	303	133	44	75	56	38	71

*Level 1 Trust/Boards are defined as those Trusts/Boards having an average donation potential^ of 60 or more in the 2013/14 and 2014/15 financial years, and/or having a neurosurgery centre. Trusts/Boards are categorised as Level 2 if there was an average donation potential of 31-60 over the two year period and Level 3 Trusts/Boards are those that had an average donation potential of 15-30 over the two year period. All other Trusts/Boards are categorised as Level 4.

^ Potential DBD donors plus eligible DCD donors.

Appendix A.4 Definitions

POTENTIAL DONOR AUDIT / REFERRAL RECORD	
Data excluded	Patients who did not die on a critical care unit or an emergency department and patients aged over 80 years are excluded.
Donors after brain death (DBD)	
Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates - less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SN-OD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf
Family approached for consent / authorisation	Family of eligible DBD asked to make a decision on donation
Family consented / authorised	Family consented to / authorised donation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SN-OD
Approach rate	Percentage of eligible DBD families approached for consent /authorisation for donation
Consent / authorisation rate	Percentage of families approached about donation that consented to / authorised donation
Expected consent / authorisation rate	The expected consent / authorisation rate given the ethnicity case mix (white or BAME (black, asian and minority ethnic)), based on those patients whose family were approached for consent /authorisation and patient ethnicity was known
SN-OD involvement rate	Percentage of family approaches where a SN-OD was involved
SN-OD consent / authorisation rate	Percentage of families approached about donation by a SN-OD that consented to / authorised donation

Donors after circulatory death (DCD)	
Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SN-OD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf
Family approached for consent / authorisation	Family of eligible DCD asked to make a decision on donation
Family consented / authorised	Family consented to / authorised donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA
Referral rate	Percentage of patients for whom imminent death was anticipated who were discussed with the SN-OD
Approach rate	Percentage of eligible DCD families approached for consent /authorisation for donation
Consent / authorisation rate	Percentage of families approached about donation that consented to / authorised donation
Expected consent / authorisation rate	The expected consent / authorisation rate given the ethnicity case mix (white or BAME (black, asian and minority ethnic)), based on those patients whose family were approached for consent /authorisation and patient ethnicity was known
SN-OD involvement rate	Percentage of family approaches where a SN-OD was involved
SN-OD consent / authorisation rate	Percentage of families approached about donation by a SN-OD that consented to / authorised donation
UK Transplant Registry (UKTR)	
Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by number of donors. The maximum number of solid organs that can be donated are 7 for a DBD and 6 for a DCD.
Number of organs transplanted	Total number of organs transplanted by organ type

On 1 April 2013 significant changes were made to the PDA. The main changes that should be borne in mind, especially when making comparisons across time periods, are as follows:

- Upper age limit increased from 75 to 80 years.
- Cardiothoracic ICUs included.
- Changes to imminent death definition to be clear that death was anticipated within four hours.
- Contraindications brought in line with current practice.
- Terminology changes, eg 'potential donor' changed to 'eligible donor', for consistency with World Health Organisation definitions.

Appendix A.5 Data description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record and the UK Transplant Registry for The Dudley Group Of Hospitals NHS Foundation Trust. The report covers the time period 1 April 2015 to 31 March 2016 and data from 1 April 2014 to 31 March 2015 are also provided in certain sections for comparison purposes.

This report is provided for information and to facilitate case based discussion about organ donation by the Donation Committee and your Trust.

As part of the PDA, patients aged over 80 years of age and those who did not die on a critical care unit or an emergency department are not audited nationally and are therefore excluded from the majority of this report. In addition, some information from this time period may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UK Transplant Registry, as appropriate.

Some percentages in this report were calculated using small numbers and should therefore be interpreted with caution.

Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SN-OD)

Appendix A.6 Table and figure description

Each table and figure displayed throughout the report is described below to aid interpretation.

1.1 Donor outcomes

Table 1.1.1 The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).

Table 1.1.2 The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UK Transplant Registry. Further information can be obtained from your local Specialist Nurse – Organ Donation (SN-OD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.

2.1 Key rates

Figure 2.1.1 Radar charts are displayed showing specific percentage measures of potential donation activity for your Trust/Board compared with national data for the UK, and compared with an equivalent time period from the previous financial year, using data from the Potential Donor Audit (PDA). The DBD charts show the percentage of patients tested for neurological death, and all four charts also show the referral rates, approach rates, proportion of approaches involving a SN-OD and observed consent/authorisation rates. Appendix A.4 gives a fuller explanation of terms used.

The blue shaded area represents your Trust/Board, and the national rates are superimposed as a solid purple line for comparison. The equivalent period from the previous year is superimposed as a dashed turquoise line. The fuller the blue shaded area the better. Note that 0% and 'not applicable (N/A)' rates appear the same. The rates have therefore been displayed on the spokes of the radar charts. The rates are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of one Trust/Board as reflected in the funnel plots (see description in figure 3.2.1 below)

Note that caution should be applied when interpreting percentages based on small numbers and when comparing time periods.

2.2 Key numbers, rates and comparison with national targets

Table 2.2.1 A summary of DBD and DCD data and key rates have been obtained from the PDA. A national comparison and a time period comparison are provided. Note that caution should be applied when interpreting percentages based on small numbers and comparing time periods. Appendix A.4 gives a fuller explanation of terms used.

The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of the Trust/Board as reflected in the funnel plots (see description for figure 3.2.1 below)

National targets specific to the financial year are displayed throughout Section 3.

3.1 Overview of lost opportunities

Figure 3.1.1 The stages at which potential donors lose the opportunity to become actual donors have been obtained from the PDA. There are four charts showing the DBD and DCD stages separately for your Trust/Board and the UK, all of which contain a comparison against an equivalent period from the previous financial year.

The number of potential donors is shown on the vertical axis for each chart and at each 'step' the proportion of potential donors lost at that stage is displayed. Caution should be applied when interpreting percentages based on small numbers and comparing time periods.

3.2 Neurological death testing

Figure 3.2.1 A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The national target is shown on the plot as a green horizontal dashed line. The national rate is shown on the plot as a black horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots.

If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the national rate. If a Trust/Board lies outside the 95% confidence limits, shaded silver or amber, this serves as an alert that the Trust/Board may have a rate that is significantly different from the national rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the national rate, while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the national rate. It is important to note that differences in patient mix have not been accounted for in these plots.

Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented.

The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.

Table 3.2.1 The reasons given for neurological death tests not being performed have been obtained from the PDA, if applicable.

3.3 Referral to Specialist Nurse - Organ Donation

Figure 3.3.1 Funnel plots of DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 3.2.1 above.

Table 3.3.1 The reasons for not referring the patient to the SN-OD have been obtained from the PDA, if applicable.

Table 3.3.2 For patients who were referred, the timings of the first contact with the SN-OD by clinical staff have been obtained from the PDA.

3.4 Contraindications

Table 3.4.1 The primary absolute medical contraindications to solid organ donation have been obtained from the PDA, if applicable.

3.5 Family approach

Figure 3.5.1 Funnel plots of DBD and DCD approach rates are displayed using data obtained from the PDA. See description for Figure 3.2.1 above.

Table 3.5.1 The reasons why families were not formally approached for a decision about solid organ donation have been obtained from the PDA, if applicable.

3.6 Proportion of approaches involving a SN-OD

Figure 3.6.1 Funnel plots of DBD and DCD SN-OD involvement rates are displayed using data obtained from the PDA. See description for Figure 3.2.1 above.

3.7 Consent

Figure 3.7.1 Funnel plots of DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 3.2.1 above.

Table 3.7.1 The reasons why families did not give consent/authorisation for solid organ donation have been obtained from the PDA, if applicable.

3.8 Reasons why solid organ donation did not occur

Table 3.8.1 The reasons why solid organ donation did not occur have been obtained from the PDA, if applicable.

4.1 Key numbers and rates by unit where the patient died

Table 4.1.1 DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Data for the current time period are included, along with an equivalent comparison period from the previous year.
If the hospitals/units are not equivalent for the two time periods, this is due to hospital/unit changes, and/or there were no patients for whom neurological death was suspected or imminent death was anticipated in one of the time periods.
Caution should be applied when interpreting percentages based on small numbers and comparing time periods.

Table 4.1.2 DCD key numbers and rates by unit where the patient died have been obtained from the PDA. See description for Table 4.1.1 above.

Appendix A.1 Bar charts of key rates

Figure A.1.1 Bar charts have been used to display the DBD and DCD key rates from the PDA. This is an alternative way of displaying the information in Figure 2.1.1.
The percentages for your Trust/Board in the latest time period are displayed on each bar. Note that caution should be applied when interpreting percentages based on small numbers and comparing time periods.

Appendix A.2 National rates by unit type

Table A.2.1 For each of the units in Table 4.1.1, the national DBD key rates from the PDA are displayed to aid comparison with equivalent units. Units have been grouped to aid a more meaningful comparison.

Table A.2.2 For each of the units in Table 4.1.2, the national DCD key rates from the PDA are displayed to aid comparison with equivalent units. Units have been grouped to aid a more meaningful comparison.

Appendix A.3 National rates by Trust/Board level

Table A.3.1 National rates for level 1, 2 and 3 Trusts/Boards are displayed to aid comparison with equivalent Trusts/Boards. Caution should be applied when interpreting percentages based on small numbers.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 6th October 2016 - PUBLIC

TITLE:	Chief Nurse Report		
AUTHOR:	Dawn Wardell – Chief Nurse Dr E Rees - Director of Infection Prevention and Control Derek Eaves - Quality Manager Nursing Carol Love-Mecrow - Head of Non-Medical Education and Training	**PRESENTER:**	Dawn Wardell Chief Nurse

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

SUMMARY OF KEY ISSUES:

For the month of September (as at 28.9.16)

- No post 48 hour MRSA bacteraemia cases since 27th September 2015.
- No Norovirus.
- As of this date the Trust has had 19 cases so far in 2016/17 4 of these cases were associated with a lapse in care. There are still 11 cases without an outcome determined.

Safer Staffing

- Amber shifts (shortfall) total figure for this month is 44 which is down from the last month (70).
- The RAG rating system has been rolled out across the wards 6 red shifts in this methodology for that period across two areas B2T and Neonatal Unit.
- Shortfall shifts were reviewed and no safety issues identified that affected the quality of care.
- The Care Hours Per Patient Day (CHPPD) has commenced collection of data in May and is reported in a limited way in this board report.

Nursing Care Indicators

- There are two escalations at level 4 and two escalations at level 3 now in place. Improvement has been seen with no red category areas. More intensive support has been provided which has seen the appropriate change in results.

Recruitment Update

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		√	

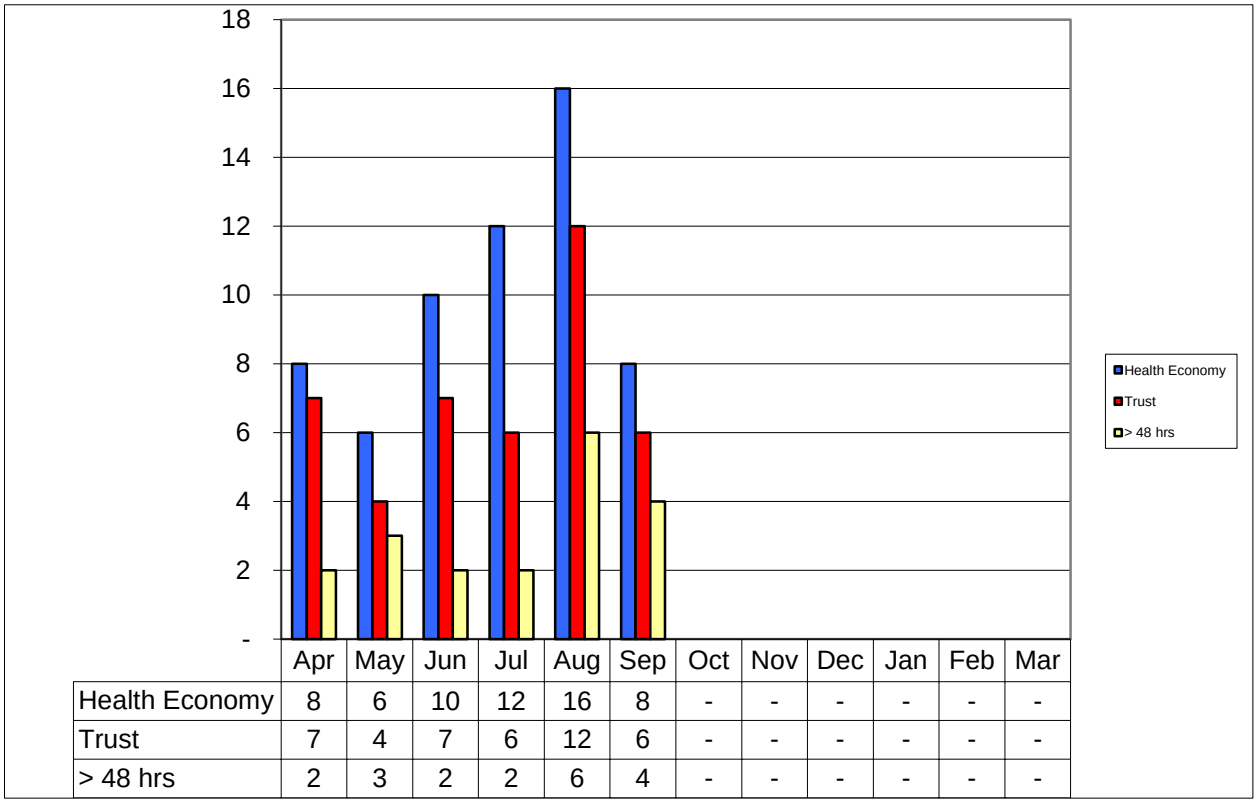
RECOMMENDATIONS FOR THE BOARD: To receive the report and note the contents.

Chief Nurse Report

Infection Prevention and Control Report

Clostridium Difficile – The target for 2016/17 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. Penalties will be associated with exceeding 29 cases associated with lapses in care. At the time of writing (28.9.16) we have 4 post 48 hour case recorded in September 2016.

C. DIFFICILE CASES 2016/17



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

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

For the financial period 2016/17 of the 19 post 48 hour cases identified since 1st April 2016, 8 cases have been reviewed and apportionment has been agreed (4 cases associated with lapse in care) and 11 cases are pending.

There is a Trustwide C. difficile action plan in place to address issues identified by the RCA process as well as local plans for each individual case. Progress against the plan is recorded at the Infection Prevention Forum.

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

Norovirus - no further cases.

Reference

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

Monthly Nurse/Midwife Staffing Position - August 2016

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

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

As indicated to the Board in June, from May 2016 all Trusts have had to submit this metric. The overall Trust results August have been:

Month	RN	Unregistered	Total
July	4.53	3.70	8.24
August	4.65	3.76	8.41

These figures obviously vary widely across wards/areas (e.g. 21.86, 1.90 and 23.76 for critical care and 2.52, 3.4 and 5.92 on Ward C5)

The only presently available comparative figures are from a short paragraph in the Carter Report which stated that of a sample of 25 Trusts the overall CHPPD varied from 6.3 to 15.48, which would put the Trust (8.41) in the middle 'of the pack'. The Trust awaits any further developments and feedback on this metric. It is expected that this and comparative data will be made available in the Model Hospital which the Department of Health is producing as a result of the Carter Review.

It can be seen from the accompanying chart (Appendix 1) the number of shifts identified as:

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

The total figure of shortfalls for this month is 44 which is the lowest number over the last six months (see Table 1). When shortfalls have occurred, the reasons for the gaps and the actions being taken to address these in the future are outlined in Table 3 (Appendix 2).

Both the qualified and unqualified shortfalls fell this month. Other than maternity, the shortfalls were fairly evenly distributed across the wards with NNU having specific skills requirements which are not easily sourced. The maternity unit continues to have vacancies, high volume cases and high workload however the midwifery shortfalls have fallen again this month (7, compared to 10 and 19 in the previous two months) as have the unqualified staff in midwifery shortfalls (9, compared to 14 and 15 in the previous two months). Maternity have now recruited to all their outstanding posts with start dates over October and November. Active recruitment initiatives are in progress and further shortlisting has occurred for the care worker posts.

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

these assessments at this early stage but it can be seen that the assessments are generally 'Green' with 6 of the 24 areas having 10 and above 'Amber' shifts. With regards to the latter, there is some consistency with the staffing figures (e.g. C8 and NNU) although this is not always the case as some Amber shifts will be related to high dependency and specific circumstances on the day.

Two areas have assessed six 'Red' shifts this month. The two recorded on Ward B2T are discussed in the Mitigating Actions chart below as are the four on NNU when the area had capacity problems and the dependency of the patients was particularly high.

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

Table 1

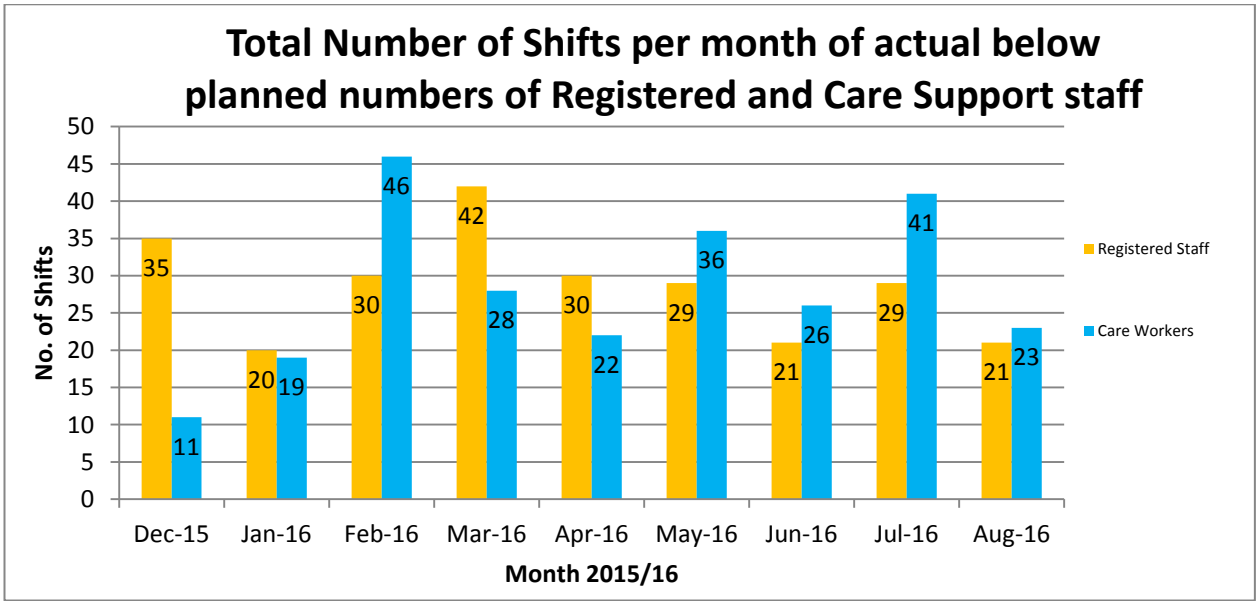


Table 2 - Self-Assessment of Workload by Senior Nurses on Each Shift for August (figures in brackets from July)

Ward/Area	RED	AMBER	GREEN	Ward/Area	RED	AMBER	GREEN
Ward A1	0	9 (18)	53 (44)	Ward C3	0	9 (9)	53 (53)
Ward A2	0	0	62 (62)	Ward C4	0	0	62 (62)
Ward A3	0	2 (1)	60 (61)	Ward C5	0	1 (0)	61 (62)
Ward B1	0 (2)	10 (8)	52 (49)	Ward C6	0	11 (17)	51 (45)
Ward B2H	0	3 (7)	59 (55)	Ward C7	0	3 (1)	59 (61)
Ward B2T	2 (0)	5 (10)	55 (52)	Ward C8	0	16 (14)	46 (48)
Ward B3	0	2 (3)	60 (59)	CCU/PCCU	0	19 (12)	43 (50)
Ward B4	0	16 (25)	46 (37)	EAU	0	0	62 (62)
Ward B5	0	8 (12)	54 (50)	MHDU	0	1 (0)	61 (62)
Ward B6	-	-	-	Critical Care	0	0	62 (62)
Ward C1	0	1 (0)	61 (62)	NNU	4 (10)	25 (16)	33 (36)
Ward C2	0	0	61* (61)	Maternity	0	6 (10)	56 (52)

*1 shift not assessed

Nurse Care Indicators (NCI's)

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

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

The escalation procedure for those areas not yet in green remains in place and has been reviewed to ensure it maximises the time and support given to areas to achieve the requirements.

Escalations for September:

NCIs	
Level 1 Matron Level	9
Level 2 Head of Nursing Level	7
Level 3 Deputy Chief Nurse level	2
Level 4 Chief Nurse	2

Nutrition Audit	
Level 1 Matron Level	11
Level 2 Head of Nursing Level	2
Level 3 Deputy Chief Nurse level	1

Recruitment Update RN and CSW

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

Planned Clinical Support Worker Recruitment

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

CSW Recruitment numbers until May 2017	
Month	**Recruitment**
August 2016	15 CSW
October 2016	35 Novices
November 2016	7 Clinical Apprentices
January 2017	35 CSWS
January 2017	10 Nursing Associates
May 2017	35 Novices
Totals	**127** *This number excludes the Nursing Associates who will be recruited from our existing clinical support workforce*

Planned Registered Nurse Recruitment

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

RN RECRUITMENT

Month	Acute	Community
Commenced in September 2016	26 RNs	6 RNs
October 2016	16 RNs	0
November 2016	0	0
February 2017	39 RNs	3
Totals	81	9

INTERNATIONAL RN RECRUITMENT

Last report shows **84 candidates** from the Philippines remaining:

- 9 passed academic IELTS at level 7
- 10 candidates have booked IELTS for September
- 1 passed CBT
- 35 places on fast track IELTS preparation course 30 places currently allocated
- Estimated arrival February/ March

Appendix 1

Aug-16			SHIFT																															
	NCI		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16	
WARD		STAFF	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	94	Reg																																
		Unreg																																
WARD A2	92	Reg																																
		Unreg							7/5					6/4																				
WARD A3	94	Reg																										3/2						
		Unreg																																
WARD B1	99	Reg																																
		Unreg																												2/1				
WARD B2 HIP	100	Reg																																
		Unreg				7/5																												
WARD B2 TRAUMA	92	Reg																									3/2					2/1		
		Unreg																																
WARD B3	88	Reg																																
		Unreg																																
WARD B4	94	Reg																																
		Unreg																															8/6	
WARD B5	85	Reg																																
		Unreg																																
WARD B6		Reg																																
		Unreg																																
WARD C1	99	Reg																																
		Unreg																																
WARD C2***	99	Reg																																
		Unreg																																
WARD C3	94	Reg			7/4																												7/5	
		Unreg																																
WARD C4	99	Reg									5/3																							
		Unreg																																
WARD C5	91	Reg																																
		Unreg																																
WARD C6	94	Reg																																
		Unreg																																
WARD C7	89	Reg																																
		Unreg																																
WARD C8	95	Reg																																
		Unreg					8/6																											
CCU/PCCU	100	Reg															7/4																	
		Unreg																																
EAU	96	Reg																																
		Unreg																																
MHDU	100	Reg																																
		Unreg																																
CRITICAL CARE*	99	Reg																																
		Unreg																																
NEONATAL**	98	Reg				8/6												9/5			7/5		8/6											
MATERNITY ****	98	Reg						17/15		17/16																								
		Unreg	8/6						8/6								8/6		8/6		7/5													

Aug-16			SHIFT																													
	NCI		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
WARD		STAFF	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
WARD A1	94	Reg																														
		Unreg																														
WARD A2	92	Reg																														
		Unreg			7/5																	6/4										
WARD A3	94	Reg																														
		Unreg																														
WARD B1	99	Reg																														
		Unreg																														
WARD B2 HIP	100	Reg																														
		Unreg								7/5							7/5															
WARD B2 TRAUMA	92	Reg																														
		Unreg																														
WARD B3	88	Reg																														
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WARD B4	94	Reg																														
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WARD B5	85	Reg																														
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WARD B6		Reg																														
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WARD C1	99	Reg																														
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WARD C2***	99	Reg																														
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WARD C3	94	Reg																					7/5									6/4
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WARD C6	94	Reg																														
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WARD C7	89	Reg																														
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WARD C8	95	Reg																														
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CCU/PCCU	100	Reg																														
		Unreg																														
EAU	96	Reg																														
		Unreg																														
MHDU	100	Reg																														
		Unreg																														
CRITICAL CARE*	99	Reg																														
		Unreg																														
NEONATAL**	98	Reg																														
MATERNITY ****	98	Reg									17/16			17/15										17/15		17/16						17/16
		Unreg											7/5								8/6								8/6		8/6	

Key

- Serious Shortfall (red)
- Registered nurse/midwife shortfall (amber)
- Care Support Worker shortfall (blue)

* Critical Care has 6 ITU beds and 8 HDU beds

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

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

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

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

Appendix 2

Table 3 - MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS AUGUST 2016

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A2	4	CSW	Vacancy x2 Sickness x2	On all occasions the 'floating' qualified nurse and lead nurse assisted with CSW duties.
A3	1	RN	Vacancy	Bank/Agency unable to fill. With current caseload and support from A1 patient safety maintained.
B1	1	CSW	Sickness x1	Full complement of RNs was present on this night shift. No harm came to patients.
B2H	3	CSW	Sickness x 2 1:1 support required x2	On one occasion, shortfall covered by B3 and on the other two CSWs present rotated between the 1:1 patients and safety maintained
B2T	2	RN	Vacancy x2	On the day shift the ratio was 1:12 and safety was maintained. On the night shift assistance was provided by staff from B2H. Safety was maintained although some care was delayed.
B4	2	CSW	Sickness x2	1-1 patients were cohorted with no adverse patient effect.
C3	4	RN	Vacancy x4	Bank and agency unable to fill. Staff distributed appropriately throughout elderly unit to maintain safety. Lead nurse worked clinically.
C4	1	RN	Sickness	There were three supernumerary nurses on duty who had completed their competencies so all tasks completed. PDN also worked between 09.00-13.00
C5	1	RN	Vacancy	All staff assisted as did nurse in charge and an extra CSW was on duty
C8	4	CSW	Sickness x 4 1:1 support required x4	On one occasion a well-being worker assisted, on two other shifts 2 student nurses were present and on two occasions 2 novices were assisting on the ward. Lead Nurse and Nurse in charge worked clinically to support on two occasions. Safety was maintained on all occasions.
CCU/PCCU	1	RN	Vacancy	Due to a late change in the off duty the bank were unable to fill with the lateness of the request. Matron supported the unit until 13.00 when a further staff member came on duty.
NNU	4	RSCN	Dependency and capacity	On all of these occasions there were capacity issues on the unit and the dependency of the patients present was high. Safety was maintained. On three occasions babies were transferred to C2. On another occasion the dependency of two babies improved. The unit was closed on one occasion. The workload was shared amongst all staff and the lead nurse worked clinically and extra hours and so safety was maintained.
Maternity	7 9	RM CSW	Vacancy Maternity leave	Escalation policy enacted on all occasions. Bank unable to fill. No patient safety issues occurred. On 6 shifts there were delayed inductions of labour.

SUMMARY OF WARDS AND SPECIALTIES

Area	Speciality
A1	Care of the Elderly
A2	Short Stay Medical
A3	Medical Short Stay
A4 MDCU	A4 Medical Day Case Unit
B1	Elective Orthopaedics
B2 Trauma	Orthopaedics
B2 Hip Suite	Orthopaedics
B3	General Surgery
B4	Mixed Colorectal & General Surgery
B5	SAU, GAU and emergency short stay ward
B6	Medical outliers
C1	Renal
C2	Children's Ward
C3	Elderly Care
C4	Georgina Unit/Oncology and Haematology
C5	Respiratory
C6	Male Urology
C7	Gastro Intestinal Medicine (GI Medicine)
C8	Stroke
Cardio Catheter Lab	Cardio Catheter Lab
CCU/PCCU	Coronary Care Unit/Post Coronary Care Unit
Critical Care Unit	Critical Care
Diabetes	Diabetic Resource Centre
EAU	Emergency Assessment Unit
ED	Emergency Department
GI Unit	Gastro Intestinal Unit
MHDU	Medical High Dependency Unit
NNU	Neo Natal Unit
Paediatric Outpatients	Paediatric Outpatients
Paediatric Specialist Diabetes Service	Paediatric Specialist Diabetes Service
Paediatric & Neonatal Community outreach	Paediatric & Neonatal Community Outreach
Renal	Renal Unit
Theatres	Theatres

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 6 October 2016

TITLE:	**27 September 2016 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	27 September 2016	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- Operational Management assurance was provided over the actions being taken in respect of the poor performance in the areas of VTE and Stroke TIA and that the impact on patient safety and experience is being mitigated (this was an area the Committee has asked for assurance on at a previous meeting).
    - In respect of Stroke TIA, management provided assurance that the issues driving the reduction in performance are understood including a change in definition of the indicator from 24 to 12 hours, the level of poor referrals from both within the Trust and from GPs where the person is not at high risk (which is what this target is established to measure the management of) and that the local target needs clarity on whether it should include DNAs as the Trust has seen an increase in these which by including them impacts on the performance of the Trust. Management assurance extended to the development of a robust action plan with a trajectory for improvement. Actions being taken will see performance improve to achieve the target by the end of the month of October.
    - In respect of VTE risk assessment, management provided assurance that with the aid of a recent internal audit review of the Trust's processes in this area, a robust action plan has been formulated to improve Trust performance. Management provided information on engagement undertaken across both divisions to ensure that the flagging of patients needing an assessment would now be brought to the attention of the doctors to allow them to undertaken the outstanding assessments in a timely manner. A ward based dash board has been developed which includes performance in this area along with other metrics. The Committee asked that the dash board be presented to a future meeting and at the same time provide an update on the delivery of the improvement plan in this area (see actions the committee is keeping an eye on later in this report).
- Operational Management assurance was provided on the performance in respect

of key quality indicators. This month saw continued challenge in Friends and Family response numbers and the texting facility is still to go live - agreement had been reached to have this implemented for November. Maternity Breast Feeding Initiation rates and smoking ceasing during pregnancy performance continues to be a challenge despite efforts of the staff to engage and provide information to mothers. Stroke Swallow Screen performance has reduced this month after a period of stronger performance and more staff training is being implemented to ensure that a greater number are competent to undertake swallow assessments and ensure that absence of staff has less of an impact on future performance. VTE performance remained poor this month as predicted in last month's report as did Stroke TIA which prompted the Committee to seek a more in-depth report on actions taken to address this as reported above. The Committee noted that the legend being used on some of the indicators, grading some performance as blue for changes in past performance, target definitions for Friends and Family response rates, had reduced the clarity of the reports and asked that this be reviewed prior to the report being presented to Board.

- There has been one reported never event in August, no harm was caused to the patient. A full review is being undertaken and the Committee have asked that a detailed presentation in respect of the cause of the incident and the revisions to trust process that have been made a as result to a subsequent meeting (see actions the committee is keeping an eye on later in this report).
- Positive assurance was provided in the form of an external review undertaken on the Trust maternity screening services. Management assurance was provided that an action plan had been formulated as a result of the review. The Committee asked that expected implementation dates be added to the action plan and that a further report come back to the Committee on progress. (see actions the committee is keeping an eye on later in this report).
- There has been an improvement in the delivery of the planned reviews of Trust policies. An Executive challenge session was held with each area which has supported this improvement and it is intended to retain this process for the short term to ensure that appropriate focus remains on this important task. At this Committee meeting there were only 18 policies that had exceeded their review date with 12 of these going to the Policy Group on the 30 September. This leaves then only 6 Polices that are al being worked on with a view to getting all but one of these to the 10th October meeting, the exception is due to the need to wider engagement in the revision to the Policy due to the need to incorporate the findings of a recent Internal Audit report into that area (see actions the committee is keeping an eye on later in this report).
- For the period April to March 2015, the Trust's SHMI is 0.98 and the HSMR for the same period is 95.88. Operational Management assurance was provided over the achievement of the operational target to review 85% of deaths within 12 weeks, with the first quarter of 2016/2017 achieving 90.7%. Two exceptions remain under review by the Mortality Surveillance Group, one relating to an open alert from the CQC which is subject to the need for the Trust to provide a small amount of additional information to enable it to be closed and the second is that the final response to the National Hip Fracture Database is not due until November 2016. The CQC had acknowledged that the proactive reporting by the Trust had meant that when they issued the alert they were already aware of actions taken and thus they only raised a small number of questions more around

clarification of the Trust initial communication with them.

- Executive Management assurance was provided that the Trust has complied with the reporting requirement timescales in respect of initially reporting of Serious Incidents (SIs) with the exception of one Incident. This month there had been no 72 hour questions from the CCG on the scope of the proposed SI Investigations. Three SIs were not closed in the required 60 day timescale as with those in the previous month this was in part due to the pressure on respective team members, both operationally and within the corporate governance team. The monthly report shows performance against the agreed developed KPIs and shows the Trust is ahead at the quarter 2 trajectory in the area of incidents being closed on th first review (ie with no questions being raised by the CCG). In respect of the 6 RCA action plans exceeded their planned dates revised dates have been obtained by the Governance Team to track their final completion, many extensions relate to the availability of staff to receive training or be communicated with in respect of the revised processes and learning from the investigations due to staff leave over the summer. The issue of exceeded RCA action plans is discussed at the relevant Division's Performance Management meeting.
- Executive Management assurance was provided in respect of progress being made against the Trust recommendations in the joint Serious Incident RCA Process Improvement plan with the CCG.
- Operational Management assurance was provided in respect of the Trust's compliance with the duty of candour. A management audit had been undertaken looking as a sample of incidents across June and July and identified that families had been engaged with in line with the requirements of duty of candour but that documentation was not fully completed in line with Trust Policy. A further audit is planned for the end of quarter 3 which will be reported to the Committee (see actions the committee is keeping an eye on later in this report).
- Executive Management assurance was received via the Quality and Safety Group in respect of the last meeting's agenda items including the prescribing and drug security and the work of the falls management group in cascading learning from falls incidents. The Committee were also informed about the outcome of a further audit on the ED blood sampling processes and that this had shown no improvement in process. The Committee asked that ED present their rectification plan to their next meeting at the end of October (see actions the committee is keeping an eye on later in this report).
- Executive Management assurance was received via the Patient Experience Group in respect of the last meeting's agenda items including action being taken in respect of the outpatients transformation programme and the improvements this will bring to the patients, the outcomes of the quality and safety reviews, the feedback from patients and families through the friend and family survey, the outcome of the recent PLACE assessment undertaken within the Trust and its associated action plan and the positive impact on patients the volunteer are having. The Committee were also informed of the actions being taken by the Group in monitoring the Trust's deliver of its patient experience strategy.

Decisions Made / Items Approved
• Approval of 9 policies and 9 guidelines / procedures that had all been considered by the Policy Group. • Approval to close 43 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.
Actions to come back to Committee (items the Committee is keeping an eye on)
• The Committee asked that the ward quality and performance dash board be presented to a future committee meeting tougher with an update on the delivery of the improvement plan in respect of VTE (likely to be at the November meeting) • The Committee asked for the addition of the delivery timescales to be added to the action plan resulting from an external review of maternity screening and that progress against these be reported to a subsequent meeting. • The next duty of candour management audit findings be reported in January. • That ED present their rectification plan in respect of blood sampling within ED. • That Surgery present the outcome of the never event incident investigation and the improvements and learning undertaken as a result. • The outcome of the executive director challenge meetings on the continued focus on Policy reviews.
Items referred to the Board for decision or action
There are no items to be referred to the Board for decision or action, over and above the assurances received at the meeting and the decisions made by the Committee.

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 6 October 2016

TITLE:	**8 September Audit Committee Summary Report to the Board**		
AUTHOR:	Richard Miner – Committee Chair	**PRESENTER**	Richard Miner – Committee Chair

CORPORATE OBJECTIVES

ALL

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

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

Audit Committee highlights report to Board of Directors 6 October 2016

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**8/9/2016**	**Richard Miner**	**yes**	**no**
			Y	

Declarations of Interest Made

None

Assurances Received

- That the Health Research Authority (HRA) approval process is now fully operational for R&D and that to achieve optimum work flow further recruitment is still necessary.
- That the revised 2015 Serious Incident reporting guidance has now been implemented.
- That counter fraud initiatives continue to focus on prevention.
- That the Trust has a system that ensures the Trust's submitted reference costs are materially compliant with the reference costs guidance (ie that its costs are within the expected parameters).
- That there is now a stronger linkage between the clinical audit programme and the Trust's risk register.
- That the strength of assurances received support the risk assessments made by the executive team.
- The continuing work of the Caldicott and Information Governance Group and the areas they are keeping under review.

Decisions Made / Items Approved

The Committee:

- Approved and noted the write off of losses which continues to reduce as the Trust implements stronger controls.
- Approved minor changes to the Trust's Standing Financial Instructions which mainly relate to name and title changes.
- Approved a change to an accounting policy on the valuation of the PFI building. In future this will be valued exclusive of VAT.
- Approved a change to the Annual Clinical Audit Plan through the addition of 1 clinical audit.

Actions to come back to Committee / Group (Items Committee / Group keeping an eye on)

- Follow up to ensure completion of agreed recommendations from Internal Audit.
- Internal Audit assurance "red" opinions in respect of data quality on Venous Thromboembolism (VTE) assessments and stroke suspected Transient Ischaemic Attacks (TIA) key performance indicators. There are 25 recommendations to be followed up.
- The follow up of emergency planning recommendations.
- That 2 ICO reportable incidents will need to be reflected in the 2016/17 annual governance statement.

Audit Committee highlights report to Board of Directors 6 October 2016

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

- The Board note that the Committee has asked for improved action tracking by Executive Directors in respect of agreed Internal Audit recommendations.
- The Risk Register and Assurance Register, together forming the Board's Assurance Framework, be recommended to the Board.
- The Board note the Internal Audit have identified required improvements to the Trust's data quality process and controls in respect of VTE and stroke suspected TIA key performance measures.

Enclosure 8

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 6 October 2016

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 25th August 2016

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.

The Dudley Group NHS
NHS Foundation Trust

Meeting	Meeting Date	Chair	Quorate	
Charitable Funds Committee	25 August 2016	Julian Atkins	yes	no
			Yes	

Declarations of Interest Made

None

Assurances Received

Fall Equipment - The Committee noted that Anne Flavell is working with Finance to develop a business case for additional fall equipment.

Charity Hub – Mrs Phillips informed the Committee that modest charges have been put in place for third party users of the Charity Hub (with the exception of Action Heart).

Departmental Spending Plans – Disappointingly, the two areas due to present their plans were not available. These will be carried forward to the November meeting.

Fundraising Update – Mrs Phillips presented her regular report:

- The income and expenditure plan is largely on track
- The Million Steps Challenge proved very popular
- The Charity Football match takes place on 25 September and the Charity Dinner on the 8 October.
- A high ropes Santa Challenge is being planned for December at Merryhill Shopping Centre
- The Charity is being refurbished at the end of September. A new User Policy is being produced.

Financial Position – The Committee received an update on the financial position of the Fund. The Committee were pleased to note that expenditure had exceeded income in the year to date (£220,867 against income of £139,233).

Total fund balances stood at £2,337,831 and General fund balances stood at £253,205.

An update was given on legacies to the fund which were noted.

Long Service Recognition - The Committee were informed by Mr Taylor that historically the fund had contributed a modest amount to catering at staff retirement functions, but this was on an ad-hoc basis and no policy existed.

The Committee agreed that a consistent policy should be put in place and that 20 years' service should be the benchmark for a contribution from Charitable Funds. It was also agreed that a contribution of up to £150 could be made towards this catering. **Approved bids** – The Committee approved a bid for Charitable Funds from Matron Kaye Shepherd for prizes in respect of the winter Flu Fighters campaign.
Decisions Made / Items Approved
• That a policy be put in place relating to the use of Charitable Funds for catering at staff retirement functions • Approved £1,500 Charitable Funds be used for the winter Flu Fighters campaign
Actions to come back to Committee
• Presentations from Mr Ali and Dr Ishaq to be carried over to the November meeting. • Fall equipment business case to be considered by the Committee.
Items referred to the Board for decision or action
None

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on Thursday, 6th October 2016

TITLE:	Medical Education and Training Update		
AUTHOR:	Dr Andrew Whallett Head of Medical Education	**PRESENTER:**	Dr Andrew Whallett
CORPORATE OBJECTIVE:			
S02	Safe and Caring Services		
S04	Be the place people choose to work		
S05	Make the best use of what we have		
S06	Deliver a viable future		

SUMMARY OF KEY ISSUES:

Promoting excellence: standards for medical education and training

- **Published by GMC, came into force January 2016.**
- **A single set of standards and requirements for all stages of medical education and training.**
- **Five themes. All centred around patient safety.**
- **Important to map themes 1-4 with Trust Objectives (see table below).**

www.gmc-uk.org/education/standards.asp

GMC Theme		**Challenge**	**How are we addressing this?**
1	Learning environment and culture	'A supportive environment for learners and educators is safer for patients' LEPs must demonstrate training is valued and supported Nationally a 'disaffected' junior doctor workforce – why? • Industrial action • Workload • Rota gaps • Breakdown of Teams • Juniors 'voting with their feet'	Understand where the gaps are and the ways to fill them e.g. Physician Associates, MTI, other healthcare professionals Guardian of Safe Working in Place 'Nerve Centre' in place (out of hours allocation of tasks)

2	Educational Governance and Leadership	LEPs must have effective systems of educational governance, leadership and accountability to manage and control the quality of education and training Financial accountability – Learning and development agreement (LDA), tariff, reference costing	Board awareness Junior Doctors are the 'eyes and ears of the organisation' Internal Quality control, and methods of raising concern in place: • Internal Quality Visits • Junior Doctors Fora • Educational leads • Real-time questionnaires • Excellent relationship with HEEWM and Medical School • LWABs - link to STPs Good Education and Finance co-operation in our Trust
3	Supporting Learners	Educational and pastoral support to achieve outcomes of curricula and demonstrate *Good Medical Practice*	Infrastructure in place • Undergraduate Academy • Postgraduate –supervision (educational and clinical) educational leads, college tutors
4	Supporting Educators	Educators must have the knowledge and skills to carry out their role GMC 'Recognition and Approval of Trainers' – requires evidence (Aug 16) Challenges of service reconfiguration	Evidence for trainer recognition built into consultant appraisal Vast majority of supervisors accredited Link to consultant Job Planning process required (EPAs)

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

ACTION REQUIRED OF THE BOARD:

Decision	Approval	Discussion	Other
		✓	

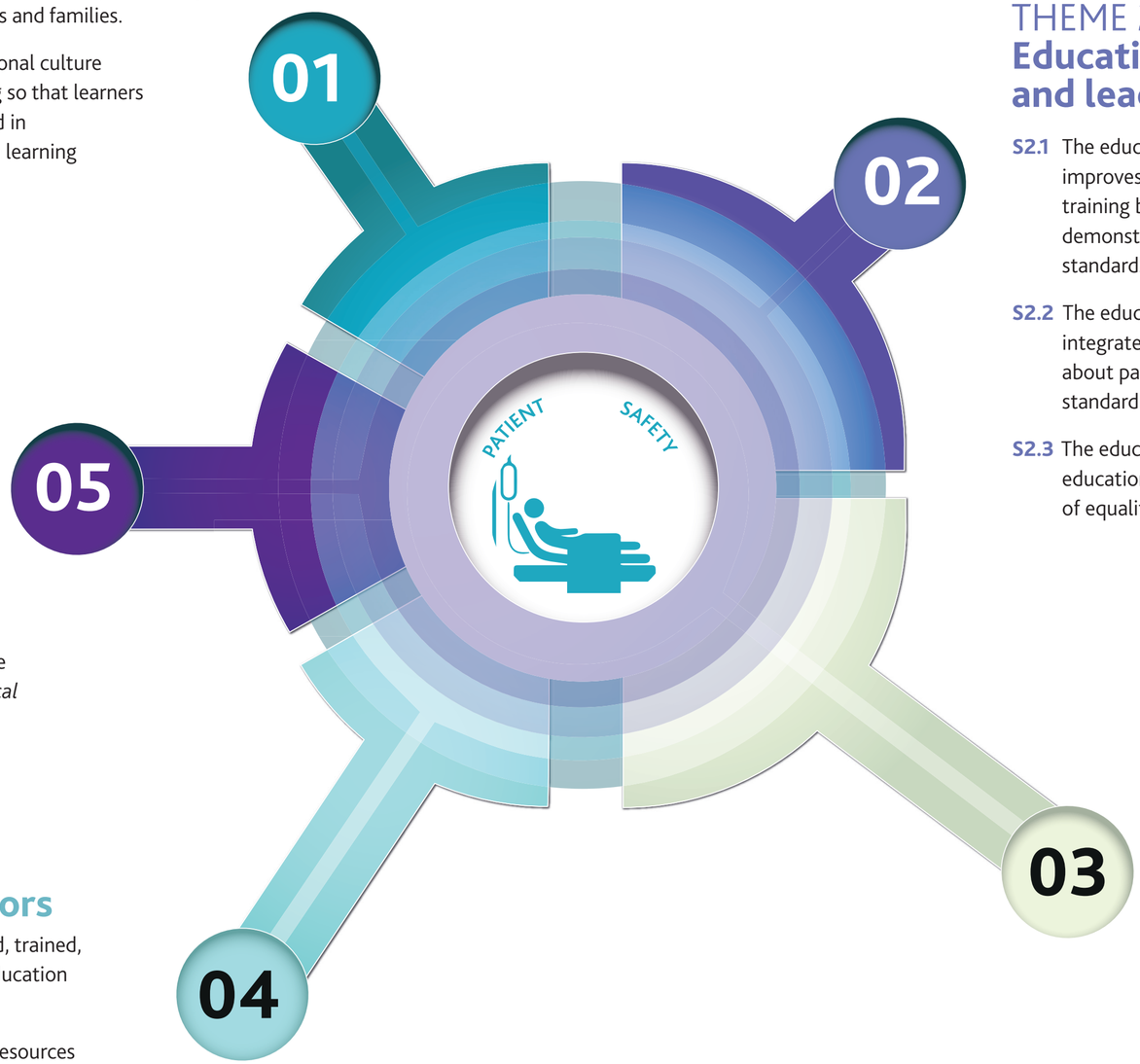
RECOMMENDATIONS FOR THE BOARD:
To note the key issues.

Promoting excellence: standards for medical education and training

THEME 1
Learning environment and culture

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training so that learners are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.



THEME 2
Educational governance and leadership

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability, and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on principles of equality and diversity.

THEME 3
Supporting learners

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

THEME 4
Supporting educators

S4.1 Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

THEME 5
Developing and implementing curricula and assessments

S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.

S5.2 Postgraduate curricula and assessments are implemented so that doctors in training are able to demonstrate what is expected in *Good medical practice* and to achieve the learning outcomes required by their curriculum.

General Medical Council

Enclosure 10

The Dudley G
NHS Foundation Trust

TITLE:	**Annual Report- Medical Appraisal & Revalidation**		
AUTHOR:	**Teekai Beach Directorate Manager to the Medical Director**	**PRESENTER**	**Mr Paul Stonelake Responsible Officer**

CORPORATE OBJECTIVE:
SO2: Safe and Caring Services
SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

This report represents the state of medical revalidation and appraisals at The Dudley Group NHS Foundation Trust as of 1st September 2016. It is the first report of the Responsible Officer (RO) appointed by the board as of that date identifying the performance of the organisation with regards to the Framework for Quality Assurance for Medical Revalidation (FQA) and the Responsible Officer Regulations and related guidance from the General Medical Council (GMC).

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: SAFE; WELL LED**
	Monitor	**Y**	**Details:**
	Other	**Y**	**Details: GMC Good Medical Practice NHS Framework for Quality Assurance for Responsible Officers**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE COMMITTEE

The Dudley Group NHS
NHS Foundation Trust

Medical Director's Directorate

Report of the Responsible Officer for Medical Revalidation to the Board of Directors

1. Executive summary

This report represents the state of medical revalidation and appraisals at The Dudley Group NHS Foundation Trust as of 1st September 2016. It is the first report of the Responsible Officer (RO) appointed by the board as of that date identifying the performance of the organisation with regards to the Framework for Quality Assurance for Medical Revalidation (FQA) and the Responsible Officer Regulations and related guidance from the General Medical Council (GMC).

As of 1st September 2016 there are 307 doctors with a prescribed connection to The Dudley Group NHS Foundation Trust as a designated body. As recently reported to the Workforce and Engagement Committee the Trust has a good overall appraisal rate and makes appropriate and timely recommendations for revalidation.

Areas for development are highlighted within the report most significantly the need to have better systems for supporting short and fixed term contract doctors, as well as those new to UK practice.

2. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in

discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

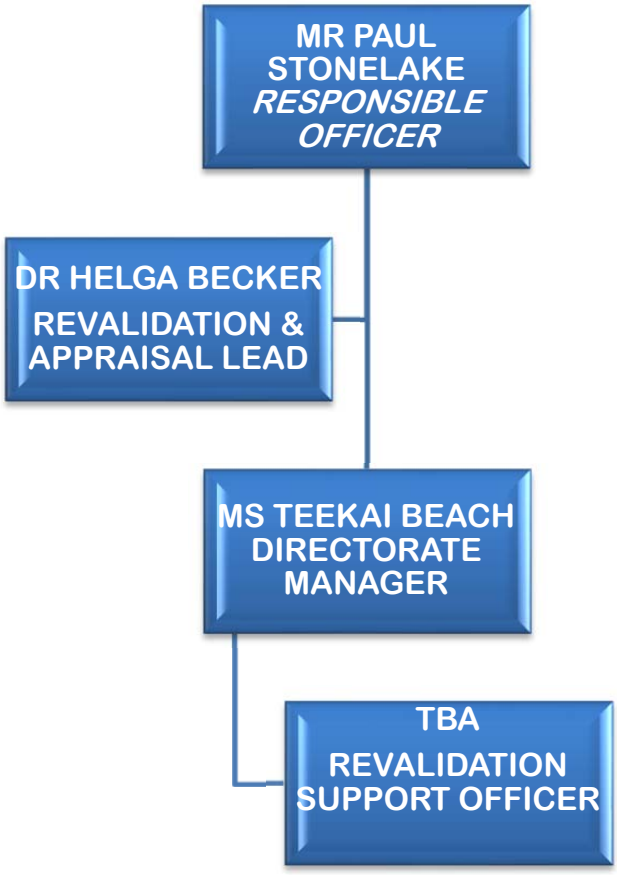
The board has directly and via the Workforce and Engagement Committee received assurance for the last 4 years from the Responsible Officer and Medical Director that the organisation meets the above duties and responsibilities as set out in the Regulations. A report on the position of the organisation for the year 2015/2016 was received by the Workforce and Engagement Committee in August 2016.

As of 1st September 2016, Mr Paul Stonelake, Consultant Surgeon, has been appointed by the board as Responsible Officer, separating the role from that of the Medical Director. As such this report provides an overview of the systems and processes for Medical Revalidation as of that date and sets out the priorities and actions for the new Responsible Officer in the coming year.

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

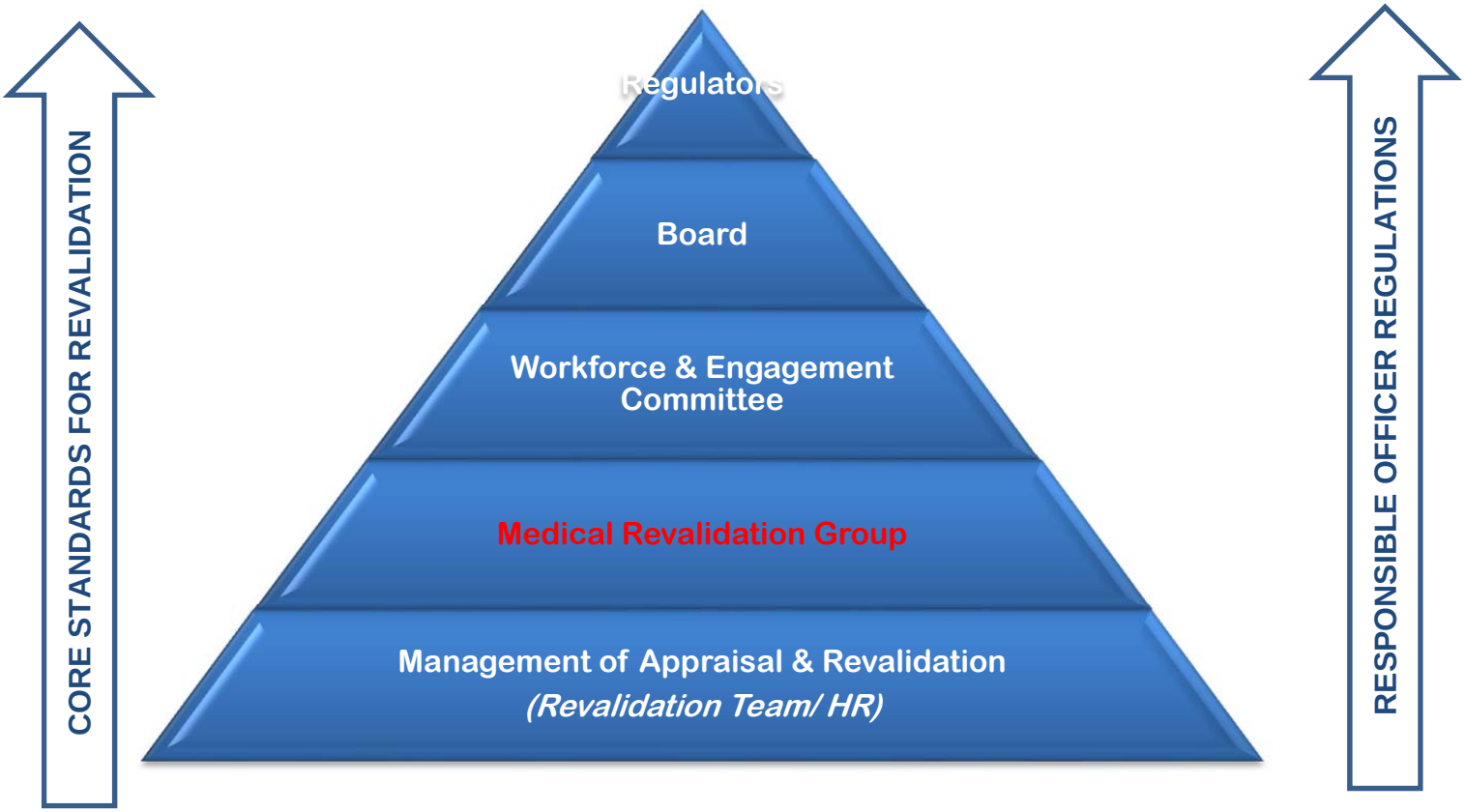
3. Governance Arrangements

The Responsible Officer is supported by a small team managed within the Medical Director's Directorate. Compliance with and support for medical appraisal is led by the Revalidation & Appraisal Lead Dr Helga Becker and managerial Support is provided by the Directorate Manager. Given the number of doctors connected to the organisation and the growing demands of maintaining a good rate of appraisal and providing oversight and assurance regarding the professional standards for doctors that dedicated project support is necessary. In accordance with best practice amongst Trusts within the NHS England Midlands & East network, the team is recruiting a Revalidation Support Officer.



Assurance is provided by reporting to the Workforce and Engagement Committee quarterly and annually to the board. In previous years an informal meeting of the revalidation team, the Medical Revalidation Group was held monthly to review appraisal progress and to escalate. As part of an initial review of systems and processes the Responsible Officer is seeking to reinstate this meeting considering formal designation as a board reporting group.

This group would be a more formal consolidation of the informal decision making undertaken to maintain an accurate list of doctors with a connection to The Dudley Group for the purpose of Revalidation as well as ensuring that appraisals are undertaken (and escalated when not) appropriately. It should, in addition, agree the Revalidation of individual doctors and receive assurance from Human Resources and the Medical Director regarding the appropriate management of concerns regarding doctors.



Reporting is undertaken within the NHS England Framework for Quality Assurance, and the Responsible Officer Regulations, which the board is familiar with.[2] There are, as the board is aware 106 Core Standards for Medical Appraisal of which 100 are applicable to The Dudley Group NHS Foundation Trust. In previous reports the board has reviewed compliance against the core standards and is satisfied with the Trust's performance against these standards.

a. Policy and Guidance

Following the separation of the role of Responsible Officer from that of the Medical Director, the following policies are being reviewed. Some policies as indicated* will be reviewed as part of the process to streamline policies across the Black Country Alliance.

- Procedure for the Initial Handling of Concerns about Doctors and Dentists and the Management of Exclusions (Maintaining Higher Professional Standards)*
- Standard Operating Procedure for the Usage of Locum Medical Staff*
- Medical Staff Appraisal Policy
- Remediation & Support Policy for Medical Staff

4. Medical Appraisal

a. Appraisal and Revalidation Performance Data

As of 1st September 2016, there were 307 doctors connected to The Dudley Group for the purpose of Medical Revalidation

As of that date there are 61 appraisal which have not progressed within the appropriate period (9-15 months from the date of the last appraisal due date) which represents an appraisal rate of 81%- which remains within the national average. The reasons for the above missed or incomplete appraisals are set out in quarterly

[2] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012' A Framework of Quality Assurance for Responsible Officers and Revalidation, NHS England

reports to the Workforce and Engagement Committee, including special circumstances such as sickness absence, new starters and maternity leave which are acceptable reasons within the framework for quality assurance.

b. Appraisers

There are a total of 68 Medical Appraisers within the Trust. The new Appraisal & Revalidation Lead holds quarterly appraisal drop in and development sessions supported by the General Medical Council (GMC).; Training and Development such as Duty of Candour, Consent and Mental Capacity Act training is mandatory for appraisers.

c. Quality Assurance

A review of active appraisers was undertaken in June-August 2016. Of 60 appraisers reviewed. 30 appraisers were at or above the expected standards, 14 appraisers were considered satisfactory with some development required. 2 Appraisers were considered unsatisfactory. 14 appraisers had not completed sufficient appraisals to be reviewed or had not had appraisees allocated.

The Appraisal & Revalidation Lead has in response reallocated all appraisers according to the above results, which will be reviewed annually. Those appraisers considered unsatisfactory will be coached by the Appraisal & Revalidation Lead or undertake retraining to improve performance.

d. Access, security and confidentiality

Information governance guidelines, storage and access to appraisal documentation are set out in the Medical Appraisal and Revalidation Policy.

There have been no incidents with regards to security and confidentiality in the last financial year with regards to appraisal documentation.

e. Clinical Governance

The PreP Revalidation System for Appraisal and Revalidation ensures that the required domains for Supporting Information for Appraisal and Revalidation[3] are completed before the appraisal can be submitted for review by an appraiser. Doctors have access to their individual complaints and incidents via the Trust Governance team and performance, mortality and morbidity data from the Informatics Team.

5. Recruitment and engagement background checks

There is a local policy in place which ensures that the Medical Staffing Team receives the relevant information from all appointments including locum and fixed term contract doctors details on induction and advises them that they are subject to the Trust Revalidation Policy. A Summary of the Recruitment of Engagement checks undertaken by the Medical Workforce Team for the Directorate Manager is set out below.

1. [3] Supporting information for appraisal and revalidation; GMC 2012

The Dudley Group NHS
NHS Foundation Trust

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	17
Temporary employed doctors	202
Locums brought in to the designated body through a locum agency	Framework only
Locums brought in to the designated body through 'Staff Bank' arrangements	36
Doctors on Performers Lists	N/A
Other (doctors who hold honorary contracys)	25
TOTAL	280

Was the following information available within 1 month of the doctor's starting date

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS investigations	Disclosure and Barring Service (DBS)	2 recent references	Name of last responsible officer	Reference from last responsible officer	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance concerns
Permanent employed doctors					By exception				Last appraisal or MPIT		By exception					Based on GMC or MPIT
Temporary employed doctors																
Locums brought in to the designated body through a locum agency		Undertaken by Agency (Framework only)														
Locums brought in to the designated body through					by exce						By exce					Based on GMC

'Staff Bank' arrangements					ption						ption					or MPIT
Doctors on Performers Lists	**Not Applicable**															

6. Responding to Concerns and Remediation

The Trust has appropriate polices in place to respond to concerns regarding doctors.

The 'Procedure for the Initial Handling of Concerns about Doctors and Dentists and the Management of Exclusions' covers the process for dealing with serious concerns about a doctor's performance. It includes sections on Conduct, Capability and Health and is currently under review.

A Medical Staff Update is provided privately to the board to compliment this report and will be provided by the Medical Director.

7. Risk and Issues

There are no existing risks on the register associated with medical appraisal and revalidation. The Risk and Assurance Committee accepted the closure of the Corporate Risk COR090 *Failure to separate the role of Responsible Officer for Medical Revalidation from that of the Medical Director may result in a failure to properly discharge the duties of Responsible Officer for Medical Revalidation and the Trusts' function as a Designated Body* as the board as now appointed a separate Responsible Officer as of 1st September 2016.

The RO on an initial review of appraisal performance will consider the inclusion the rate of appraisal and revalidation deferral amongst trust grade doctors and doctors new to UK practice.

8. Recommendations

The board is asked to accept the report as the findings of the newly appointed Responsible Officer, and note any actions set out within the report.

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Trust Board on 6th October 2016

TITLE:	**People Plan – Workforce Strategy Update**		
AUTHOR:	Andrew McMenemy, Director of Human Resources	**PRESENTER**	Andrew McMenemy, Director of Human Resources

CORPORATE OBJECTIVE:

SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: Deliver for a viable future

SUMMARY OF KEY ISSUES:

The Trust People Plan sets out the Workforce Strategy for the Trust supported by key actions that allow the strategy to be implemented throughout the year and also looking towards 2020. The People Plan is divided into the following sections in order prioritise particular parts of the workforce strategy:

1. Proactive HR/OD Service
2. Workforce Capacity
3. Workforce Capability and Skill Mix
4. Leadership & Talent Management
5. Performance and Productivity
6. Engagement, Culture and Values
7. Be the Place People Choose to work.

The People Plan was approved by the Trust Board in 2015 and is monitored regularly by the Workforce Committee to ensure relevant progress is being made alongside the actions that support the plan.

The enclosed paper provides an update of progress alongside the main actions indicating assurance. The update also highlights changes that may have occurred in the year that may have changed priorities.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or	**CQC**	**Y**	**Details: Well Led**
	Monitor	**N**	**Details:**

LEGAL REQUIREMENTS	Other	N	Details:

ACTION REQUIRED OF BOARD - No

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD

For the Trust Board to take consideration of the progress made against the actions within the People Plan and be assured that these meet the requirements to support the Trust Workforce Strategy.

People Plan – Workforce Strategy Update

1. Proactive HR/OD Service

The Workforce Directorate has reviewed the actions within this area and will be prioritising the following actions:

- A revised performance dashboard that takes consideration of the detail of workforce performance information that best supports local management teams understand the priority areas for management and support.
- To consider the use of workforce information in order that we have one consistent version of information that is considered credible.
- To develop a way forward using a consistent workforce information system in the Trust and possibly alongside our NHS partners in the Black Country.
- There is a timetable for Allocate roll-out, which continues to be delivered with Pharmacy and Radiology the areas currently being placed on the system. There have been difficulties with the implementation process and therefore timescales will require to be changed.
- Junior Doctor Contract implementation has identified risks and we continue to work alongside the Guardian to manage the contract by speciality with Obstetrics and Gynaecology being the first speciality to work towards the new conditions of employment.

2. Workforce Capacity

The Workforce Directorate has reviewed the actions within this area and will be prioritising the following actions:

- Alongside the required submission of the workforce plan on behalf of the Trust there is a requirement to develop a more sophisticated approach to planning for the workforce. The skill set of the Workforce Department is being reviewed to develop our skills in this area that will support better recruitment and also better planning regarding the development of staff.
- The Trust has made significant progress with the appointment of apprentices with an agreed priority at the Workforce Committee to extend this further in order to achieve our target and access as much levy funding as possible.

3. Workforce Capability and Skill Mix

The Workforce Directorate has reviewed the actions within this area and will be prioritising the following actions:

- A review of Mandatory Training has commenced and will be completed by the end of October 2016. A proposal will be developed on the back of the review providing an agreed and consistent way forward to the recording and remit of mandatory training.
- There continues to be progress for further development of Advanced Nurse Practitioners via HEWM and Assistant Nursing roles alongside University of Wolverhampton.

4. Leadership and Talent Management

The Workforce Directorate has reviewed the actions within this area and will be prioritising the following actions:

- The principles of the new Leadership Development programme is in place with supporting mechanisms of coaching and 360 degree feedback available for participants.
- A business case has been developed to support our strategy for talent management that is being considered prior to implementation.

5. Performance and Productivity

The Workforce Directorate has reviewed the actions within this area and will be prioritising the following actions:

- The performance on workforce key performance indicators continues to be a concern in particular areas such as appraisal and mandatory training compliance.
- The work is continuing with the BCA in relation to joint working initiatives for back office support that will create efficiencies.

6. Engagement, Culture and Values

The Workforce Directorate has reviewed the actions within this area and will be prioritising the following actions:

- The staff survey will be initiated in October 2016 with some additional questions associated to Staff Health & Well Being initiatives.

7. Be the Place People Choose to Work

The Workforce Directorate has reviewed the actions within this area and will be prioritising the following actions:

- The SEQOHS accreditation for Occupational Health services has been reviewed with confirmation that the service is compliant and working within the remit of the conditions set.
- The CQUIN action plans for Health & Well Being and Flu Vaccinations have been developed and are being implemented.

Enclosure 12

Paper for submission to the Board on the October 6th 2016

TITLE:	**Freedom to Speak Up Guardian role implementation and progress.**		
AUTHOR:	**Carol Love-Mecrow Head of Non-Medical Education and Training Freedom to Speak Up Guardian**	**PRESENTER**	**Carol Love-Mecrow Head of Non-Medical Education and Training Freedom to Speak Up Guardian**

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

SUMMARY OF KEY ISSUES:

- Overview and rationale for the post
- Development of the Raising Concerns polices
- Communication of the raising concerns agenda
- Progress to date

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD
To discuss the implications highlighted by the paper and subsequent strategies to address these.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Freedom to Speak up [FTSU] Guardian role implementation and progress

Introduction

In February 2015, Sir Robert Francis published his final report following the Freedom to Speak up review. The purpose of the review was to provide independent advice and recommendations on creating a more open and honest reporting culture in the NHS. The review followed on from the Public Inquiry, also chaired by Sir Robert, into the Mid Staffordshire NHS Foundation Trust which exposed unacceptable levels of patient care and an organisational culture that deterred staff from raising concerns.

In particular, the report emphasised the need for a culture of safety and learning in which all staff feel safe to raise a concern and for these conversations to take place as part of everyday practice, without fear of blame or retaliation. Two key elements of the report included the appointment of a local FTSU guardian in each Trust and a national guardian for the NHS.

Appointment

In May 2016, in response to the recommendations of the report The Dudley Group NHS Foundation Trust appointed Carol Love-Mecrow, Head of Non-Medical Education to the role of Freedom to Speak Up Guardian. Carol has worked for the Trust for over 30 years as a nurse and then in nurse education having responsibility for the education and development of all non-medical clinical staff and nurse recruitment.

Role Specification

Acting in an independent capacity, the Freedom to Speak Up Guardian will be appointed by the Board, working alongside them and members of the executive team to help support the organisation to become a more open, transparent place to work.

In particular the Freedom to Speak Up Guardian will:

- Work with the chief executive and Board to help create an open culture which is based on listening and learning and not blaming.
- Develop, alongside the Board, chief executive and executive team a range of mechanisms, in addition to the formal processes, which empower and encourage staff to speak up safely.
- Ensure that staff with disabilities and those from black and other minority ethnic backgrounds are encouraged to speak out and are not disadvantaged by doing so.
- Participate in the organisation's educational programme for all staff so that they understand how they can raise concerns and for managers about how they respond to concerns and supporting the member of staff appropriately.
- Be entirely independent of the executive team, so they are able to challenge senior members of staff, reporting to the Board or externally as required.

- Be a highly visible individual, who spends the majority of their time with ‘front line’ staff, providing expertise in developing a safe culture which supports and encourages staff to speak up using the local procedures and if necessary advising them on how to raise concerns, including externally.
- Act in an independent and impartial capacity, listening to staff and supporting them to raise concerns they may have by using the available structures and policies, both within the organisation and outside.
- Independently review any complaints from members of staff about the way they have been treated as a result of raising a concern and report back to the individual and, with their agreement, to their manager, the chief executive and the director of human resources.
- Ensure members of staff who speak up are treated fairly through the investigation, inquiry and or review and that there is effective and open communication during this time.

Policy

The previous Trust Whistleblowing has been reviewed and ratified, in line with new national legislation for the NHS. There are now 2 Trust policies in place addressing raising concerns:

- Raising Concerns Speak Up Safely (Whistleblowing) Policy
- Raising Concerns (Including Whistleblowing) Management Policy

Responsibility for both of these policies now sits within Governance; previously the whistleblowing policy came under the remit of Human Resources.

Communications Strategy

The communication strategy for the FTSU guardian has been implemented as follows:

- HUB article introducing the newly appointed guardian
- The addition of the FTSU guardian’s contact details to the existing ‘whistle’ on the HUB.
- Introduction of the role at senior meetings
- Governance board posters sign posting staff to the work of the guardian and contact details.
- Posters with a photo of the FTSU guardian placed around the Trust.
- Awareness sessions for new staff are currently being set up.
- The national guardian office has been informed of my appointment and I am now on the guardian map.

Activity May-Sept 2016

	Month	No of Concerns raised	Investigation required	Progress
1	**May**	1	Already in progress	Closed 19/9/16
2		2	No	Closed 4/5/16
3		3	No	Ongoing
4		4	Already in progress	Closed 15/5/16
5	**June**	1	No	Ongoing
6		2	Review carried out	Closed 9/6/2016
7		3	Review carried out	Closed 9/6/2016
8		4	Review carried out	Closed 9/6/2016
9		5	Review carried out	Closed 9/6/2016
	July	No concerns raised		
	Aug	No concerns raised		
	Sept	No new concerns at the time of report		

Themes

May and June saw a number of concerns raised, the majority of which did not relate directly, to lapses in patient care. All but one of the concerns were made confidentially but not anonymously.

The lack of concerns relating to patient care can be viewed positively with the assumption that staff are confident enough to tackle this directly and do not need to seek support outside of the clinical area.

Issues / Reflections

The last 6 months as the Guardian have been eventful and a little stressful at times; managing a full time role and the Guardian work can be challenging. Whilst staff seem responsive to the role I was sometimes initially met with a slight degree of suspicion when I attempted to clarify facts about the concerns raised. This has abated as staff have become more familiar with the purpose of the role.

I am now in touch with a number of other guardians and this provides a support forum that I can tap into.

Future plans

In the next few months there will be development of an evaluation tool to measure the effectiveness of the role, some partnership working with the Guardian for safer staffing and increased visibility.

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 6th October 2016

TITLE:	**Outpatient Optimisation Programme**		
AUTHOR:	**Louise McMahon & Steve Gasking**	**PRESENTER**	**Louise McMahon & Steve Gasking**

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 choose to work
SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

Outpatients is a highly complex area of the hospital due to the vast array of services, multiple points of delivery, varied methods for delivering the services and numerous pathways within each service.

Six months into a 2 year service improvement programme, this report sets out to update the Board of the approach, scope, objectives and benefits of the Outpatient Optimisation programme of work.

Based on patient and staff feedback there were key areas where patient experience and efficiency improvement opportunities were clearly defined:

- Hospital Cancellations
- Patient Communications
- Delays in Clinic
- General Planning
- Patient Flow

To manage this complex and wide reaching programme three work streams were developed:

- Referral Management – everything prior to the appointment with the exception of Medical Records logistics
- Clinic Management – all activities whilst the patient is on site
- Records Management – library management, logistics and case note contents

Within each stream a number of objectives have been prioritised for delivery during the initial phase, addressing some of the immediate issues raised by staff and patients while setting the foundations for larger transformational process improvements.

Some of the larger process changes are being planned not only to deliver greater

patient and staff benefits in year two but to also ensure EPR readiness.

The programme relies on and will continue to engage with all service users and stakeholders while the Steering Group plays a key part in keeping both the progress rapid and aligned to the user requirements.

A quality and performance dashboard is in development with reports already being used to measure improvement and focus sight on areas requiring further development.

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

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	✓		

RECOMMENDATIONS FOR THE BOARD

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**

The Dudley Group NHS
NHS Foundation Trust

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**

Outpatient Optimisation Programme 2016 - 2018

The Dudley Group NHS
NHS Foundation Trust

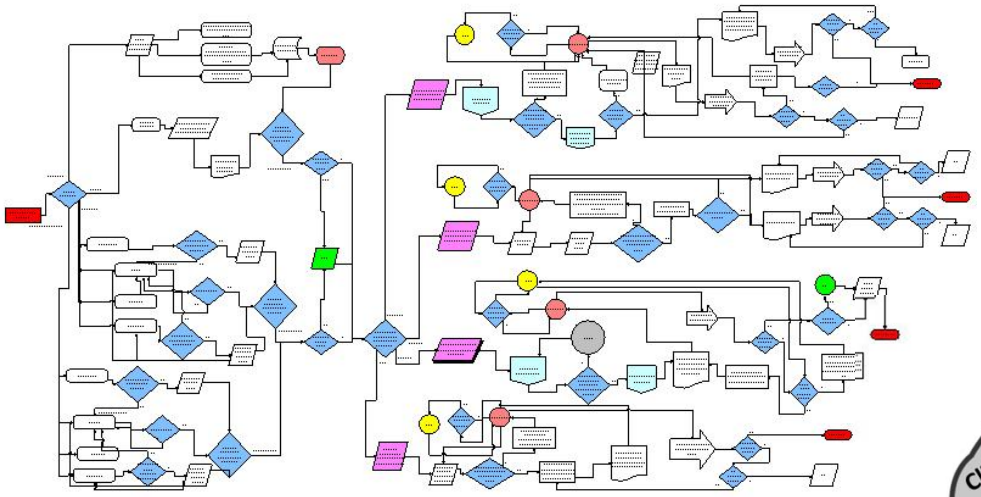
Outpatient Optimisation Programme

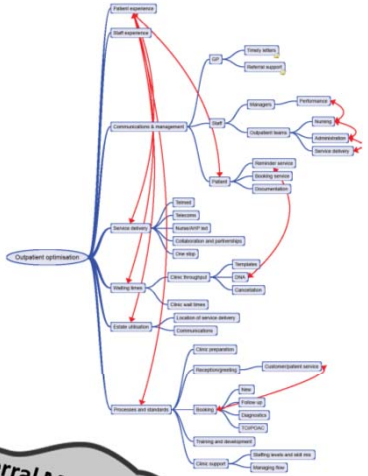
Summary of where we are

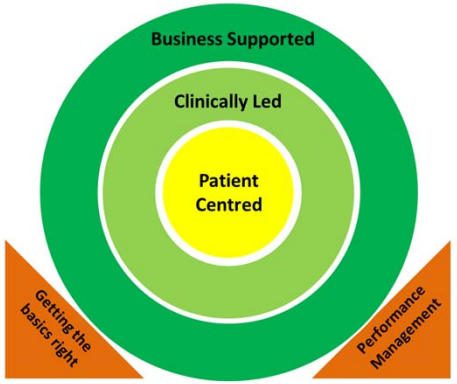
Presented by:
Louise McMahon – Divisional Manager Patient Access
Steve Gasking – Change Support

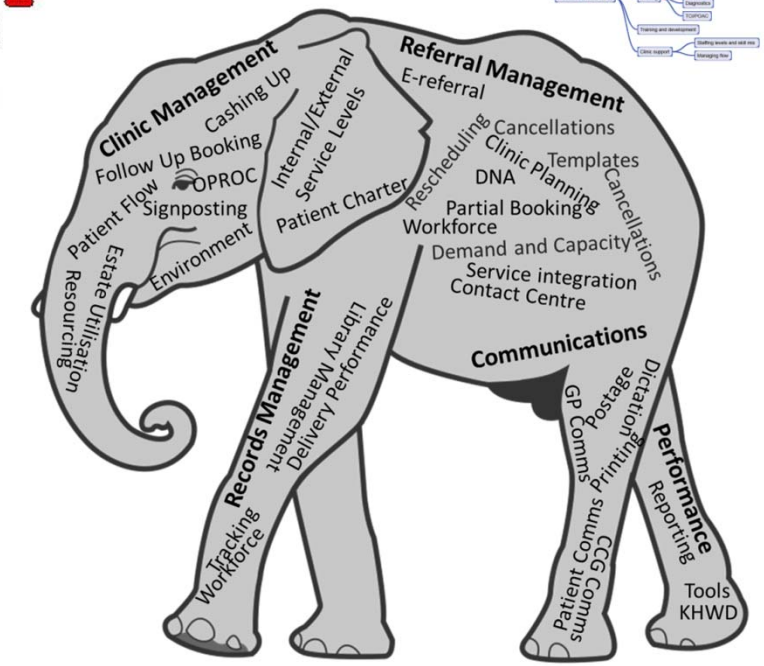
Optimising Outpatients

Highly complex with multiple interdependences







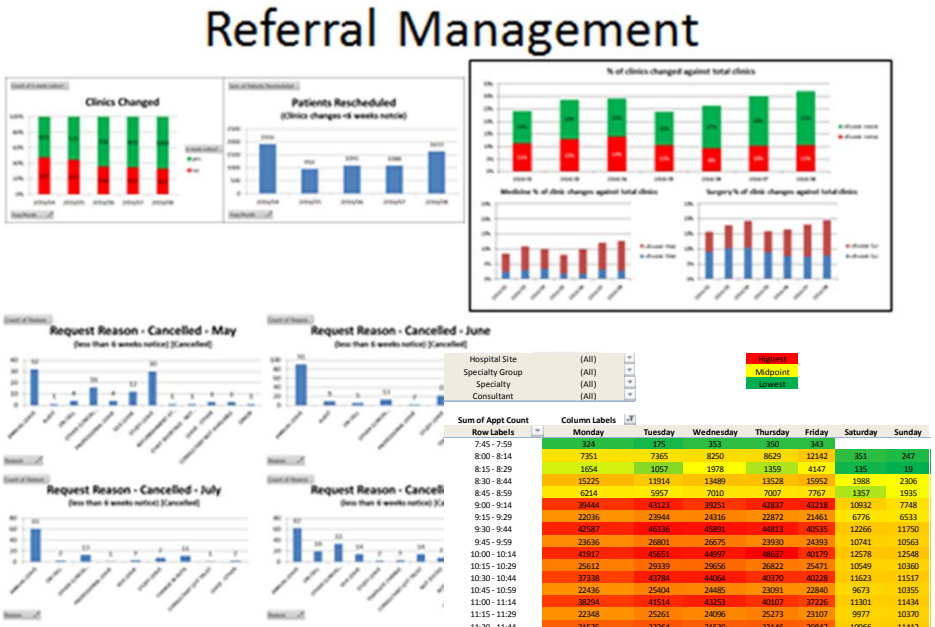


Outpatient Programme

		
Referral Management	Clinic Management	Records Management

Referral Management

- **Top three areas to focus on:**
  - Booking Processes and Standards
  - Cancellations and Reschedules
  - Demand and Capacity Management
- **Results so far…**
  - Baseline data and metrics generated
  - Booking rules established
  - Workforce development
  - Standardised approach to demand and capacity modelling with roll out plan by Specialty



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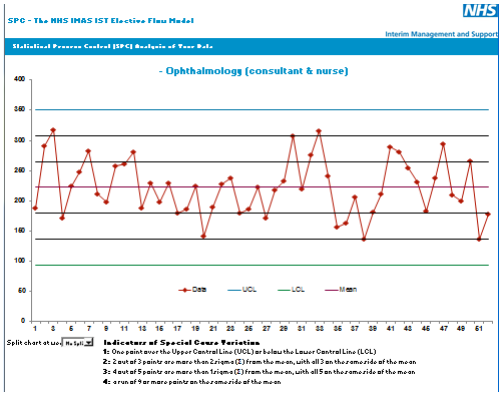
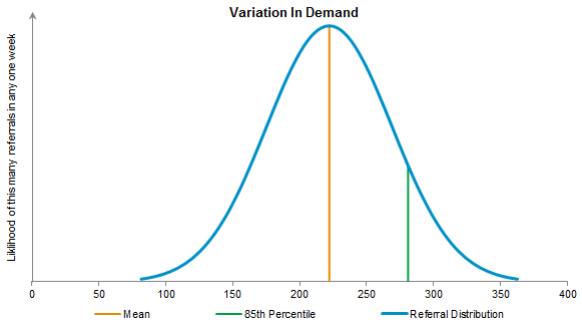
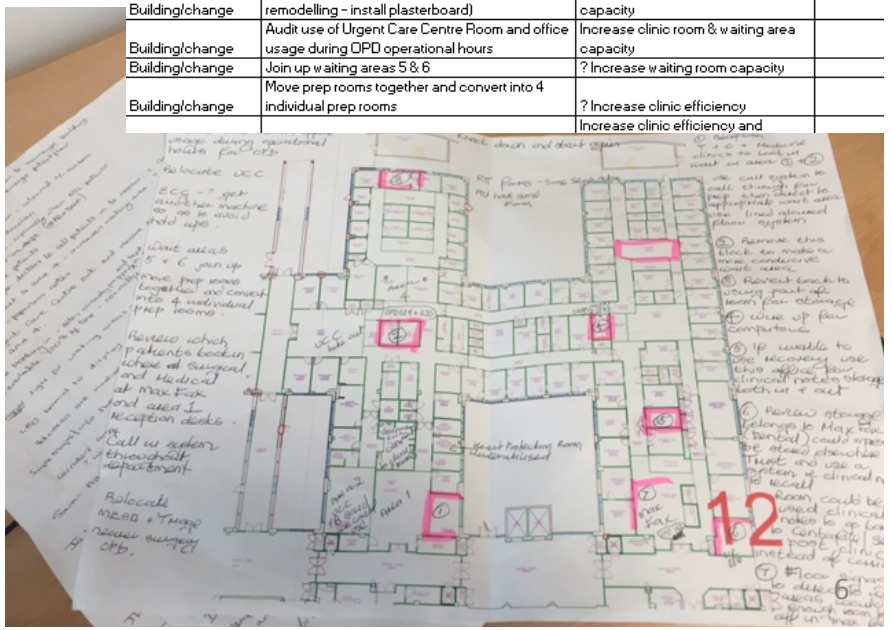




Clinic Management

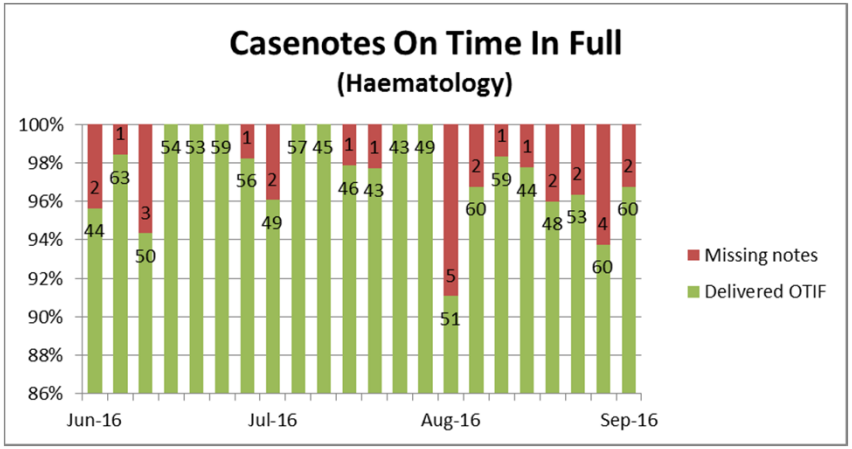
- **Top three areas to focus on:**
  - Booking Processes and Standards
  - Clinic Cashing Up
  - Environment
- **Results so far…**
  - Staff engagement events and regular briefing sessions
  - Aligned reception areas to standard operating procedures
  - Rapid Clinic Review process established
  - Raised staff awareness of what a patient sees

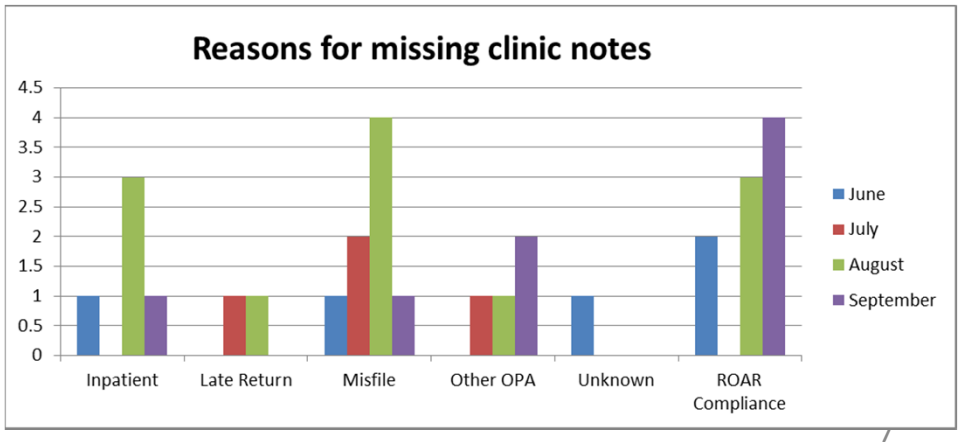
Group	Suggested change/action	Benefit	Priority
Staff/equipment	Another ECG machine +/- Technician	Increase clinic efficiency/capacity and reduce patient waiting times	
Staff/equipment	Get another ECG machine to reduce hold ups	Increase clinic efficiency/capacity and reduce patient waiting times	
Building/change	Dedicated phlebotomy area - especially useful for NSL patients	Take pressure off current phlebotomy area/? Still an issue	
Building/change	Remove sluice next to area 4	Increase waiting area - more seats for patients?	
Building/change	? Remove extra toilet	Increase waiting area - more seats for patients?	
Building/change	Move Urgent Care Centre out and remove most of the block next to area 4	Increase clinic room & waiting area capacity	
Building/change	Remove/relocate urgent care centre	Increase clinic room & waiting area capacity	
Building/change	Relocate Urgent Care Centre	Increase clinic room & waiting area capacity	
Building/change	Widen corridors/increase OPD space	Increase patient satisfaction, patients with walking aids,	
Building/change	Use the phlebotomy cubicles as consulting rooms (would require a small amount of remodelling - install plasterboard)	Increase clinic room & waiting area capacity	
Building/change	Audit use of Urgent Care Centre Room and office usage during OPD operational hours	Increase clinic room & waiting area capacity	
Building/change	Join up waiting areas 5 & 6	? Increase waiting room capacity	
Building/change	Move prep rooms together and convert into 4 individual prep rooms	? Increase clinic efficiency	
		Increase clinic efficiency and	



Records Management

- **Top three areas to focus on:**
  - Service Performance (delivery to clinic)
  - Processes and Standards
  - Library Management
- **Results so far…**
  - Resource planning
  - Improved case note request process to improve OTIF
  - Changed logistics to reduce manual handling and delivery near JIT
  - Re-focussed performance indicators to quality based metrics
  - Created a Team culture





Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 6th October 2016

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Transformation Executive Committee (TEC) met on 22nd September 2016 to:

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

Based on the Month Five position, the Trust has identified 46 schemes totalling **£11,407K** against a Full Year target of **£11,908K**, leaving a shortfall against the target of **£501K**. Further, the Trust is forecasting £10,017k of the £11,407k it has identified to date. This creates an additional shortfall of **£1,389k** against identified schemes. As a result, the Trust's is forecasting an overall shortfall of **£1,890K** for 2016/17.

Of the 42 PIDs approved by TEC, 33 have been approved by the Quality Impact Assessment (QIA) panel. The remaining 7 projects will be submitted to the QIA panel on 13th October 2016 which will scrutinise all projects to ensure all risks to quality are identified and suggest mitigations to address any potential risks.

IMPLICATIONS OF PAPER:

RISK	**Y**	**Risk Description:** ST001 – Capability to deliver the Programme of work ST002 – Delivery of the Programme negatively

			impacting on Quality of Care or Patient Experience COR080 – Failure to deliver 2016/17 CIP
	Risk Register: **Y**		**Risk Score:** 4, 4, 16 (respectively)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	Monitor	**Y**	**Details:** Non delivery of CIP
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR THE BOARD

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

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

SO1:	**Deliver a great patient experience**
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CARE QUALITY COMMISSION CQC) : *(Please select for inclusion on front sheet)*

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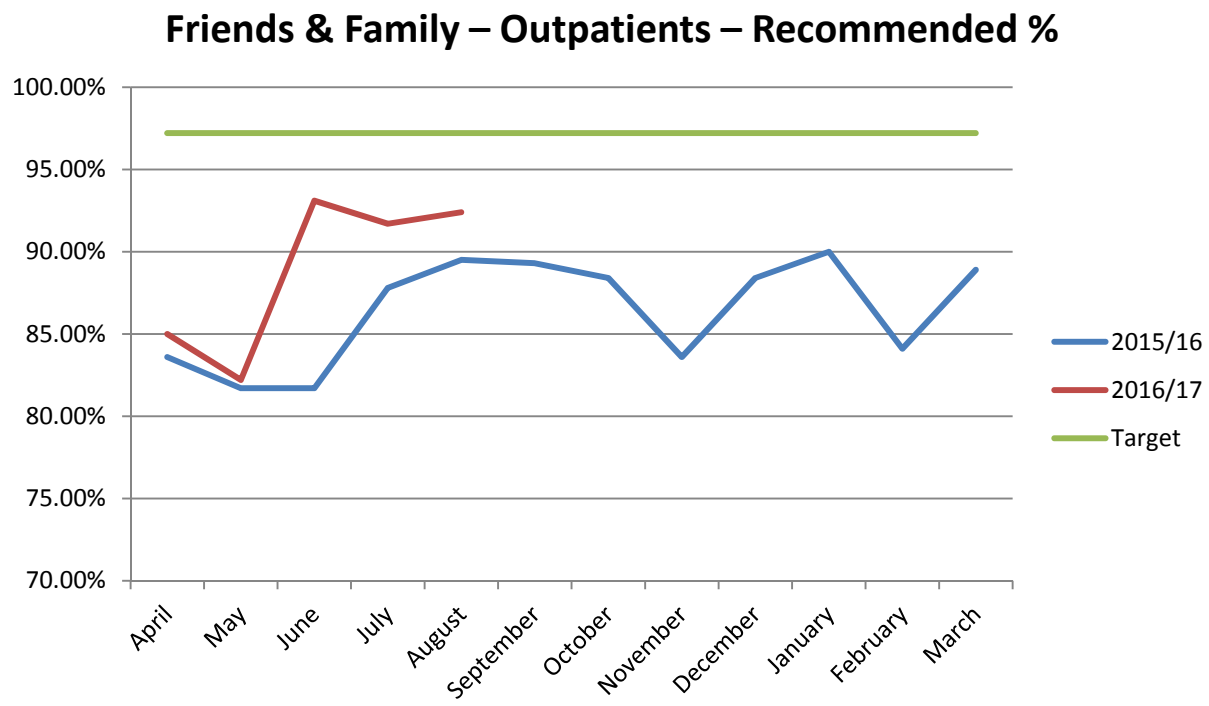
WELL LED	**The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and innovation, and**

	promotes an open and fair culture

In Summary

- Clearly communicated a shared vision for Outpatients
- Widely engaged with staff and patients
- Are on a journey of creating a “Can Do Patient Focused” culture



The Dudley Group NHS
NHS Foundation Trust

Trust Board of Directors

Service Improvement and PMO Update

6th October 2016

Executive Summary

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

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

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

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

	Full Year (FY)			YTD Performance against identified Plans			Y/E Forecast of identified Plans	
CIP Project Plans	FY Target	FY Identified	Shortfall against FY Target	YTD Plan (from identified schemes)	YTD Actual	YTD Variance (against identified schemes)	Y/E FOT of identified schemes	Y/E FOT Variance of identified schemes
TOTAL	£11,908k	£11,407k	-£501k	£4,583k	£3,691k	-£891k	£10,017k	-£1,389k

Based on the Month Five position, the Trust has identified schemes totalling **£11,407k** against a Full Year (FY) target of **£11,908k,** leaving a shortfall against the target of **£501k**. Further, the Trust is forecasting to deliver £10,017k of the £11,407k it has identified to date. This creates an additional shortfall of **£1,389k** against identified schemes. As a result, the Trust is forecasting an overall shortfall of **£1,890K** for 2016/17.

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

Quality Impact Assessment (QIA)

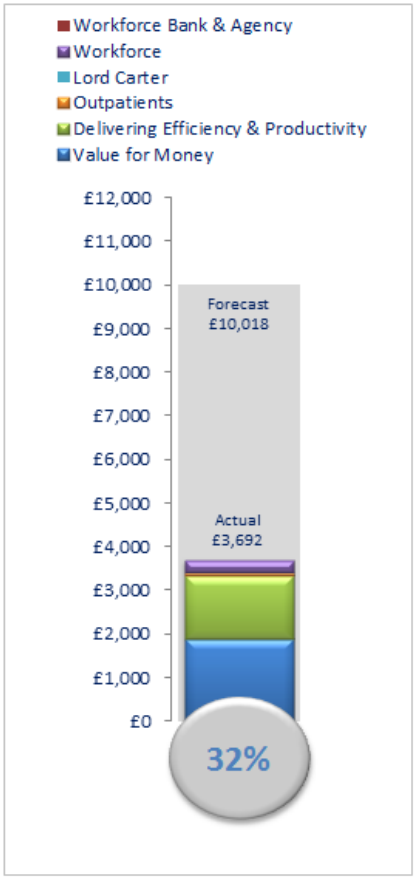
Of the 42 PIDs approved by TEC, 33 have been approved by the Quality Impact Assessment (QIA) panel. The remaining 7 projects will be submitted to the QIA panel on 13th October 2016 which will scrutinise all projects to ensure all risks to quality are identified and suggest mitigations to address any potential risks.
During the panel meeting on 13th October 8 projects were signed off and 2 postponed until the next meeting pending some changes. Of the outstanding 7 QIAs, 2 projects remain in scoping phase with no approved PID, 2 pending approval, and 3 new QIAs to be presented.

Executive Summary

	YTD	FYE
Planned	£4,583,302	£11,406,963
Actual	£3,691,572	£3,691,572
Forecast		£10,017,725
Variance	-£891,730	-£1,389,238

	Submitted Plan	Overall Shortfall
Identified	£11,406,963	
Target	£11,907,990	
Variance	-£501,027	-£1,890,265

Programme (Click for details)	Executive Lead	FYE Plan	FYE Forecast	YTD Plan	YTD Actual	Forecast Shortfall	Planned Lord Carter Contribution
Delivering Efficiency and Productivity	Paul Bytheway	£4,665,059	£3,722,857	£1,795,493	£1,455,042	-£942,202	£2,993,347
Value for Money Infrastructure	Paul Taylor	£4,895,783	£4,874,963	£2,049,839	£1,881,227	-£20,820	£1,343,000
Workforce	Dawn Wardell	£950,321	£778,185	£395,970	£274,189	-£172,136	£300,004
Outpatients	Anne Baines	£303,800	£265,137	£126,583	£81,113	-£38,663	£303,800
Lord Carter	Anne Baines	£0	£0	£0	£0	£0	£0
Workforce Bank & Agency	Paul Taylor	£592,000	£376,583	£215,417	£0	-£215,417	£592,000
View all Projects	Total	£11,406,963	£10,017,725	£4,583,302	£3,691,572	-£1,389,238	£5,532,151



2016/17 Forecast Non Recurrent	£2,041k	% of Total CIP Forecast as Non Recurrent	20.37%

Enclosure 15

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 6 October 2016

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	Jonathan Fellows Non-Executive Director
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: Summary reports from the Finance and Performance Committee meeting held on 29 September 2016.			

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report

The Dudley Group NHS
NHS Foundation Trust

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

Declarations of Interest Made

None

Assurances Received

- The performance and financial position of the Surgery Division at Month 5 was good.
- The up to date position of the Ophthalmology Department regarding serious incidents and was noted and the progress made in mitigating the risks.
- The financial position to Month 5 was noted as being "on plan" and there is confidence that forecast position for Q2 is the same.
- The major performance targets were likely to be "on or above" national targets for Q2 apart from 6-week diagnostic waits which was slightly below target at 96.69% at Month 5.
- The self-assessment against the new Single Oversight Framework was noted, and that the formal NHSI assessment would be reported back when it was received.
- The likely impact of the Operating Plan 2017-19 guidance was noted.

Decisions Made / Items Approved

Actions to come back to Committee

Performance Issues to be referred into Executive Performance Management Process

- The level of sickness rates in the Nursing Division to be reviewed.
- The forecast capital spending position at Month 6 to be reviewed with budget holders.
- The absolute number of vacancies to be included on the corporate performance report.
- The number of overdue appointments in Ophthalmology to be reviewed regularly.

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

- The current risk associated with agency spending is reviewed to ensure it is appropriate.
- That risk relating to the monthly review of performance indicators in the single.

Items referred to the Board for decision or action

- Further debate about the forecast financial position of the Trust to be discussed.
- The financial assessment of the impact on the Trust's 5 year financial model of the decision to procure an EPR will be considered at the Trust Board meeting (in private) on 6th October 2016. The final approval of the tender, which may still be subject to NHS Improvement agreement, is scheduled for the Trust Board on 3rd November 2016.

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - August 2016

Quality & Risk			2015				2016									
Description		LYO	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD	YEF
Friends & Family – Community – Footfall		1%	0.8%	0.8%	0.6%	1.8%	1.7%	1.9%	1.8%	1.4%	1.1%	1.5%	0.4%	1.3%	1.1%	
Friends & Family – Community – Recommended %		96.4%	92.8%	96.8%	94.7%	98.8%	96.5%	97.9%	95.4%	96.8%	94.7%	94.4%	93.6%	96.1%	95.3%	
Friends & Family – ED – Footfall		7.5%	3.2%	7.4%	5.9%	6.2%	5.2%	7.4%	6.1%	5%	3.8%	1.6%	8.4%	10.7%	6.1%	
Friends & Family – ED – Recommended %		92.3%	91%	95.8%	92.5%	88.4%	95.8%	92.9%	97.9%	91.4%	91.3%	88.2%	91.7%	91.8%	91.5%	
Friends & Family – Maternity – Footfall		21.6%	23.4%	25.1%	32.1%	18%	17%	20.4%	15.9%	17.6%	33.2%	16.6%	33.8%	32.7%	27.1%	
Friends & Family – Maternity – Recommended %		98.2%	99.2%	97.9%	98.2%	96.6%	97.8%	98.2%	98.4%	97.5%	97.3%	98.9%	96%	98.6%	97.5%	
Friends & Family – Outpatients – Footfall		-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Friends & Family – Outpatients – Recommended %		87.6%	89.3%	88.4%	83.6%	88.4%	90%	84.1%	88.9%	85%	82.2%	93.1%	91.7%	92.4%	89.3%	
Friends & Family – Ward – Footfall		25.7%	29.9%	23%	23%	17.2%	16.5%	17.6%	18.4%	18.9%	17.3%	13.6%	19.2%	19%	17.6%	
Friends & Family – Ward – Recommended %		97%	96.2%	96.7%	96.6%	99%	95.9%	95.5%	94.1%	93.7%	94.8%	96%	95.1%	95.6%	95%	
HCAI – Post 48 hour MRSA		2	2	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI CDIFF - Total Number of Cases		-	5	5	5	8	4	1	0	2	3	2	2	-	-	
Incidents - Patient Falls, Injuries or Accidents		-	119	111	118	114	129	-	-	-	-	-	-	-	-	
Incidents - Pressure Ulcer		2,047	132	125	141	172	187	242	246	253	240	194	193	196	1,076	
Mixed Sex Sleeping Accommodation Breaches		4	0	0	2	0	2	0	0	0	0	0	0	0	0	
Never Events		1	1	0	0	0	0	0	0	0	0	0	0	1	1	
Serious Incidents – Not Pressure Ulcer		104	11	11	11	10	9	4	7	7	6	4	12	11	40	
Serious Incidents - Pressure Ulcer		228	10	18	17	30	26	12	19	13	9	8	10	17	57	
Stroke - Suspected TIA Scanned < 24hrs of Presentation		85.35%	85%	92.31%	50%	52.63%	85.71%	66.67%	94.12%	84.62%	78.57%	36.36%	63.64%	43.48%	59.72%	

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - August 2016

Quality & Risk			2015				2016									
Description		LYO	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD	YEF
Stroke Admissions : Swallowing Screen		80.58%	75%	78.38%	88.89%	87.88%	83.78%	76.32%	86.67%	89.36%	88.37%	85.11%	78.72%	73.17%	83.11%	
Stroke Admissions to Thrombolysis Time		56.31%	75%	37.5%	71.43%	33.33%	45.45%	37.5%	50%	60%	50%	83.33%	36.36%	60%	55%	
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		89.16%	92.68%	88.68%	88.68%	90.91%	92.68%	84.09%	70.83%	82.76%	91.11%	91.53%	90.2%	88.1%	88.63%	
VTE Assessment Indicator (CQN01)		95.96%	96.19%	96.1%	96.67%	96.47%	95.4%	94.43%	94.46%	94.65%	95.5%	95.09%	93.09%	94.28%	94.52%	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - August 2016

Finance			2016						
Description		LYO	Apr	May	Jun	Jul	Aug	YTD	YEF
Budgetary Performance		£773k	(£71)k	£266k	(£110)k	(£23)k	£3k	£65k	
Capital v Forecast		69.5%	61.8%	66.5%	76.2%	76.4%	73.9%	73.9%	
Cash v Forecast		122.3%	94.8%	93.2%	96.2%	74.9%	89%	89%	
Debt Service Cover		1.18	1.4	1.58	1.63	1.74	1.69	1.69	
EBITDA		£20,460k	£2,228k	£2,820k	£2,755k	£3,321k	£2,358k	£13,482k	
I&E (After Financing)		(£2,945)k	£280k	£859k	£818k	£1,380k	£403k	£3,742k	
Liquidity		7.07	7.1	8	8.84	10.39	10.93	10.93	
SLA Performance		£1,031k	(£122)k	£326k	£144k	£15k	(£15)k	£348k	
SLR Performance		(£2,945)k	£281k	£859k	£819k	£1,381k	£403k	£3,743k	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - August 2016

Performance			2015				2016									
Description		LYO	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD	YEF
A&E - 4 Hour A&E Dept Only % (Type 1)		96.79%	97.57%	98.93%	97.5%	97.13%	91.76%	92.74%	91.53%	93.24%	92.88%	94.48%	93.34%	92.97%	93.38%	
A&E - 4 Hour UCC Dept Only % (Type 3)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)		98.18%	98.53%	99.38%	98.63%	98.47%	95.73%	96.06%	95.62%	96.3%	96.06%	96.76%	96.21%	95.81%	96.22%	
Activity - A&E Attendances		96,141	8,003	8,099	7,900	7,754	8,088	7,946	8,626	7,807	8,801	8,430	8,973	8,580	42,591	
Activity - Community Attendances		407,248	35,088	36,008	34,642	33,385	33,694	32,322	30,817	32,681	32,631	32,846	31,684	33,631	163,473	
Activity - Elective Day Case Spells		45,020	3,675	3,952	3,757	3,719	3,677	3,938	3,820	3,801	3,720	3,998	3,826	3,922	19,267	
Activity - Elective Inpatients Spells		6,394	537	572	580	481	500	515	534	514	523	549	563	482	2,631	
Activity - Emergency Inpatient Spells		52,037	4,105	4,296	4,265	4,552	4,573	4,359	4,714	4,823	5,246	5,076	5,061	5,046	25,252	
Activity - Outpatient First Attendances		130,956	10,758	10,712	11,159	10,604	11,304	11,569	12,255	10,329	10,632	10,618	10,527	11,003	53,109	
Activity - Outpatient Follow Up Attendances		313,888	26,290	25,988	27,022	25,643	26,438	26,699	26,435	26,540	26,976	27,061	25,356	25,326	131,259	
Activity - Outpatient Procedure Attendances		52,451	4,553	4,864	4,968	4,268	4,117	4,691	3,324	4,989	4,960	5,219	5,089	4,318	24,575	
RTT - Admitted Pathways within 18 weeks %		94.2%	94.3%	92.5%	93.3%	93.4%	94.4%	92.8%	91.5%	92.5%	93.5%	94.2%	94.2%	95%	93.9%	
RTT - Incomplete Waits within 18 weeks %		95.1%	95.1%	94.6%	94.4%	94.9%	95%	95.6%	95.4%	97.1%	96.8%	97.1%	97.1%	96.6%	96.9%	
RTT - Non-Admitted Pathways within 18 weeks %		97.7%	98.3%	97.5%	97.8%	97.8%	97.3%	97.4%	96.7%	96.7%	97.7%	98.1%	98%	98.4%	97.8%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		98.97%	98.41%	97.87%	98.85%	99.29%	99.52%	99.53%	99.03%	98.04%	99.39%	99.16%	98.96%	97.69%	98.66%	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - August 2016

Staff/HR			2015				2016									
Description		LYO	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	YTD	YEF
Appraisals		77.5%	80%	78.3%	75.5%	80.3%	79.9%	79.2%	77.5%	80.9%	80.5%	81%	78.1%	78.3%	78.3%	
Mandatory Training (Professional Requirements)		-	-	-	-	-	-	-	-	-	71.3%	72.8%	72.5%	-	-	
Mandatory Training (Substantive)		83.3%	83.1%	84.1%	84.7%	85.1%	83.9%	83.3%	83.3%	83.8%	75.4%	76.3%	77.4%	78.6%	78.6%	
Sickness Rate (Performance Dashboard)		3.80%	3.28%	3.83%	3.80%	4.10%	4.54%	4.38%	4.01%	3.82%	4.17%	3.98%	4.05%	3.71%	3.95%	
Staff In Post (Contracted WTE)		4,116.31	4,039.04	4,075.01	4,069.24	4,064.03	4,087.57	4,125.26	4,116.31	4,093.54	4,091.47	4,083.01	4,083.49	4,112.05	4,112.05	
Vacancy Rate		9.41%	9.92%	9.93%	10.31%	10.59%	10.05%	9.24%	9.41%	10.24%	10.53%	10.78%	10.75%	10.31%	10.31%	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - August 2016

Description	Target	All Tumour Sites	Brain	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Paediatric	Skin	Upper GI	Urology	Total
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	93%	-	100%	96.3%	95.6%	100%	100%	95.7%	95.8%	80%	89.3%	94.7%	91.2%	**93.5%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	-	98.4%	-	-	-	-	-	-	-	-	-	**98.4%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	-	100%	100%	90.9%	-	100%	100%	-	100%	100%	91.7%	**97.6%**
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	98%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	94%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	96%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	85%	-	-	-	84.6%	100%	-	100%	-	-	100%	100%	88.2%	**93.8%**
Cancer - 62 day - From Referral for Treatment following national screening referral	90%	-	-	100%	100%	-	-	-	-	-	-	-	-	**100%**
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85%	-	-	92.9%	75%	50%	0%	33.3%	56.2%	-	94.1%	40%	80%	**72.9%**

Performance

Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Cancer: Patients on a 62 day pathway treated on or over 104 days (1: patients treated at DGFT)	33	0	0	4	2	-	-	-	-	-	-	-	-	6
Cancer: Patients on a 62 day pathway treated on or over 104 days (2: patients treated at a Tertiary Centre)	60	2	3	3	3	-	-	-	-	-	-	-	-	11
Cancer: Patients on a 62 day pathway treated on or over 104 days (3: combined)	93	2	3	7	5	-	-	-	-	-	-	-	-	17

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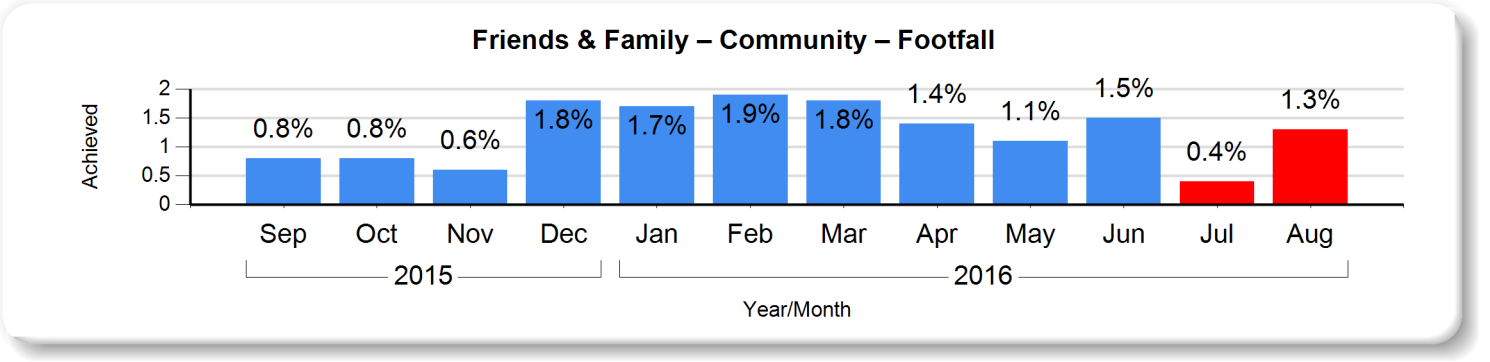
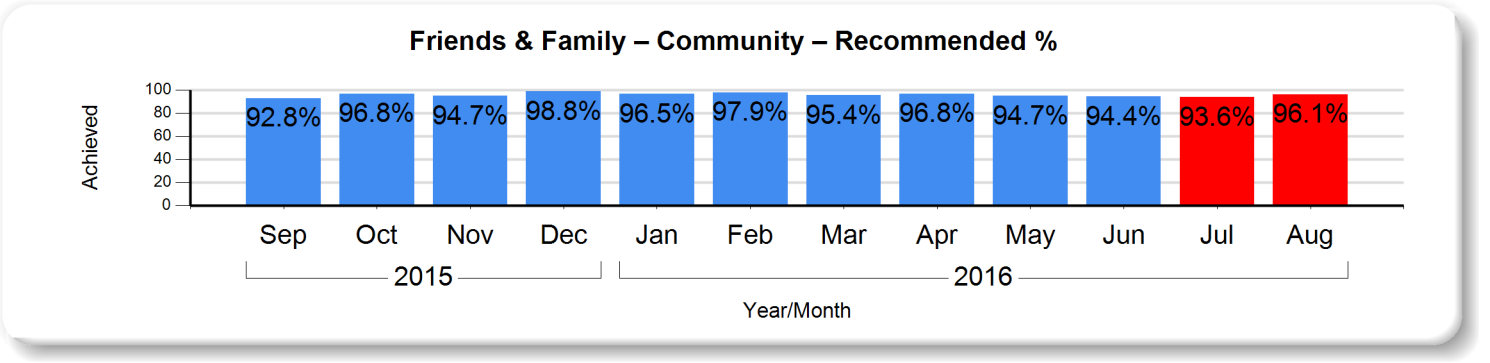
NHS Foundation Trust

Quality & Risk Fails

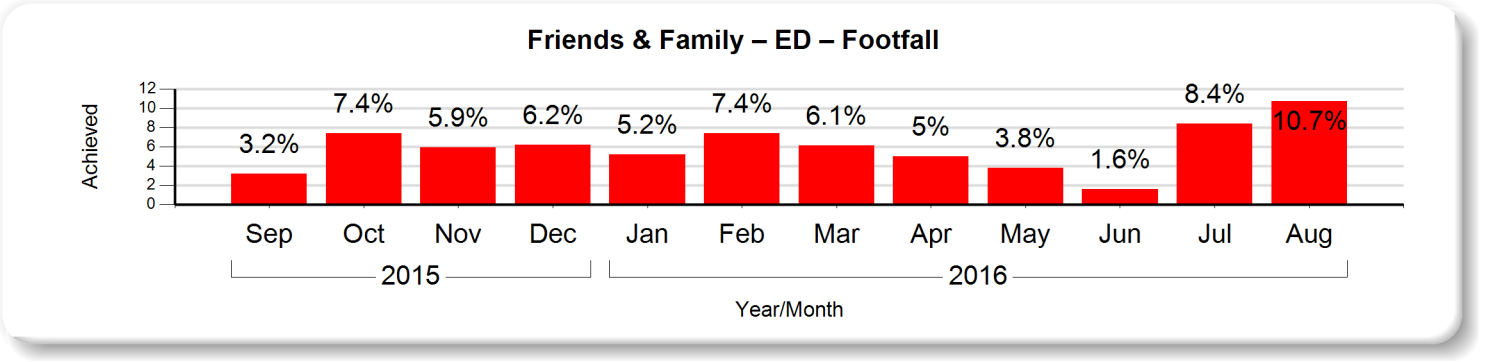
Friends & Family – Community – Footfall



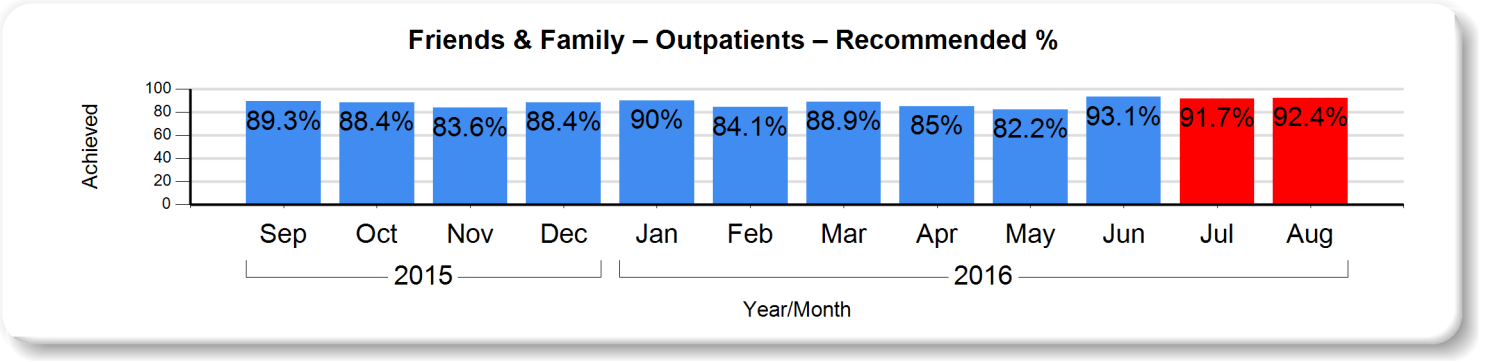
Friends & Family – Community – Recommended %



Friends & Family – ED – Footfall



Friends & Family – Outpatients – Recommended %



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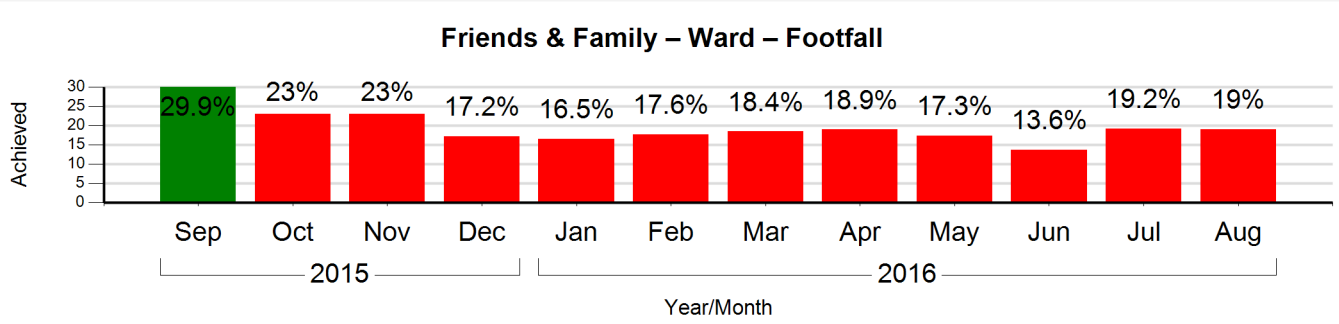
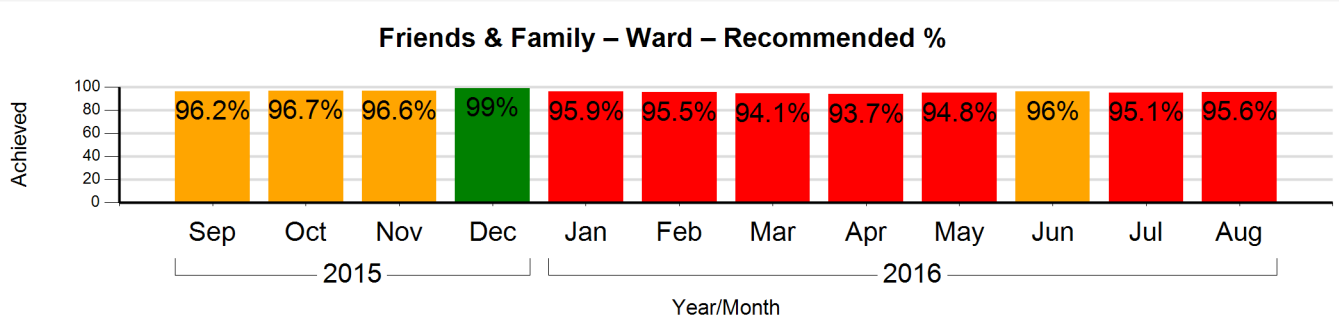
Quality & Risk Fails

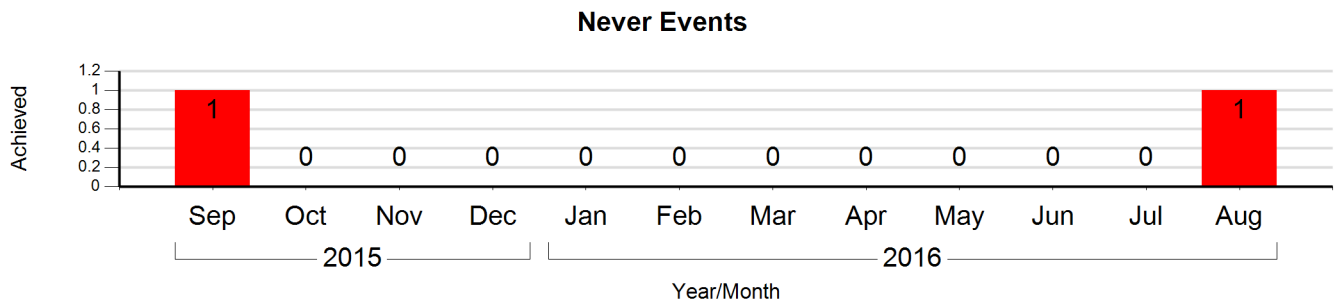
Friends & Family – Ward – Footfall



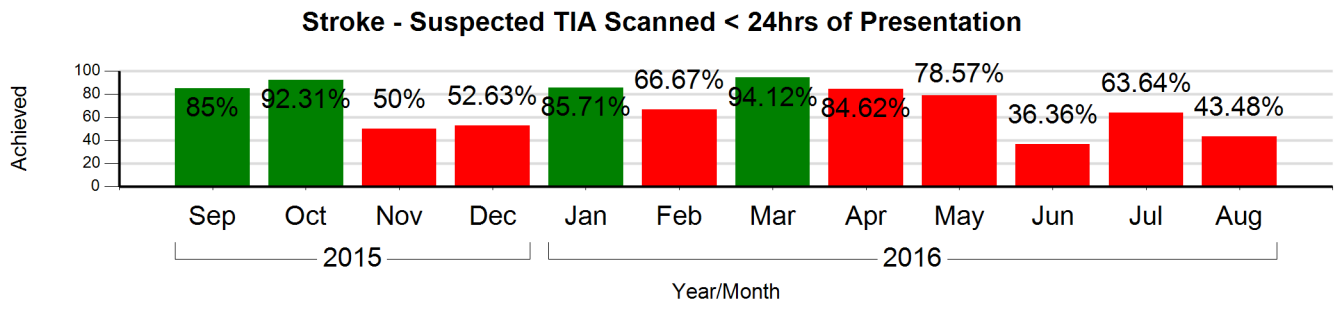
Friends & Family – Ward – Recommended %



Never Events



Stroke - Suspected TIA Scanned < 24hrs of Presentation



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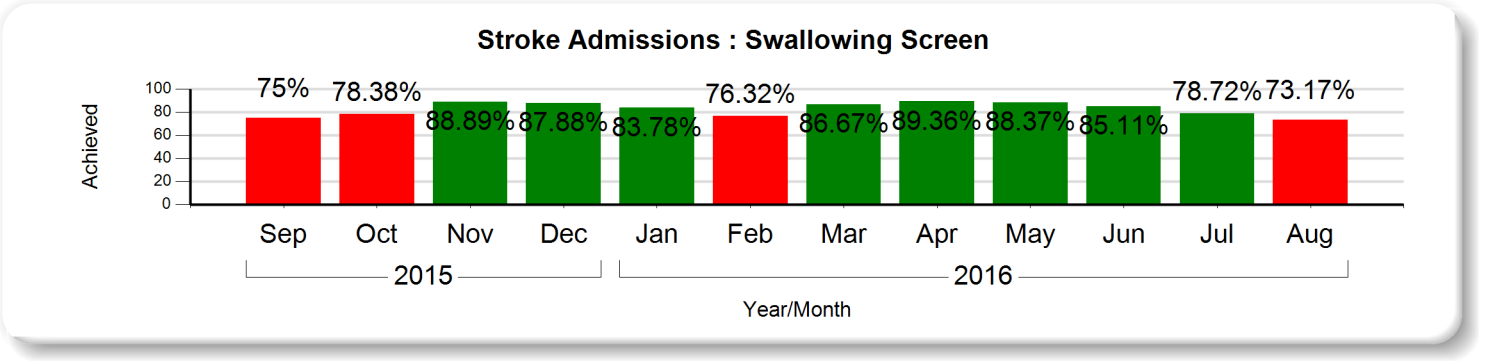
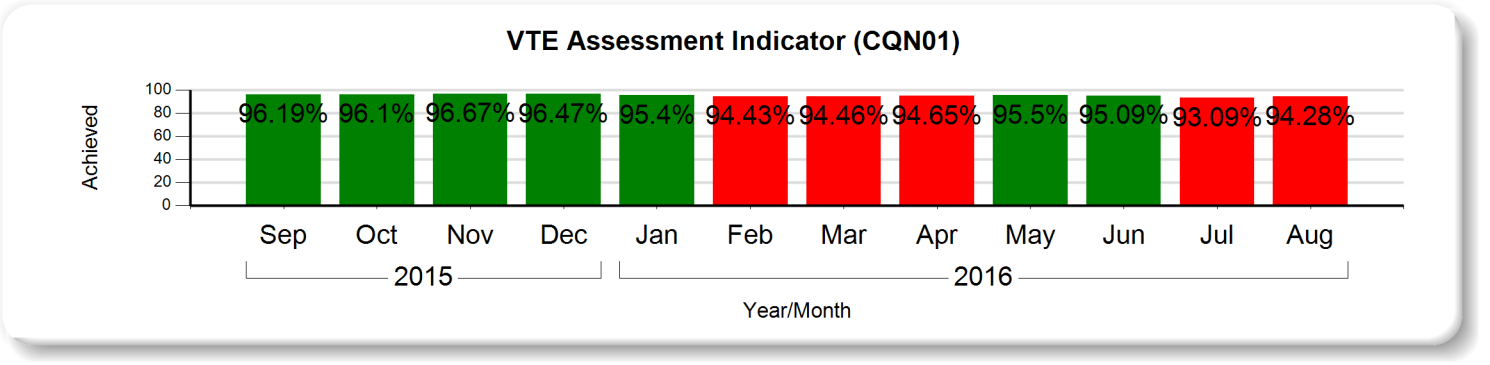
Quality & Risk Fails

Stroke Admissions : Swallowing Screen



VTE Assessment Indicator (CQN01)



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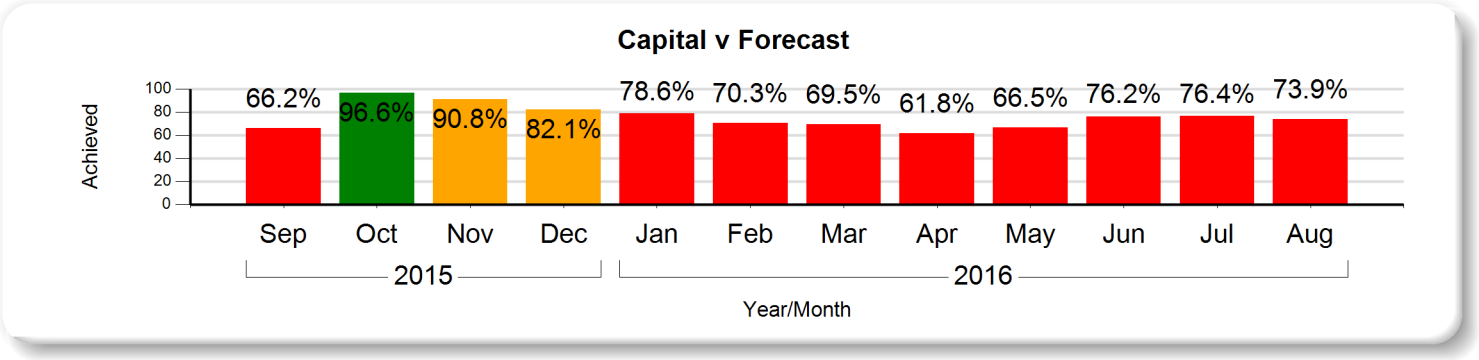
Finance Fails

Capital v Forecast



The Dudley Group NHS
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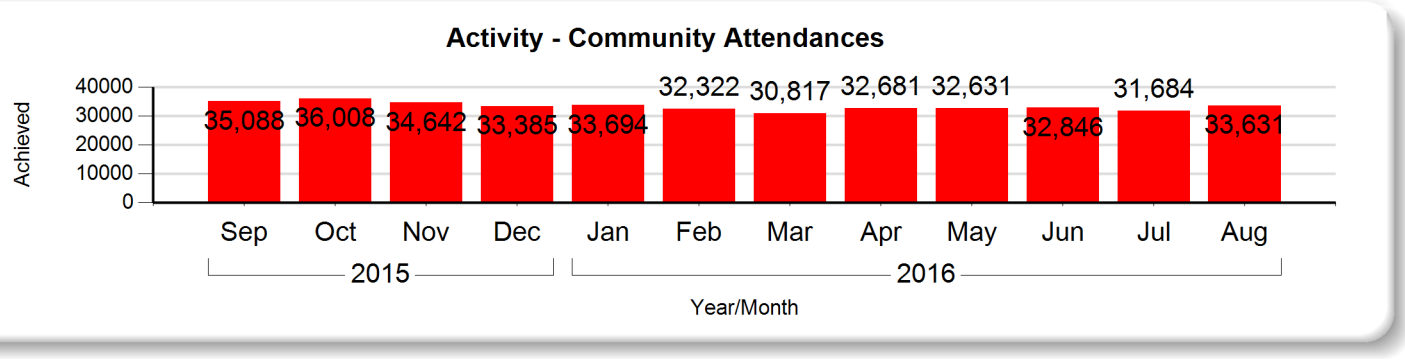
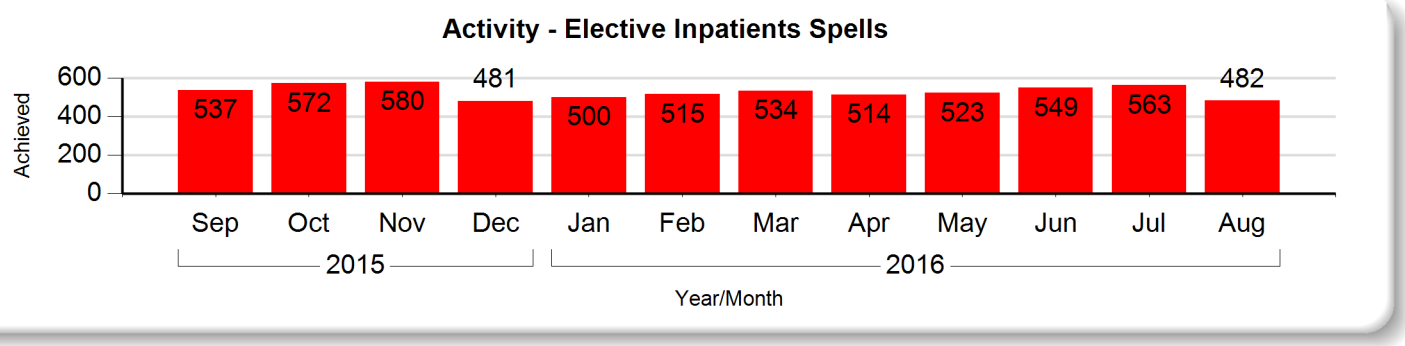
Performance Fails

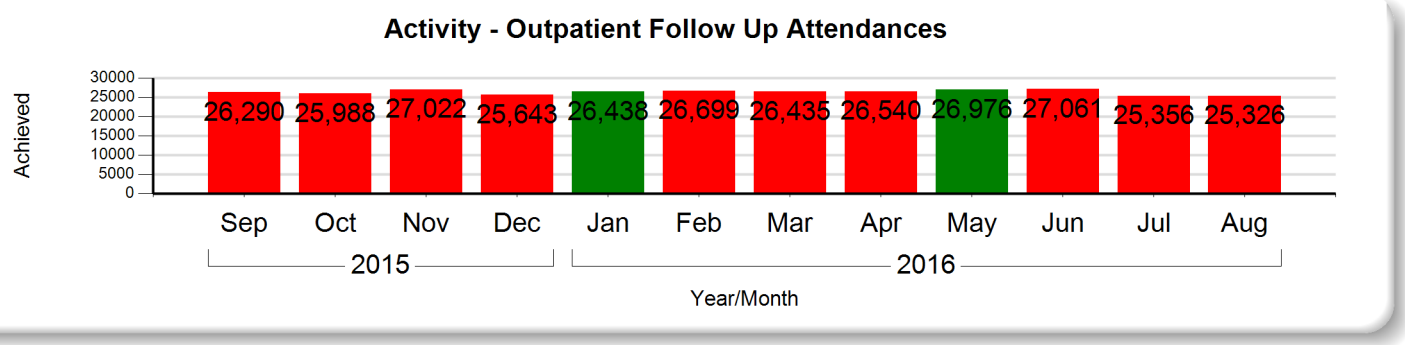
Activity - Community Attendances



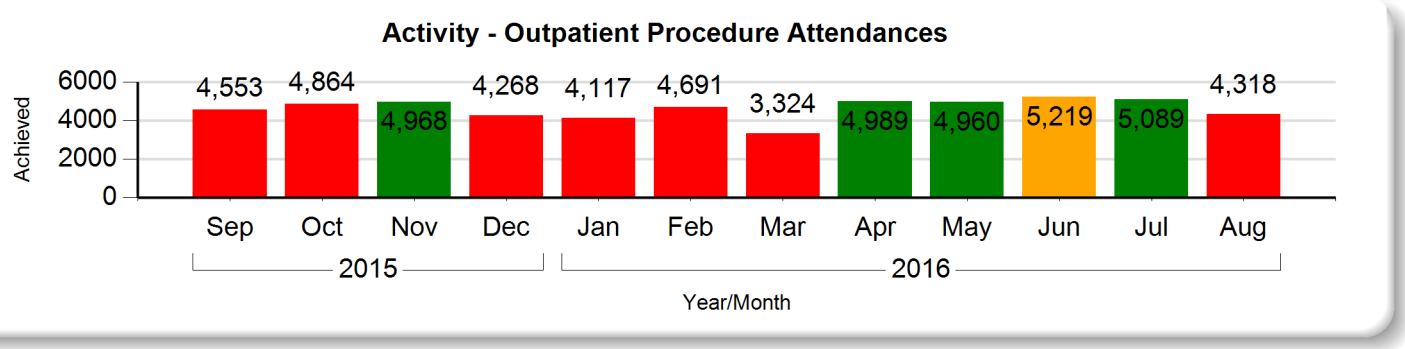
Activity - Elective Inpatients Spells



Activity - Outpatient Follow Up Attendances



Activity - Outpatient Procedure Attendances



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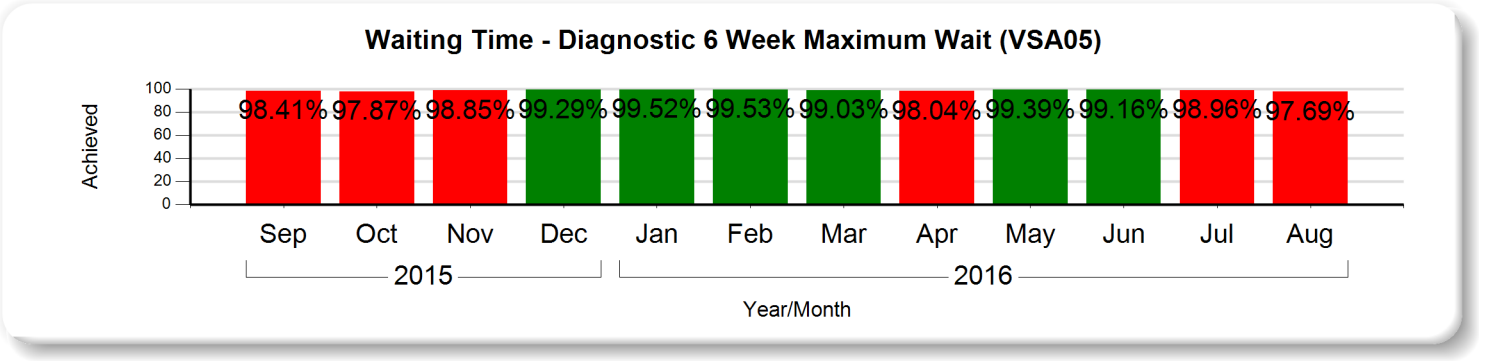
Performance Fails

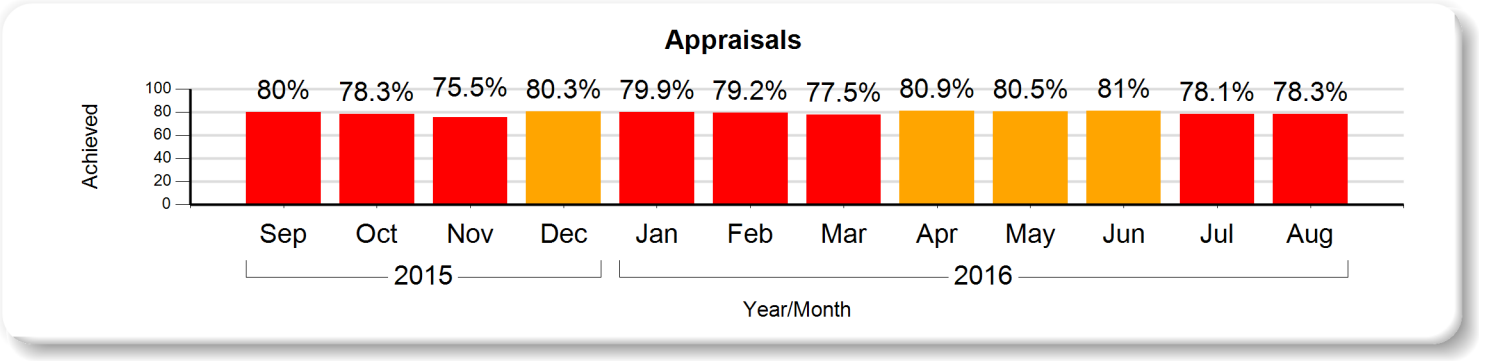
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)



The Dudley Group NHS
NHS Foundation Trust

Staff/HR Fails

Appraisals



Mandatory Training (Substantive)