The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 2 February, 2017 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	9.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	9.30
3.	**Announcements**		J Ord	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 5 January 2017	Enclosure 1	J Ord	To Approve	9.30
	4.2 Action Sheet 5 January 2017	Enclosure 2	J Ord	To Action	9.35
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Harrison	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Chief Nurse Report	Enclosure 4	D Wardell	To Note & Discuss	10.10
	7.2 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 5	D Wulff	To Note & Discuss	10.20
	7.3 Corporate Risk Register/Board Assurance Framework	Enclosure 6	G Palethorpe	To Note	10.30
	7.4 Safeguarding Report	Enclosure 7	D Wardell	To Note	10.40
	7.5 Annual Plan Quarter 3 Report	Enclosure 8	L Peaty	To Note	10.50
	7.6 Audit Committee Exception Report	Enclosure 9	R Miner	To Note	11.00
	7.7 Complaints Report	Enclosure 10	G Palethorpe	To Note	11.10
	7.8 End of Life and Palliative Care Report	Enclosure 11	D Wulff	To Note	11.20
	7.9 Black Country Alliance Report	Enclosure 12	P Harrison	To Note	11.30
8.	**Finance and Performance**				
	8.1 Cost Improvement Programme and Transformation Overview Report	Enclosure 13	A Gaston	To Note	11.40
	8.2 Finance and Performance Committee Exception report	Enclosure 14	J Fellows	To Note	11.50
9.	**Any other Business**		J Ord		12.00

10.	**Date of Next Board of Directors Meeting** 9.30am 2 March 2017 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 5th January, 2017 at 9:30am in the Clinical Education Centre.

Present:

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

In Attendance:

Helen Forrester, EA
Glen Palethorpe, Director of Governance/Board Secretary
Andrew McMenemy, Director of HR
Liz Abbiss, Head of Communications and Patient Experience
Mark Stanton, Chief Information Officer

17/001 Note of Apologies and Welcome
9.35am

Apologies were received from Anne Baines, Paul Bytheway and Matt Banks.

17/002 Declarations of Interest
9.35am

The Chief Executive's standing declaration was noted and it was confirmed that this did not conflict with any items on the agenda.

There were no other declarations of interest.

17/003 Announcements
9.35am

None to note.

17/004 Minutes of the previous Board meeting held on 1st December, 2016 (Enclosure 1)
9.36am

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

17/005 Action Sheet, 1st December, 2016 (Enclosure 2)
9.37am

17/005.1 Complaints and Claims Report

Dr Wulff, Non Executive Director, confirmed that the item was covered in the Clinical Quality, Safety, Patient Experience report. The Director of Governance/Board Secretary confirmed that the Coroner had acknowledged receipt of the Trust's response.

17/005.2 Patient Story

The Board noted that the story is now shown at every Senior Leadership meeting. The first time a patient story was presented was at the December meeting and this had been very well received.

All other items on the action sheet were agreed as either complete or will be presented at a future meeting as indicated in the enclosure.

17/006 Patient Story
9.40am

Liz Abbiss, Head of Communications and Patient Experience, presented the patient story. The video was of a patient being treated at the Trust for Lung Cancer.

The Board noted the issue relating to gowns in Radiology. This related to the patients experience in 2013 and Liz confirmed that all gowns had now been replaced.

The patient had experienced excellent care and told an extremely positive story, in particular with regard to the respect shown by all staff.

The Chairman and Board noted the story. The Chairman asked that thanks be passed on to staff.

17/007 Chief Executive's Overview Report (Enclosure 3)
9.52am

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

- **Friends and Family:** The detailed report had been presented at the Finance and Performance Committee. The Board noted that the text messaging pilot in ED was going live the following Monday.

- **Visits and Events:** The Board noted the meetings and events attended by the Chief Executive during the previous month.

- **Breast Feeding Initiative:** The Trust has received positive feedback on its Breast Feeding Initiative assessment and is confident that it will retain full accreditation. Both the assessors and mothers interviewed commented on how caring the staff were.

- **National Staff Survey:** The final response rate was 45.2% which is the same as last year. This is a positive achievement considering the capacity issues faced by the Trust.

- **New Chief Executive Announced:** The Trust is delighted to announce the appointment of Diane Wake as its new Chief Executive. Diane will join the organisation in April 2017.

- **Thank You from NHS Improvement:** NHS Improvement recently wrote to all Chief Executive's and Chairs expressing their thanks and sincere gratitude for the huge efforts made by NHS staff. The Chief Executive advised that this had been passed on to Trust Staff.

- **Maternity Training Fund:** The Board was pleased to note that the Trust had been awarded £60,000 from the fund which will be used to continue with service improvements.

- **NHS Apprenticeship Awards:** The Trust has been shortlisted for an award at an event taking place in February.

- **Capacity Issues:** A record number of attendances and ambulances had been seen at the Trust in the preceding month and continued into this week. It was noted that the whole Health Economy system was under immense pressure. All options to improve the situation are being explored. Mr Fellows, Non Executive Director, asked about the reasons for the increase in demand. The Chief Executive confirmed that the health system was seeing the outcome from a "demographic time bomb" in terms of the aging population. Dr Wulff, Non Executive Director, asked how we were supporting staff at this difficult time. The Chief Nurse confirmed that staff from Corporate areas were providing support. All non essential meetings had been cancelled. Mrs Becke, Non Executive Director, asked that sufficient supplies are provided for patients and carers experiencing extended delays. The Chief Nurse confirmed that she will ensure that supplies are available. Mr McMenemy confirmed that he would check that supplies were readily available.

Dr Wulff, asked for a report back to the Board on the capacity pressures when more information is available and actions that the Trust is taking.

The Chairman and Board noted the report and the good news reported within it. The Board noted with concern the issues around demand and capacity pressures facing the Trust.

The Board recognised the work and endeavours over the Christmas and New Year period to date by all staff at the Trust and recorded their thanks for the Trust staff for the sustained efforts over this period.

De-brief report on demand and capacity to be presented to Board when further information is available.

17/008 Patient Safety and Quality

17/008.1 Chief Nurse Report (Enclosure 4)
10.07am

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

The Board noted the points relating to infection control, including:

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

C.Diff: The Trust has recorded 28 cases to date in 2016/17, with only 6 of the reviewed cases associated with a lapse in care at the Trust.

Norovirus: No outbreaks. Although the Trust had 5 separate cases confirmed.

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

- Shortfall shifts total figure for the month was 104 which was a reduction from the last month (136).
- The shift RAG rating system had been rolled out across the wards. There were 30 red shifts across 10 areas using this methodology for the period. For each of the red shifts there were no safety issues identified.
- Shortfall shifts are all reviewed and no safety issues were identified that affected the quality of patient care.
- The Care Hours per Patient Day (CHPPD) is reported in the report. The model hospital dashboard will be providing more national benchmark data in the new year.

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

- The escalation at level 4 which was is the same area as the one in the previous month's report.

- A Nutrition Audit and focus on MUST assessment completion is underway with 2 weekly meetings in place.

The Board noted the typing error on the summary of key issues. The month should read December, reflecting the report was covering the most recent month's performance.

Mr Miner, Non Executive Director, asked about the cumulative C.Diff target. The Chief Nurse confirmed that of the 28 cases, 15 have been apportioned. It is 6 of these 15 cases which had been noted as lapses in care at the Trust. 13 cases were still to be determined. Mr Miner noted that the Trust was inside target at this point in the year.

Dr Wulff, Non Executive Director, asked about the prevalence of Norovirus. The Chief Nurse confirmed that the Trust had not experienced any difficulties in relation to Norovirus but remained vigilant and focused on applying good hygiene processes.

The Chairman confirmed that the Trust is still working on remaining complaint with NHS Improvements agency usage requirements. The Chief Nurse confirmed that the Trust had remained overall at a green level for safer staffing.

The Chairman and Board noted the report.

17/008.2 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 5)
10.13am

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

Assurances Received

- The Rule 28 issue had been covered on the action sheet and the Trust has responded swiftly and fully to the report received.

- The Committee had received a report from Ophthalmology regarding an investigation into a never event. The Committee was assured that the issue had been well investigated and identified failings and introduced control measures to stop any re-occurance. The Board noted that lessons learnt had been shared with all areas.

Decisions Made/Items Approved

- The Committee endorsed the Trust's change to the reimbursement of patient travel from offering this by cheque to an offer of reimbursement by day saver tickets. This had been well received by patients.

Actions to come back to the Committee

- The Committee asked that the Trust bed occupancy levels be added into the performance report to the Committee allowing commentary to be provided on any changes.

The Board noted the closure of Serious Incidents and policy review updates included in the report.

Mr Miner, Non Executive Director, asked how content the Chief Nurse was around the Trust's Stroke TIA performance and measurement. The Chief Nurse confirmed that the Trust had seen improvement in both the data quality and actual performance as a result of the measures introduced following the Internal Audit report into this area. The Director of Governance/Board Secretary confirmed that a series of checks had been put in place to ensure data reporting was correct and that Internal Audit are re-auditing this area.

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

17/008.3 New Requirements in NHS Standard Contracts for Hospitals in Relation to Hospital/General Practice Report (Enclosure 6)
10.20am

The report on the New Requirements in NHS Standard Contracts for Hospitals in Relation to Hospital/General Practice Report, given as Enclosure 6, was presented for information.

The Director of Governance/Board Secretary confirmed that the question marks in the end column should be ticks indicating conformation as to which group would receive assurance on the requirement delivery.

The Chief Executive confirmed that the CCG are in discussion with GPs and there will be no issues for the Trust in the current quarter over compliance with these areas before they become contractual requirements.

The Chairman asked if any risks had been identified. The Director of Governance/Board Secretary confirmed that there were no identified significant risks to their future achievement. The Board noted that the Communications Team were producing a new GP brief which offers an opportunity to communicate how the Trust will be delivering these requirements and other pertinent information.

The Chairman asked if the Trust could incur any penalties. The Director of Finance and Information confirmed that there will be penalties in 2017/18, if requirements were not met.

The Chairman asked that Non Executive Directors receive a copy of the GP bulletin.

The Chairman and Board noted the report and that the Trust was on track with requirements.

Non Executive Directors to receive a copy of the new GP Bulletin.

17/009 Finance and Performance

17/009.1 Cost Improvement Programme and Transformation Overview Report (Enclosure 7)
10.25am

The Director of Finance and Information presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 17.

The Board noted the following key highlights:

- The Trust was a little behind on the 2016/17 Cost Improvement Programme.

- For 2017/18 schemes a lot of work had been undertaken from October to December and the Deloitte work is bearing fruit. There was more to do internally but a good start had been made.

The Chairman asked which schemes did not come to fruition in the current year. It was agreed that this information would be presented at the next meeting.

The Chairman asked about the confidence levels in identifying further savings for 2017/18. The Director of Finance confirmed that there were definitely more savings to find, including non-recurrent savings and confidence was high although the capacity situation was adding extra pressure to the Trust's overall financial position.

The Chairman and Board noted the report.

Details on schemes that did not come to fruition to be included in the next report to Board.

17/009.2 Finance and Performance Committee Exception Report (Enclosure 8)
10.30am

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 8.

The Board noted the following key issues:

- The EPR contract was now signed and Allscripts were eager to start work. The Trust was hoping for some quick wins.

- The Control Total had been agreed.

- The Contract had been agreed with the CCG.

- Agency spend was noted to be decreasing.

- Diagnostic waits remain a challenge.

- The A&E 4 hour wait was proving difficult nationally but Dudley was still one of the highest performers.

- The Vascular Hybrid Business Case would be presented back to Board.

- A risk had been escalated onto the Risk Register with regard to the delivery of the EPR project.

The Board noted that the Chief Executive was attending a meeting on 31st January, 2017, with Medical Directors and NHSE regarding Vascular Surgery.

The Chairman asked about the Trust's work with Wyre Forest. The Chief Executive confirmed that this was still in progress.

The Chairman and Board noted the report, financial position and additional risks driven by demand pressures.

17/009.3 Charitable Funds Committee Report (Enclosure 9)
10.34am

Mr Atkins, Committee Chair, presented the Charitable Funds Committee Report given as Enclosure 9.

The Board noted the following key areas:

- The Committee received a presentation from Professor Ishaq. The Board noted that Fund Managers had been asked to attend meetings to present their spending plans.

- The approved the continued spending plans for 2017.

- The Fund Raising Manager presented her report which was showed that Trust was slightly behind on its raising funds programme and the Committee noted that she was trying to close the gap.

- Mrs Taylor confirmed that the total fund balance stood at £2.3m and the general fund at just under £400k.

- 4 bids for the funding of expenditure were approved.

- The Director of Finance and Information presented ideas for supporting the Chaplaincy Service and further work was requested in this area. A further report will be provided at the next meeting.

- It was agreed that the Board would be informed in respect of the Trust's fundraising performance which is kept under close review by the Committee.

- It was noted that Professor Ishaq was keen to publicise Flexible Endoscopic Therapy which was a new procedure unique to the Trust and wanted to bring this work to the attention of the Board.

The Chief Executive confirmed that Professor Ishaq is supported in promoting this work.

The Chairman and Board noted the report and the work undertaken by Professor Ishaq.

17/010 Any Other Business
11.10am

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

17/011 Date of Next Meeting
11.10am

The next Board meeting will be held on Thursday, 2nd February, 2017, 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 5 January 2017

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
16/118	Chief Nurse Report	Results of nutritional pilots and 2 weekly meetings on nutrition to be reported to CQSPE Committee.	DW	24/1/17	
16/118.3	Black Country Alliance	Terry Whalley to further define governance arrangements where parties outside of the BCA are involved in specific projects. Terry Whalley to review style and content of the BCA Board report.	TW TW	2/3/17 2/3/17	
16/118.5	Research and Development	The Finance Director to update the business case procedure. The Medical Director to produce a Research and Development gap analysis.	PT JN	2/2/17 1/6/17	In Progress
17/008.3	New Requirements in NHS Standard Contracts for Hospitals in Relation to Hospital/General Practice	Non Executive Directors to receive a copy of the new GP Bulletin.	LA	2/2/17	Done
17/009	Cost Improvement Programme and Transformation Overview Report	Details on schemes that did not come to fruition to be included in the next report to Board.	AG	2/2/17	Done
16/096.5	Charitable Funds Committee	The use of Charitable Funds for educational requirements to be discussed at the next Committee meeting.	JA	23/2/17	
17/007	Chief Executive's Overview Report	De-brief report on demand and capacity to be presented to Board when further information is available.	PB	2/3/17	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 2nd February 2017

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

SUMMARY OF KEY ISSUES:

- Friends and Family
- Visits and Events
- Awards Shortlists
- MCP Market Engagement Event
- AAA External Assessment
- Capacity Update
- New Chief Executive
- Mental Health Concordat

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		Y	**Y**

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

The Dudley Group NHS
NHS Foundation Trust

Chief Executive's Report – Public Board – February 2017

Patient Experience Friends and Family Test (FFT): Update February 2017 Board

Quality Priority - Patient Experience

Based on the latest published NHS figures (Nov 2016), it is pleasing to report that all areas of the Trust met the quality priority target of monthly scores that are equal to, or better than, the national average for the percentage of patients who would recommend the service to friends and family except the November score for inpatients which achieved 95% compared to the national average of 96%.

It is pleasing to note that outpatient scores have continued to maintain a percentage recommended score equal to or above the national average improving by more than 10% since May 2016.

% FFT Scores	Apr 16	May 16	Jun 16	Jul 16	Aug 16**	Sep 16	Oct 16	Nov 16	Dec 16
Inpatient	**97%**	**97%**	**97%**	**95%**	**96.6%**	**96.6%**	**97.9%**	**95.0%**	**97.9%**
National	96%	96%	96%	96%	95%	96%	95%	96%	n/a
A and E	**91%**	**91%**	**88%**	**92%**	**91.8%**	**91.9%**	**93.8%**	**93.1%**	**90.1%**
National	86%	85%	86%	85%	87%	86%	86%	86%	n/a
Maternity Antenatal	**95%**	**100%**	**100%**	**96%**	**98%**	**99%**	**100%**	**97.6%**	**98.6%**
National	96%	96%	95%	95%	95%	96%	95%	96%	n/a
Maternity Birth	**100%**	**96%**	**99%**	**96%**	**100%**	**99%**	**98.2%**	**98.8%**	**100%**
National	96%	97%	97%	97%	96%	96%	96%	97%	n/a
Maternity Postnatal Ward	**95%**	**96%**	**99%**	**94%**	**98%**	**97%**	**100%**	**99.2%**	**99%**
National	94%	94%	94%	93%	93%	94%	94%	94%	n/a
Maternity Postnatal Community	**100%**	**100%**	**100%**	**99%**	**99%**	**100%**	**98.2%**	**98.9%**	**100%**
National	97%	98%	98%	98%	97%	98%	98%	97%	n/a
Community	**97%**	**95%**	**94%**	**98%**	**96.1%**	**96.1%**	**95.1%**	**95.5%**	**94%**
National	95%	95%	95%	95%	96%	95%	95%	95%	n/a
Outpatients	**85%**	**82%**	**93%**	**92%**	**92.4%**	**92.4%**	**93.2%**	**94.9%**	**93.1%**
National	93%	93%	93%	93%	93%	93%	93%	93%	n/a

*** note from August, rounding for local reporting now to the nearest 0.1 decimal point as part of a local rebasing exercise. n/a National figures not available*

FFT response rates

Work continues to encourage as many patients as possible to complete the friends and family test survey to ensure we have information to help us make improvements to our services. In January we launched the SMS text message service to collect the FFT from ED patients. Preliminary feedback is positive with patients welcoming another way to give their view on our services.

Visits and Events

9th January:	Committed to Excellence Judging
	Diane Wake Visit
	Collaborative Leadership Team
10th January:	AAA QA Screening Visit
11th January:	Black Country Alliance Board
13th January:	West Midlands Provider Chief Executives
19th January:	Transformation Executive Committee
25th January:	Partnership Board

Award Shortlists

We are thrilled two services offered by The Dudley Group NHS Foundation Trust have been shortlisted in a national award for demonstrating outstanding practice as well as cutting-edge innovations.

The Day Case Unit at Russells Hall Hospital has made the shortlist for improvements that have resulted in patients waiting less time for their procedures. Improvements to privacy and dignity mean that patients are no longer admitted directly to the ward to wait by their beds until surgery: they now stay in the admissions lounge, fully clothed, until just before their procedure. Patients with learning disabilities experience less stress because their admissions paperwork can be done in their homes before they come into hospital.

The unit has been shortlisted in the category of 'Improving the value of surgical services' while a service that offers a fast-track emergency kidney operation (a nephrostomy) is shortlisted in the category of 'Acute sector redesign'.

The 24/7 nephrostomy service means patients across the Black Country and Wolverhampton can now receive their procedures over weekends and bank holidays. The new out-of-hours service, run by teams of interventional radiologists and urologists working together, is improving healthcare for many patients.

MCP Market Engagement Event

The CCG held a Market Engagement event on 17th January 2017. The event was aimed at potential suppliers of the MCP contract. The papers for the event can be found here http://www.dudleyccg.nhs.uk/mcp-procurement/

The Trust has submitted an "expression of interest" to form a joint venture with Birmingham Community Healthcare NHS Foundation Trust to form the nucleus of an MCP provider from April 2018 with GPs in Dudley. Many of the details have yet to be worked out, and the CCG indicated that the first stage of the formal bidding process would take place in mid-March 2017 when a Pre-Qualification Questionnaire (PQQ) would be issued. This can only be done once the CCG regulators have agreed to the procurement plan. We will keep the Board informed of progress regularly on this key work.

AAA External Assessment

Public Health England undertook a planned Quality Assurance (QA) visit of the Abdominal Aortic Aneurysm (AAA) Screening Programme on 10th January, 2017. The visit feedback was positive, with no immediate concerns and no high priority risks identified. Many areas of good practice were recognised, including the support for patients who speak other languages, and the offering of alternative screening locations and even home visits to patients. The visiting QA team noted all the hard work being undertaken by the AAA Screening Programme team, particularly in the context of a recent change of Programme Coordinator. As always with such visits, some areas for improvement were identified which the AAA Screening Programme team are now reviewing, and the Trust will receive the draft formal feedback report within 6 weeks.

Capacity Update

Pressure since the New Year has been extreme, the Trust had a winter plan that looked at ensuring that all 'ward' space was opened and staffed to cope with the predicted demand along with a workforce plan that utilised all of the Trust's teams to support patient safety. Support was received from areas such as corporate nursing and Interserve to cope with this demand.

You will also know that the week prior to Christmas we began running the Trust as if we had declared an 'incident' with all meetings cancelled until mid-January and all routine non-urgent elective procedures postponed to allow for increased bed capacity. Day Surgery expanded during this time in line with the plan to allow for more patients through the unit.

Compared to the same period last year, the Trust has seen:

12% increase in ambulances
7% increase in A&E attendances
4% increase in emergency admissions

Table – Comparison for last year on Emergency Department Pressure (up to 22nd January 2017)

	Jan 2017	Dec 2016	Jan 2016
Attendances	6048	6272	5596
Ambulances	2472	2408	2098
No. of days > 100	19	17	9

The biggest issue has been the continuation of the high numbers of ambulances and admissions for most of January, the continued high acuity of these patients and in the resultant lower than normal discharges on a day by day basis, despite additional Consultant Ward rounds and increased weekend presence to support 7 day services.

Our partners in social care have been extremely supportive of the Trust throughout this period, with high numbers of discharges and a very pragmatic response, unfortunately because of the increase in activity the numbers of delays remains over 120, but this is not due to anything other than the volume and acuity of patients through the health and social care system.

To ensure that we maintain safety of patients and the experience that our staff have, the Trust has opened Surgical Day Case and GI unit to support flow on a number of occasions over the last few weeks. The professionalism and the support of all staff has been truly amazing and the Executive team has passed on their thanks to our staff.

New Chief Executive

Diane Wake has visited the Trust and has a programme of planned visits ahead of her start date in April, 2017.

Mental Health Concordat

The Trust has confirmed that it is happy to sign up to the new West Midlands Mental Health Concordat being established by the West Midlands Mental Health Commission.

The Concordat confirms:

“We will work together to improve mental health and wellbeing, to reduce the burden of mental ill health across the West Midlands. We will work to improve people’s lives and to encourage healthy communities.

We will ensure services meet the needs of people with mental ill health and are provided with empathy and compassion. We will involve people who have experienced mental ill health and their carers at the earliest opportunity in decisions about services.

We will work together to develop and deliver the actions agreed across the West Midlands Combined Authority area”

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 2nd February 2017 - PUBLIC

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

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

SUMMARY OF KEY ISSUES:

Infection Prevention and Control for the month of January (as at 24.1.17)

- No post 48 hour MRSA bacteraemia cases since 27th September 2015.
- Norovirus outbreak on B1 ward (13 patients and 15 staff) – ward reopened on 23rd January 2017.
- As of this date the Trust has had 29 C *Diff* cases so far in 2016/17. So far 15 cases have had their lapses in care determined; 6 of these cases were associated with a lapse in care.
- Cluster of cases of Enterobacter cloacae on Neonatal Unit.

Safer Staffing

- Shortfall shifts total figure for this month is 77 which is a reduction from the last month (136).
- The RAG rating system has been rolled out across the wards with 13 red shifts in total across eight areas in this month using this methodology. No safety issues were identified.
- Shortfall shifts were reviewed and no safety issues identified that affected the quality of care.
- The Care Hours per Patient Day (CHPPD) is reported in this board report. The model hospital dashboard will be providing more national benchmark data shortly.

Nursing Care Indicators

- January had three areas Red which are now under increased support and escalation.
- Nutrition Audit and focus on MUST completion is underway with two weekly meetings due to recommence in February 2017.

IMPLICATIONS OF PAPER:

RISK	Yes		**Risk Description:** • Failing to meet initial target for C *Diff* 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

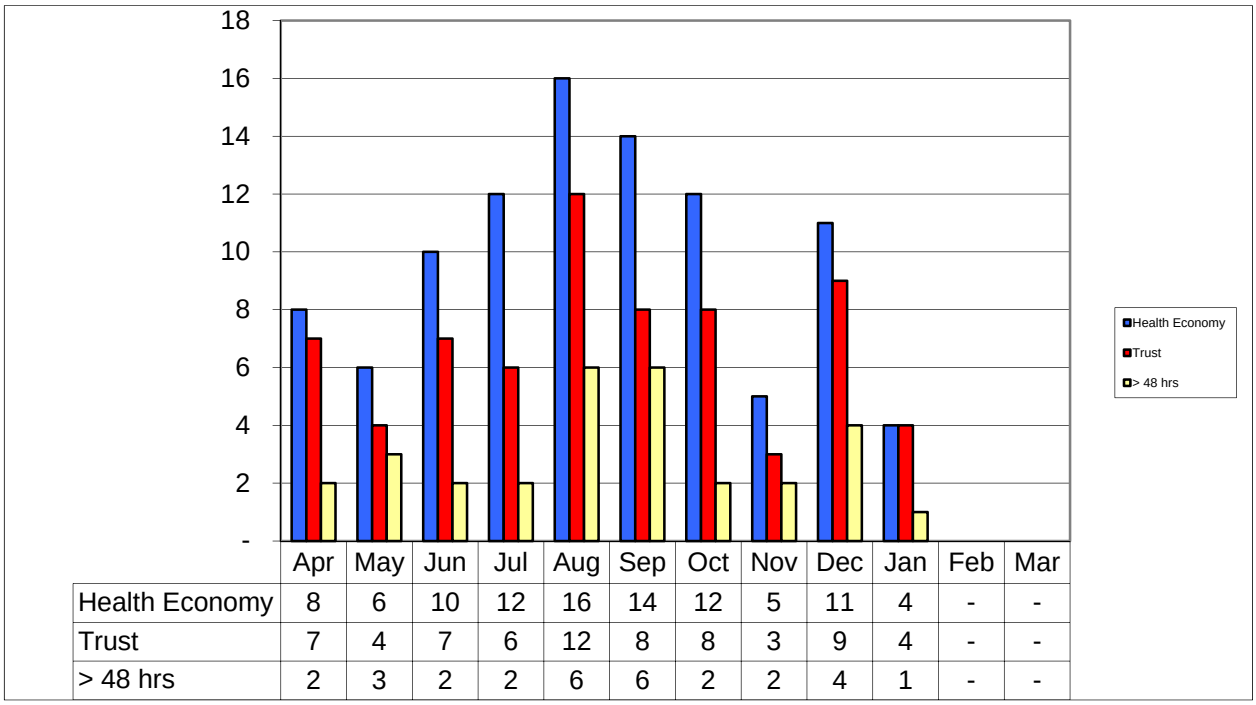
Clostridium Difficile – The target for 2016/17 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. Penalties will be associated with exceeding 29 cases associated with lapses in care. At the time of writing (24.1.17) we have 1 post 48 hour case recorded in January 2017.

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 29 post 48 hour cases identified since 1st April 2016, 15 cases have been reviewed and apportionment has been agreed (6 cases associated with lapse in care) and 14 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.

C. DIFFICILE CASES 2016/17



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	6	10	12	16	14	12	5	11	4	-	-
Trust	7	4	7	6	12	8	8	3	9	4	-	-
> 48 hrs	2	3	2	2	6	6	2	2	4	1	-	-

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

Norovirus - An outbreak occurred on B1 ward from 10th January to 23rd January 2017. This involved 13 patients and 15 members of staff. The ward was closed during this period. Public Health England and the Office of Public Health were involved in the management of this episode.

Neonatal Unit – Five babies colonised/infected with indistinguishable strains of Enterobacter cloacae were identified during December 2016. Public Health England and CCG were involved in investigating and managing the situation. The Unit was closed to transfers to and from other Neonatal Units whilst babies were screened. The Unit was fully reopened following a meeting 30th December 2016.

Reference

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

THE DUDLEY GROUP NHS FOUNDATION TRUST
Monthly Nurse/Midwife Staffing Position
December 2016

One of the requirements set out in the 2014 National Quality Board (NQB) Report 'How to ensure the right people, with the right skills, are in the right place at the right time' and the Government's commitments set out in 'Hard Truths', is the need for the Board to receive monthly updates on staffing information. A revised NQB report 'Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time' was published in July 2016, the contents of which have had no impact on the requirement to produce these monthly reports.

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

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

Month	RN	Unregistered	Total
September	4.44	3.63	8.07
October	4.39	3.56	7.95
November	4.19	3.34	7.53
December	4.25	3.40	7.65

These figures obviously vary widely across wards/areas (e.g. 21.13, 8.13 and 29.26 for Maternity and 2.64, 2.83 and 5.47 on Ward B4)

The only presently available comparative figures are from a short paragraph in the Carter Report which stated that of a sample of 25 Trusts the overall CHPPD varied from 6.3 to 15.48, which would put the Trust (8.07 to 7.53) in the middle 'of the pack'. Up to November the overall hours per patient day was reducing although this has increased slightly in December. The Trust awaits any further developments and feedback on this metric. It is expected that this and comparative data will be made available in the Model Hospital which the Department of Health is producing as a result of the Carter Review. The Trust has recently become a pilot site for the ward element of the Model Hospital.

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

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

The total figure of shortfalls for this month is 77 which is a large fall from last two months (104,136) (see Table 1). When shortfalls have occurred, the reasons for the gaps and the actions being taken to address these in the future are outlined in Table 3.

The area with the largest number of shortfalls in December was Maternity which had 15 (with 8 RM shifts and 7 CSW shifts) but, again, this was a big fall from previous months e.g. October when there were 42 (32 RM shifts and 10 CSW shifts). This reflects the recent recruitment of staff. The next area with the largest number of shortfalls was ward C3 which had 12 RN shortfall shifts (9 in November/6 in October). Due to the number of beds on C3 (52), when the ward is short of 1 RN from the planned day time 6 staff and planned night time 5 staff the staffing just breaks the agreed 1:10 (day) and 1:12 (night) ratios. The problems experienced by NNU last month (9 red shifts) have receded. The rest of the shortfalls are evenly spread throughout the hospital, as in previous months.

As well as the quantifiable staffing numbers discussed above, as indicated at the June 2016 Board, from May onwards the senior clinical staff on each shift are undertaking a professional judgement RAG (Red, Amber, Green) rating system of the overall workload status on the ward. The results of this are tabulated below (the figures for November are 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 but, as previously, it can be seen that the highest proportion of assessments are 'Green' (76%) which is the same as last month. With regard to the Red rated shifts these have dropped to 13 from 30 last month and account for 0.01% of the total. They were spread across 8 areas. On all of these occasions safety was maintained. These have been described within the table 3 below.

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

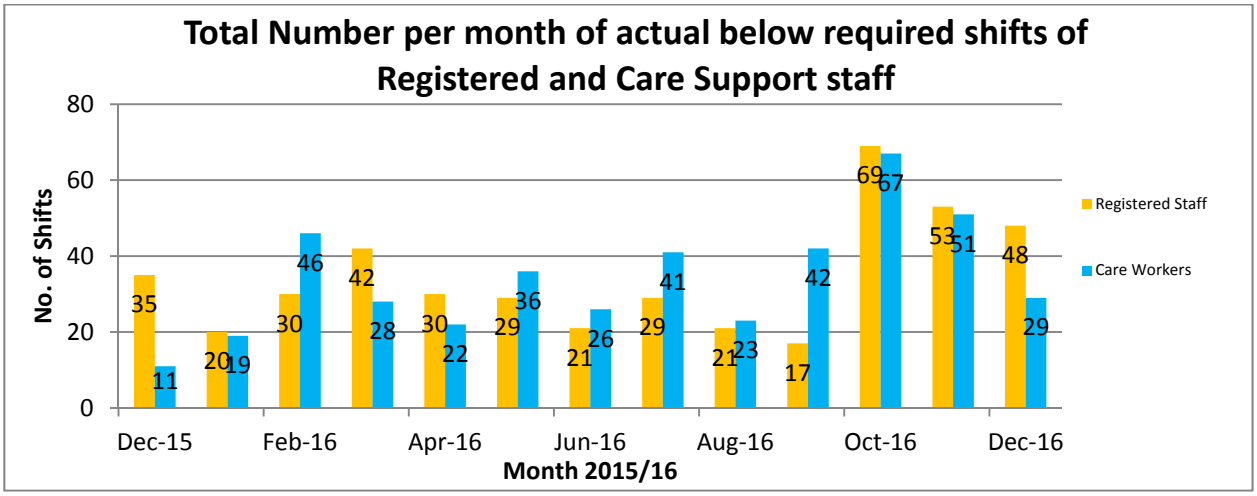


Table 2 - Self-Assessment of Workload by Senior Nurses on Each Shift for December (figures in brackets from November)

Ward/Area	RED	AMBER	GREEN	Ward/Area	RED	AMBER	GREEN
Ward A2	1 (1)	27 (42)	34 (17)	**Ward C4**	0 (0)	1 (1)	61 (59)
Ward A3	2 (2)	12 (4)	48 (54)	**Ward C5**	0 (2)	14 (23)	48 (35)
Ward B1	1 (0)	25 (12)	36 (48)	**Ward C6**	1 (1)	13 (20)	39 (52)
Ward B2H	1 (0)	9 (19)	52 (41)	**Ward C7**	0 (3)	30 (17)	32 (40)
Ward B2T	1 (0)	9 (9)	52 (51)	**Ward C8**	0 (0)	30 (28)	32 (32)
Ward B3	0 (0)	11 (24)	51 (36)	**CCU/PCCU**	2 (1)	26 (18)	34 (41)
Ward B4	0 (1)	33 (32)	29 (27)	**EAU**	0 (0)	4 (4)	58 (56)
Ward B5	4 (2)	30 (20)	28 (38)	**MHDU**	0 (0)	1 (3)	61 (57)
Ward C1	0 (0)	0 (1)	62 (60)	**Critical Care**	0 (0)	0 (0)	62 (60)
Ward C2	0 (8)	5 (35)	57 (17)	**NNU**	0 (9)	2 (15)	60 (36)
Ward C3	0 (0)	38 (34)	24 (26)	**Maternity**	0 (0)	8 (8)	54 (52)

Totals	RED	AMBER	GREEN
June	4	119	1257
July	12	163	1251
August	6	147	1273
September	1	126	1253
October	18	207	1135
November	30	369	921
December	13	313	1038

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	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17
RED	15	4	3	7	6	3	2	3	1	3	0	1	0	4	3
AMBER	5	11	14	12	13	15	14	10	7	2	11	8	12	10	11
GREEN	4	9	9	8	8	9	11	14	19	22	16	18	14	13	13
TOTAL	24	24	26	27	27	27	27	27	27	27	27	27	26	27	27

COMMENT:
November 16 - Ward A1 changed to Evergreen and no audits undertaken.
December 16 - Ward B6 open. Ward Evergreen starts audits in January 2017.
January 17 - Still testing Evergreen audit tool.

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.

Nutrition and MUST scoring continue to be a priority for training and engagement with staff. Two weekly meetings with lead nurses and senior team in Nursing Division have been put in place. These will recommence in February.

Escalations January:

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

Nutrition Audit	
Level 1 Matron Level	10
Level 2 Head of Nursing Level	4
Level 3 Deputy Chief Nurse level	0
Level 4 Chief Nurse	0

Nutrition audit still hasn't been submitted for EAU.

Allied Health Professionals (AHP) Council

The first meeting has now been held which was attended by Paul Bytheway (Chief Operating Officer) supported by Pam Ricketts (Quality Lead for AHPs). It was a positive meeting with regular meetings planned going forward. This was as a result of feedback from the LiA Event in October 2016.

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS DECEMBER 2016 TABLE 3

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A2	1 3	RN CSW	Sickness x 3 Compassionate Leave x1	The one qualified shortfall was a red shift as there were three very confused patients and some highly dependent medical patients which resulted in some care being delayed but safety was maintained. For the CSW shortfalls, staff were reallocated to ensure safety was maintained at all times.
A3	2	RN	Staff moved to other areas x 2	These two night shifts were assessed as red shifts as a staff member had to move to the help assist elsewhere on both occasions which led to some delays in care but no patient adverse effects occurred.
B1	3 1	RN CSW	Sickness x 4	On the one red shift four patients were admitted for surgery with only 1 bed available. Patients had to go to surgery from the dayroom while patients were being discharged. Last bed became available at 14.00hrs. Delays in care occurred. A CSW came from the discharge lounge for 2hrs. On the other shortfall shifts patient numbers were 12 or below and so care needs were prioritised however on one shift eight patients were transferred to the ward so care needs were high but no harm came to patients.
B2H	1	RN	Vacancy	This one red shift was patients admitted during the shift resulted in six vascular patients on one station. The lead nurse worked clinically to assist and a student was on the ward. No safety issues occurred.
B2T	1	RN	Staff moved to another area	This one red shift was assessed as such as a CSW was moved to another ward and the patient dependency was high which included two spinal patients with several patients requiring two hourly skin bundles. Workload was prioritised and patient safety maintained. There was some delays in care.
B3	1 1	RN CSW	Sickness x1 Vacancy x 1	On the RN shortfall shift no bank was available and it was not escalated to agency as an Amber shift. Station 3 was covered by a nurse from another ward. Safety was maintained. For the CSW shortfall, a CSW from another ward covered station 3. There were no safety issues.
B4	9	CSW	Sickness x5 Vacancy x3 Staff moved to other area x1	On one occasion the lead nurse assisted, on two occasions patients were cohorted and on the rest care was prioritised appropriately and staff were re-distributed to take into account the patients requiring 1 to 1 care. No safety issues occurred.
B5	4 1	RN CSW	Vacancy x 5	There were four red shifts. On one occasion, the surgical bed manager supported the ward and on the others the lead nurse assisted due to the high volume and dependency of the patients on SAU. Some delays in care were noted. On the CSW shortfall students were available on the ward. No safety issues occurred.
C1	5	CSW	1:1 required x3 Vacancy x3	Bank unable to fill. Lead nurse worked on ward on a number of occasions and staff were delegated accordingly to maintain safety.
C2	5	RSCN	Increased dependency	The increased dependency resulted in the nurse in charge assisting the relevant areas. Bank and agency were unable to fill. Safety was maintained at all times.
C3	12	RN	Vacancy x12	Bank unable to fill. Staff throughout the ward were rotated in order to cover the shortfall. Safety was maintained at all times.
C5	1	RN	Vacancy	Bank unable to fill. Workload was redistributed ensuring that safety was maintained at all times.
C6	1	RN	Vacancy	This was a red assessed shift. Two new graduates assisted under supervision. Safety was maintained.
C7	1	CSW	Sickness	A supernumerary CSW assisted and student nurses were on the ward. No reported harm to patients.

C8	2	RN	Sickness x2	For these two red assessed shifts, on both occasions the bleep holder supported the ward and HASU. There were some delays in care but safety was maintained.
EAU	1	CSW	Sickness	The Lead nurse worked clinically and so safety was maintained.
CCU	5	RN	Vacancy x5 Sickness x5	Bank unable to fill. On all occasions the dependency of the patients was such that all care was managed and safety was maintained.
NNU	1	RSCN	Dependency of patients	The NNU was closed to admissions and with all babies stable safety was not compromised.
Maternity	8 7	RM CSW	Vacancy Short Term sickness	Escalation policy enacted on all occasions. Bank unable to fill. Midwives were moved to areas of highest dependency No patient safety issues occurred

Dec-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 A2	79	Reg					8/7																											
		Unreg					7/4																						6/4					
WARD A3	90	Reg																						3/2										
		Unreg																																
WARD B1	94	Reg																					4/3											
		Unreg																																
WARD B2 HIP	98	Reg									4/3																							
		Unreg																																
WARD B2 TRAUMA	99	Reg												2/2																				
		Unreg																																
WARD B3	99	Reg																					6/4											
		Unreg																															6/4	
WARD B4	95	Reg																																
		Unreg	7/5				7/5						7/5										7/5		7/5									
WARD B5	92	Reg					6/4																											
		Unreg																															3/1	
WARD C1	96	Reg																																
		Unreg											11/9																		10/7			
WARD C2***	97	Reg		10/5		11/7																				10/6		9/5						9/5
		Unreg																																
WARD C3	91	Reg				5/4												5/4				5/4		5/4						5/4		5/4		
		Unreg																																
WARD C4	94	Reg																																
		Unreg																																
WARD C5	98	Reg											6/4																					
		Unreg																																
WARD C6	86	Reg											3/1																					
		Unreg																																
WARD C7	82	Reg																																
		Unreg																							5/3									
WARD C8	76	Reg																																6/4
		Unreg																																
CCU/PCCU	93	Reg																					7/5		7/4								7/5	
		Unreg																																
EAU	75	Reg																																
		Unreg											5/3																					
MHDU	100	Reg																																
		Unreg																																
CRITICAL CARE*	98	Reg																																
		Unreg																																
NEONATAL**	99	Reg																									6/4							
MATERNITY ****	97	Reg																			15/15				18/16	17/16								
		Unreg	7/5																				7/5											

		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 A2	Reg																														
	Unreg																		6/4												
WARD A3	Reg		3/2																												
	Unreg																														
WARD B1	Reg																		2/1			4/2									
	Unreg																		3/1												
WARD B2 HIP	Reg																														
	Unreg																														
WARD B2 TRAUMA	Reg																														
	Unreg																														
WARD B3	Reg																														
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WARD B4	Reg																														
	Unreg							7/5		7/5		7/5				7/5															
WARD B5	Reg																				5/5			6/5		6/6					
	Unreg																														
WARD C1	Reg																														
	Unreg		6/4									9/6						9/7													
WARD C2***	Reg																														
	Unreg																														
WARD C3	Reg		5/4		5/4	6/5					5/4		5/4				5/4														
	Unreg																														
WARD C4	Reg																														
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WARD C5	Reg																														
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WARD C6	Reg																														
	Unreg																														
WARD C7	Reg																														
	Unreg																														
WARD C8	Reg	7/4																													
	Unreg																														
CCU/PCCU	Reg	7/4		7/5																											
	Unreg																														
EAU	Reg																														
	Unreg																														
MHDU	Reg																														
	Unreg																														
CRITICAL CARE*	Reg																														
	Unreg																														
NEONATAL**	Reg																														
MATERNITY ****	Reg			17/16	17/15	17/17	16/16				17/14																				
	Unreg		5/3											7/5				7/5						7/4							5/3

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

Enclosure 5

The Dudley Grou
NHS Foundation Trust

Paper for submission to the Board on 2nd February 2017

TITLE:	**24 January 2017 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Sharon Phillips – Deputy Director of Governance (Risk and Standards)	**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 and that the Board endorses the approval of the Quality Improvement Strategy reviewed by this Committee.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	24 January 2017	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- Operational Management assurance was provided on the performance in respect of key quality indicators. This month saw
    - A continued challenge in securing a good response level to the Friends and Family test with a continued reduction in responses received in ED and inpatients. However the launch of the FFT text option was showing early signs of improving response rates (recorded as footfall).
    - The Trust recorded in December 7 cases of mixed sex breaches within MHDU. The patients were medically wardable but were not able to be moved for capacity reasons and it was determined safe to leave the patient where they were albeit this led to a single sex breach for that bays.
    - The Swallowing Screen (target 75%). Although this target was regularly achieved prior to June 2016, the team have struggled to achieve and maintain the target for the second month December Provisional performance 73.17%.
    - Performance against the Nursing Care Indicators saw a decrease from 95% to 75% in EAU. due to capacity pressures.
    - VTE Assessment indicator (CQN01- target 95%) – The Trust has struggled to maintain the target with Provisional figures showing the target (95%) will just not be met at 94.55%.
    - Continued good performance in respect of infection control both in terms of MRSA and *C diff*. The Committee noted that the continued achievement of this performance will remain a challenge especially over the winter months.
    - Maternity Breast feeding initiation – although still below the target there was a small improvement in December, with its provisional performance recorded at 56.96%.
    - Continued good performance in respect of Stroke Patients spending 90% of time on the stroke unit.

- Maternity smoking in pregnancy showed a 2% improvement.

- Operational management assurance was provided in respect of action being taken by the Surgery Division following the Fractured Neck of Femur Mortality Audit. Following a letter from the Hip Fracture Data base organisation identifying the Trust as an outlier there has been significant improvements made to the pathway. The Division has also looked in detail at the cases referred to and identified that in many the mortality was not associated with the Hip Fracture Treatment. The changes in the pathway and the work around discharge has improved the patient experience and the mortality rate has significantly reduced and is now comparable to the national average with a goal of reducing it further.
- Executive Management assurance was received that there are no policies that have exceeded their review dates, although there are 38 policies coming up for review over the next 6 months.
- Executive Management assurance was provided that the Trust has complied with the reporting requirement timescales in respect of initially reporting of Serious Incidents (SIs) within two days. The Trust did not close 3 of the investigations within the 60 day timescale this month due to an error occurring in nhs.net email system whereby the RCAs had been moved to the draft folder and were not actually sent. The monthly report shows performance against the agreed developed KPIs and that for the month the number being closed after considering and responding to initial questions from the CCG, was 67.9%, above the agreed target of 50%. Although the number closed after second review was 25% which is below the agree target of 43%. The number of actions not being implemented in line with the agreed RCA action plans timescales has fallen this month with 19 exceeding the timeline (11 nursing, 2 surgical Division and 2 Medicine and Integrated Care). Of the 5 actions that had revised dates in the previous months report 3 had been achieved.
- Assurance was provided of learning from incidents and complaints. Although Q3 saw an increase in the number of concerns raised to PALs which related mainly to the delay in appointments within ophthalmology and increased demands in the Emergency Department and associated extended waits. Positive assurance was received of the significant reduction in the number of moisture lesions reported over the last 4 quarters. This was attributed to a change in the continence products used with an estimated savings of £35,000 in 2016/17. There has been a rise in falls across the Trust in Q3. Falls while mobilizing alone is an area of high reporting and an increase in patient falls from bed. The Trust is purchasing high to low beds and alarms that can be used on the toilets to reduce the risk
- Operational Management assurance was provided in respect of the number of External Reviews completed in the organisation. Of these there were 15 reviews where the actions identified had yet to be taken, of these 7 had past their identified time scales.
- Operational Management assurance was provided in respect of the Trust compliance to “Learning, Candour and Accountability, A review of the way NHS Trusts review and investigate the death of patient in England”. The Trust’s current systems showed that the Trust are compliant with the recommendations.
- Operational Management assurance was received via the Learning Disability Strategy Action Plan in respect of the progress of the action plan. In summary 22 actions are completed and 3 actions in progress. Of the 6 Monitor required

standards for patient with learning disabilities incorporated with the ongoing work of the Learning Disability Strategy, all 6 are completed.

- Operational Assurance in Response to NHS Blood & Transplant Actual and Potential Organ Donors Report highlighted good practice which included 100% brain stem death testing where appropriate, and collaborative approach between ICU clinicians and NHSBT. But despite a collaborative approach none of the 3 families where in a position to make to any donations.
- Executive Management assurance was received via the summary of the minutes from the Internal Safeguarding Board. There continues to be an issue of access to Tier 4 beds due and no further progress with the implementation of a CAMHS Tier 3.5 service. Adult and children's safeguarding training is showing a positive increase for all levels of training.
- Executive Management assurance was received via the Quality and Safety Group in respect of the last meeting agenda items including nutrition and falls. Pharmacy presented three risks relating to drug security (corporate), storage of gases (corporate) and Physicians associates. Divisional actions are being developed to manage the two corporate risks and for the third risk each division is making its own assessment of this risk which will see an entry on their divisional risk registers at the next rRsk and Assurance Group in March.

Decisions Made / Items Approved

- The Committee approved 4 policies.
- The Committee approved the closure of 27 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.
- The Quality Improvement Strategy reviewed by this Committee subject to the minor changes agreed it be recommended for endorsement by the Board.

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

- Nothing specific over and above those actions from the previous month which are planned to come back to the next meeting.

Items referred to the Board for decision or action

The Committee asks the Board to note the assurances received at the meeting and the decisions made by the Committee and ratify the approval of the Quality Improvement Strategy attached for reference.

Quality Improvement Strategy		
	DOCUMENT TITLE:	**Quality Improvement Strategy (including plan)**
	Originator/Author & Specialty:	Dawn Wardell – Chief Nurse Derek Eaves – Professional Lead for Quality Liz Abbiss – Head of Communications and Patient Experience
	Director Lead:	Chief Nurse
	Target Audience:	All Staff
	Version:	4.0
	Date of Final Ratification:	January 2017
	Name of Ratifying Committee:	Clinical Quality, Safety and Patient Experience Committee
	Review Date:	
	Expiry Date:	
	Registration Requirements Outcome Number(s) (CQC)	Standard 16: Assessing and monitoring the quality of service provison
	Relevant Documents /Legislation/Standards	NHSI Single Oversight Framework Oct 2016 NHS (2014) Five Year Forward View NHS (2016) Shared commitment to quality from the National Quality Board
	Linked Procedural documents	Clinical Strategy Patient Experience Strategy Operational Plan Risk Management Strategy Nursing Strategy
	The electronic version of this document is the definitive version	

Quality Improvement Strategy	**Contributors:**	**Designation:** Chief Nurse Clinical Professional Lead for Quality Head of Communications and Patient Experience
	Consulted:	**Designation:** Executive Directors Divisional Directors Leads (as listed in Quality Improvement Plan)

CHANGE HISTORY

Version	Date	Reason
Version 1	Nov 11	New Document
Version 2	Mar 13	Changes to NHS organisations and Annual Forward Plan
Version 3	Nov 14	Update of strategy and change of title. Taken to Policy Group in November 14 and agreed. Previous ratification, expiry and review dates apply.
Version 4	Jan 17	Review as previous version expires

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

Contents

THE DUDLEY GROUP NHS FOUNDATION TRUST

QUALITY IMPROVEMENT STRATEGY

1. INTRODUCTION

This strategy has been drawn up in the context of the Trust's overall vision: *'Trusted to provide safe, caring and effective services because people matter'* and developments within the NHS in England.

External factors that have influenced the Trust's vision and this strategy are the NHS Constitution (2013), directives from NHS England, in particular its National Quality Board and the need to comply with regulators, such as NHS Improvement and the Care Quality Commission (CQC) and local commissioners such as Dudley Clinical Commissioning Group.

This strategy also links in with other strategies within the Trust such as the overall Clinical Strategy, which has aims such as:

1. Providing the highest quality local hospital care in the most effective and efficient way
2. Excellent integrated services enabling people to stay at home and be treated as close to home as possible
3. Providing a series of specialist services across the Black Country

Providing care in hospital and the community is more complex than ever before. Healthcare is changing, with more technology involved, more specialist care offered and more complex patient needs being supported. However, the most fundamental aspects of care remain the same as they ever were: patients and users expect to be safe and treated effectively and with courtesy, respect and kindness. These basic principles are vital to ensuring that patients have confidence in the care they receive.

The increasing complexity of healthcare and differing expectations of what quality is means measuring the quality of the service delivered is done in many different ways. This strategy outlines a framework of structures and processes to achieve the quality strategic objectives of the Trust outlined above.

This strategy, is based on national and local NHS requirements, NHSI Single Oversight Framework, CQC fundamental standards and registration requirements as well as on listening to a wide range of staff and patients. The latter was comprised from a variety of mechanisms including local Quality and Safety Reviews and Listening Events with staff, patients and Governors.

2. STATEMENT OF INTENT/PURPOSE

The key objectives related to quality within the Trust's overall vision are:

'Deliver a great patient experience'
'Deliver safe and caring services'

3. DEFINITIONS

The trust has adopted the definition of quality from the Darzi (2008) report. A quality service is seen as:

1. Clinically Effective 2. Safe 3. Personal

This strategy covers all three elements with the Personal section covering Patient Experience, although a more detailed Trust Patient Experieince Strategy has been drawn up based on the principles outlined here. This strategy also complements a number of other Trust associated documents which include:

- Trust Operational Plan
- Clinical, Risk Management and Nursing Strategies
- Policies on: Clinical Guidelines, NICE, National Confidential Enquiries, Responding to External Recommendations, Clinical Audit, Incident Reporting, Claims, Complaints and Investigations of Incidents.

In addition, this strategy is underpinned by the Trust's education, research & development, workforce and information/IT strategies.

It has also taken into consideration, national documents such as the NHS (2014) Five Year Forward View and NHS (2016) Shared commitment to quality from the National Quality Board

4. DUTIES (RESPONSIBILITIES)

Ensuring patients receive good quality care and have a positive experience of the service is everyone's responsibility.

The organisation and structure of Trust services and departments have been devised to support the successful delivery of corporate objectives, Trust values, and the Quality Improvement Strategy. This includes:

- Clear reporting lines (leadership and supervision)
- Clear accountabilities for teams and individuals
- Decision-making as near to front line service delivery as possible
- Avoidance of duplication
- Clear lines of communication

The organising principle of the Trust is to cluster associated clinical services/directorates into a coherent Division that, with earned autonomy, through evidence of high performance, can have the authority to act in the Trust's interests to deliver its goals. The following Divisions have been established:

- Medicine
- Surgery
- Nursing and Midwifery

Each Division is responsible for the delivery of the strategy and will work in partnership with the corporate Medical and Governance Directorates as well as the operational support directorates of Pharmacy and Patient Access to ensure the Trust achieves its goals. Divisional quality improvement strategies that detail each Division's contribution to achieving the corporate aims will be developed jointly with the Medical and Governance Directorates. Divisions will have responsibility for implementing and in some cases leading the projects outlined in this strategy.

Links with external groups and organisations

The Trust aims to work in partnership with others on quality improvement activities including:-

Healthwatch Dudley
The Trust will support and include Healthwatch Dudley in Patient Experience activity. The Patient Experience Group will receive reports with recommendations from Healthwatch Dudley and consider appropriate actions.

Dudley Metropolitan Borough Select Committee on Health and Adult Social Care (Overview and Scrutiny Committee)
The Trust will co-operate with and respond to requests from the committee.

Independent Complaints Advocacy Service (ICAS)
The Trust ensures that patients who wish to complain have information about the service and access to contact details via the PALS and Complaints Departments.

Local Commissioning Organisations
The Trust has close contact with the Dudley Clinical Commissioning Group (CCG) and aims to achieve a number of quality indicators as set out by national and local commissioning requirements. It also liaises closely with all of its local commissioners at the monthly Clinical Quality Review Meeting (CQRM) organised by Dudley CCG.

5. PROCESS/MEASUREMENT

There is no one way of measuring and monitoring quality but to achieve the outcomes outlined in Section 2 the following initiatives are in place and the following indicators are being used. All of these are included and published in the Annual Quality Account.

5.1 Quality Priorities

Following consultation with staff, patients and Governors each year the Trust concentrates on agreed key quality issues, which from 2016/17 to 2018/19 are:

Patient Experience
Infection Prevention and Control
Pressure Ulcer Prevention
Nutrition and Hydration
Medications

Specific targets have been set on each of these topics. For 2016/17 these are:

Target 1. Patient Experience
a) Achieve monthly scores in Friends and Family Test (FFT) for all areas (Inpatients, Outpatients, Maternity, Emergency Department and Community) that are equal to or better than the national average.
b) Ensure that in 95% or more cases, a patient's pain score is recorded at least four hourly (unless otherwise indicated in the exception box)
c) Ensure that in 95% or more cases, there is documentary evidence of the monitoring of the efficacy of all analgesia (pain relief) administered

Target 2. Pressure Ulcers
Hospital: a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year. b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2016/17 reduces from the number in 2015/16.
Community: a) Ensure that there are no avoidable stage 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable stage 3 pressure ulcers acquired on the district nurse caseload in 2016/17 reduces from the number in 2015/16.

Target 3. Infection Control
Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care. a) Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections). b) Have no more than 29 post 48 hour cases of Clostridium difficile where a lapse in care is identified.

Target 4. Nutrition/Hydration
Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items):
a) is 90 per cent or above in each of the first three quarters for the Trust as a whole
b) has a 'Green' rating (93 per cent or above) in the final quarter for every ward in the hospital

Target 5. Medication
The results for the following two indicators will be equal to or better than the end of year results of 2015/16: All medications that have been administered have been signed and dated. b) Omission codes are evident for all medication including Enoxaparin not administered as prescribed

The priority topics and targets are decided each year and are set taking into account the performance of the previous year, any targets set nationally and by local commissioners and the views of what is important at the time according to staff, patients,Governors and Trust Members.

5.2 Sign Up to Safety

The Trust developed its sign up to safety priorities through the analysis of clinical incidents, feedback from patients in the form of complaints and comments and the areas raised as priorities from the Quality Account discussions with our Governors.

The priorities agreed are:
• Reducing Pressure Ulcers
• Reducing Falls
• Effective Management of Infection Prevention and Control
• Effetive review and management of Mortality figures
• Reducing the incidence of Patient Deterioration (including the effective prevention and management of Sepsis)
• Effecitve Medicines Management
• Supporting and encouraging a Safety Culture

5.2.1 Pressure Ulcer Prevention

The Trust will have systems in place to reduce its level of avoidable harm with regards to pressure ulcers,it will support self care by patients and their families and adopt new prevention and treatment evidence as and when it arises.

5.2.2 Falls Prevention

The Trust will have systems in place to reduce its level of avoidable harm with regards to avoidable patient falls, in particular those that result in fractures.

5.2.3 Healthcare Acquired Infection (HCAI) Prevention and Anti-microbial resistance Reduction

The Trust will have systems in place to reduce its level of avoidable harm with regards to healthcare acquired infections and ensure that there is effective use of antibiotics to minimise anti-microbial resistance. It will share information and expertise with relevant community teams and organisations ensuring a health economy wide approach to infection preventionand control.

5.2.4 Mortality monitoring and lessons learned

The Trust will have systems in place to locally review all deaths that occur at the Trust and partake in the review using the new nationally agreed indicator - Summary Hospital-level Mortality Indicator (SHMI).

5.2.5 Recognition and escalation of the deteriorating and septic patient

The Trust will have systems in place to ensure the effective prevention, identification, escalation and management of all deteriorating patients, including those at risk of developing sepsis. It will have educational programmes in place so that staff are aware of and respond to early changes in patients' conditions.

5.2.6 Safe Administration, Storage and Prescription of Medicines

The Trust will ensure there are effective systems in place for the safe storage, prescribing and administration of medicines. It will ensure that learning is identified and improvements made from both specific and trends of incidents.

5.2.7 Safety Culture

The Trust will promote and make visible a safety culture to all staff, visitors and and the public.

5.3 Other Key Quality Initiatives

5.3.1 Participation in local and National Clinical Audits

All specialties and professional groups will have audit and monitoring systems in place to ensure that both national and local guidelines are being audited and monitored. When results indicate that deficiencies in practice are occurring, plans to rectify the situation are drawn up, implemented and re-audit will occur.

5.3.2 Achievement of the four priority standards for seven day services

Delivering services 24/7 is a key part of our strategic goal to drive service improvement, innovation and transformation.

5.3.3 Compliance with national guidance on Safer Staffing and Monitoring Care Hours Per Patient Day (CHPPD)

The Trust will monitor its staffing levels which impact on the quality of care, comply with national guidance and take action to improve these when necessary. It will incorporate any developments that come from both the Carter Review and the Model Hospital.

5.3.4 Compliance with the relevant Mental Health Standards (Early intervention in psychosis and improved access to psychological therapies)

The Trust will work with local adult and child mental health providers to ensure that effective systems are in place to implement these standards.

5.3.5 Investigate serious and other incidents with learning and action

The Trust will ensure that when incidents do occur, these will be investigated thoroughly and lessons learned to reduce and prevent re-occurrence.

5.3.6 Achievement of CQUINs (Commissioning for Quality and Innovation)

The Trust will continue to have robust systems in place to monitor and improve its performance, when necessary, in order to achieve National CQUIN targets.

5.3.7 Patient Experience

The Trust will ensure that robust methods are in place for collecting real time patient views, monitoring improvements to services as a result of patient feedback and ensuring overall patient involvement.

5.3.8 End of Life Care

The Trust is committed to transform end of life care, not only in the acute setting but in the wider community. It will work together with colleagues in primary care, hospices and social care to meet the following goals across all settings - improve the quality of care and patient, family and carer experience; improve decision making, planning and communication; improve education and training of our workforce.

5.3.9 'Better Births'

The Trust will ensure it is compliant with the recommendations in the 'Better Births' report.

5.3.10 NICE

All NICE guidance will be assessed for its relevance to the organisation, complied with where appropriate and its compliance monitored and audited.

5.3.11Nursing/Midwifery Care Indicators

The Trust will monitor the quality of nursing and midwifery care both in the hospital and community using care indicators (NCIs/MCIs) and other tools which cover specific key areas of care e.g. 'Think Glucose', Nutrition and take improvement action when required.

5.3.12 Risk Assessment

The Trust and all specialities will have proactive systems in place to assess and manage risk and hold active risk registers in order to reduce incidents (including externally reportable Serious Incidents and 'Never Events'), complaints and claims occurring.

5.3.13 Safety Thermometer

The Trust will continue to partake in the monthly national Safety Thermometer survey, monitor its results with comparisons against national and local benchmarks and take action as necessary.

5.3.14 Transforming Services to maintain and improvement quality of care

The Trust continues to develop and implement a programme of transformational change to ensure improved quality and efficiency across a range of services. The focus during 2017/18 will be in Theatres, Outpatients and Patient flow. The key priorities for 17/18 have been developed through a series of workshops, ideas from staff and learning best practice from various networks.

5.4 Overall Monitoring and Assurance

A strategy such as this which covers a wide range of issues requires an equally diverse series of monitoring and assurance mechanisms. These include:

5.4.1 Quality and Safety Reviews

The Directors with input from Governors, commissioners and key senior staff will undertake regular scheduled visits to wards and departments to assess the area on

its quality of care and compliance with CQC standards, talk to staff and patients about any safety concerns they may have and take action as necessary to any identified issues. The results are reported quarterly to Quality and Safety Group and CQSPE.

5.4.2 Dashboard of Quality Indicators

The Trust has an electronic performance dashboard that has a quality section which contains a variety of quality indicators from ward through to Trustwide level. Posters of a summary of ward level indicators are distributed each month to each area. An exception report of the indicator results is presented monthly to CQSPE.

5.4.3 Performance Review

The Directors undertake monthly performance reviews of each clinical division with each senior clinical team. These reviews include the assessment and challengeof the relevant quality indicators for that area. Action plans are drawn up and implemented, as required. A report of the results of the reviews are presented each month to the Finance and Performance Committee.

5.4.4 External Reviews

The Trust will co-operate with all relevant outside bodies undertaking reviews of the quality of care and put in place any necessary improvement requirements from the variety of external reviews that occur.

5.4.5 Main Commissioners perspective

The Trust in conjuction with Dudley CCG (and other local commissioners) will monitor and provide assurance on its quality of care both at the monthly CQRM meetings and on individual requests. Following discussions the Trust is open for Dudley CCG to undertake themes reviews of its services.

5.4.6 Specific Monitoring and Assurance

At local level, the regular Performance Reviews by Directors of individual specialties will include monitoring of the relevant initiatives/indicators from the list above that apply to that area.

In addition every Trust Cost Improvement Plan (CIP) is assessed by the Trust's Medical Director and Chief Nurse.

Divisions will be requested to complete a **Clinical Quality Impact Assessment** for each individual CIP. Any new CIP introduced partway through the financial year will be assessed as and when they arise.

The **Clinical Quality Impact Assessment** includes the provision of the following information:

- The possible impact of implementing the CIP on clinical services, quality of service, access to services, patient safety etc
- Current controls in place
- Gaps in control
- Sources of assurance

- Gaps in assurance
- Mitigating actions
- A numerical risk assessment "likelihood x impact" scoring

The Medical Director and Chief Nurse review each of these **Clinical Quality Impact Assessment** and **Statements of Assurance** and rate as follows:

- **Green** - proceed as normal
- **Amber** - further details/assurances required then reassess and consider what elements should continue and/or what additional controls need to be introduced
- **Red** - either scheme is stopped immediately, or alternatively further information is requested with a specific deadline. A scheme cannot continue to be red rated - it is either reassessed as green or amber or stopped
- **Blue** - scheme is green rated but required to undertake a post implementation review. This would normally be after 6 months via the performance review process. Subject to successful review, the CIP will then be green rated

All of the specific initiatives listed in sections 5.1 and 5.2 have a plan of structures and processes in place to ensure improvement occurs. The Board gains assurance on their progress through reports to the sub-committees of the Board. The structures and processes in place as well as the assurance gained from these are listed in Appendix 1.

6. TRAINING/SUPPORT

The Trust has an extensive programme of clinical education and development and staff support, all of which contribute to the quality of care provided by staff.

7. PROCESS FOR MONITORING COMPLIANCE

While Quality impinges on everything that the Trust does, this strategy indicates specific structures and processes to ensure that it remains a focus for the whole organisation. This strategy and its associated structures and processes will evolve and change dependant on both national and local factors. The Clinical Quality, Safety and Patient Experience Committee will constantly monitor the strategy to ensure it remains uptodate and relevant.

8. EQUALITY

The Dudley Group NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This document has been assessed appropriately.

9. REFERENCES

Carter (2016) Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. DOH
Darzi (2008) High Quality Care For All – NHS Next Stage Review Final Report June 2008
NHS (2014) Five Year Forward View
NHS (2016) Shared commitment to quality from the National Quality Board

COMPLIANCE MONITORING CHECKLIST

MONITORING THE EFFECTIVENESS OF THIS POLICY- As a minimum the following will be monitored to ensure compliance:

	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Key elements of the strategy	Chief Executive and Directors	Developed framework	Quarterly	CQSPE	Identify actions required and delegate individuals to take forward	Communications Department to publicise Annual Report Reports to Monitor
Key Quality Priority Targets	Nursing/Medical Directors Executive Directors	Quality Account	Quarterly	CQSPE/Trust Board	Identify actions required and delegate individuals to take forward	Communications Department to publicise. Quality Account /Report published

Please see Appendix 1 for detailed monitoring processes

APPENDIX 1

The Dudley Group NHS
NHS Foundation Trust

Quality Improvement Plan (which includes 'Sign up to Safety')
(Patient Safety & Quality)

(The Trust monitors that this plan & priorities are consistent with the aspirations of the Black Country Sustainability and Transformation Plan (STP)).

Strategy Section	Objective	Key Structures and Processes in Place	Lead(s)	Main Assurance	Status (RAG)
Sign up to safety topics					
5.2.1	**Improve Levels of Avoidable Harm in Pressure Ulcers and in particular achieve the associated Quality Priority Targets**	Tissue Viability Team Care Bundles Weekly table top assessment and RCA review meetings	**J. Bree**	Quarterly Report to Q and S Group Summary Q and S Report to CQSPE Quarterly Quality Priority Report to CQSPE	
5.2.2	**Improve Levels of Avoidable Harm in Falls**	Lead Nurse for Patient Falls Prevention Ward Falls Safe Champions, MDT Meeting Trust Falls Prevention and Management Group, Falls RCA meetings	**J. Pain**	Quarterly Report to Q and S Group Summary Q and S Report to CQSPE	
5.2.3	**Improve Levels of Avoidable Harm in HCAI and in particular achieve the associated Quality Priority Targets. Ensure that actions are taken to reduce anti-microbial resistance**	Director of Infection Prevention and Control/Infection Prevention and Control Team Quarterly IPC Forum Meetings Monthly audits e.g. Saving Lives Incident Investigations Post Infection feedback	**E. Rees** **A. Murray**	Monthly Report to Q and S Group Summary Q and S Report to CQSPE Quarterly Quality Priority Report to CQSPE Monthly Chief Nurse Report to Board	
5.2.4	**Mortality to be maintained within agreed limits. Improve the quality of mortality review and subsequent learning and action**	Mortality Review Tracker Sharing learning at Grand Rounds, Audit days and Learning Events Learning shared through events as listed and will continue.	**R. Callender**	Quarterly Report to CQSPE	

Strategy Section	Objective	Key Structures and Processes in Place	Lead(s)	Main Assurance	Status (RAG)
5.2.5	**Robust recognition and escalation of the deteriorating patient** **Robust identification, escalation and treatment of the patient with sepsis.**	Three linked groups: Resuscitation Group, Deteriorating Patient Group and Sepsis Group. Undertaking a Review of these Groups. Clinical Audits on these topics e.g. unplanned admissions to ITU Mandatory training of staff Review of relevant clinical incidents and trends and themes	**K. Sheppard** **B. Dainty**	Quarterly reports to Q and S Group Summary Q and S Report to CQSPE	
5.2.6	**Ensure Safety in the Administration, Storage and Prescription of Medicines**	Drug and Therapeutics Group Safer Medicines Group Clear improvement plan for focus of work Review of Incidents to identify trends Safer Medicines Branding and regular newsletters Training sessions for staff on Safer Medicines	**R. Kahlon**	Bi-Monthly Drug and Therapeutics Report to Q and S Group Monthly verbal pharmacy report to Q and S Group	
5.2.7	**Safety Culture in the Organisation is visible to all visitors and public**	Quality and Safety Reviews are undertaken throughout the year Sign up to Safety Campaign events and communications during the next 2 years. Feedback to staff from Chief Exec Staff briefings on safety culture Undertake Safety Culture Questionnaire after winter period	**D. Wardell/ Quality Team**	Quarterly report from Sign Up to Safety Group to Q and S Meeting To review culture questionaires available to determine one to use and how it will be disseminated in the organisation when due.	
	Public commitment by the Board to Sign up to safety	Board Paper and agreement to sign up to safety	**D. Wardell**	Quarterly progress report to Q and S Six monthly report to CQSPE	

Strategy Section	Objective	Key Structures and Processes in Place	Lead(s)	Main Assurance	Status (RAG)
Other Key Topics					
5.3.1	**Participate in relevant National Clinical Audits**	Clinical Audit Department and Clinical Leads National Audits are priority on plan Quarterly Clinical Audit Meetings	**G. Palethorpe**	Quarterly Report to Audit Committee Quarterly Quality Priority Report to CQSPE Annual Clinical Audit Plan and Report Annual Quality Report	
5.3.2	**Achieve the four priority standards for seven-day hospital services**	Working together with our BlackCountry Alliance partners to make the provision of such services more achievable e.g. pilot and expansion plans of 7 day interventional radiology Professional standards and daily checklist re. time and frequency of consultant reviews Key standards incorporated into current service delivery and wider strategic plans.	**P. Bytheway/M. Banks**	Six monthly national audit Comparative results received back from NHS England every six months Six monthly Audit report to audit committtee Annaul Audit Report	
5.3.3	**Ensure that the Trust complies with national guidance on Safe Staffing and monitoring Care Hours Per Patient Day (CHPPD)**	Nursing Dashboard Shift by shift data collection Safer Nursing Tool exercises Explicit escalation processes Compliance with the relevant existing and any new national requirements. CHPPD is calcualted Confirm/Challenge Rostering meetings Pilot site for the ward element of the Model Hospital	**D. Wardell**	Board monitoring reports of the Trust's shift by shift staffing position monthly and the results of the Safer Nursing Tool exercise every six months to ensure it is continually aware of the nurse staffing situation.	
5.3.4	**Ensure that the Trust complies with the relevant Mental health standards (Early Intervention in Psychosis and Improving Access to Psychological Therapies)**	Clinical Lead for Mental Health Internal Safeguarding Board Continue to work with local adult and child mental health providers to ensure that effective systems are in place to implement these standards.	**M. Aworinde**	Quarterly report on Mental Health to Internal Safeguarding Board Quarterly report (Safeguarding) to CQSPE and Board	

Strategy Section	Objective	Key Structures and Processes in Place	Lead(s)	Main Assurance	Status (RAG)
5.3.5	**Improve the quality of Serious Incident investigation and subsequent learning and action**	Datix Reporting System RCA Process RCA Training Learning Events Bi-monthly Divisional Performance Meetings	**G. Palethorpe**	Monthly report on incidents to CQSPE Quarterly Aggregated incident and complaint report to CQSPE Quarterly learning report to CQSPE	
5.36	**Ensure that there are robust systems in place to monitor and improve performance when necessary, in order to achieve National CQUIN targets.**	Monthly Executive performance meetings. Project Management governance structure and reporting in place including monthly project status reports. Operational, Clinical and Executive Leads identified for all schemes	**A. Gaston**	Quarterly report to Finance and Performance Committee. Reporting to CQRM (Clinical Quality Review Meeting) when required. Monthly Contract discussion meetings.	
5.3.7	**Ensure that the Trust has effective systems in place to gain the patient experience and learn lessons as necessary and in particular achieve the associated Quality Priority Targets**	Patient Experience Group (PEG) Local and National Surveys Freinds and Family Test NHS Choices/Patient Opinion monitoring. PLACE assessments Listening Events Complaints Single Sex Accomodation monitoring	**L. Abbiss**	Quarterly report from PEG to CQSPE	
5.3.8	**Ensure that the Trust has comprehensive systems in place so that effective end of life care is provided**	End of Life Group with workstreams and sub-groups Health Economy EOLC Group Care of Dying Audit Group Clinical Lead for End of Life	**D. Wardell**	Quarterly report to CQSPE Quarterly Report ot Board	
5.3.9	**Ensure the Trust implements recommendations from 'Better Births'.**	Continue to monitor outstanding actions and agree priorities with Dudly CCG Black Country STP 'Better birth' sub group comparing and sharing best practice	**D. Lewis**	Gap analysis completed Report to CQSPE	

Strategy Section	Objective	Key Structures and Processes in Place	Lead(s)	Main Assurance	Status (RAG)
5.3.10	**Ensure that the Trust complies with all relevant NICE Guidance**	Clinical Audit Department NICE Policy	**G. Palethorpe**	Quarterly Report to Risk and Assurance Committee	
5.3.11	**Monitor the quality of nursing and midwifery care using care indicators (NCIs/MCIs) and other tools which cover specific key areas of care and in particular achieve the associated Quality Priority Targets**	Quality and Audit Development Nurse Monthly Audits Escalation Process for compliance	**D. Wardell**	Monthly Chief Nurse report to Board Quarterly report to Q and S Quarterly Quality Priority Report to CQSPE Q and S summary report to CQSPE	
5.3.12	**Ensure systems in place to assess and manage risk and hold active risk registers in order to reduce incidents, complaints and claims occurring.**	Divisional Risk Meetings Internal Governace Audit Programme	**G. Palethorpe**	Quarterly Report to Risk and Assurance Committee	
5.3.13	**Partake in the monthly national Safety Thermometer survey and monitor its results with comparisons against national and local benchmarks.**	Quality and Audit Development Nurse Monthly Audits Divisional Performance Reviews	**D. Wardell**	Quarterly report to Q and S Summary report to CQSPE	
5.3.14	**The Trust will Transform services to ensure that the quality of care and patient experience improves**	Monthly Confirm and Challenge meetings for each workstream. Monitoring of KPIs at Transformation Executive Committee. Monthly Outpatient Optimisation Steering Group. Monthly Patient Flow Project Board. Workshop events with Clinical and Operational Teams when required. Formal learning opportunities through completion of a NVQ Business Improvement Techniques course.	**A.Baines**	Monthly report to Board Monthly report to Finance and Performance Committee Monthly report to Transformation Executive Committee	

Glossary: Q and S Group = Quality and Safety Group, CQSPE = Clinical Quality, Safety and Patient Experience Committee (Sub-committee of the Board)
There is a report of all key issues from the monthly CQSPE Committee meetings to the Board

The Dudley NHS Foundation Trust

Enclosure 6

Paper for submission to the Board
2 February 20167

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

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

Corporate Risk Register

The Corporate Risk Register records the Trust's key risks linked to each of the Trust's six objectives. The Register includes those key risks to the Trust's objectives as recorded with the Trust's annual plan (these are seen as the top down risks), it also includes those risks that have been escalated from the Trust's Divisions / Directorates (these are seen as bottom up risks). *Note there is one less risks scoring 20 this quarter down from 8 to 7.there is also one less risk scoring 16 this quarter down from 9 to 8.*

<u>New / escalated risks</u>

There have been **4 new and 1 escalated** risk this quarter. These relate to

COR111 – Risk of cyber threats. This risk has been placed on the register based on the increase prevalence of such threats in the NHS. The Trust's strategy to deal with these was presented to the Audit Committee.
COR114 – Failure to provide secure medicines related practice. The Trust's action plans to address this risk are being presented to the Trust's Quality and Safety Group.
COR115 - Failure to provide safe storage of medical gas cylinder practice within the Trust. This risk has been placed on the register following work undertake by the newly formed medical gases group. Again action being taken to address this risk will be presented to the Quality and Safety Group.
COR12 – Poor compliance to recommended training as identified in the Autism Act. This risk has been escalated by the Nursing Division as it affects more than just nurses. Compliance rates for training is monitored by the workforce committee.
COR110 – Resourcing of the B6 flex ward. This risk has been placed on the risk register in part due to the increased demands being placed on the Trust.

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

There are **2 increased risks** within the 3rd quarter of the year. These relate to:

COR084 – Failure to learn and be ready for our next CQC inspection. This risk has increased due to further negative assurance received from operational and executive management on the outcomes of actions being taken to achieve sustained

improvements.

COR105 – Reduced ability to control temporary staffing. This risk has increased to reflect the costs of the use of agency staffing. (noting this risk description has been redefined to remove reference to only nursing)

Risks where the current score has decreased since the last meeting

There are **7 risks where their score has decreased** within the 3rd quarter of the year. These relate to:-
COR098 – failure to meet the expectations of the Accessible Information Standard. This is supported by the receipt of positive assurance in the quarter from operational management about work undertaken in the Trust to deal with patient's needs.
COR108 – confidence in the Trust's maternity services. This is supported by the receipt of positive assurance in the quarter including feedback from the CCG via their maternity and assurance group.
COR086 – patients' nutritional needs are not fully met. This is supported by the receipt of positive assurance in the quarter from improved NCI audit outcomes.
COR089 – EPR programme is delayed. This is supported by the receipt of positive assurance in the quarter and the Trust's signing of the contract to progress with this procurement.
COR102 – the implementation of the revised JD contract. Whilst some negative assurance was received this quarter this risk has reduced based on the balance of positive assurance also received in the quarter. Also that the Trust has appointed its own guardian of safe working to support Junior Doctors.
COR103 – Potential for the MCP procurement exercise to adversely impact on the Trust's sustainability. The Trust has been actively engaging with the CCG who are leading on the procurement to discuss the risks and potential strategies for their mitigation.
COR101 – the risk to the delivery of a number of capital schemes. This has reduced this quarter as the Trust has managed to progress its key scheme of the EPR.

De-escalated risks and Achieved risks since the last report

There has been no risks de-escalated this quarter.

Corporate Assurance register

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

Assurance gaps

There is only one risk, excluding those new this quarter, for which assurance has not been logged in this quarter, excluding the new risks identified this quarter. This risk

is

COR107 The agreed outcome of the STP is not aligned with the current Trust Business Strategy (Note - there was no assurance logged against this risk in the last 2 quarters, but as the STP has only just been produced and the detail is still to be worked up this gap in assurance should be expected). It should be noted this risk score has not changed.

Negative Assurance

Negative assurance has been logged in this quarter across a number of risks, and for most this has not led to a change in the risk score. However the negative assurance has caused two risks to increase:-
COR084 – Failure to learn and be ready for our next CQC inspection. This risk has increased due to further negative assurance received from operational and executive management on the outcomes of actions being taken to sustain improvements.

COR105 – Reduced ability to control temporary staffing. This risk has increased to reflect the costs of the use of agency staffing. (noting this risk description has been redefined to remove reference to only nursing)

In should be noted that in two cases both negative assurance and positive assurance was logged the risk has reduced based on the counter balance of positive assurance logged. These relate to *COR102 - The implementation of the revised JD contract may result in reduced availability of JD leading to gaps in rotas and COR103 – Potential for MCP procurement exercise adversely impacts on Trust sustainability.* This balance and treatment of the risk score was debated and agreed at the risk and assurance group meeting.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y	Y	

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

The Dudley Group NHS
NHS Foundation Trust

CORPORATE RISK REGISTER – January 2017

Risk Dashboard – rolling risk score trend

Strategic Objective	Oversight Committee	Risk Lead	ID	Risk Description	Inherent risk score	Current Score									Trend	Target Risk Score
						17/03/15	05/06/15	26/08/15	21/12/15	02/03/16	04/05/16	30/06/16	30/09/16	03/01/17		
SO1	F	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer)	20	15	20	15	15	15	20	20	20	20	→	8
	F	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	20	16	16	16	16	16	16	16	20	20	→	8
	C	DG	COR084	Failure to learn and be ready for our next CQC inspection*	16	new	8	12	12	12	12	12	12	16	↑	6
	C	DG	COR098	Failure to meet the expectations of the Accessible Information Standard	16					new	16	12	12	9	↓	8
	F	COO	COR099	Failure to reduce the number of delayed transfer of care may result in poor patient experience and may impact on patient safety, as patients will have to be managed in outlying / contingency areas	20					new	20	20	20	20	→	16
	C	CN	COR108	An inability to consistently maintain confidence in the quality of delivery of maternity care, resulting in negative reputation, loss of public and national confidence, reduction to bookings and financial loss	16						new	16	16	8	↓	8
	F	DIT	COR111	Risk of cyber threat exploiting a vulnerability to threaten confidentiality, availabiliyt or integity of data services	16								new	16		4
	C	CN	COR114	Failure to provide secure medicines related practice within the Trust	20								new	15		5
	C	COO	COR115	Failure to provide safe storage of medical gas cylinder practice within the Trust	20								new	12		5
SO2	F	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	15	15	15	15	10	10	10	10	10	→	10
	F	DF	COR104	Failure of the electricty supply to Hospital Site	20					esc	16	16	12	12	→	4
	C	CN	COR085	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing	20	20	20	20	15	20	20	20	20	20	→	10
	C	CN	COR081	Nurse / Midwifery revalidation fails	12	new	16	8	4	4	8	8	4	Arc		4
	C	CN	COR082a	Failure to achieve the target of no more than 29 C.Diff cases where a laspe in care is judged by the CCG to have occured	8	Clarified that risk relates to lapses in			10	8	8	8	8	8	→	8

Strategic Objective	Oversight Committee	Risk Lead	ID	Risk Description	Inherent risk score	Current Score									Trend	Target Risk Score
						17/03/15	05/06/15	26/08/15	21/12/15	02/03/16	04/05/16	30/06/16	30/09/16	03/01/17		
							care									
	C	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16	new	16	8	4	8	8	8	8	4	↓	4
	C	CN	COR087	An inability to reduce the incidence of hospital and community service acquired avoidable stage 3 and 4 pressure ulcers to an acceptable level resulting in suboptimal care for patients	12	esc	12	12	8	8	8	12	9	9	→	4
	C	CN	COR093	Management of young people requiring care under the mental health act (tier 4 beds are not available)	20		new	12	8	12	16	16	12	12	→	8
	F	CN	COR097	Fail to achieve the best practice target for falls in hospital	12					new	9	9	9	9	→	6
	C	CN	COR096	Failure to prevent avoidable deterioration of patients leading to cardiac arrests	20			new	10	10	10	10	15	15	→	8
	F	DF	COR100	Failure to comply with Fire Safety requirements	20					esc	15	15	12	12	→	10
	C	CN	COR112	Poor compliance to recommended training as identified in the Autism Act 2012 - potentially affecting patient experience and care and safety	16								esc	16		8
S03	C	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20	new	20	20	16	16	16	16	16	16	→	15
	F	DIT	COR089	EPR programme is delayed and fails to deliver expected benefits **	16	new	16	12	12	12	16	16	16	12	↓	12
SO4	W	COO	COR102	The implementation of the revised JD contract may result in reduced avaiavility of JD leading to gaps in rotas	16					new	16	16	16	12	↓	8
SO5	F	DIT	COR091	The IT DR arrangements are not effective	20	esc	20	15	15	15	10	10	12	12	→	4
	F	DSP	COR080	Failure to deliver our 2016/17 CIP programme ***	20	20	12	9	4	4	20	20	20	20	→	9
	C	CN	COR110	B6 Flexi ward is frequently opened to create. There is no establishment resource	15								new	15		9

Strategic Objective	Oversight Committee	Risk Lead	ID	Risk Description	Inherent risk score	Current Score									Trend	Target Risk Score
						17/03/15	05/06/15	26/08/15	21/12/15	02/03/16	04/05/16	30/06/16	30/09/16	03/01/17		
SO6	F	DF	COR061	Failure to maintian financial sustainability	20	20	16	16	12	12	16	16	16	16	→	5
	F	DSP	COR103	Potentail for MCP procurement exercise adversly impacts on Trust sustainability	20					new	12	20	20	16	↓	8
	F	DF	COR101	The risk to the delivery of the number of capital schemes the Board would like to commit to which require external financial support	20					new	20	20	20	16	↓	15
	F	DHR	COR105 ****	High dependency on agency staff, particularly in clinical areas, is contributing to high levels of expenditure on pay and also contributing to an inconsistent workforce delivering care to patients.	20						esc	16	16	20	↑	12
	F	DSP	COR107	The agreed outcome of the STP is not aligned with the current Trust Business Strategy.	16						new	16	16	16	→	12
	W	DHR	COR109	Inability to recruit and retain staff in key posts could impact on service quality, patient and staff experience of the Trust coupled with a need to then fill via agency use putting further pressure on the Trust's budget and its ability to secure the Sustainability and Transformation Fund in quarters 2, 3 and 4	20						new	20	20	20	→	12

* reworded risk but it remains similar to risk COR084 tracked last year
** reworded risk but very similar to risk COR089 tracked last year
*** reworded risk but it remains similar to risk COR080 tracked last year
**** reworded risk to reflect does relate to all staff groups

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

The Dudley Group NHS
NHS Foundation Trust

CORPORATE RISK ASSURANCE SUMMARY – JANUARY 2017

Assurance Dashboard – rolling assurance trend

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 30/06/16	Level 1	Level 2	Level 3	Risk Sept 16	Level 1	Level 2	Level 3	Risk Dec 16	Level 1	Level 2	Level 3	Risk March 16	Level 1	Level 2	Level 3	
SO1	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer)	20	10	A	A		20		G		20		G						8
	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	20	16	G	G		20		G		20		G						8
	DG	COR084	Failure to learn and be ready for our next CQC inspection*	16	12	A	A		12	G	R		16	R	R						6
	DG	COR098	Failure to comply with Accessible Information Standard	16	12	G			12	G			9	G							8
	COO	COR099	Failure to reduce the number of delayed transfer of care may result in poor patient experience and may impact on patient safety, as patients will have to be managed in outlying / contingency areas	20	20	R	R		20	R	R		20	R							16
	CN	COR108	An inability to consistently maintain confidence in the quality of delivery of maternity care,	16	16	New - no assurance logged			16	G	G	A	8	G		G					8
	DIT	COR111	Risk of cyber threat exploiting a vulnerability to threaten confidentiality, availabiliyt or integity of data services	16									16	New - no assurance logged							4
SO2	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	10	G	G		10	G	G	G	10	G	G	G					10

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 30/06/16	Level 1	Level 2	Level 3	Risk Sept 16	Level 1	Level 2	Level 3	Risk Dec 16	Level 1	Level 2	Level 3	Risk March 16	Level 1	Level 2	Level 3	
	DF	COR104	Failure of the electricty supply to Hospital Site	20	16	No assurance logged			12			G	12			G					4
	CN	COR085	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing	20	20	G	G		20	A	G		20	A							10
	CN	COR082a	Failure to achieve the target of no more than 29 C.Diff cases where a laspe in care is judged by the CCG to have occured	8	8	G	G		8	G			8		G						8
	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16	8	A	A		8	A	G		4	G							4
	CN	COR087	An inability to reduce the incidence of hospital and community service acquired avoidable stage 3 and 4 pressure ulcers to an acceptable level resulting in suboptimal care for patients	12	12	A			9	A			9	R							4
	CN	COR093	Management of young people requiring care under the mental health act (tier 4 beds are not available)	20	16	R	R		12	R		G	12	A							8
	CN	COR097	Fail to achieve the best practice target for falls in hospital	12	9		G		9	G			9	G							6
	CN	COR096	Failure to prevent avoidable deterioration of patients leading to cardiac arrests	20	10		G		15		A		15	R	A						8
	DF	COR100	Failure to comply with Fire Safety requirements	20	15	No assurance logged			12	G		G	12	G		G					10
	CN	COR112	Poor compliance to recommended training as identified in the Autism Act 2012 - potentially affecting patient experience and care and safety	16									16	New – no assurance logged							8

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 30/06/16	Level 1	Level 2	Level 3	Risk Sept 16	Level 1	Level 2	Level 3	Risk Dec 16	Level 1	Level 2	Level 3	Risk March 16	Level 1	Level 2	Level 3	
	CN	COR114	Failure to provide secure medicines related practice within the Trust	20									15		New – no assurance logged						5
	COO	COR115	Failure to provide safe storage of medical gas cylinder practice within the Trust	20									12		New – no assurance logged						5
S03	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20	16		G		16	A			16		A						16
	DIT	COR089	EPR programme is delayed and fails to deliver expected benefits **	16	16	No assurance logged			16		G		12		G						12
SO4	COO	COR102	The implementation of the revised JD contract may result in reduced avaiavility of JD leading to gaps in rotas	16	16	G			16	A			12	A							8
SO5	DIT	COR091	The IT DR arrangements are not effective	20	10	No assurance logged			12		G		12		G						4
	DSP	COR080	Failure to deliver our CIP programme **	20	20	A	A		20		G		20		G						9
	CN	COR110	B6 Flexi ward is frequently opened to create. there is no establishment resource	15	New								15	G							9
SO6	DF	COR061	Failure to maintian financial sustainability	20	16	A	A		16	No assurance logged			16		G						5
	DSP	COR103	Potentail for MCP procurement exercise adversly impacts on Trust sustainability	12	20	A	A		20		A		16		A						8
	DF	COR101	The risk to the delivery of the number of capital schemes the Board would like to commit to which require external financial support	20	20		R		20	No assurance logged			16	G		G					15
	DHR	COR105 ****	High dependency on agency staff, particularly in clinical areas, is contributing to high	16	16	New - no assurance logged			16	A	R		20	G	A						12

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Q3 Assurance				Q4 Assurance				Target Risk Score
					Risk 30/06/16	Level 1	Level 2	Level 3	Risk Sept 16	Level 1	Level 2	Level 3	Risk Dec 16	Level 1	Level 2	Level 3	Risk March 16	Level 1	Level 2	Level 3	
			levels of expenditure on pay and also contributing to an inconsistent workforce delivering care to patients.																		
	DSP	COR107	The agreed outcome of the STP is not aligned with the current Trust Business Strategy	16	16	New - no assurance logged			16	No assurance logged			16	No assurance logged							12
	CN	COR109	Inability to recruit and retain staff in key posts could impact on service quality, patient and staff experience. agency use putting further pressure on the Trust's budget and its ability to secure the Sustainability and Transformation Fund in quarters 2, 3 and 4	20	20	New - no assurance logged			20	A			20	A							12

* reworded risk but it remains similar to risk COR084 tracked last year
** reworded risk but very similar to risk COR089 tracked last year
*** reworded risk but it remains similar to risk COR080 tracked last year
**** reworded risk to reflect does relate to all staff groups

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

Analysis of Risk

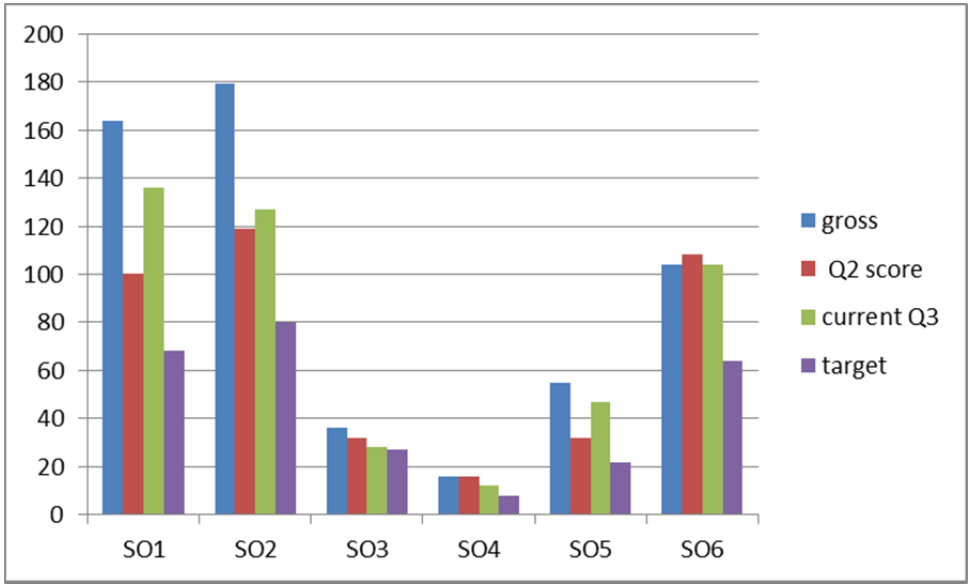
Overview of current positon

Number of risks at start of the year	Total number CURRENT risks	Prior Quarter total risk score	CURRENT total risk score	Target risk score
25	32	402	454	269

4 new risks and 1 esculated risk were added at during quarter 3 (3 for SO1, 1 for SO2 and 1 for SO5). These new risks account for the main increases in SO1 and SO2 (notin that within these two objectives some of the risks have reduced).

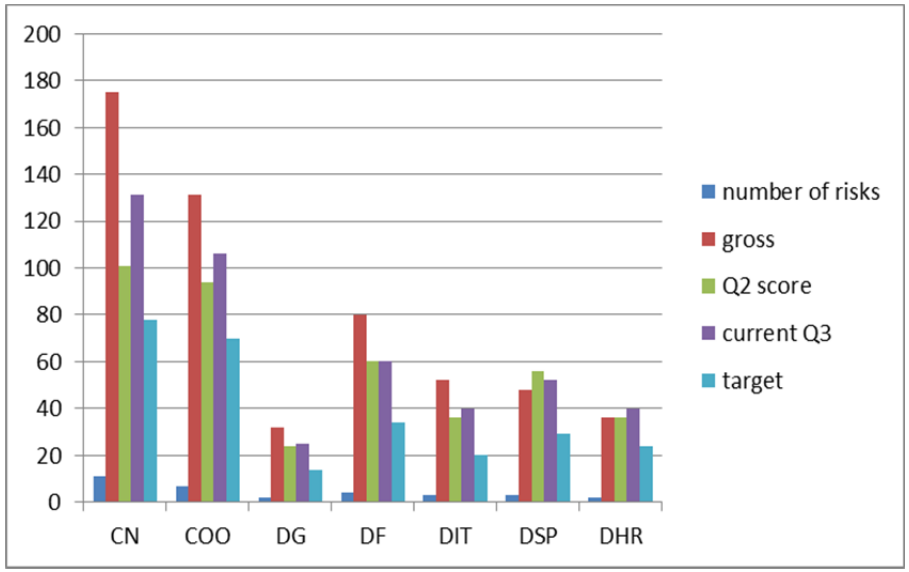
Risk Analysis by Trust Objective

	gross	Q2 score	current Q3	target
SO1	164	100	136	68
SO2	179	119	127	80
SO3	36	32	28	27
SO4	16	16	12	8
SO5	55	32	47	22
SO6	104	108	104	64
Totals	**554**	**407**	**454**	**269**



Risk Analysis by Director

	number of risks	gross	Q2 score	current Q3	target
CN	11	175	101	131	78
COO	7	131	94	106	70
DG	2	32	24	25	14
DF	4	80	60	60	34
DIT	3	52	36	40	20
DSP	3	48	56	52	29
DHR	2	36	36	40	24
Totals	**32**	**554**	**407**	**454**	**269**



Risk Assessment Matrix

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

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

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

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

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

Likelihood

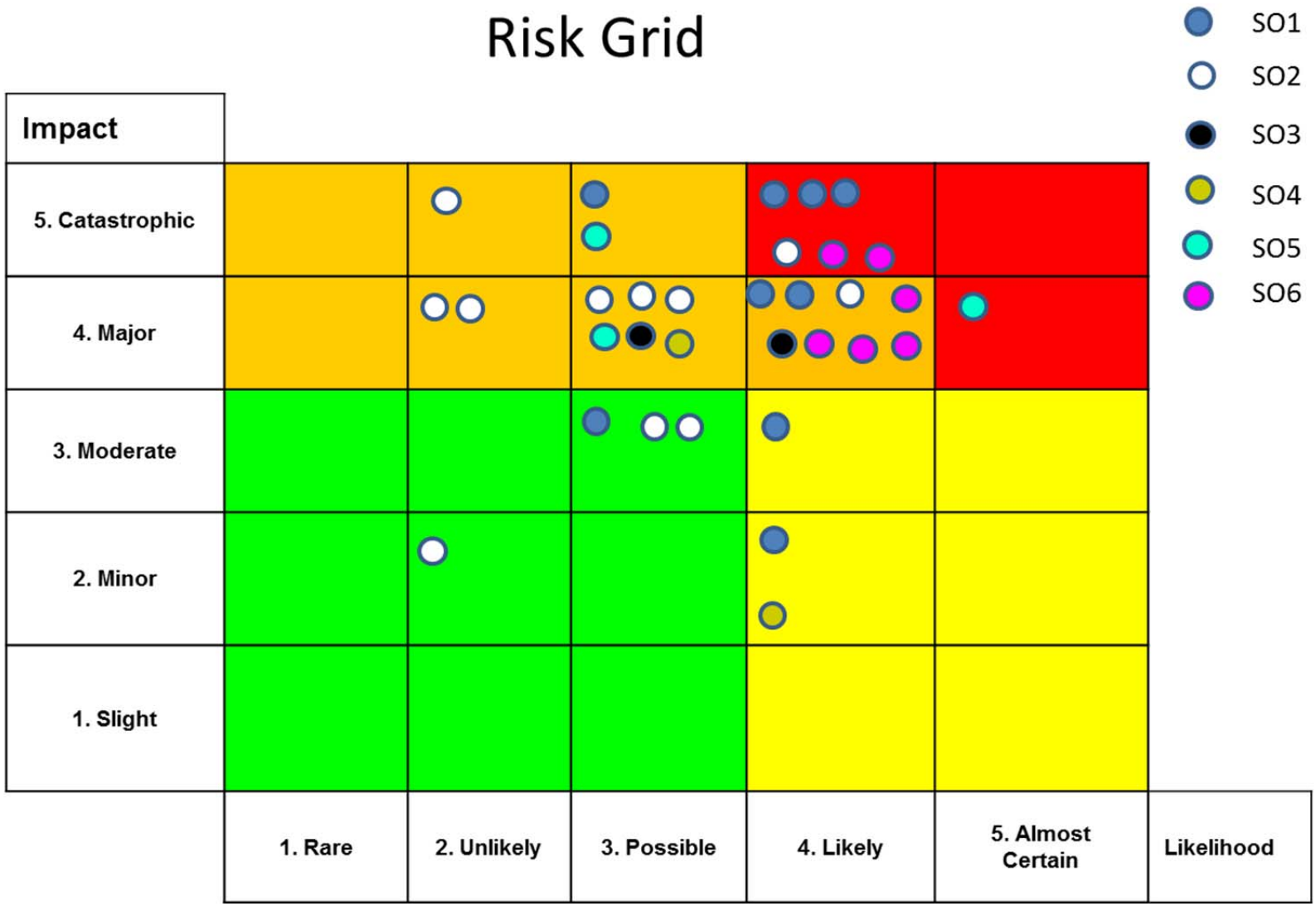
House Keeping Group
Basic mechanisms should be in place - Risk Management will confirm

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

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

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

Risk Grid


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

Paper for submission to the Board of Directors on 2nd February 2017

TITLE:	Quarterly Safeguarding Report to the Board of Directors – February 2017		
AUTHOR:	Pam Smith Deputy Chief Nurse	**PRESENTER:**	Dawn Wardell Chief Nurse

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

SUMMARY OF KEY ISSUES:

OFSTED INSPECTION CHILDREN'S SAFEGUARDING
The Trust continues to work with Dudley Safeguarding Children's Board and the local authority to address the actions identified by the Ofsted inspection into Children's Safeguarding in January 2016. Feedback from Ofsted at their last visit in October 2016 was positive and inspectors identified that significant progress had been made. Ofsted are due to re-visit the local authority in February 2017.

CQC REVIEW OF HEALTH SERVICES FOR CHILDREN LOOKED AFTER AND SAFEGUARDING IN DUDLEY
The action plan which was developed in response to the review of health services for Children Looked After and Safeguarding in Dudley by the Care Quality Commission (CQC) on 23rd May 2016 – 27th May 2016 was reviewed and updated in December 2016. Of the 25 recommendations 7 actions were not completed within the identified timescales. The delay in completion in these is due to work that is being implemented across the health economy. The Trust is an active participant in this work which is being led by the Clinical Commissioning Group. An update on the action plan has been shared with the CQC in the Trust's Engagement meeting with the local CQC inspector.

TRAINING COMPLIANCE
Safeguarding training compliance continues to be monitored at the Internal Safeguarding Board monthly. Overall the compliance percentages are between 77% and 85%. Recovery plans are in place. These are being updated to include a trajectory for the next three months which will be monitored by the Internal Safeguarding Board.

ACCESS TO CAMHS TIER 4 BEDS
Concerns regarding access to CAMHS tier 4 beds remain despite a CAMHS Tier 3.5 service being commissioned from Dudley and Walsall Mental Health NHS Trust. This is due to difficulties in recruiting to the team. CAMHS do now review a child/young people earlier in the ward than previously; however, they are unable to provide additional support to the children/young people at home. The risk for the Trust continues to be highlighted at the Safeguarding Children's Board. The Trust has to secure additional one to one support via bank/agency staff for children/young people in the children's ward regularly. This will be discussed at the Health Safeguarding Clinical Quality Review Meeting with the Clinical Commissioning Group in February 2017.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		Y	

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

The Dudley Group NHS
NHS Foundation Trust

SAFEGUARDING REPORT TO TRUST BOARD
FEBRUARY 2017

1. OFSTED INSPECTION CHILDREN'S SAFEGUARDING

The Trust continues to work with Dudley Safeguarding Children's Board and the local authority to address the actions identified by the Ofsted inspection into Children's Safeguarding in January 2016. Ofsted visited the local authority in October 2016 and explored a range of issues in the Multi Agency Safeguarding Hub (MASH) and court team as well as interviewing a number of staff and partners as part of the case tracking exercise. Feedback was positive and inspectors identified that significant progress had been made. A number of strengths were highlighted as well as some areas which still require improvement. Ofsted are due to re-visit the local authority in February 2017.

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

The action plan which was developed in response to the review of health services for Children Looked After and Safeguarding in Dudley by the Care Quality Commission (CQC) on 23rd May 2016 – 27th May 2016 was reviewed and updated at the Trust Children's Services Group in December 2016. Twenty five recommendations were identified. Of these 7 actions were not completed within the identified timescales, however, actions were progressing. The delay in completion in some of the actions is due to work that it is being implemented across the health economy. The Trust is an active participant in this work which is being led by the Clinical Commissioning Group. An update on the action plan has been shared with the CQC in the Trust's Engagement meeting with the local CQC inspector.

3. LEARNING DISABILITY

3.1 Learning Disability Strategy

The Learning Disability Strategy action plan has been updated and presented to the Clinical Quality and Patient Experience Committee in January 2017. There are currently 22 completed actions in green and 3 outstanding amber actions. There are 6 Monitor required standards for patients with learning disabilities incorporated within the on-going work of the Learning Disability Strategy and in the action plan – all 6 actions are in green.

Achievements to note include Easy read 'Welcome to Russell's Hall Hospital' leaflets available on all wards; a process to record on OASIS the patients preferred method of communication; accessible signage is under development with the Communications Team.

A final Listening into Action (LiA) meeting was held with parents of children with disabilities in November 2016. Parents have agreed to continue to meet with the Trust as a Parents by Experience panel – 'Shout up parents'

Actions within the amber actions includes the work of the Internal Learning Disability Mortality review panel which is reviewing the deaths in Trust of patients with a Learning Disability which occurred from April 2015 to April 2016; 14 cases were reviewed. The final panel met on 26thJanuary 2016. A report of the findings of the review is in progress. This will be reported to the Clinical Quality, Safety and Patient Experience committee by the Internal Safeguarding Board.

The mortality review panel process has been updated to ensure that the acute Liaison Nurse for Learning Disability and the Safeguarding Lead Consultant are in attendance at the panel when the case is reviewed.

4. TRAINING COMPLIANCE

4.1 Safeguarding Children compliance

Foundation Level 1 & 2 training compliance (as at 31st December 2016) is at 84.23%. This is a decrease of 1.33%.
Intermediate Level 3 training compliance (as at 31st December 2016) is at 84.18%. This is an increase of 18.38%.
A recovery plan is in place for all levels of safeguarding children training. This is being updated to include a trajectory for the next three months which will be monitored by the Internal Safeguarding Board.

4.2 Safeguarding Adults compliance

Safeguarding Adults training compliance (as at 31st December 2016) is 82.23%. This is a decrease of 1.1%. A recovery plan is in place. This is being updated to include a trajectory for the next three months which will be monitored by the Internal Safeguarding Board.

4.3 Mental Health Compliance

Mental Health training compliance (as at 31st December 2016) is 77.52%. This is a decrease of 1.14%

Timetabled sessions are currently fully booked so work is in progress to check that the percentage compliance is accurate. A recovery plan is in place. This is being updated to include a trajectory for the next three months which will be monitored by the Internal Safeguarding Board.

4.4 Safeguarding Maternity Compliance

Safeguarding Maternity compliance level 1 & 2 (as at 31st December 2016) is 84.23%. This is a decrease of 10%.
Safeguarding Maternity compliance level 3 as at 31st December is 84.18%. This is an increase of 8.89%. A recovery plan is in place. This is being updated to include a trajectory for the next three months which will be monitored by the Internal Safeguarding Board.

4.5 Learning Disability Compliance

3400 staff members have been identified as requiring Autism Awareness Training. A risk assessment has been developed and added to the corporate risk register. Autism awareness training is in the process of being added to the Mandatory Training programme and an E-Learning package has been sourced. Training for Learning Disability champions training dates have been identified.

4.6 Prevent Training compliance

Level 1 and 2 - Training compliance is 87% as at 31st December 2016.

Level 3 WRAP (Workshop to Raise Awareness of Prevent) - Training compliance is at 19% as at 31st December 2016. This is a 6.7% increase.

A recovery plan is in place. This is being updated to include a trajectory for the next three months which will be monitored by the Internal Safeguarding Board.

4.7 Interserve Safeguarding Training Compliance

Interserve safeguarding compliance is currently 93% as at October 2016. A further update on this is due to be presented to the Internal Safeguarding Board in February 2017.

5. ACCESS TO CAMHS TIER 4 BEDS

Concerns regarding access to CAMHS tier 4 beds remain despite a CAMHS Tier 3.5 service being commissioned from Dudley and Walsall Mental Health NHS Trust due to difficulties in recruiting to the team. CAMHS will now review a child/young people earlier in the ward than previously; however, they are unable to provide additional support to the children/young people at home. The risks for the Trust continue to be highlighted at the Safeguarding Children's Board. The Trust has to secure additional one to one support via bank/agency staff for children/young people in the children's ward regularly. The number of additional one to one shifts will be discussed at the Health Safeguarding Clinical Quality Review Meeting with the Clinical Commissioning Group in February 2017.

6. SECTION 11 AUDIT

The Trust's Section 11 audit action plan has been reviewed at the Internal Safeguarding Board and the Trust Children's Services Group in December 2016 to ensure that the actions are being implemented. The Internal Safeguarding Board is planning to complete the section 11 audit in March 2017. The results and action plan will be reported to the Clinical Quality, Safety and Patient Experience committee.

7. LAMPARD REPORT

The action plan which was developed in response to the Lampard Report continues to be monitored at the Internal Safeguarding Board. The three outstanding actions are now complete.

8. FEMALE GENITAL MUTILATION (FGM)

The FGM working group continue to progress work to raise the profile of FGM within the Trust. A risk assessment regarding poor recognition and awareness of FGM which may lead to failure in line to protect women and children at risk of FGM has been added to the Nursing & Midwifery Division risk register and actions are in progress to mitigate the risk. Progress continues to be reported to the Clinical Quality, Safety and Patient Experience committee.

9. JAY INQUIRY – Independent inquiry into child sexual abuse

This inquiry continues to be monitored at the Internal Safeguarding Board to ensure that any actions identified for acute Trusts will be implemented within the Trust. There is no action for the Trust to take at this time.

10. REVIEW OF SAFEGUARDING SERVICE

Karen Anderson, Matron Paediatrics & Neonates has been identified as the Matron Lead for Safeguarding children and Adults. The review of the safeguarding service remains in progress. It is anticipated that this will now be completed by March 2017.

Pam Smith
Deputy Chief Nurse
25th January 2017

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 2nd February, 2017

TITLE:	**Operational Plan 2016/17: Quarter Three Report**		
AUTHOR:	**Lisa Peaty Deputy Director: Strategy & Performance**	**PRESENTER**	**Lisa Peaty Deputy Director: Strategy & Performance**
CORPORATE OBJECTIVE: **All Objectives**			

SUMMARY OF KEY ISSUES:

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

Strategic Objective	RAG rating			
	Red	Amber	Green	No Status
Deliver a great patient experience	1	1	3	1
Deliver safe and caring services	2	6	9	0
Drive service improvement, innovation and transformation	2	2	4	0
Be the place people choose to work	1	4	1	2
Make the best use of what we have	3	3	2	0
Plan for a viable future	0	1	3	0
Total	9	17	22	3

The position in Quarter Three is an improvement from Quarter Two

- 5 more greens compared to Quarter Two
- The same number of reds and ambers compared to Quarter Two
- 5 fewer indicators are grey

Two measures of achievement are rated as red for the first time but mitigating actions are in place:

- Deliver a great patient experience
  - 95% emergency access standards

- Make the best use of what we have
  - Review the Clinical Strategy

Seven measures of achievement have improved such that they are now rated green in quarter three:

- Deliver a great patient experience
  - Demonstrate engagement through feedback

- Safe and Caring Services
  - Achievement of nursing care indicators (MUST Community)
  - Implement a standardised process for operational risk management

- Service improvement, innovation and transformation
  - Improvement in service performance: renal

- Making the best use of what we have

- Procurement of EPR completed
- Leverage from clinical systems and increasing orders from order comms

- Deliver a viable future
  - Play a clear role in the delivery of the MCP

The summary of the **forecast Quarter Four** position is:

Strategic Objective	**RAG rating**			
	Red	Amber	Green	No Status
Deliver a great patient experience	0	3	2	1
Deliver safe and caring services	3	4	10	0
Drive service improvement, innovation and transformation	1	3	4	0
Be the place people choose to work	1	1	5	1
Make the best use of what we have	3	1	4	0
Plan for a viable future	0	1	3	0
Total	8	13	28	2

The forecast Quarter Four position is a further improvement when compared to Quarter Three.

- 6 more greens compared to Quarter Three
- 1 fewer red compared to Quarter Three
- 4 fewer ambers compared to Quarter Three
- 1 fewer indicator is grey compared to Quarter Three

Nevertheless, the following measures of achievement are **forecast to be red at the end of Quarter Four**:

- Deliver safe and caring services:
  - Achievement of nursing care indicators: MUST Hospital (relates to Corporate Risk 086)
  - Zero avoidable stage 4 pressure ulcers (relates to Corporate Risk 087)
  - Deliver CQUIN schemes to expected levels (relates to Corporate Risk 109)

- Drive service improvement, innovation and transformation
  - Expand research & development Academic Health Sciences Network role: greater involvement and engagement

- Be the place people choose to work
  - Leadership development/OD/talent management

- Make the best use of what we have:
  - Deliver the agency threshold targets (relates to Corporate Risk 105)
  - Deliver the CIP & financial target (relates to Corporate Risk 080)
  - Review the clinical strategy

Risks and mitigating actions have been identified for those measures of achievement that are forecast as being red at the end of Quarter Four. Zero stage four pressure ulcers, agency threshold targets and delivery of the CIP currently have a risk score that is higher than their target risk score. These are being managed as part of the Trust's risk management process.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD OF DIRECTORS

Decision	Approval	Discussion	Other
Y		Y	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS

- The outcome of Quarter Three and forecast outcome for Quarter Four for each of the goals is noted.
- Confirm whether the proposed mitigating actions are sufficient to improve performance.
- Confirm whether any new risks should be added to the Corporate Risk register to reflect measures of achievement that are forecast to be red or red/amber at the end of Quarter Four.

The Dudley Group NHS
NHS Foundation Trust

Operational Plan 2016/17 Corporate Annual Goals: Quarter Three Outturn and Forecast for Quarter Four

Key to RAG rating:

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

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
Strategic objective: deliver a great patient experience								
➢ Achieve good FFT results/patients survey	✓ Monthly scores equal or better than national average	Monthly	Chief Executive	Q1	Q2	Q3	Q4	Risks to delivery: In Quarter 3, the trust achieved scores equal to or better than the national average in all areas - Inpatient, A&E, maternity, Community and Outpatients. National benchmarking figures for December are available in February 2017. Mitigating actions: We will continue to use patient feedback to drive improvement at local and corporate level
➢ Ensure patients, carers & public fully engaged &	✓ Improved National Patient Survey results	On-going	Chief Executive	Q1	Q2	Q3	Q4	Risks to delivery: 2016 survey results will be available in early 2017 and reported in Quarter Four.

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
involved								Mitigating actions: An Improvement Group, chaired by the Chief Nurse, meets regularly to deliver actions for improvement.
	✓ Demonstrate engagement through feedback	Annual	Chief Executive	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: 'You said, we have' feedback and improvements are reported to the Patient Experience Group whose membership includes external stakeholders, local and Trust wide improvement plans. Feedback is displayed in individual wards/areas and departments, including community locations. A comprehensive reporting schedule is in place to ensure data is shared from Ward to Board.
➢ Achieve key performance standards	✓ 95% emergency access standard met	Monthly	Chief Operating Officer	Q1	Q2	Q3	Q4	Risks to delivery include: • increase in DTOC • Ability to deliver ward rounds over the 7 days by senior medical staff • Sustained increase in ED attendance / emergency admission/WMAS conveyances Mitigating actions include: • Patient flow improvement plan. • A&E Delivery board partner actions • Internal additional plans being implemented to support Q4
	✓ 18 weeks RTT met	Monthly		Q1	Q2	Q3	Q4	Risks to delivery include the volume of elective cancellations due to insufficient Trust bed capacity; cost reductions on weekend theatre activity and the impact of the ASI clock start change. Mitigating actions: Internal daily plans enacted to mitigate cancellations
	✓ Cancer treatment standards met	Monthly		Q1	Q2	Q3	Q4	Risks to delivery: Reduced activity in January and backlog of treatments from December

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
								Mitigating actions: Continued surveillance of activity via weekly escalation meetings and monthly executive performance meetings
Strategic objective: deliver safe and caring services								
✓ Deliver quality improvements	✓ Achievement of nursing care indicators: Pain Score (Target ≥95%)	Quarterly measurement for year-end achieve-ment	Chief Nurse	Q1 92%	Q2 92%	Q3 92%	Q4	Risks to delivery: Unfilled vacancies. Staffing to Amber. Mitigating actions: NCI escalation process for individual wards includes these specific items. Two weekly meeting with lead nurses take place and a Recruitment and Retention Plan is in place.
	✓ Achievement of nursing care indicators: Efficacy of Analgesia (Target ≥95%)			Q1 92%	Q2 95%	Q3 97%	Q4	Risks to delivery: Mitigating actions:
	✓ Achievement of nursing care indicators: MUST (Hospital) (Target ≥95%)			Q1 88%	Q2 89%	Q3 85%	Q4	Risks to delivery: Unfilled vacancies and the use of bank/agency staff who do not complete the documentation. Staffing to Amber. Mitigating actions: NCI escalation process for individual wards includes these specific items. Two weekly meeting with lead nurses take place and a Recruitment and Retention Plan is in place.
	✓ Achievement of nursing care indicators: MUST (Community) (Target ≥95%)			Q1 100%	Q2 94%	Q3 96%	Q4	Risks to delivery: Mitigating actions:
	✓ Achievement of nursing care			Q1	Q2 95%	Q3 91%	Q4	Risks to delivery: Unfilled vacancies. Staffing to Amber.

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
	indicators: Medications Signed and Dated (Target ≥98%)			94%				Mitigating actions: NCI escalation process for individual wards includes these specific items. Two weekly meeting with lead nurses take place and a Recruitment and Retention Plan is in place.
	✓ Achievement of nursing care indicators: Omission codes (Target ≥95%)			Q1 92%	Q2 93%	Q3 85%	Q4	Risks to delivery: Unfilled vacancies. Staffing to Amber. Mitigating actions: NCI escalation process for individual wards includes these specific items. Two weekly meeting with lead nurses take place and a Recruitment and Retention Plan is in place.
	✓ Zero avoidable stage 4 pressure ulcers	Monthly		Q1	Q2	Q3	Q4	Risks to delivery: A single avoidable pressure ulcer has occurred in the hospital and a potential single one has occurred in the community for which the outcome of the review is awaited. Mitigating actions:
	✓ Reduction in stage 3 pressure ulcers from 15/16	Monthly		Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:
	✓ Zero post 48 hour MRSA cases	Monthly		Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:
	✓ No more than 29 post 48 hour *Clostridium difficile* lapses in care	Monthly		Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
	✓ Achievement of improvement trajectory in nutritional audit ending year in all wards as green (93%).	Monthly		Q1	Q2 96%	Q3 96%	Q4	Risks to delivery: Mitigating actions:
✓ Deliver agreed CQUIN requirements	✓ Deliver CQUIN schemes to expected levels	On-going	Director of Strategy & Performance	Q1	Q2	Q3 October/ November – 57% of schemes Green, 14% Amber and 29% Red.	Q4	Risks to delivery: Negotiations with commissioners to alter milestones as appropriate are yet to be finalised. Negotiations are underway to get agreement from commissioners to accept Local Incentive Payment Schemes. Targets for full achievement of CQUIN in the following schemes are at risk: - Health and Wellbeing Staff Survey - Health and Wellbeing Flu vaccinations - Sepsis ED - Consultant in Community: Paediatric Management - Consultant in Community: Respiratory Management - Maternal smoking Mitigating actions: Local Incentive payment schemes triggered where appropriate, plans shared with Commissioners and waiting sign off for Health and Wellbeing Staff Survey and Health and Wellbeing Flu vaccinations. The Sepsis Working Group is working on mitigating actions against an agreed action plan. Negotiations with commissioners are taking place to alter milestones for delays in recruitment of consultants to support community clinics.
✓ Maintain good	✓ SHMI/HSMR	On-going	Medical Director	Q1	Q2	Q3	Q4	Risks to delivery:

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
mortality performance	within expected range							Mitigating actions:
	✓ 85% of in hospital deaths have a multidisciplinary review within 12 weeks	On-going	Medical Director	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:
✓ Develop operational risk management process	✓ Implement a standardised agreement process and reporting framework to replicate the Corporate report	November 2016	Director of Governance	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: A report from Internal Audit will also provide independent assurance.
✓ Deliver requirements from key quality inspections eg WMQRS, CQC, Deanery	✓ Deliver inspection action plans as required and develop a monitoring tool with baselines (e.g. deliver x% within x timescale – to be agreed following baseline audit)	December 2016	Director of Governance	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: A baseline report will be presented to CQSPE in January 2017.
✓ Safe staffing levels	✓ Deliver safe staffing	Monthly	Chief Nurse	Q1	Q2	Q3	Q4	Risks to delivery: Increased activity and areas open requiring additional staffing. Mitigating actions: A dashboard is being used to monitor staffing levels. Staff are moved from green areas to mitigate any risks.
Strategic objective: drive service improvement, innovation and transformation								

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
➢ Develop integrated services & redesigned community provision	✓ Introduce case load management systems	June 2016	Chief Operating Officer	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:
	✓ Introduce SPA	June 2016		Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:
➢ Increase access to 7 day services In the key standards: • Inpatients seen by a consultant within 14 hours • Diagnostic services available 7 days a week • Interventional services available 7 days a week • On-going review of patients by consultants	✓ Maintain the position from the audit completed in April 2016	March 2017		Q1	Q2	Q3	Q4	Risks to delivery include: • Evidence (e.g. documentation) of standards. • Financial constraints to job plan sufficient Consultant time to deliver the <14hr review standard. • Ability to recruit sufficient Consultants Mitigating actions: Divisions have been asked to identify plans as part of annual planning. A Trust plan is required to further support
➢ Continued improvement in key services	✓ Improvements in service performance delivered for: Theatres	Review quarterly	Chief Operating Officer	Q1	Q2	Q3	Q4	Risks to delivery include utilisation performance being detrimentally affected by volume of elective cancellations Mitigating actions: A Theatre Utilisation programme with Deloitte's to support in T&O and Ophthalmology is near completion a

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
								number of actions agreed.
	✓ Improvements in service performance delivered for: Out Patients			Q1	Q2	Q3	Q4	Risks to delivery: Management time to embed and sustain performance Mitigating actions: Discussion required for further Management consultant time Q1 2017/18
	✓ Improvements in service performance delivered for: Renal			Q1	Q2	Q3	Q4	Risks to delivery: Ability to embed and sustain improvement efficiencies Mitigating actions: Divisional discussion taking place to understand and identify a plan to support
	✓ Improvements in service performance delivered for: Imaging			Q1	Q2	Q3	Q4	Risks to delivery: Ultrasound capacity and lack of qualified workforce Mitigating actions: Recruitment plan & use of agency staff and community imaging plan being implemented
➢ Expand Research & Development / Academic Health Sciences Network role	✓ Demonstrate greater involvement & engagement	On-going	Medical Director	Q1	Q2	Q3	Q4	Risks to delivery: AHSN membership is not considered cost effective (£30K PA membership fee). Mitigating actions: The BCA work stream for R&D regional engagement takes priority. 2017/2018 goals will be redrafted to focus on improving research performance (based on national measures) and maximising commercial income.

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
Strategic objective: be the place people choose to work								
➢ Develop a programme to enhance colleague engagement e.g. Board to Ward, Listening into action	✓ Regular events in place	On-going	Chief Executive	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: Meet the chair sessions were held in Quarter 3 and a Listening event was held by Pharmacy. There is on-going proactive use of digital and social media (i.e. Facebook, The Hub and Twitter). A 'back to the floor' event for Directors is being organised in Quarter 4 and MCP briefing events for staff are scheduled
	✓ Improved scores in National Staff Survey	Annually	Chief Executive	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: Results from the 2016 survey will be available in Quarter 4.
➢ Improve workforce performance in sickness, mandatory training, appraisal	✓ Sickness absence target 3.5% met by end of year.	Data collected monthly	Director of HR	Q1	Q2	Q3	Q4	Risks to delivery: The winter period has, and will continue, to bring an increase in absence levels. Mitigating actions: Sickness Absence Policy is being applied. Flu vaccines continue to be promoted amongst all staff.
	✓ Mandatory training target of 90% met be end of year	Data collected monthly		Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: A review of mandatory training will be implemented from January which will have a positive impact on performance.
	✓ Appraisal target of 90% met by end of year	Data collected monthly		Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: A review of appraisals will be implemented from January which will have a positive impact on performance.
	✓ Information Governance training target of 95% met by end of	Data collected monthly		Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: Due to capacity issues being experienced by the trust, the target for this measure of achievement has been reduced to

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
	the year							85%.
➢ Achievement of staff health & well-being CQUIN	✓ Achieve 5% improvement in each of the 3 health & well-being staff survey questions	Annual		Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: Results will not be known until the outcome of the staff survey in March/April 2017.
➢ Leadership development/OD/ Talent management	✓ Achieve a 50% target of potential successors in the Ready Now or Ready with Development category for all leadership posts at 8a & above on the talent map	Quarterly		Q1	Q2	Q3	Q4	Risks to delivery: The business case for Leadership Development has been postponed whilst the needs of the organisation are assessed further. Mitigating actions: The Leadership Strategy will be reviewed by the Director of HR.
Strategic objective: make the best use of what we have								
➢ Develop the Digital Roadmap	✓ Procurement of EPR completed	November 2016	Chief Information Officer	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:
	✓ Leverage from clinical systems & increasing orders from order comms. 5% each quarter	March 2017		Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:
➢ Match capacity to	✓ Optimise capacity	Quarterly	Chief	Q1	Q2	Q3	Q4	Risks to delivery include:

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
demand	to match demand		Operating Officer					• National workforce challenges in certain specialties (e.g. Ophthalmology, Paediatrics) • Physical space in Ophthalmology outpatient department Mitigating actions: • Hybrid Theatre • Ophthalmology capital build
➢ Deliver agreed financial plan	✓ Effective plans in place & monitored	Monthly	Director of Finance	Q1	Q2	Q3	Q4	Risks to delivery: Whilst still reporting a control total deficit of £800k at the year-end, the in-year position remains difficult and a number of measures are being recommended to Finance and Performance Committee to maintain this position. Mitigating actions: Additional income from CCG; the movement back to Amber/Green for nurse staffing; full implementation of Evergreen Ward; accounting treatment review; fines in respect of delayed transfers of care.
➢ Deliver the agency threshold targets	✓ Meet the trajectory	Monthly	Chief Nurse	Q1	Q2	Q3	Q4	Risks to delivery: Additional areas of the hospital are open to manage capacity pressures and activity which has increased the use of agency staff. Mitigating actions: Use of Corporate nursing teams 8-8 to support ED/EAU and other areas. 1-1s being monitored and challenged to ensure other alternatives to agency have been exhausted.
➢ Deliver the CIP	✓ Deliver CIP & financial target	Monthly	Director Strategy & Performance	Q1	Q2	Q3 Performance to Month 8; £886k behind plan and	Q4	Risks to delivery: Inability to deliver DEP Integrated Care Scheme (benefit released through bed closures) as a result of increased emergency activity and delayed transferred of care. Agency spend levels remain above monitor cap meaning the efforts to reduce Agency spend have not been able to be realised as a CIP saving. The capacity of the workforce to deliver existing CIP plans and

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
						£1.6m forecast shortfall in delivery of 2016/17 plan.		mitigation plans following the workforce reduction savings is an issue. Delays in implementing the Pathology Managed Service Contract have caused slippage in CIP savings for this scheme. Mitigating actions: Governance process have been enacted with mitigation plans required for any CIP schemes off track and additional project support has been identified/planned for schemes where slippage has occurred. A Business Improvement Training course has been offered to all staff across the organisation to develop LEAN tools and techniques skills across the wider organisation. Improve project governance has been implemented for the Pathology Managed Service Contract and a project plan is being developed. CIP planning for future years is in final stages, which is earlier than previously. This will enable more schemes to deliver full year effect savings in 2017/18. Deloitte commissioned to support this.
➢ Deliver the Lord Carter targets	✓ Deliver against the agreed targets	Annual	Director of Strategy & Performance	Q1	Q2	Q3 To month 8 the progress is; 64% in progress, 23% awaiting guidance	Q4	Risks to delivery include the capacity of the workforce to deliver action plans and support workshop events and lack of co-ordinated responses from NHS Improvement with requests being sporadic and *ad hoc*. Mitigating actions include: • Alignment of Lord Carter recommendations to current workstreams. • Attendance to quarterly NHS Improvement

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
						from NHSi and 13% complete		Networking events by Head of Service Improvement.
➢ Review the Clinical Strategy	✓ Revised plans in place	December 2016	Director of Strategy & Performance	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions: An exercise to create a Service Directory commenced in November 2016. This will be discussed at the Trust Board Workshop in February 2017. The Service Directory will help to provide an evidence base from which the Clinical Strategy can be developed.
Strategic objective: deliver a viable future								
➢ Develop an economy-wide Sustainability & Transformation Plan, (STP), with CCG & other providers in the Black Country footprint	✓ Play a full part in this work	July 2016	Chief Executive/ Director of Strategy & Performance	Q1	Q2	Q3	Q4	Risks to delivery: The STP plan was submitted on time, including plans for vertical and horizontal integration in Dudley. However, there are some concerns about the viability of some of the solutions (extent of QIPP schemes in the vertical integration group; the potential double count in the horizontal integration schemes with manpower and estates schemes). Mitigating actions:
➢ Play a part in the continued development of the Black Country Alliance	✓ Plan & Programme in place across alliance	Throughout 2016/17	Chief Executive	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:
➢ Dudley Partnership – ensure that the new care model	✓ An agreed position in place regarding the shadow	June 2016	Chief Executive	Q1	Q2	Q3	Q4	Risks to delivery: The MCP Procurement process is now underway with the PIN notice and supplier market event both having taken

Annual Goal	Measures of Achievement	Timescale	Lead	Q1, Q2 & Q3 RAG Q4 Forecast				Risks to Delivery and Remedial Actions
works in the best interest of the Trust	contract.							place. Whilst working well so far, there is no certainty that Dudley Group bid will be successful. Mitigating actions: We are working with Birmingham Community Healthcare to maximise the chances of a successful bid.
	✓ Play a clear role in the delivery of the MCP to ensure the financial impact is minimised.	March 2017	Chief Executive	Q1	Q2	Q3	Q4	Risks to delivery: Mitigating actions:

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 2 February 2017

TITLE:	**24 January 2017 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.

Committee highlights report to Board / Committee

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**24/1/2017**	**Richard Miner**	**yes**	**no**
			x	

Declarations of Interest Made

None

Assurances Received

- That R&D research studies continue albeit that attaining recruitment levels is still a challenge.
- That the Trust has identified its cyber threats and has a cyber security strategy albeit these threats continue to evolve.
- That progress continues to be made against the 2016/17 Internal Audit plan. This included receiving "Reasonable Assurance" reports in respect of Management Action Follow Up – Data Security and Payroll; "Partial Assurance" on right to work in the UK and "Substantial Assurance" in respect of Cash and Treasury and Income and debtors.
- That counter fraud (mainly pro-active) initiatives continue with a view to prevention.
- That based on the Risk and Assurance Group's debate on 10 January, the 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 particularly that there were no specific actions requiring referral to the Audit Committee. The Trust has received ISO27001 accreditation for its IT infrastructure.

Decisions Made / Items Approved

The Committee:

- Approved the reduction of some clinical audit work in the area of falls, for the 2016/17 Annual Clinical Audit Plan, following a request from HQIP to remove a specific audit from the national programme.
- Approved a number of minor changes, for issues previously identified, to the Internal Audit Plan.
- Approved and noted the write off of losses in Q3, particularly in respect of overseas visitors. The Trust has seen some increase in these but it seems to be as a consequence of the Trust's stronger identification procedures and controls over this area of debt.
- Noted and agreed the 2017 Audit Committee business cycle.
- Approved the Trust's updated approach to treasury management processes applied by the Trust.
- Approved a number of minor changes to the accounting policies for 2016/17.
- Reviewed and supported the approach to segmental analysis (how the Trust discloses its activities for the purposes of the annual accounts).
- Ratified the revisions to two policies relating to research and development, following recent Policy Group detailed review and recommendation to the Committee.

Committee highlights report to Board / Committee

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

- Data quality follow up work due to previous “red” opinions (VTE and TIA data quality). These are due Q4.
- The continuing risks to the Trust form fraud and the outcome of current investigations as identified in the Local Counter Fraud Specialist.
- The review of the EPR Groups’ Terms of Reference.

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

- The Risk Register and Assurance Register, together forming the Board’s Assurance Framework, be recommended to the Board.

Enclosure 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to Board
2 February 2017

TITLE:	**Complaints and claims report for Q3, ending 31 December 2016**		
AUTHOR:	Maria Smith (Complaints & litigation manager)	**PRESENTER:**	Glen Palethorpe - Director of Governance / Board Secretary

CORPORATE OBJECTIVE: SO1 – Deliver a great patient experience

SUMMARY OF KEY ISSUES: The key aspects from this report are:-

Complaints for Q3 ending 31 December 2016

It is essential to provide patients and service users with a mechanism to feed back their positive and negative experiences. The Trust has a robust complaints process which investigates and responds to issues raised and gives complainants the opportunity to meet with senior staff involved in a patient's care; many patients and families have been pleased to accept this offer.

The figures in [ ] refer to Q2.

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

83% [95%] The revised timescale for a reply (within 40 working days) has shown a big improvement in response times during Q1. ***NOTE a response time is indicative only, as the 2009 regulations state that timescales should be agreed with complainants. A local resolution meeting actually brings clarity and realism to these timescales.***

57% [34%] of complaints received and closed were upheld/partially upheld during Q3

7 [7] complainants expressed dissatisfaction with their response (received and investigated) during Q3

24 [36] local resolution meetings held with complainants during Q3

8 [3] Inquests held and closed during Q3

1 [0] rule 28 - reports on 'Action to Prevent Future Deaths' received from Senior Coroner during Q3

2 Complaints referred to the Parliamentary and Health Service Ombudsman

Claims - Q3 ending 31 December 2016

9 [14] CNST claims ***closed*** during Q3

6 [10] CNST claims ***opened*** during Q3

3 [2] Employer's/Public liability claims ***closed*** during Q3

2 [2] ***new*** Employer/Public liability claims during Q3

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Domains** **Safe, effective and caring**
	Monitor	**Y**	**Details: supports effective governance**
	Other **Ombudsman**	**Y**	**The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 No. 309** **2 complaints accepted for investigation by Ombudsman during the quarter**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS:

To note details of complaints and claims activity during Q3 ending 31 December 2016

Key Facts – Complaints, Inquests & Ombudsman

Key facts During qtr/year	Qtr 3 ending 31/12/15	Qtr 4 ending 31/03/16	Year ending 31/03/16	Qtr 1 ending 30/6/16	Qtr 2 ending 30/9/16	**Qtr 3 ending 31/12/16**
Total number of complaints rec'd within qtr/year	72	66	294	81	64	**66**
% Complaints ack'd within 3 working days	100%	100%	100%	100%	100%	**100%**
% Complaints rec'd and replied within 40 working days	25% ** [see note below]	38%** [see note below]	38% ** [see note below]	95%** [see note below]	85%** [see note below]	**83%** [see note below]**
Number of upheld/ partially upheld complaints replied within qtr/year	43*	36*	173* (59%)	54*	22*	**38***
Complaints accepted for investigation by PHSO	0	2	4	0	2	**2**
Privacy/dignity incl as a concern in complaint	1	3	4	3	0	**4**
Complaints referring to shared accommodation	0	0	0	0	0	**0**
Complaints incl safeguarding issue	1	2	3	1	1	**0**
Number of meetings held with complainants (% of complaints rec'd)	28 (38%)	37 (56%)	101 (34%)	36 (44%)	31 48%	**24 (36%)**
Total number and % of dissatisfied complaints rec'd	2	2	11 (4%)	9 (11%)	7 (11%)	**7 (11%)**
Total CCG/DWMH led complaints	1	3	7	3	4	**3**
New Coroner's cases opened	1	7	16	8	6	**7**
Coroner's Inquests held/closed	0	3	12	6	3	**8**
Coroner's Rule 28 (was rule 43)	0	0	1	0	0	**1**

Note

* Includes c/fwd from previous quarters

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

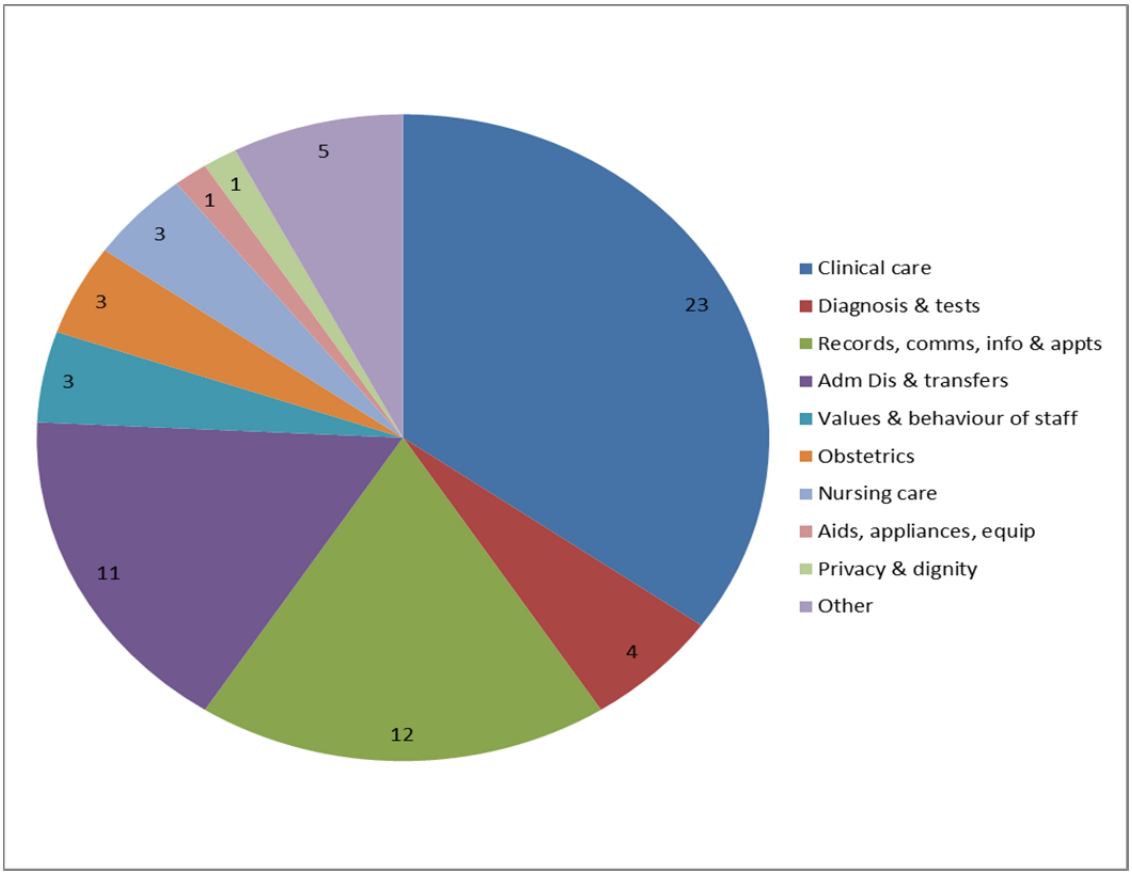
Category * [see note below]	Trust yr ending 31/3/15	National yr ending 31/3/15	Qtr 3 ending 31/12/15	Qtr 4 ending 31/3/16	Trust yr ending 31/3/16	Qtr 1 ending 30/06/16	Qtr 2 ending 30/9/16	Qtr 3 Ending 31/12/16
Clinical Care (Assessment/Monitoring)	**134 (43%)**	**45%**	23 (32%)	20 (31%)	**124 (42%)**	**30 (37%)**	**23 (36%)**	**23 (35%)**
Diagnosis & Tests	**56 (18%)**	NA	8 (11%)	3 (5%)	**30 (10%)**	**4 (5%)**	**4 (6%)**	**4 (6%)**
Records, comms, Information or appts (incl delay)	**17 (5%)**	**22%**	18 (25%)	17 (26%)	**56 (19%)**	**20 (25%)**	**10 (16%)**	**12 (19%)**
Admission, discharge & transfers	**33 (11%)**	**5%**	8 (11%)	6 (10%)	**27 (9%)**	**7 (9%)**	**10 (16%)**	**11 (17%)**
Values & behaviour of staff (prev 'staff attitude')	**20 (6%)**	**11%**	3 (4%)	4 (6%)	**15 (5%)**	**5 (6%)**	**5 (8%)**	**3 (5%)**
Obstetrics	**12 (4%)**	**3%**	3 (4%)	7 (11%)	**16 (5%)**	**1 (1%)**	**3 (5%)**	**3 (5%)**
Nursing care (incl District Nurses)	**2 1%)**	NA	1 (1%)	1 (1%)	**2 (1%)**	**3 (4%)**	**2 (3%)**	**3 (5%)**
Medication	**13 (4%)**	NA	0 (1%)	4 (6%)	**7 (2%)**	**2 (2%)**	**3 (5%)**	**0**
Patient Falls, Injuries or Accidents	**5 (1%)**	NA	2 (3%)	0	**5 (2%)**	**0**	**0**	**0**
Aids, appliances, equipment,	**4 (1%)**	**1%**	3 (4%)	1	**4 (1%)**	**2 (2%)**	**2 (3%)**	**1 (1%)**
Safeguarding	**1 (1%)**	NA	1 (1%)	0	**1 (1%)**	**0**	**0**	**0**
Theatres	**4 (1%)**	NA	0	1 (1%)	**1 (1%)**	**0**	**0**	**0**
Privacy & dignity	**6 (1%)**	1%	1 (1%)	1 (1%)	**2 (1%)**	**1 (1%)**	**1 (1%)**	**1 (1%)**
Pressure ulcer	**2 (1%)**	NA	0	0	**0**	**0**	**0**	**0**
Violence, aggression	**2 (1%)**	NA	0	0	**0**	**0**	**0**	**0**
Other (incl security, workforce, catering)	**2 (1%)**	**4%**	1 (1%)	1 (1%)	**4 (1%)**	**6 (6%)**	**1 (1%)**	**5 (8%)**
Total:	**313 (100%)**		**72 (100%)**	**66 (100%)**	**294 (100%)**	**81 (100%)**	**64 (100%)**	**66 (100%)**

Complaints received in Q3 shows a slight increase over those received in Q2 but a decrease on the same period Q3 in the previous year.

Note

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

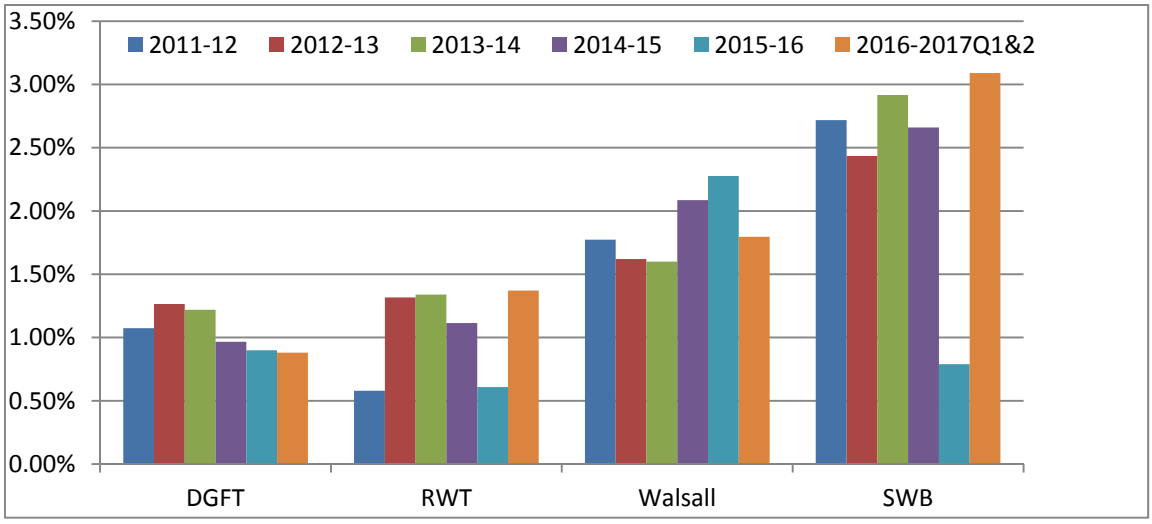
Analysis of complaints received by category – Q3



Examples of changes made as a result of a compliant

- Staff trained to fit and adjust hard collars
- Bed boards used to highlight patients requiring assistance/special diet.
- Snack boxes purchased for those who stay outside of meal times
- New, clearer signage on doors of imaging department to assist patients attending during the night
- Hot food to be provided to longer-stay patients on day case unit
- Second specialist recruited to assist with peaks in demand
- Number of rapid access slots increased to cope with demand
- Leaflet used by orthodontic team reviewed and revised to provide clearer guidance

Complaints as percentage of admissions



Complaints as a % of patient safety incidents year ending 31/03/2016 - Benchmarked to other

	Complaints	Pt Safety Incidents	% complaints against incidents
The Dudley Group NHS Foundation Trust	294	10704	3%
Sandwell & West Birmingham Hospitals NHS Trust	929	11495	8%
The Royal Wolverhampton NHS Trust	401	10407	4%
Walsall Healthcare NHS Trust	403	11566	3%
Worcestershire Acute Hospitals NHS Trust	660	11110	6%

Complaints as % of patient safety incidents

	The Dudley Group of Hospitals NHS FT		
	Complaints	Pt Safety Incidents	% complaints against incidents
Year ending 31 March 2016	294	10704	3%
Q1 ending 30 June 3016	81	2927	3%
Q2 ending 30 September 2016	64	3008	2%
Q3 ending 31 December 2016	66	3942	2%

Complaints as % total hospital activity

ACTIVITY	TOTAL year ending 31/3/15	Total Qtr 3 ending 31/12/15	Total Qtr 4 ending 31/3/16	TOTAL year ending 31/3/16	Total Qtr 1 ending 30/6/16	Total Qtr 2 ending 30/9/16	Total Qtr 3 ending 31/12/16
Total patient activity	736,510	185460	188840	745455	198194	189578	188952
% Complaints against activity	0.04%	0.03%	0.03%	0.03%	0.04%	0.03%	0.03%

Compliments received during Q3

1915 compliments received during Q3 which equates to 1% of patient activity.

Senior Coroner – Inquests opened/closed during Q3

8 inquests held and closed
7 inquests opened
1 rule 28 (formerly rule 43) 'preventing future deaths' letter received from the Senior Coroner.

In respect of the rule 28 report the Trust has responded along with the other NHS Trust involved in the case to the coroner with an action plan to improve processes to prevent such issues occurring again.

Parliamentary & Health Service Ombudsman (PHSO)

Total number of complaints made to the PHSO for ALL NHS Acute Trust's

	Total no complaints rec'd about Acute Trusts	Total no complaints accepted for investigation	Total no investigations fully or partly upheld	Total no investigations not upheld	Total no investigations discontinued or closed without a finding	Ave upheld rate for all investigated complaints involving acute Trusts
Q2 2016/17	2980	497	247	284	51	42%
Q1 2016/17	2711	594	205	299	35	38%

	Total no complaints rec'd about Acute Trusts	Total no complaints accepted for investigation	Total no investigations fully or partly upheld	Total no investigations not upheld	Total no investigations discontinued or closed without a finding	Ave upheld rate for all investigated complaints involving acute Trusts
Q4 2015/16	2780	685	285	275	51	47%
Q3 2015/16	2629	469	223	211	35	48%
Q2 2015/16	2672	337	217	226	36	45%
Q1 2015/16	2401	516	176	181	36	45%

	Total complaints rec'd by PHSO	Total complaints accepted for investigation by PHSO	Complaints part/fully upheld by PHSO	Complaints not upheld by PHSO	Discontinued/ Resolved by PHSO without findings
Q3 2014/15	10	1	0	0	0
Q4 2014/15	11	4	1	1	0
Q1 2015/16	7	1	1	1	0
Q2 2015/16	4	2	3	0	0
Q3 2015/16	3	0	2	0	0
Q4 2015/16	8	3	2	0	1
Q1 2016/17	6	1	0	1	0
Q2 2016/17	9	2	0	0	0

Benchmarking with other Trusts (Qtr 2 – 2016/17 latest available)

	Total complaints rec'd by PHSO	Total complaints accepted for investigation by PHSO	Complaints part/fully upheld by PHSO	Complaints not upheld by PHSO	Discontinued/ Resolved by PHSO without findings
Russells Hall Hospital	9	2	0	0	0
Heart of England	29	2	2	3	1
Sandwell & West B'ham	26	9	2	6	0
Royal W'ton	19	9	0	2	0
Walsall Healthcare	9	2	0	1	0

The summary analysis below of investigations carried out by PHSO shows communication is a common element they agree was an issue in several of their investigations.

Comp ref	Date complaint rec'd	Category	Upheld	Partly upheld	Not upheld	Report awaited
2183	13/02/2014	Nursing care		✓		
2136	26/02/2014	Diagnosis			✓	
2314	27/03/2014	All aspects of clinical care		✓		
2360	07/04/2014	Unhappy with diagnosis		✓		
2480	12/05/2014	Delay in diagnosis/treatment		✓		
2577	04/06/2014	Communication/information			✓	
2871	08/08/2014	Communication/information		✓		
3674	22/04/2015	Communication/lack of interpreters	Discontinued – ref back to Trust			
2190	04/01/2014	Clinical care			✓	
3273	10/11/2014	Medical/nursing care		✓		
4631	04/09/2015	Delay in diagnosis/treatment		✓		
5255	14/10/2015	Communication/information			✓	
4619	11/08/2015	Medical/nursing care			✓ *	
		TOTAL:	**0**	**7**	**5**	**0**

*Draft report decision

Closed claims – Q3

9 clinical negligence claims closed during Q3, costs were awarded against the Trust in 5 of these cases,

2 personal injury claims closed during Q3, costs were awarded against the Trust in one case

1 public liability claim closed during Q3 with no costs awarded against the Trust

New claims – Q3

6 clinical negligence claims were received Q3,

1 personal injury claim was received Q3

1 public liability claim was received Q3

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 2nd February 2017

TITLE:	**10 January 2017 End of Life and Palliative Care Group highlights report to the Board**		
AUTHOR:	Doug Wulff – Committee Chair)	**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 Group's terms of reference.

The Dudley Group NHS
NHS Foundation Trust

Group Highlights Report

Committee	Meeting Date	Chair	Quorate	
End of Life and Palliative Care Strategy Group	**10 January 2017**	**Dr Doug Wulff**	**yes**	**no**
			Y	

Declarations of Interest Made
Nil
Assurances Received
Assurance on progress of work streams relating to Key Milestones, Concerns, Work Completed, Work Planned were presented the update to the Group and a proposal that the priority for the the future work stream reporting should focus on three key areas, these being • Strategy Delivery / Implementation • Implementation of the Shared Record • Implementation of the Individualised care records
Decisions Made / Items Approved
1 Group approved the End of Life and Palliative Care Implementation Plan with some minor amendments and agreed that the End of Life and Palliative Care Strategy, implementation plan and self-assessment would be taken to the Clinical Strategic Board. 2 Group agreed to update the Terms of Reference to reflect the reporting relationship to the Clinical Strategic Board as part of the annual review of the Terms of Reference
Actions to come back to Committee (items Committee keeping an eye on)
Terms of Reference as part of the annual review.

Items referred to the Partnership Board for decision or action
That the future reporting relationship to the Clinical Strategic Board be approved by the Board.

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on Thursday, 2nd February, 2107

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

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			To Note

RECOMMENDATIONS FOR THE BOARD

To note contents of report.

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**

ENC 1

MINUTES OF THE BLACK COUNTRY ALLIANCE PUBLIC BOARD MEETING
HELD AT 10:30AM ON WEDNESDAY 14TH DECEMBER 2016
IN SEMINAR ROOM, TRUST HQ, SOUTH BLOCK, RUSSELL'S HALL HOSPITAL, DUDLEY

Present:	Mr R Samuda (RS)	SWBH Chair
	Mr T Lewis (TL)	SWBH CEO
	Dr P Harrison (PH)	DGFT CEO (Acting)
	Mrs J Ord (JO)	DGFT Chair
	Mr R Kirby (RK)	WHC CEO
	Mrs D Oum (DO)	WHC Chair (Chair)
In Attendance:	Mr T Whalley (TW)	BCA Programme Director
	Miss S Astley (SA)	BCA Executive Assistant
	Mrs L Abbiss (LA)	Comms Lead
	Mrs K Dhami (KD)	Governance Lead
	Mr M Sinclair (M)	Executive Sponsor

BCA/16/114 INTRODUCTIONS / CHECK IN — **ACTION**

Mrs Oum welcomed members to the meeting.

BCA/16/115 APOLOGIES

Apologies were noted from Mr Roger Stedman – CRG Chair

BCA/16/116 MINUTES OF LAST MEETING – 11TH NOVEMBER 2016

Page 1, paragraph 1 BCA/16/104, JO requested the minutes reflect that she requested the word "possibly" be included within minutes of 12th October regarding the statement around collaborating on creating a virtual BCA Bank. DO acknowledged that this request had been made, but could not recall agreeing to change the minute, so the amendment was not made. JO said that she had made clear at DGFT Public Board that she had stated DGFT's position that we explore possibility and that local minutes would reflect this. JO also acknowledged that matters were moving on and the subject would be further discussed on the agenda.

PH requested his title to read Acting rather than Interim Chief Executive.

Minutes of the meeting held on the 11th November were accepted as a true and accurate reflection other than for the point described above.

BCA/16/117 REVIEW ACTIONS DUE

Action 10 – TW reported the last children's services meeting was not well attended with little prospect of any immediate progressive action from that group. TW described the alternate approach he is proposing to take, meeting with each Trust separately to map out services and to get a Trust view on SWOT on which to then base a further group discussion. BCA Board agreed it was something they were keen for TW to continue and move forward. TL suggested the CEOs join the next scheduled meeting to reinforce the importance of acting together in respect of Children's services and long term clinical and financial sustainability and quality improvements through working together.

Action 32 – KD reported a paediatric ophthalmologist had been appointed. Once in post they will get together with the paediatricians to identify what can be carried out collaboratively under the BCA. Change due date on action sheet to April 2017. **TW**

Action 34 – PH agreed to take forward any information relating to Tier 4 CAMHS beds forward during dialog with NHSE regarding specialised commissioning **PH**

Further actions were noted as completed or not yet due.

BCA/16/118 CHAIR'S BUSINESS

There was no business from the Chair.

BCA/16/119 PROGRAMME DIRECTORS REPORT

Medical Training Initiative

Continues to progress well with Royal Colleague of Physicians supporting. TW requested an executive sponsor to help drive the project forward, the suggestion being a medical director. RK said he would approach Mr Khan and all agreed Mr Khan would be a good choice. **RK**

ACTION:

- ***RK to ask Mr Khan to be executive sponsor for MTI project.***

Rheumatology

TW reported that the Steering Group, chaired by Roger Stedman, have come to the conclusion that their project is complete with the service now settling into business as usual. There is no appetite to do more transformational activity until the current working arrangement has settled, on that basis they have suggested closing the project.

JO asked if the Group had undertaken an assessment to establish financial and non-financial benefits realised as this would demonstrate the value of the work done. TW reported this had not yet been done, but that the team would be asked to do this now. TL asked for a clear statement of benefit to patients be included in this. JO asked if a generic document exists to describe financial and non-financial benefits to help develop the case in terms of positive or not so positive impact for proposed project. TW replied that we have a Mandate that describes in high level terms the case for change, but that there was no generic set of benefits on which projects could base assessment of benefits. TL agreed it would be advantageous to have a standard generic document that takes our well established triple aim and expands into a set of generic benefits which projects could then assess themselves against and enable relative merits to be better judged by BCA Board and CRG. JO said it was important to do this prospectively and then test out the realisation of and performance against those expectations post implementation. TW reported on the emergence of QIA process which does some detailed quality impact assessments. PH said the QIA is a sensible route to assess detailed quality impacts, but that financial and non-financial benefits need to identified, quantified and then assessed in the way JO described. JO asked when the BCA Board might expect to see progress on this, TW stated by end of Q1 2017... RK wanted a thank you formally noted to TL/PH and the teams at SWBH and Dudley for making the Rheumatology arrangement work.

ACTION:

- ***TW bring back Rheumatology Benefits assessment, with focus on patient benefits.***
- ***TW define generic benefits to elaborate on triple aim and form the basis for prospective assessment of public value associated with future proposed work.***
- ***TW pass on Board thanks to project teams for work done.***

Upper Limb Trauma

No further progress has been made, the group appear to be focussed on repatriating a small amount of hand work. TW asked the Board if they still considered this to be a priority project given the need to focus on a smaller number of priority areas expressed previously. TL confirmed that SWBH intended still to progress Black Country Hand Centre, and while not perhaps the highest priority, suggested they continue with the work they are doing with others joining if they so wish. **Board endorsed this decision**.

Neurology

Good progress being made. TW asked given the current situation in respect of Walsall consultant neurologist posts if they wish to take the Rheumatology exemplar and do something similar as a BCA solution for Neurology. Clinical colleagues at Sandwell and Dudley have indicated they would be willing to have that conversation. RK reported he understood that Walsall is a fair way down the line in conversations with UHB who are soon to advertise jobs on Walsall's behalf. If that weren't the case, or if an alternative model could be proposed quickly and offer better benefits to patients, then that would be welcomed.

TL said SWBH have upcoming Neurology consultant retirements, and so they could construct a series of joint posts and advertise together which would be more attractive as we saw in Rheumatology with 4 consultants appointed on the back of a similar approach. BCA Board agreed they would need to work out quickly how to do work under the BCA. TL suggested David Nicholl from SWBH could help engage in conversation.

Action

- ***RK to confirm WHC position re Neurology dialog with UHB***
- ***TW to work with Neurology Steering Group to consider BCA option***

Clinical Coding

TW reported that the group are keen to link in with trailblazer apprenticeship as opposed to doing something stand-alone within the 3 trusts. JO commented we should link to this and make most of any national funding / support to take forward apprenticeship schemes. **The BCA Board endorsed this**. **TW**

Atrial Fibrillation

TW asked the BCA board to endorse that we immediately begin the process of advertising for an AF Nurse Specialist (Band 7) on a substantive basis who will be recruited as joint post across the Trusts. **Board endorsed this decision**.

Collaborative Working

TW reported that work to enable collaborative working is starting to move forward however, it does appear to be a lower priority for informatics colleagues and there continues to be constraints with video and tele conferencing access which prevents virtual facilities being routinely made available for collaborative meetings. TL stated it was key to effective collaboration that we avoid the need for increasing numbers of busy people travelling across the patch when we could easily enable remote / virtual collaboration. As BCA drives more and more of the STP horizontal collaboration agenda with RWT, this requirement will become ever more important and so we need to quickly resolve. CEOs requested TW draft a request which CEOs can use with their CIOs to encourage more focus and support. Board agreed this was a priority.

ACTION:

- ***TW draft request re: teleconference/video conference restraints***

BCA/16/120 CLINICAL REFERENCE GROUP CHAIR'S REPORT

TW presented the report on behalf of RS. The last CRG was not quorate with only SWBH MD and DoN in attendance. RS has agreed to take the role of Chair now that PH is acting CEO at DGFT. All matters were approved by CRG subject to email confirmation from those not attending in line with CRG agreed process for when not quorate. Exception being Bariatric mandate which requires discussion with MD at WHC who is proposing the project.

BCA/16/121 PERFORMANCE REPORT

TW presented the paper and confirmed the performance on costs is unchanged and remains in line with expected costs. TW also confirmed that benefits identified in year had more than covered the investment made. TW re-stated the need to be more articulate about non-financial benefits from projects and be able to provide assurance that those benefits are on track. This links back to previous discussion earlier on agenda. TW reported desk top assessment has been carried out of a PMO tool that would enable better tracking of all aspects of projects in one place, including benefits tracking. This would also allow better access to this information in formats accessible to BCA Board and indeed Trust Boards, a point made at recent DGFT Public Board. TW indicated the cost was minor, and could be accommodated within previously agreed budget.

The Board endorsed pilot of this tool. JO asked when we might see results. TW stated that supplier was on standby ready to work with us in January and that by end of Q1 we should have something to bring back to BCA Board.

JO asked if David Coley had been able to define level of benefits associated with joint procurement as he had indicated he would at November's meeting. TW reported that David Coley confirmed he had agreed a position with FDs in time for plan submissions end of November as he had said he would. This position was c£500k of additional benefit achievable through collaboration which would be effective by April 2017 to give full year effect. The remaining £1.5 of potential supply chain benefit remains subject to detailed analysis and clinical engagement.

TL stated all Trusts have invested significantly in this procurement role and require assurance of progress and rapid escalation of impediments to progress. A significant ROI is expected and required. TW reported that last Clinical Procurement Group was only attended by DGFT Exec Sponsor, so little progress had been made via that forum. TW also reported the procurement nurse specialist recruitment has also stalled and not yet gone out to advert. TW suggested it may be preferable to have David Coley attend BCA board bi-monthly to give assurance on progress and raise impediments. DO replied that the BCA Board would not become a programme management forum for procurement and that this would not be appropriate. TL confirmed the Procurement Steering Group needs to be the forum for David to report, with escalations as required via Programme Director to CEO forum. TL requested a paper be brought back to January Board setting out the larger savings around procurement, and specific plan to achieve. If significant non-pay reduction benefits cannot be achieved within the next 10 weeks he would then need to meet with the CEOs to discuss. RK said they would need to discuss areas they are unable to get focus on and whose teams are not getting involved so that CEOs can help remedy. Each trust has put forward an exec sponsor Russell Caldicott (WHC), Chris Walker (DGFT), Tony Waite (SWBH).

BCA Board endorsed the PMO tool.

ACTION:

- ***TW bring back benefits tracking update to March or April BCA Board.***

BCA/16/122 TEMPORARY STAFFING

MS presented the temporary staffing paper.

MS reported that since the paper had been written some things had moved on. MS reported from January 2017 the 3 Trusts might start to offer or encourage nurse staff to join each other's nursing bank. To make it easier for staff to work at alternate locations, we would need access to car parking across the 3 sites as well as consistent mandatory training and other details described in the paper. It would also require standardisation of some policies. MS reported that the Group were not now advocating a total ban on agency use within a specific timeframe, but that we would link with broader CEO level discussion about use of agency staff across the West Midlands. Until that was clear, we aim to work together to take a firmer stance on use of agencies.

TL confirmed SWBH plan to reduce their bank rates from 1st March 2017 to bring them in line with rates paid at Dudley and Walsall, provided we can be clear on that rate and complete assessment of risks associated. RK confirmed that WHC and DGFT published rates were pretty similar and significantly below those paid by SWBH. RK also indicated that WHC were taking a look at those rates to see if there was a case for increasing them as they were below those being paid by DGFT and generally accepted market rate. PH confirmed DGFT had taken action to reduce agency spend, with a £200k reduction in the previous month resulting. On that basis, PH advised that DGFT see no case to increase bank rates at this time. It was agreed that maximising our ability to fill shifts from a virtual bank would be improved by a harmonised rate, but it was not clear what that rate needed to be. TL requested that the detail on rates be completed by mid-January, this being the latest point for SWBH to serve notice on change to rate from 1st March.

DO asked for clarification that we are not proposing to create one single bank, but rather to enable virtual links between extant banks to enable more flexible working and shifts to be filled at neighbouring Trusts if required. MS confirmed that is the intention at this time.

JO wanted to understand why we need to do anything with bank rates when colleagues at RWT appear to have focussed on firm stance with agency use. JO also asked if we had compared the merits of each course of action. TL replied that he felt that BCA Trusts faced unacceptable risks taking an overly firm line on agency use until we had clarified broader West Midlands plans in this respect, this broader view being scheduled for CEO discussion led by Mr Loughton (CEO at RWT) due to take place in Feb 2017. MS confirmed that we have not done a detailed comparison of one

against the other, the view being that both establishing a virtual bank and getting firmer on use of agency needed to be a part of our plan.

JO asked if there was expectation this may enable people's career experience by offering more flexible working and experience in different locations. MS answered yes, and that they would be looking at contracts for consultants, junior doctors, and maybe nursing staff to create career opportunities cross the patch under the BCA. JO asked if there have been any tests of likely uptake of the bank offer. MS said they have not yet carried out any survey work and committed to carrying out a survey. **MS**

PH expressed some doubt as to the numbers of nurse staff who would wish to undertake shifts in different locations. TL stated that many agency staff do exactly that, and that some staff who work on the borders between our patches may well wish to take the opportunity if provided. While the majority may not choose to register to undertake shifts, a sizeable minority might.

RK confirmed we cannot go live with a virtual bank until clarity on rate has been reached, until we are clear about enabling costs and the likely uptake. RS asked if there were other variables to be considered such as travel expenses, logistics of access, admin to support manual processing etc. DO requested a revised paper be brought to a future meeting. MS agreed to report back to the board in January exact figure of proposed rate and an idea of how many are likely to take it up. PH commented that he was slightly anxious around timescales as there would be a lot of underlying work which needs to be carried out within each organisation. **MS**

Regarding the specific recommendations contained in the paper presented, the BCA Board agreed the following;

- All new starters will automatically 'register their interest' in joining all 3 Trust banks from January 17 with any relevant paperwork completed; **NOT endorsed** until further detail brought back, but intention remains to do this in Q1.
- Activation of the joint registration (required to fill shifts) will take place only once harmonisation of rates has occurred and final green light given to 'go live'; **NOT endorsed**, it is possible we may enable registration without harmonising rates, provided we have clarity on the actions agreed re rates, uptake and admin.

- We seek to harmonise rates of pay for bank nurses across BCA Trusts by the 1st April 17, specifically that SWBH rates are decreased and WHC/ DGFT rates are increased (Detailed financial modelling will be provided to the BCA Board early in Q1 2017 before any changes are made). **Not endorsed**, SWBH intend to reduce rates to a level to be decided, no decision yet taken at WHC and DGFT.
- The actions outlined in appendix 1 are undertaken between January and March 17; **Supported**, subject to priority on 3 actions agreed and demonstrated benefit.
- Existing bank staff will be invited to register across all 3 banks on a first come, first served basis with a timeline agreed between bank and ESR colleagues for when all staff will be transferred; **Supported in principle**, HRDs to consider when and how this will now be done but subject to further papers to be presented
- A total ban on nurse agency to be enforced from April 17 on the basis that a robust communications and engagement plan is implemented to shift mind-sets and with clear leadership and endorsement from Executives, particularly from HRDs, COOs, MDs and CNs; **NOT endorsed**, linked to wider regional discussion as to how best to tackle agency spend. Trusts agreed to continue to share thoughts about how to reduce agency need, but at this time no ban agreed.
- The existing preferential agreement between DGFT and A&E agency is extended across all BCA Trusts; **Supported in principle**, HRD at DGFT to advise when negotiations complete and when BCA Trusts can access.
- Establishment of a HR Director led Steering Group, with invitational representation from Chief Nurses and Chief Operating Officers and accountability to the BCA Board. **ENDORSED**, Mark Sinclair to act as Exec Sponsor.

ACTION:

- ***MS to report back in January the proposed rate***
- ***Further paper to be brought back to BCA Board in early 2017 confirming rate, uptake, required support to enable, and specific benefits.***

BCA/16/123 SUBSTANTIVE NURSING WORKFORCE

TW presented paper. This was a suggestion from the CRG to carry out a piece of work around substantive recruitment. Rachel Overfield produced the paper on behalf of the CRG stating areas we think there could be collaboration, the paper was produced with HRDs and DoN input. TW requested the board endorse, with MS asked to act as executive sponsor alongside the Temporary Staffing project.

JO said she was supportive of the work, but asked that a typo in the mandate which refers to children's health outcomes and experience be amended, TW to change the wording on the mandate. **TW**

JO suggested MS secure support from HEE-WM, particularly a nurse by way of clinical background, to ensure link with broader STP workforce development. This may also enable route to some support in some of the delivery needs. PH enquired as to RWT vacancy rates, and MS responded he believed they had 200-250 vacancies.

BCA Board endorsed the mandate.

ACTION:

- ***TW to make minor amendments in the mandate***

BCA/16/124 REFLECTIONS ON THE MEETING

There were no reflections to note.

BCA/16/125 ANY OTHER BUSINESS

There was no other business to discuss.

BCA/16/126 DATE AND TIME OF NEXT METING

11th January 2017 @ 10:30am

Meeting Room 10, MLCC, 3rd Floor, Walsall Healthcare

Chair: Mrs D Oum

ENC 6

The Black Country Alliance

Programme Director's Update – January 2017

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

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

KEY ISSUES:
None other than those covered in the paper

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BCA BOARD:

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BCA BOARD:

The Black Country Alliance Board is invited to receive and comment on the above update, and endorse our expression of interest to the NHS Leadership Academy Graduate Management Trainee Scheme.

1 Purpose

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

2 Project updates

2.1 Urology

Due to capacity challenges the December Steering Group did not take place. Ideas identified at the Urology Conference will be discussed further at the next Steering Group meeting on Thursday 19 January 201. The next Urology Complex Stones MDT will take place on Wednesday 25 January 2017.

2.2 Complex MDR TB

The proposal to develop an MDT forum for complex/multi-drug resistant (MDR) tuberculosis meets NICE guidelines by ensuring that best practice for infection control of patients is maintained at all times to prevent further transmission. The Terms of Reference and a QIA have been developed and were submitted to CRG where they were endorsed. The MDT will now be established, with expectation of quarterly forums with on demand reviews should they be required.

2.3 Audiology

The Audiology Steering group continues to collaborate on opportunities to improve outcomes and make better use of resources on a number of fronts. With Bone-Anchored Hearing Aids (BAHA) service, the proposal being considered is for Sandwell to refer their adult patients within the patch rather than outside. A workshop scheduled for 4th Jan explored the potential to establish a Black Country Wax Removal service and proposals for this will be developed over the coming weeks. Other areas still being considered include audit data software program (procurement of) where economies of scale may exist and collective response to CCGs in respect if Any Qualified Provider (AQP) concerns. A meeting is scheduled 18th Jan to discuss the latter.

2.5 Neurology

Neurophysiology; Following approval of the two neurophysiology posts at the November BCA Board, the job description and job advert have been developed and are in the process of being finalised. The Job Plan has been drafted and needs to be agreed. This information will be submitted to the Royal College of Physicians (RCP) for approval in early January 2017. As soon as approval is given by the RCP these two posts will be advertised in mid to end January 2017 with a view to interviewing in February. In parallel, a more detailed business case for the February 2017 BCA Board.

Multiple Sclerosis (MS); The opportunity exists to improve resilience in this nurse led service by employing an additional MS nurse collaboratively across 3 trusts, the group will discuss this at their workshop on 11th January.

Complex Headaches; The emerging proposal is to recruit two additional comlex headache nurse specialists who will then be trained by existing nurse specialist (SWBH) and then provide clinics aross BCA. This will greatly reduce pressure on general neurology clinics. A paper will be submitted to the BCA Board in February, possibly March, to support this.

2.6 ESR

As reported to the December BCA Board meeting, the NHS ESR Programme has recently launched a new ESR Assessment, designed to help user organisations better understand their use of the current ESR functionality, in particular Self Service and Oracle Learning Management (OLM), which enables comprehensive control over all the activities associated with the learning and development of staff. Optimal use of ESR can help to address workforce challenges such as reducing sickness absence, monitoring workforce diversity, managing staff costs, and improving the quality of workforce data.

Since the previous report, all 3 BCA Trusts have now signed up to undertake the assessment and these will be completed by early February. Following the Assessment, organisations will be given an Assessment Report, which includes a detailed section for the ESR, Workforce, and L&D Leads outlining current usage and providing a series of recommendations.

Any potential collaborative work that arises from the ESR audit will be considered alongside other initiatives to avoid any risk of duplication.

2.7 Interventional Radiology

In respect of the proposed pilot extension of the IR on-call service to Gastroenterology, the revised IR operational policy was reviewed at the BCA IR Steering Group on 29th November and following minor amendment this was disseminated to all group members for further consultation. Operational Leads from each Trust were asked to review the pathway, undertake an operational gap analysis and make arrangements to address funding for any posts required for the extended service. In updates received, RWT states that it is resourced adequately but DGFT and SWBH are developing business cases to secure the resource required. WHC view is that there will be no up-front costs, since WHC do not host any part of the rota.

To progress recruitment of Radiologists, Radiographers and other clinical staff required to support the Gastroenterology pilot, Operational Leads have provided Trust individual job descriptions and personal specs for staff posts. Due to a national shortage of appropriately trained staff, recruitment is identified as an area of risk in the delivery of the extended service, and as such, there is a significant risk that the date of launch will need to move back from original aspiration of April. SWBH in particular have expressed their concerns regarding recruitment and potential impact on start date associated with this.

To determine any training needs required to deliver the extended weekend on-call IR service to Gastroenterology, a training needs analysis has been carried out and a list of additional procedures [Arterial Embolization (upper GI and iatrogenic), US/CT guided drainage, PTC, Cholesystotomy and IVC filter insertion) circulated to all Consultant Interventional Radiologists. Responses have been received from 6 Consultant Interventional Radiologists from DGFT and RWT and all have stated competence and confidence in undertaking the procedures put forward. Responses are still awaited from WHT and SWBH.

2.8 Clinical Coding

Further progress has been made in respect of the national trailblazer group for Clinical Coding Apprenticeships. The Expression of Interest is almost complete and has been sent to NHS Digital and the 3 national Coding Academies for their feedback before the submission deadline (17th January). The BCA membership of the trailblazer group has been confirmed following the Board's endorsement of this in December.

We are now in the process of gathering the required information in order to support the full application process. This includes basic information including the names of lead

representatives, total numbers of employees in the BCA Trusts and projected number of enrolments onto the apprenticeship programme if approved. In terms of the latter, the consensus is to submit a relatively conservative estimate at this stage, most likely between 1 and 2 posts per Trusts. This allows each organisation to properly assess their requirements for apprenticeship posts as well as the level of resource required to support individuals in these roles. We would not be prevented from recruiting additional apprentices in future if desired.

3. Other News

HealthWatch - A very positive meeting took place on 4th Jan to explore citizen and patient engagement with HealthWatch in respect of BCA projects. Given the role of BCA within STP Horizontal Integration, this meeting explored further the link between BCA and STP and was attended by HealthWatch Wolverhampton in addition to Sandwell, Dudley and Walsall. As well as discussing some of the projects in progress which were positively received, we explored the potential to work with HealthWatch on developing an approach to earlier engagement to form a view of patient's preferences in more generic terms and in advance of (potentially emotive) service specific engagement. While the former wouldn't negate the need for the latter, it would enable a potentially segmented view of citizen's preferences to be available to lean on when considering range of possible priorities for future changes. There are various techniques available to support this kind of work, and the benefit of doing so is believed to be significant when it comes to equality & diversity assessments, demonstrating genuine early engagement when further more granular and formal consultations may become necessary and potentially in identifying seldom heard voices to involve in more detailed co-creation / engagement activity. HealthWatch CEOs are keen to support developing an approach with us and a further paper describing this will be brought back to either Feb or March Board.

Enabling collaborative working – We are now routinely including teleconference facilities in BCA project meetings. This has required a second line being made available given the number of meetings. Not all locations have the same level of capacity to host teleconference meetings and so until they do, meetings will be more typically hosted in a venue with the necessary facility and colleagues from other locations will be encouraged to dial in from their desks if they prefer to avoid travelling.

NHSLA Graduate Management Trainee Scheme – We were successful in 2016 in securing Sophia Emmanuel via the NHSLA GMTS. Expressions of Interest from organisations to host a Trainee during 2017 are now invited, with closing date of Wednesday 15th February 2017. The Scheme is delivered in partnership with the NHS Leadership Academy, Health Education England (working across West Midlands) and local NHS organisations to provide an integrated and holistic learning experience for trainees. The Government is supporting an increase in numbers to the scheme, but for 2017 the West Midlands can expect the same number of trainees as in previous years. In 2016 we were allocated 8 General Management trainees and 1 for each of the HR, Informatics and Finance work streams. Competition is expected to significant again, with many more organisations wanting GMTs than there are available. It is recommended that the BCA makes an expression of interest once again, with a submission of a Statement of Commitment then expected by Monday 1st May 2017 ahead of decision making process.

4. The Ask of the Black Country Alliance Board

The Black Country Alliance Board is invited to receive and comment on the above update, and endorse our expression of interest to the NHSLA GMTS.

The Black Country Alliance CAN – January 2017

Welcome to the latest edition of the Black Country Alliance CAN newsletter. Here is a brief update on the current projects being undertaken within the Black Country Alliance together with a roundup of other news items. This update follows the BCA Board meeting held on the 11th January 2017. The BCA Board will meet again in public on 15th February 2017. You can find papers from the public BCA Board on www.blackcountryalliance.org

Working together on developing our workforce

The BCA Board initiated a piece of work to explore how we could work better together to maximise the BCA recruitment and retention potential for the benefit of all trusts within the alliance.

Specifically, the BCA board has tasked our three Trusts with collaborating more around our use of Bank and Agency workers, and on working more closely together between our three banks. The long term intention is to scope how we would manage and deliver one Trust Bank for the Black Country with the overall aim being to reduce our reliance on expensive agency workers. A staff survey is being undertaken in January to ascertain the interest in this, which will allow initial results to be tabled at the next BCA Board meeting in February. In parallel with the work to increase the uptake of staff onto Trust banks, HR Directors are establishing a Steering Group with Chief Nurses to progress the substantive nursing work-stream, and will meet with Medical Directors to discuss options relating to the medical workforce.

HR Directors can be contacted for more information about the scope of these projects.

BCA Medical Training Initiative makes progress

We continue to make good progress developing a Black Country Alliance Medical Training Initiative (MTI), with all three trusts having taken steps independently to secure MTI Fellows.. Going forward, we will build on the existing work in each Trust to develop a BCA-wide MTI recruitment campaign, with candidates offered rotational posts. We are also working closely with Wolverhampton University to incorporate a post-graduate qualification for MTI fellows, thereby attracting more candidates to our Trusts. Mr Amir Khan, Medical Director for Walsall Healthcare is the executive sponsor of this work and can be contacted via email (amir.khan@walsallhealthcare.nhs.uk).

Atrial Fibrilation

A grant application made to Pfizer has been awarded to support quality improvement in the diagnosis, treatment and management of patients with Atrial Fibrillation in the Black Country.

The main component of the bid is funding for an AF nurse that will support an integrated model of care. The aim of the project is to develop existing pathways towards better integration and more streamlined movement between primary and secondary care. We are in the process of engaging with colleagues in primary care as well as working closely with other partners through the West Midlands Academic Health Science Network.

Neurology

Job descriptions and job adverts are currently under development for two Neurophysiology posts for BCA. Once approved by the Royal College of Physicians (RCP) they will be advertised with a view to interviewing thereafter.

HSJ Value in Healthcare Awards 2017

We are delighted to announce that our entry for the **Black Country Alliance (BCA) Interventional Radiology fast-track 24/7 Nephrostomy Service** from **Black Country Alliance** has been shortlisted in the **Acute service redesign** category. The winner will be announced in May.

Find out more about the Black Country Alliance at www.blackcountryalliance.org or follow us on twitter @TheBCAlliance or, contact our programme director on terry.whalley@nhs.net

Dr Paul Harrison
Acting Chief Executive
The Dudley Group

Toby Lewis
Chief Executive
Sandwell and West Birmingham

Richard Kirby
Chief Executive
Walsall Healthcare

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 2nd February 2017

TITLE:	**Transformation and Cost Improvement Programme (CIP) Summary Report**		
AUTHOR:	Amanda Gaston, Head of Service Improvement and Programme Management	**PRESENTER**	Amanda Gaston Head of Service Improvement and Programme Management (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 19th January 2017 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 9 position, the Trust has identified schemes totalling **£11,431k** against a Full Year (FY) target of **£11,908k**, leaving a shortfall against the target of **£476k**. Further, the Trust is forecasting to deliver **£10,156k** of the **£11,431k** it has identified to date. As a result, the Trust is forecasting an overall shortfall of **£1,751k** for 2016/17.

Of the 46 projects due to deliver savings in 2016/17, 43 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC).

Of the 43 PIDs approved by TEC, 39 have been approved by the Quality Impact Assessment (QIA) panel with the remaining PIDs not requiring QIAs.

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	**CQC**	**N**	**Details:**
	Monitor	**Y**	**Details:** Non delivery of CIP
	Other	**N**	**Details:**

and/or LEGAL REQUIREMENTS			

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

RECOMMENDATIONS FOR THE BOARD

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

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

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

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

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

The Dudley Group NHS
NHS Foundation Trust

Trust Board of Directors

Service Improvement and PMO Update

2nd February 2017

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 9 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	£11,431k	-£476k	£7,499K	£6,613k	-£886k	£10,227k	-£1,204k

Based on the Month 9 position, the Trust has identified schemes totalling **£11,431k** against a Full Year (FY) target of **£11,908k,** leaving a shortfall against the target of **£476k**. Further, the Trust is forecasting to deliver £10,156k of the £11,431k it has identified to date, creating a shortfall of **£1,275k** against identified schemes. As a result, the Trust is forecasting an overall shortfall of **£1,751k** for 2016/17.

Of the 46 projects due to deliver savings in 2016/17, 43 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC).

All Quality Impact Assessments (QIAs) have now been fully approved, with 38 QIA approved by the panel.

No additional risks have been escalated from the Workstreams.

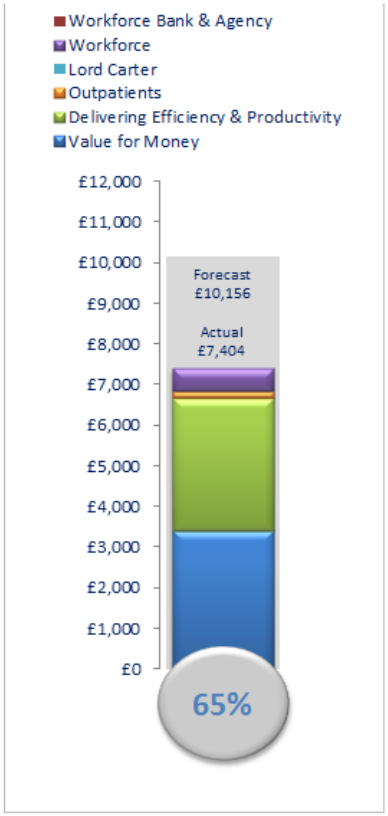
2017/18 CIP planning has identified a full year effect of between £7.3m - £9.4m with a part year effect of these schemes £7m - £8.9m, against a CIP target of £12.5m (c.70%).

Executive Summary

	YTD	FYE
Planned	£8,479,316	£11,431,963
Actual	£7,403,629	£7,403,629
Forecast		£10,156,460
Variance	-£1,075,686	-£1,275,504

	Submitted Plan	Overall Shortfall
Identified	£11,431,963	
Target	£11,907,990	
Variance	-£476,027	-£1,751,530

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	£4,690,059	£4,346,881	£3,437,750	£3,289,273	-£343,178	£2,993,347
Value for Money Infrastructure	Paul Taylor	£4,895,783	£4,531,392	£3,675,723	£3,388,954	-£364,391	£1,343,000
Workforce	Andrew McMenemy	£950,321	£775,825	£712,742	£561,101	-£174,496	£300,004
Outpatients	Anne Baines	£303,800	£202,362	£227,850	£164,302	-£101,438	£303,800
Lord Carter	Anne Baines	£0	£0	£0	£0	£0	£0
Workforce Bank & Agency	Paul Taylor	£592,000	£300,000	£425,250	£0	-£292,000	£592,000
View all Projects	Total	£11,431,963	£10,156,460	£8,479,316	£7,403,629	-£1,275,504	£5,532,151



2016/17 Forecast Non Recurrent	£2,801k	% of Total CIP Forecast as Non Recurrent	27.58%

2016/17 Schemes behind plan

2016/17 CIP is £1,275k behind plan. The main schemes that have contributed to the slippage are detailed below.

Project	Planned CIP	Forecast CIP	Slippage CIP	Project Deliverables	Risks/Issues	Mitigations
Creating an Integrated Service	£1,450k	£1,014k	£436k	• Clear provision of co-ordinated services across Community / Integrated Care services. • Ensuring that the right tools are being used to manage to ensure patients are in the right place, right time, first time • Capacity management for Community/Integrated care services. • Improve clinical outcomes. • Reduced admissions.	• Increase in Emergency Admissions resulting in closed ward area not coming to fruition	• Patients treated in a different care setting 'Evergreen unit' • Continuation of the plan into 2017/18
Managed Service Contract (MSC) Pathology	£300k	£0k	£300k	• Replacement of existing Pathology equipment • Reduce cost of equipment to a more competitive rate	• Procurement process is complex • Delays in agreeing and signing contract • 3rd party contractor existing commitments are delaying implementation dates • Minor works building works are behind initial schedule	• Additional Project Support identified • Negotiations with 3rd Party • Continuation of the plan into 2017/18
Workforce Bank & Agency	£592k	£300k	£292k	• Increased use of bank shifts at Agenda for Change rates • Reducing escalated bank rates or inflated agency rates	• Increase in Emergency Admissions has resulted in additional nursing shifts required • Ward Closures have not come to fruition as a result of increased demand	• Continuation of workforce strategy • Continuation of the plan into 2017/18

Enclosure 14

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 2 February 2017

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 26 January 2017.			

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

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

The Dudley Group NHS
NHS Foundation Trust

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**26 January 2017**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- Good progress has been made with the implementation of the junior doctors' contract
- The action plan for diagnostic waits is unlikely to return the Trust to be compliant until April 2017 because of the limitations on capacity
- December's financial position was in line with our plans and so the finance element of the STP will be paid
- There is an appeals process for the performance element of the STP which will be used by the Trust in respect of the A&E targets because of the unprecedented levels of activity in November and December 2016, and the very high levels of Delayed Transfers of Care
- Discussions will continue with the CCG and Local Authority to secure additional resources if possible for the Dudley area because of the potential for this to be augmented by national money through the STF Incentive scheme

Decisions Made / Items Approved

- None

Actions to come back to Committee

- None

Performance Issues to be referred into Executive Performance Management Process

- The agency spend position needs to continue to be managed and monitored, particularly the movement back to Amber/Green management of ward staffing levels
- The steps required to improve the A&E access target of 95% patients seen within 4 hours
- Action required to improve the level of appraisals completed by the year end, and for Directors to set a good example in this
- Steps to be taken to improve the level of nurse sickness

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

- None (all previously noted)

Items referred to the Board for decision or action

- To note the intention to eliminate unregistered nurse agency usage before 31st March 2017 and the steps being taken to ensure this doesn't impact of the quality of ward based care
- There is a risk that the Forecast Out-turn for 2016-17 of an underlying deficit of £0.726m (or a £9.774m surplus if you add the Sustainability and Transformation Fund) will not be achieved unless there is a slow-down in the monthly spend on agency staff, and is subject to receiving some additional support from the CCG

- There is a significant risk that the A&E Access target of 95% will not be achieved for the full year, and the diagnostic wait target of 99%will also be missed
- Good progress has been made in developing the Cost Improvement Plan for 2017-18 although it remains a significant challenge to achieve £12m savings in a single financial year

THE DUDLEY GROUP NHS FOUNDATION TRUST

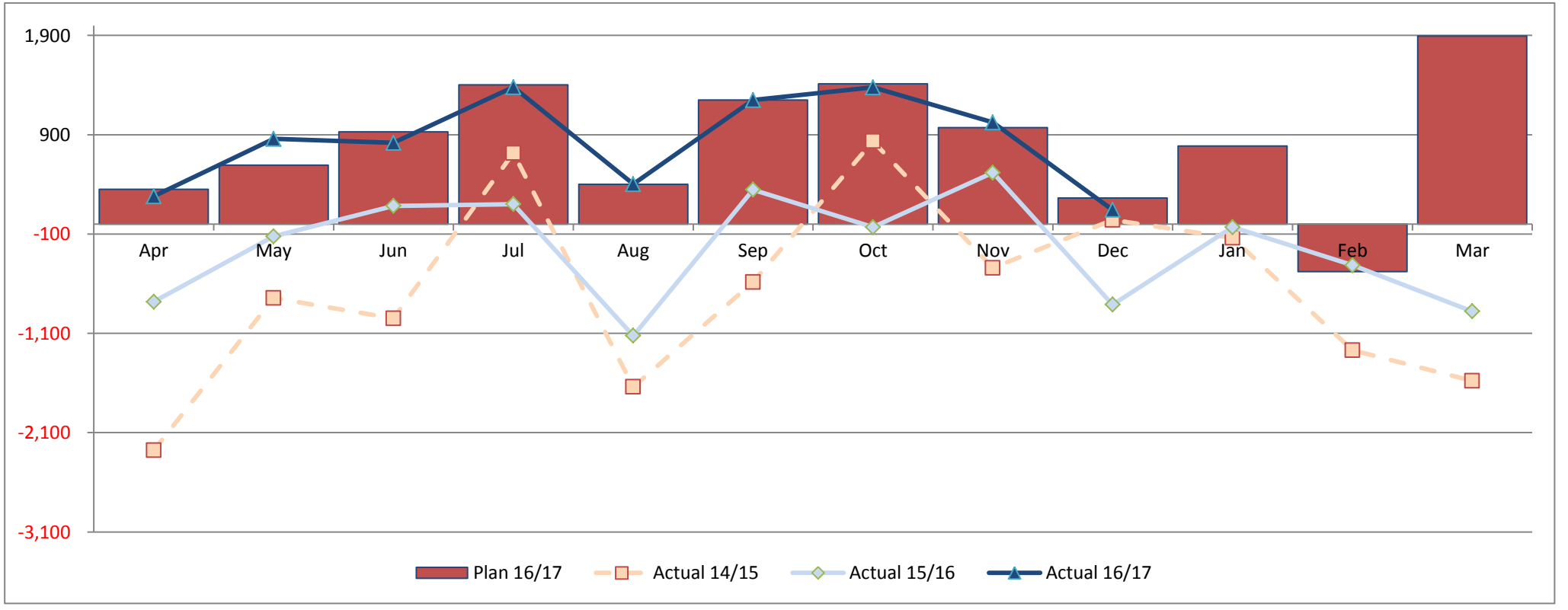
FINANCIAL SUMMARY **DECEMBER 2016**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£28,248	£28,455	£206
PAY	-£16,578	-£16,602	-£24
NON PAY	-£9,438	-£9,554	-£116
EBITDA	**£2,233**	**£2,299**	**£66**
OTHER	-£1,971	-£2,155	-£184
NET	**£262**	**£144**	**-£118**

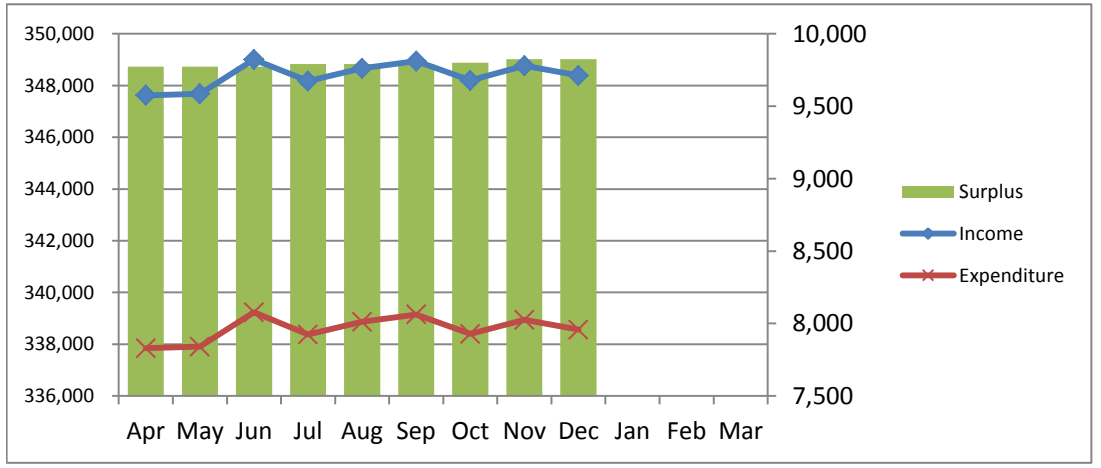
	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£259,576	£260,872	£1,296
PAY	-£149,229	-£151,348	-£2,119
NON PAY	-£85,035	-£85,137	-£102
EBITDA	**£25,312**	**£24,387**	**-£925**
OTHER	-£17,739	-£16,851	£888
NET	**£7,573**	**£7,536**	**-£37**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£345,991	£348,384	£2,393
PAY	-£199,245	-£202,002	-£2,757
NON PAY	-£113,320	-£113,862	-£542
EBITDA	**£33,426**	**£32,520**	**-£906**
OTHER	-£23,652	-£22,695	£957
NET	**£9,774**	**£9,825**	**£51**

NET SURPLUS/(DEFICIT) 16/17 PLAN & ACTUAL **DECEMBER 2016**



FORECAST MOVEMENT **DECEMBER 2016**



KEY FINANCIAL RATIOS **DECEMBER 2016**

	Annual Plan	Plan to Date	Actual to Date
EBITDA Margin *1	9.7%	9.8%	9.3%
EBITDA Achieved *2			96.3%
I&E Surplus Margin *3	2.8%	2.9%	2.9%
Pay/Income Ratio *4	57.3%	57.2%	57.6%

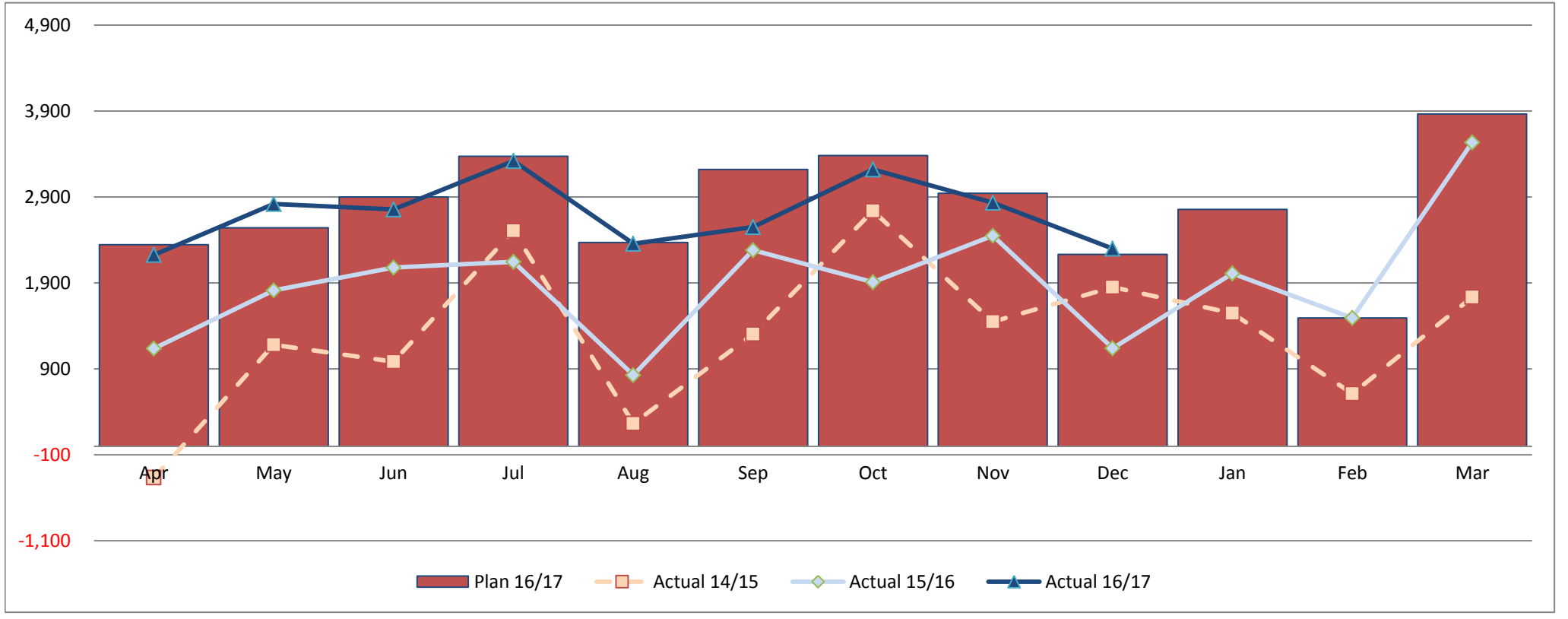
*1 EBITDA Margin = EBITDA/Total Income (excludes profit/loss/impairment)

*2 EBITDA Achieved = Actual YTD EBITDA/Planned YTD EBITDA

*3 I&E Surplus Margin = Net Surplus/(Deficit)/Total Income

*4 Pay/Income Ratio = Pay/Total Income

SUMMARY OF EBITDA 16/17 PLAN TO ACTUAL **DECEMBER 2016**



The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - December 2016

Quality & Risk			2016													
Description		LYO	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	YEF
Friends & Family – Community – Footfall		1%	1.7%	1.9%	1.8%	1.4%	1.1%	1.5%	1.1%	1.3%	1.1%	0.6%	1.3%	1.3%	1.2%	
Friends & Family – Community – Recommended %		96.4%	96.5%	97.9%	95.4%	96.8%	94.7%	94.4%	97.3%	96.1%	96.1%	95.1%	95.5%	94%	95.6%	
Friends & Family – ED – Footfall		7.5%	5.2%	7.4%	6.1%	5%	3.8%	1.6%	8.4%	10.7%	5%	5%	3.7%	4.3%	5.4%	
Friends & Family – ED – Recommended %		92.3%	95.8%	92.9%	97.9%	91.4%	91.3%	88.2%	91.7%	91.8%	91.9%	93.8%	93.1%	90.1%	91.8%	
Friends & Family – Inpatients – Footfall		25.7%	16.5%	17.6%	18.4%	17.7%	15.8%	13.9%	17.9%	18.6%	20.5%	19.2%	19.2%	17%	17.7%	
Friends & Family – Inpatients – Recommended %		97%	95.9%	95.5%	94.1%	96.8%	96.7%	97%	94.6%	96.6%	96.6%	97.9%	95%	97.9%	96.5%	
Friends & Family – Maternity – Footfall		21.6%	17%	20.4%	15.9%	17.6%	33.2%	16.6%	33.8%	32.7%	32.3%	27.6%	36.5%	33.9%	29.4%	
Friends & Family – Maternity – Recommended %		98.2%	97.8%	98.2%	98.4%	97.5%	97.3%	98.9%	96%	98.6%	98.8%	98.8%	99.5%	99.4%	98.3%	
Friends & Family – Outpatients – Footfall		-	-	-	-	1.2%	1.1%	1%	1.7%	1.5%	1.4%	1.5%	2.5%	1.5%	1.5%	
Friends & Family – Outpatients – Recommended %		87.6%	90%	84.1%	88.9%	85%	82.2%	93.1%	91.7%	92.4%	92.4%	93.2%	94.9%	93.1%	91.5%	
HCAI – Post 48 hour MRSA		2	0	0	0	0	0	0	0	0	0	0	0	0	0	
HCAI CDIFF - Total Number of Cases		-	4	1	0	2	3	2	2	-	-	-	-	-	-	
Incidents - Patient Falls, Injuries or Accidents		-	129	-	-	-	-	-	-	-	-	-	-	-	-	
Incidents - Pressure Ulcer		2,047	187	242	246	253	240	194	193	196	188	192	202	212	1,870	
Mixed Sex Sleeping Accommodation Breaches		4	2	0	0	0	0	0	0	0	0	4	4	7	15	
Never Events		1	0	0	0	0	0	0	0	1	0	0	0	0	1	
Serious Incidents – Not Pressure Ulcer		104	9	4	7	7	6	4	12	11	6	7	9	8	70	
Serious Incidents - Pressure Ulcer		228	26	12	19	13	9	8	10	17	16	14	8	9	104	
Stroke Admissions : Swallowing Screen		80.58%	83.78%	76.32%	86.67%	89.36%	88.37%	85.11%	78.72%	73.91%	62.5%	75.68%	73.33%	73.17%	78.44%	

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - December 2016

Quality & Risk			2016													
Description		LYO	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	YEF
Stroke Admissions to Thrombolysis Time		56.31%	45.45%	37.5%	50%	60%	50%	83.33%	36.36%	54.55%	50%	66.67%	37.5%	25%	49.23%	
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		89.16%	92.68%	84.09%	70.83%	82.76%	91.11%	91.53%	90.2%	88.64%	89.36%	97.5%	86.54%	87.5%	89.19%	
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation		85.35%	85.71%	66.67%	94.12%	84.62%	78.57%	36.36%	63.64%	66.67%	83.33%	93.33%	80%	90.91%	76.15%	
VTE Assessment Indicator (CQN01)		95.96%	95.4%	94.43%	94.46%	94.65%	95.5%	95.09%	93.91%	94.5%	93.91%	95.63%	95.63%	94.55%	94.82%	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - December 2016

Finance			2016										
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	YEF
Budgetary Performance		£773k	(£71)k	£266k	(£110)k	(£23)k	£3k	(£1)k	(£35)k	£52k	(£118)k	(£37)k	
Capital v Forecast		69.5%	61.8%	66.5%	76.2%	76.4%	73.9%	72.1%	69.6%	57.4%	88.4%	88.4%	
Cash v Forecast		122.3%	94.8%	93.2%	96.2%	74.9%	89%	93.7%	80.4%	93%	92.7%	92.7%	
Debt Service Cover		1.18	1.4	1.58	1.63	1.74	1.69	1.72	1.77	1.77	1.71	1.71	
EBITDA		£20,460k	£2,228k	£2,820k	£2,755k	£3,321k	£2,358k	£2,550k	£3,221k	£2,835k	£2,299k	£24,387k	
I&E (After Financing)		(£2,945)k	£280k	£859k	£818k	£1,380k	£403k	£1,249k	£1,378k	£1,023k	£144k	£7,536k	
Liquidity		7.07	7.1	8	8.84	10.39	10.93	11.94	13.23	14.14	12.51	12.51	
SLA Performance		£1,031k	(£122)k	£327k	£145k	£12k	£231k	(£201)k	(£13)k	£281k	(£167)k	£493k	
SLR Performance		(£2,945)k	£281k	£859k	£819k	£1,381k	£403k	£1,249k	£1,378k	£1,024k	£144k	£7,537k	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - December 2016

Performance			2016													
Description		LYO	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	YEF
A&E - 4 Hour A&E Dept Only % (Type 1)		96.79%	91.76%	92.74%	91.53%	93.24%	92.88%	94.48%	93.34%	92.97%	92.14%	92.3%	86.08%	82.86%	91.13%	
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%	95.73%	96.06%	95.62%	96.3%	96.06%	96.76%	96.21%	95.81%	95.29%	95.51%	91.97%	90.78%	94.93%	
Activity - A&E Attendances		96,141	8,088	7,946	8,626	7,807	8,801	8,430	8,973	8,580	8,597	8,934	8,479	8,725	77,326	
Activity - Community Attendances		407,248	33,694	32,322	30,817	32,681	32,631	32,846	31,673	33,863	33,078	32,365	34,044	33,291	296,472	
Activity - Elective Day Case Spells		45,020	3,677	3,938	3,820	3,801	3,720	3,998	3,798	3,895	3,912	3,722	3,924	3,443	34,213	
Activity - Elective Inpatients Spells		6,394	500	515	534	514	523	549	561	482	506	540	519	458	4,652	
Activity - Emergency Inpatient Spells		52,037	4,573	4,359	4,714	4,823	5,246	5,076	5,056	5,002	4,937	5,040	5,123	5,200	45,503	
Activity - Outpatient First Attendances		130,956	11,304	11,569	12,255	10,329	10,632	10,618	9,943	10,073	10,904	10,615	11,927	10,101	95,142	
Activity - Outpatient Follow Up Attendances		313,888	26,438	26,699	26,435	26,540	26,976	27,061	25,260	25,543	26,762	25,712	27,923	23,845	235,622	
Activity - Outpatient Procedure Attendances		52,451	4,117	4,691	3,324	4,989	4,960	5,219	5,099	4,906	5,016	4,861	5,087	3,918	44,055	
RTT - Admitted Pathways within 18 weeks %		94.2%	94.4%	92.8%	91.5%	92.5%	93.5%	94.2%	94.2%	95%	93.2%	93.9%	92.6%	92.9%	93.6%	
RTT - Incomplete Waits within 18 weeks %		95.1%	95%	95.6%	95.4%	97.1%	96.8%	97.1%	97.1%	96.6%	96.1%	95.6%	95%	94.5%	96.2%	
RTT - Non-Admitted Pathways within 18 weeks %		97.7%	97.3%	97.4%	96.7%	96.7%	97.7%	98.1%	98%	98.4%	97.1%	95.9%	96.3%	96.3%	97.2%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		98.97%	99.52%	99.53%	99.03%	98.04%	99.39%	99.16%	98.96%	97.69%	98.12%	98.59%	97.38%	93.5%	97.84%	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - December 2016

Staff/HR			2016													
Description		LYO	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD	YEF
Appraisals		77.5%	79.9%	79.2%	77.5%	80.9%	80.5%	81%	78.1%	78.3%	77.4%	77%	77.1%	73.9%	73.9%	
Mandatory Training (Professional Requirements)		-	-	-	-	-	71.3%	72.8%	72.5%	72.4%	70.1%	69.7%	70.7%	69.9%	69.9%	
Mandatory Training (Substantive)		83.3%	83.9%	83.3%	83.3%	83.8%	75.4%	76.3%	77.4%	78.6%	77%	78.5%	79.6%	79.4%	79.4%	
Sickness Rate (Performance Dashboard)		3.80%	4.54%	4.38%	4.01%	3.86%	4.15%	4.01%	4.05%	3.71%	4.02%	4.35%	4.27%	4.43%	4.10%	
Staff In Post (Contracted WTE)		4,116.31	4,087.57	4,125.26	4,116.31	4,093.54	4,091.47	4,083.01	4,083.49	4,112.05	4,146.74	4,199.22	4,236.4	4,230.95	4,230.95	
Vacancy Rate		9.41%	10.05%	9.24%	9.41%	10.24%	10.53%	10.78%	10.75%	10.31%	9.61%	9.18%	9.09%	9.18%	9.18%	

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

The Dudley Group NHS
NHS Foundation Trust

Finance & Performance Report - December 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%	97.2%	97.5%	96.3%	100%	97.9%	88%	100%	98.5%	94.8%	98.6%	**97.3%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	-	98%	-	-	-	-	-	-	-	-	-	**98%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	100%	100%	100%	80%	100%	100%	100%	-	100%	100%	89.7%	**96.4%**
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	98%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	94%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	96%	100%	-	-	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	85%	-	100%	-	100%	80%	100%	100%	64.7%	-	100%	100%	100%	**91.2%**
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%	-	-	90.9%	42.9%	55.6%	100%	33.3%	100%	-	100%	100%	86.2%	**85.7%**