The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 4 May, 2017 at 9.30am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies – P Taylor, A Becke**		J Ord	To Note	9.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	9.30
3.	**Announcements**		J Ord	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 6 April 2017	Enclosure 1	J Ord	To Approve	9.30
	4.2 Action Sheet 6 April 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	D Wake	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 4	D Wulff	To Note & Discuss	10.00
	7.2 Safeguarding Report	Enclosure 5	S Jordan	To Note	10.10
	7.3 2016/17 Annual Plan Final Quarter's Monitoring Report	Enclosure 6	L Peaty/ A Baines	To Note	10.20
	7.4 Complaints Report	Enclosure 7	G Palethorpe	To Note	10.30
	7.5 End of Life and Palliative Care Report	Enclosure 8	D Wulff	To Note	10.40
	7.6 Staff Survey Report	Enclosure 9	L Abbiss/ A McMenemy	To Note	10.50
	7.7 Annual Declarations	Enclosure 10	G Palethorpe	To Note	11.00
	7.8 Workforce Committee Exception Report	Enclosure 11	J Atkins	To Note	11.10
	7.9 Revalidation Report	Enclosure 12	P Stonelake	To Note	11.20

8.	**Finance and Performance** 8.1 Cost Improvement Programme and Transformation Overview Report 8.2 Finance and Performance Committee Exception report	 Enclosure 13 Enclosure 14	 A Gaston J Fellows	 To Note To Note	 11.30 11.40
9.	**Any other Business**		J Ord		11.50
10.	**Date of Next Board of Directors Meeting** 9.30am 1 June 2017 Clinical Education Centre		J Ord		11.50
11.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		11.50

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 6th April, 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
Ann Becke, Non Executive Director
Diane Wake, Chief Executive
Paul Bytheway, Chief Operating Officer
Paul Harrison, Medical Director

In Attendance:

Helen Forrester, EA
Glen Palethorpe, Director of Governance/Board Secretary
Andrew McMenemy, Director of HR
Liz Abbiss, Head of Communications and Patient Experience
Mark Stanton, Chief Information Officer
Anne Baines, Director of Strategy and Performance
Dr Mark Hopkin, Associate Non Executive Director
Pam Smith, Deputy Chief Nurse
Andrea Gordon, BCA Programme Director
Amanda Gaston, Head of Service Improvement (Item 17/042.1)

17/034 Note of Apologies and Welcome
9.33am

Matt Banks – Operational Medical Director gave his apologies

The Chairman welcomed Diane Wake, new Chief Executive and Dr Mark Hopkin, new Associate Non Executive Director, to their first Board meeting.

17/035 Declarations of Interest
9.33am

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

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

There were no other declarations of interest.

17/036 Announcements
9.34am

The Chairman thanked Paul Harrison for his work as Acting Chief Executive over the previous six months.

The Board noted the contribution of Dawn Wardell as Chief Nurse who is now working with NHS England.

17/037 Minutes of the previous Board meeting held on 2nd March, 2017 (Enclosure 1)
9.35am

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.

17/038 Action Sheet, 2nd March, 2017 (Enclosure 2)
9.37am

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

The Board noted that the Guardians Reports will be presented to the June Board meeting rather than May as initially stated.

17/039 Patient Story
9.38am

Liz Abbiss, Head of Communications and Patient Experience, presented the patient story. The video had been produced for the HSJ Awards and focussed on Day Case Surgery.

The Chairman and Board noted the story. The Board acknowledged the Unit's assistance during the winter period. The Director of Strategy and Performance commented on the quality of care aspect of the Unit having experienced receiving care there herself. Mr Atkins, Non Executive Director, confirmed that it was encouraging to see such improvements to patient experience. The Chief Operating Officer confirmed that similar improvements were now being made within the main Theatre environment.

17/040 Chief Executive's Overview Report (Enclosure 3)
9.51am

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

- **New Chief Executive:** Diane joined the Trust on Monday, 3rd April, 2017.

- **Friends and Family:** The detailed report had been presented at the Finance and Performance Committee. The ED SMS service had been successful and had increased response rates significantly.

  The Trust was now undertaking work on utilising this method to improve Community response rates. Overall the Friends and Family Scores were noted to be favourable when compared to other Trusts both locally and nationally.

- **Visits and Events:** The Board noted the meetings and events during the previous month. The visit from Gavin Williamson MP had been cancelled but would be rearranged. The Chairman confirmed that the visit from James Morris MP had been very positive and he would like to return to the Trust again.

- **Chief Nurse takes up new role:** Dawn Wardell, Chief Nurse with the Trust since June 2015, left the Trust on 31st March, 2017, to take up a new role at NHS England West Midlands as Deputy Director of Nursing and Quality.

- **Interim Chief Nurse, Siobhan Jordan:** Siobhan commences with the Trust as Interim Chief Nurse from Monday, 10th April, 2017. The Trust will advise staff and stakeholders of the details of permanent arrangements when they are finalised.

- **Upcoming Consultants Conference:** Consultants have all been invited to the next Consultants' Conference on Friday, 28th April, 2017, at Himley Hall. The conference will give Consultants an opportunity to meet with the Chief Executive face to face and discuss current issues and areas of interest.

- **ChemoCare, Go-Live:** The new chemotherapy electronic prescribing and medicines administration IT system went live on Monday, 27th March, 2017.

The Chairman and Board noted the report.

17/041 Patient Safety and Quality

17/041.1 Chief Nurse Report (Enclosure 4)
10.00am

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

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

MRSA: There has been no post 48 hr MRSA bacteraemia cases since 27th September, 2015.

C.Diff: The Trust has recorded 33 cases of post 48 hour C.Diff. to date in 2016/17, 30 of these cases have had their lapses in care determined, 12 of these cases were associated with a lapse in care at the Trust.

Norovirus: There had been no cases to note.

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

- Shortfall shifts total figure for the month was 73 which was an increase from the last month (65).

- Shortfall shifts are all reviewed and no safety issues were identified that affected the quality of care.

- The RAG rating system had been rolled out across the wards. There were 16 red shifts across 8 areas using this methodology for the period. For each of the red shifts there were no safety issues identified.

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

- 2 red areas in March, both of which are now under increased support and escalation review.

- Nutrition Audits and a focus on MUST completion is underway with 2 weekly meetings recommenced in February 2017.

- MUST: Work has been progressed on C1 in January as a pilot for new work and they had now achieved 100%.

The Chairman asked about the Trust's participation in the Model Hospital pilot work. The Deputy Chief Nurse confirmed that it was hoped that the Trust could learn a lot from its participation and would report via the usual governance routes.

The Chairman and Board noted the report. Dr Wulff, Non Executive Director, confirmed that it was encouraging to hear the improvements on the MUST scores.

17/041.2 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 5)
10.05am

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:

- Executive management assurance was provided that the actions in respect of the recent coroner's case were progressing. The Trust had yet to receive an update from UHB on their actions which was having an impact on the Trust's ability to close the action plan. The Trust is seeking confirmation that all joint actions are completed before it meets with the family but would arrange this if further delays were experienced.

- Executive management assurance was provided in respect of the overall process applied within the Trust in respect of Central Alerts. With respect to one alert relating to Naso Gastric Tube placements the Committee were informed of the work undertaken so far and the challenges that remain with regards to the training of staff by the required deadline of 21st April, 2017.

  The Committee were informed that a risk assessment has been completed promoting a corporate risk being added to the register.

- Items Referred to the Board for decision or action: The Committee requested that the Board note the risk, for which a risk assessment had been completed, to the delivery of the National Patient Safety Agency Alert in respect of Naso Gastric Tube placements by the deadline of 21st April, 2017. The Board was requested to ratify that the Committee should remain with its current terms of reference for the forthcoming year based on the positive review of the Committee performance in 2016/17.

The Chief Executive asked about the training of staff for NG tubes. The Deputy Chief Nurse confirmed that the training process had been undertaken and a large number of staff had been trained. There was an issue with ensuring that all relevant medical training can be completed by the deadline.

Mrs Becke, Non Executive Director, attended the Children's Board the previous day and confirmed that the Trust will be under pressure to maintain breast feeding numbers.

The Chairman and Board noted the report and assurances received. The Board ratified the Terms of Reference and noted the risk regarding the National Alert.

17/041.3 Black Country Alliance Report (Enclosure 6)
10.13am

Andrea Gordon, the new BCA Programme Director, presented the Black Country Alliance Report, given as Enclosure 6, which included the minutes of the BCA Board and Programme Directors update.

The Board noted the following key issues:

- The next BCA Board meeting will be used as a development session.

- Terry Whalley will continue working on Pathology and Back Office until the end of May, 2017.

The Medical Director confirmed that the BCA will start to look at engagement outside of secondary care.

Mr Miner, Non Executive Director, advised that the BCA reports format were not helpful and stated that he would like to see a clearer way of showing progress against the various projects. This had been raised previously and would now be for the Programme Director to take forward.

The Director of Strategy and Performance asked if Dudley were engaged in all of the pieces of work included in the report. Andrea confirmed that she will be looking at the role of the clinical sponsors and would make the level of engagement clearer in future reports.

The Chief Executive stated that feedback from all external meetings will now be discussed at the Executive Directors meeting. She also commented on the apparent lack of input from Commissioners into proposed developments.

The Director of Finance and Information added that the Trust should look to be more STP orientated than just BCA focussed.

The Chairman and Board noted the report.

17/041.4 Audit Committee Exception Report (Enclosure 7)
10.30am

Mr Miner, Chair of the Audit Committee, presented the Audit Committee Exception Report, given as Enclosure 7. The Board noted the following key areas:

- This was the last Audit Committee before the May Audit Committee meeting when the Trust's Annual Accounts and Annual Report will be approved following external audit review.
- A reasonable assurance report had been received in respect of quality and safety outputs.
- The Head of Internal Audit gave his draft opinion for the year which was positive.
- Assurance had been taken from Jo Newens on the work undertaken around capacity.
- The Draft Annual Governance statement was considered to be balanced and will be finalised ahead of the external audit.
- Approval was provided for various annual plans relating to clinical audit, internal audit and counter fraud.
- The Risk and Assurance Register was recommended to the Board by the Committee following their review.

The Director of Strategy and Performance confirmed that safety and quality is picked up through the performance management process.

The Chairman and Board noted the report and approved the adoption of the audit recommendation in relation to the Risk and Assurance Register which was for discussion later in the meeting. The Chief Executive commented that the Trust needs to have the Risk and Assurance Register in an electronic format.

Mr Miner commented that the Trust's work in respect of risk management has been considered by the Trust's auditors as leading edge but agreed about the need for an electronic process.

17/041.5 Charitable Fund Committee Report (Enclosure 8)
10.34am

Mr Atkins, Committee Chair, presented the Charitable Funds Committee Report, given as Enclosure 8. The Board noted the following key issues:

- Matters arising: The Committee had previously discussed a proposal regarding Chaplaincy Services. It was noted that Chaplain Mark Stobert was in agreement with the proposal. Retrospective funding had been approved for training and equipment.

- It was noted that Mr Ali and Mrs Rees could not attend the meeting and would present to the Committee in May in respect of proposals to use their funds.

- The Committee was inviting the top 3 fund managers to attend future meetings to provide information on their intensions to spend their funds.

- The Fundraising Manager reported a shortfall in the general fundraising plan of £30k. The Committee agreed that Mrs Phillips should focus more on corporate fundraising and grants.

There was £2.4m available within the respective funds with £230k in the General fund. It was positive to note that the Trust was spending more than it was receiving.

The Committee approved 6 bids for expenditure, including a pager system for Trauma and Orthopaedics.

The Director of Finance and Information confirmed that the Trust may not be able to fund the whole of chaplaincy element from the general funds.

The Chief Executive asked if the Trust is trying to align funds outside of the general fund. Mr Atkins confirmed that the Trust is trying to increase the general fund and make use of separate funds where possible, noting that some donations are very specific.

Mr Miner confirmed he noted as previous Chair, that the Committee did reduce separate funds but there were still a large number despite the efforts of the fundraising manager.

Mr Atkins had attended the Annual General Meeting of the Leukaemia Unit Trust which was a very positive experience.

The Chairman and Board noted the report and the ongoing work to increase the general fund.

17/041.6 Winter Evaluation Review (Enclosure 9)
11.20am

The Chief Operating Officer presented the Winter Evaluation Review, given as Enclosure 9. The Board noted the following key issues:

- A set of engagement events had been held which fed into an economy group view of last winter's experiences. The majority of schemes worked well, but key issues for further improvement for next winter will be picked up through the A&E Board.
- A higher than anticipated percentage growth in emergency activity had been experienced over last winter.
- The Board noted that next year's plan will need to be more stretching in terms of activity expectations.
- No urgent or cancer patients were cancelled over the period despite the pressure on the system.
- The Trust used day surgery and the GI unit during periods of increased pressure. Concerns had been raised regarding the use of the GI Unit and its use for next year is to be reviewed.
- The plan was well received and supported by staff.

Dr Wulff, Non Executive Director, asked about the impact of pressure on staff, for example had there been an increase in sickness given the period of sustained effort asked of the staff. The Director of HR confirmed that sickness was not particularly higher during the period. Capacity pressures are being discussed in staff focus groups following receipt of the staff survey. Dr Wulff asked that pressure on staff is considered when producing the next plan.

Mr Fellows,Non Executive Director, suggesting included patient experience as a dimension in the plan for next year.

Mr Atkins, Non Executive Director, asked how the reliance on agency staff would change. The Chief Operating Officer confirmed that there will be an early focus on workforce.

The Medical Director commented that the main problem was the increased number of urgent admissions, in particular patients over the age of 70 with co-morbidities.

Dr Hopkin commented that there is confusion about the number of community teams and how primary care access these. He also raised the importance of nursing staff taking a lunch break for their own wellbeing. The Chief Operating Officer confirmed that actions were being taken around both of these issues.

The Chief Executive suggested establishing a community coordination centre that GPs could ring in to.

The Chairman and Board noted the report and the comments regarding agency usage, admissions avoidance, community teams and health and wellbeing of nursing staff, with recognition that all improvements would be led by the A&E Delivery Board.

17/041.7 Corporate Risk Register and Assurance Report (Enclosure 10) 10.40am

The Director of Governance/Board Secretary presented the Corporate Risk Register and Assurance Report, given as Enclosure 10. The Board noted the following key issues:

- Infection Control: For the second year running the Trust was below the set target for C.Diff lapses in care. The target for next year will remain at 29 so this risk is de-escalated from a corporate risk to an operational risk. It was important to note that many reasons for these attributed lapses were because of poor or timely documentation.

- A Cyber Security risk had been added based on the external factors facing the NHS sector.

- Page 3 of the report confirmed that it was not just the Audit Committee who had responsibility to look at the Risk and Assurance Register, but that risks had been reviewed through the Clinical Quality, Safety and Patient Experience Committee, Finance and Performance Committee and the Workforce Committee. The review of risks at the other Committees had confirmed the executive view of the impact and likelihood of risk to be reasonable

- The draft Annual Governance statement reflects the final residual risk ratings and risks addressed during the year within the corporate risk register.

- Assurance had been received for all risks across the year as demonstrated within the assurance register .

The Chairman raised the accessible information standard risk that had increased. The Director of Governance/Board Secretary confirmed that the Trust is engaging with patient groups and also looking at electronic solutions to improve its processes in this area. The Trust is compliant at the basic level of the standard but wishes to improve from that position and hadn't across the year. The engagement meeting is scheduled for 11th May, 2017. Mark Stanton and his team are providing support with the work on alternative patient communication solutions for next year.

Dr Hopkin asked about the MCP risk. The Medical Director confirmed that the Trust continually considers this risk, part of which is financial and part operational. The Director of Governance/Board Secretary confirmed that the risk had previously been rated as red, but based on the work undertaken by the Trust had reduced slightly. The Chief Executive stated that the risk will change as more details around the MCP emerge.

The Chief Executive asked whether the impact of the new apprenticeship levy should be included. The Director of HR confirmed that this is currently being considered and would be reported to the Workforce Committee.

The Chairman asked that the Executive Team consider its inclusion on the Register. The Director of HR confirmed that this is also considered through the vacancy control process.

The Chairman and Board noted the report

The Executive Team to consider the inclusion of the new Apprenticeship levy on the Risk Register.

17/041.8 Black Country Pathology Report (Enclosure 11)
11.42am

The Chief Operating Officer presented the Black Country Pathology report, given as Enclosure 11.

There had been multiple discussions at previous Board meetings on this subject. A report had been requested to outline the process that the Pathology project was following. The Trust had not formally signed up to any actions but was continuing to engage in the process.

Mr Fellows, Non Executive Director, confirmed that he was disappointed to see that the report remained focused on the management aspect. The Board needed to be better sighted on costs, potential savings and service impacts and he remained concerned that more information on these issues is needed.

The Chairman advised that a start needs to be made on required analysis and confirmed that Mr Fellows could be instrumental in influencing that work, given he is the BCA NED lead for the project.

The Director of Strategy and Performance commented that there was no current finance and information support being provided to the project and this would be needed in the analysis stage and development of options.

The Chief Executive agreed that there needs to be wider engagement. She confirmed that this work has been done elsewhere across the country and suggested that Mr Fellows contacted other Pathology Steering Group Chairs to obtain background on how he could influence the process.

The Chairman and Board noted the report and the feedback and concerns regarding the contents of the paper, the ongoing process and the further analysis required.

17/042 Finance and Performance

17/042.1 Cost Improvement Programme and Transformation Overview Report (Enclosure 12)
11.06am

The Head of Service Improvement presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 12.

The Board noted the following key highlights:

- £10m CIP delivered.
- Slide 4 gave an overview of work for 2017/18.
- £10m of projects had been scoped for next year with a part year effect of £9m.
- Slide 5 documented lessoned learnt from 2016/17.

The Chairman commented that she wanted to look at lessons learnt from the whole programme not just one of the projects that had not delivered savings. The Director of Strategy and Performance confirmed that this would be included in the next report.

The Chief Executive confirmed that she would be heavily involved in the CIP programme. There also needs to enhanced governance around assurance on schemes given the shortfall experienced in the last year.

The Director of Finance and Information confirmed that to achieve its control total the Trust needs to significantly reduce agency spend.

The Chairman and Board noted the report.

17/042.2 Finance and Performance Committee Exception Report (Enclosure 13)
11.57am

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 13.

The Board noted the following key issues:

- Phase 1 of the Digital Health System goes lives on 21st April, 2017.
- Compliance rates were improving for appraisals and mandatory training.
- If the 2016/17 control total is achieved the Trust will get the full £10.5k of STP funding.

- There will be a considerable amount of money outstanding to the Trust at year end from other NHS organisations which will require follow up.

- The budget for 2017/18 and the associated capital programme were approved by the Committee under delegated authority from the Board.

- A control total of £2m surplus was set for 2017/18 which if achieved will deliver £8m STF funds.

- Capital spend is £16m which includes £7.5m of digital health spend.

- The business case for the Urgent Care Centre was approved. The new Urgent Care Centre will be built on the side of the ED waiting room thus improving patient flow. The capital cost of the build is £2.2m with a timescale of 32 weeks.

The Director of Finance and Information confirmed that the Trust still did not know how much extra STF funds may be received as result of achieving its 2016/17 control total.

The Chief Executive asked about the NHS debt. The Director of Finance and Information confirmed that most of it was with Staffordshire CCG relating to overperformance on Trust activity. The Chief Executive suggested escalating to NHSI/NHSE.

The Chief Executive asked if the timeframe for the new build exceeded national requirements. The Director of Finance and Information to check if timescales could be reduced.

The Chairman and Board noted the report.

The Director of Finance and Information to check if timescales for the build could be reduced.

17/043 Any Other Business
11.50am

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

17/044 Date of Next Meeting
11.50am

The next Board meeting will be held on Thursday, 4th May, 2017, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 6 April 2017

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/042.2	Finance and Performance Committee Exception Report	The Director of Finance and Information to check if timescales for the build could be reduced.	PT	4/5/17	Project Team to meet to discuss escalating the project.
16/118.5 & 17/027.1	Research and Development	The Medical Director to produce a Research and Development gap analysis.	JN	1/6/17	
17/030.7	Freedom to Speak Up Guardian Report	Further update to the Board in 3 months time.	CLM	1/6/17	
17/030.8	Guardian of Safe Working Report	Further update to the Board in 3 months time.	BE	1/6/17	
17/041.7	Corporate Risk Register and Assurance Report	The Executive Team to consider the inclusion of the new Apprenticeship levy on the Risk Register.	ET	6/7/17	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 4th May 2017

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

SUMMARY OF KEY ISSUES:

- Department of Health Funding for the Emergency Department
- Directors Blog
- Dying Matters Awareness Week
- Educators Shortlisted for Student Nursing Times Awards
- Thanking our Caring Profession
- Friends and Family Test (FFT) Summary Review of 2016/17
- Visits and Events

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		Y	**Y**

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

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – May 2017

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

Items below are not reported in any order of priority.

Department of Health Funding for the Emergency Department

The Department of Health has announced we are to receive £1m funding for our A&E. We are absolutely thrilled to be receiving the funding to relieve pressure on our Accident and Emergency (A&E) Department. This really is very good news for our patients. We plan to use the money to build a brand new Urgent Care Centre (UCC) integrated with our Emergency Department.

This will allow a centralised point of access for patients who will be directed to A&E or the UCC depending on their clinical need. Having the two services side by side will mean patients will benefit from a seamless service with clinicians from primary care and the hospital working even more closely together.

Directors Blog

Directors across the Trust are blogging about the news in their areas, as another way to communicate with staff and the public about key issues. I have been very active on my blog which you can find blog.dudleygroup.nhs.uk and I would like to encourage people to keep up with the news here and engage with us, please leave a comment or ask questions, we would love to hear from you.

Dying Matters Awareness Week

The Trust is taking part in Dying Matters awareness week (8th May - 14th May). One of the aims of the week is to highlight the importance and raise awareness of engaging in individualised planning for patients who are dying, establishing priorities for their care and the kinds of things involved with supporting patients and their families.

The End of Life Team will be in the Clinical Education Centre and at the Health Hub in Russells Hall Hospital's main reception during the week to raise awareness about their work with staff and patients. Activities include an opportunity to find out more about what the team do at a Q&A session.

Educators Shortlisted for Student Nursing Times Awards

Three members of staff from The Trust have received national recognition from the Student Nursing Times Awards by making the shortlist in the category of Educator of the Year. The team, made up of Sarah Clarke, Victoria Perry and Kate O'Connor, has been shortlisted for inspiring and motivating students. Their award entry included testimonials about their work from students and colleagues.

Winners will be announced on Thursday 27th April 2017 at the awards ceremony in London. **Good luck to Victoria, Kate and Sarah!**

Sarah Clarke, Professional Development Nurse for Pre-registration, was also interviewed on Black Country Radio at 8.30am on Wednesday 26th April. You can listen back if you missed available to listen again here https://audioboom.com/posts/5856789-dave-chats-to-sarah-clark-from-the-dudley-group-nhs-trust?t=0

Thanking our Caring Profession

International Day of the Midwife is on 5th May and International Nurses Day is 12th May. The Trust will be celebrating all of our caring professionals across all areas of the organisation and we will be encouraging staff to say why they love what they do and patients to say thank you.

Friends and Family Test (FFT) Summary Review of 2016/17

Friends and Family Test (FFT) responses make up more than 85% of all patient feedback (<34,000 pieces of feedback) received by the Trust and provides a rich source of patient feedback. We are pleased that the majority of feedback we receive is positive however, we need to ensure that all areas of the Trust collect a sufficient amount of data to provide valuable feedback to make improvements.

Area	Total responses	Trust % response rate	National average % response rate 2015/16*
Inpatient (including day case)	**12,163**	17.8%	26%
Emergency Department	**3,905**	7.9%	14.5%
Maternity	**4,346**	30.1%	21.7%
Community	**2,033**	1.2%	3.5%
Outpatients	**5,959**	1.1%	Data not reported nationally
Total	**28,406**		

**based on full year 2015/16 latest available data*

Actions to improve response rates are being refreshed. Following the successful rollout of the FFT SMS messaging service to ED (January 2017) and day case (March 2017), consideration is being given to the introduction of the system for those areas where response rates remain consistently low – inpatients, community and outpatients.

Responses received using the FFT SMS messaging service has positively impacted the overall response rate for ED achieving 18.6% in March compared to 4.3% in December. The response rate for inpatient areas, which includes day case, was 18.3% in March compared to 18.1% in February. See table in section 2.

The Dudley Group
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Recommended percentage rates

In March 2017, all areas achieved a recommended percentage that was equal to or better than the national average with the exception of ED who achieved 81% compared to the national average of 87% (Feb '17) and since the introduction of the SMS messaging service in January 2017 has continued to see an improvement. The table below illustrates the performance across the year.

Description	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Community – Recommended %	96.8%	94.7%	94.4%	97.3%	96.1%	96.1%	95.1%	95.5%	94%	94.4%	97.8%	97.3%
ED – Recommended %	91.4%	91.3%	88.2%	91.7%	91.8%	91.9%	93.8%	93.1%	90.1%	75.3%	76%	81%
Inpatients – Recommended %	96.8%	96.7%	97%	94.6%	96.6%	96.6%	97.9%	95%	97.9%	95.8%	97.3%	97.3%
Maternity – Recommended %	97.5%	97.3%	98.9%	96%	98.6%	98.8%	98.8%	99.5%	99.4%	97.6%	98.2%	99%
Outpatients – Recommended %	85%	82.2%	93.1%	91.7%	92.4%	92.4%	93.2%	94.9%	93.1%	95%	94.1%	96.2%

FFT comments

Just over half of all FFT responses received included a comment where:

74% of feedback received was positive

25% was negative

Top themes

- ✓ Care and treatment
- ✓ Staffing
- ✓ Appointments and discharge
- ✓ Staff attitude

- X Appointments and discharge
- X Facilities/environment
- X Access
- X Food and drink

The Dudley Group
NHS Foundation Trust

Visits and Events

7th April:	West Midlands Provider Chief Executive's Meeting
	Chief Executive Development Event
24th April:	Trust/CCG Board to Board Meeting
26th April:	Partnership Board
	STP Sponsorship Group
27th April:	Dudley Clinical Services Improvement Board
28th April:	Consultants Conference
4th May:	Council of Governors

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 4th May 2017

TITLE:	**25 April 2017 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe – Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

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

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

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

The Committee requests that the Board note that following the work undertaken across the Trust, the Trust has self assessed itself as compliant with the National Patient Safety Agency Alert in respect of Naso Gastric Tube placements by the deadline of the 21 April 2017. The Trust has established a programme of routine audits to monitor adherence to Trust policy in this area given the prominence of the alert, with a view that over the year this check will be subsumed into routine patient safety / experience checks.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	25 April 2017	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- Executive Management assurance was provided that following the actions undertaken the Trust has self assessed itself as compliant with the National Patient Safety Agency Alert in respect of Naso Gastric Tube placements by the deadline of the 21 April 2017. The Trust has established a programme of routine audits to monitor adherence with Trust policy in this area given the prominence of the alert, with a view that over the year this check will be subsumed into routine patient safety / experience checks. The Committee endorsed the original risk be changed to a risk of continued compliance for which the assurance from the planned audits will provide and be reported to this Committee
- Executive Management assurance was provided on the performance in respect of key quality indicators. This month saw:
    - Stroke Swallowing Screen (performance target of 75%). Although this target was regularly achieved prior to July 2016, it has not been consistently achieved since then. The provisional performance figure for March of 76.32% shows positive signs that the work put in place in respect of recruitment and team resilience is paying off.
    - VTE Assessment indicator (CQN01- target 95%) – The Trust has achieved the performance target in March with a provisional performance figure of 95.97% which may increase further with data validation done at month end.
    - The Trust recorded in March a further in mixed sex breaches to just 7 instances.
    - Performance in respect of securing a reduction in smoking within pregnancy has improved again this month to a rate of 15.33% which above the target is nearly a 5% reduction that January and is better than the month of January.
    - There continued to be good performance in respect of infection prevention and control both in terms of MRSA and *C diff*. The Committee noted the continued achievement of this performance.
- There is currently only 1 policy that is under review which exceeds the planned

review date of end of March 2017. The lead executive director is aware of this instance.

- Executive Management assurance was provided in respect of the Trust's mortality case review process with some 98% of deaths having been subject to a case review. The latest Standardised Hospital Mortality Indices for the Trust published by NHS Digital is for the period October 2015 – September 2016 and gives a value of 0.98 which is below the national average and shows the continuing improvement by the Trust against this indicator. The Committee was updated on the Trust's self assessment against the requirements of the latest national guidance on learning from deaths. This assessment concluded that the Trust's Mortality Tracking System (MTS) already addresses many of the points in the guidance, including structured review, and goes beyond the guidance in that all deaths (except children & neonates) are recorded on the MTS, and that all Trust consultants are engaged in the process. We also have recently developed a specific process to review deaths when learning difficulty has been flagged. However amendments to the Trust's policy and supporting procedures in this area will be needed and these will be considered by the Mortality Surveillance Group ahead of this Committee.
- Executive Management assurance was provided in respect of the Trust progress with its associated actions flowing from the last CQC Safeguarding Children Inspection Plan. The Committee was informed that whilst work was progressing there had been some slippage on the delivery to the original timescales and revised dates were provided for each appropriate action. The Committee was updated on the opportunity the urgent care redevelopment work will offer to address the deficiency in offering a separate children's waiting area.
- The Committee was updated on action being taken by the Trust in respect of the risk of un-reported plain film x-rays. The Committee asked that further information is brought back to the Committee at it's next meeting on the results of the audit of such x-rays.

Decisions Made/Items Approved

- The Committee approved 2 policies.
- The Chair approved the closure of 12 Root Cause Analyses (RCA) action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.

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

- The outcome of the audits in respect of the NPSA alert is reported back to this Committee.
- The Committee as part of its discussion on the performance report asked that a separate report on maternity performance be brought back to the Committee.
- The Committee receive a further report in respect of Learning from Deaths and the update to the Trust's supporting policy and procedures once reviewed by the

Mortality Surveillance Group.

- The developed action plan in respect of the National Emergency Department Patient Survey, noting the survey is due to be report formally reported in August 2017.
- The outcome of the audit on plain film x-rays be brought back to next month's meeting.

The Committee deferred a number of items from this meeting's agenda to its next meeting, a number of these items report monthly therefore the deferred items will form part of next month's reports.

Items referred to the Board for decision or action

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

The Committee requests that the Board note that based on the actions taken by the Trust, the Trust has registered that it is compliant with this alert and has established a programme of routine audits to monitor adherence to Trust policy in this area given the prominence of the alert, with a view that over the year this check will be subsumed into routine patient safety / experience checks.

Enclosure 5

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 4th May 2017

TITLE:	Quarterly Safeguarding Report to the Board of Directors – April 2017		
AUTHOR:	Pam Smith Deputy Chief Nurse	**PRESENTER:**	Siobhan Jordan 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 in collaboration 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 conducted a monitoring visit in February 2017 and stated that the authority is making 'positive progress' in a number of key areas. They identified that areas of concern were being addressed and that as a result, a great number of children were receiving 'the right response at the right time'.

CQC REVIEW OF HEALTH SERVICES FOR CHILDREN LOOKED AFTER AND SAFEGUARDING IN DUDLEY
The action plan developed in response to the review of health services for Children Looked After and Safeguarding in Dudley by the Care Quality Commission (CQC) in May 2016 was reviewed and updated at the Trust Children's Services on 9th March 2017. This was presented to the Clinical Quality Safety and Patient Experience committee on 25th April 2017.

Of the 9 actions that remain in progress 3 actions are in green and have been completed and there are 6 actions in amber. These have progressed but are still in progress. Revised action dates have been identified. These are being monitored at the Trust's Children's Services Group in June 2017.

The Trust is also working collaboratively with the Clinical Commissioning Group and other health providers to implement an action plan across the health economy to address the recommendations identified in the review.

LEARNING DISABILITY
Learning Disability Strategy
The Learning Disability Strategy action plan has been updated and presented to the Clinical Quality and Patient Experience Committee on 25th April 2017. There are 22 completed actions in green and 3 outstanding amber actions.

Achievements to note within the green actions are:

- Internal Learning Disability Mortality review panel completed - a report of the findings has been scheduled to be presented to the Clinical Quality, Safety and Patient Experience committee in May 2017.
- Process developed to record on OASIS patients preferred method of communication; easy read information available on request.
- Initial 'Shout up Parents' meetings held with parents. Walk through of Emergency Department to review pathway for admission for children with a disability.

Progress to note within the amber actions are:

- Further training for Learning Disability Champion training in June, September and December 2017.
- The Trust has transferred to the Disability Confident scheme.

TRAINING COMPLIANCE
Safeguarding training compliance continues to be monitored at the Internal Safeguarding Board monthly. Overall the compliance percentages are between 63% and 84%. 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
2016/17 saw an increase in activity from 145 to 197 patients who required assessment by the CAMHS team. The number of patients referred for tier 4 placement was similar however, the total number of days length of stay reduced. Work is in progress to capture the length of stay for tier 4 patients from the point of decision to referral to tier 4.

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 Foundation Trust

SAFEGUARDING REPORT TO TRUST BOARD
APRIL 2017

1. OFSTED INSPECTION CHILDREN'S SAFEGUARDING

The Trust continues to work in collaboration 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 conducted a monitoring visit on 21st and 22nd February 2017 and stated that the authority is making 'positive progress' in a number of key areas. They identified that areas of concern were being addressed and that as a result, a great number of children were receiving 'the right response at the right time'. They concluded that the management team were driving an 'ambitious programme of improvement work to support positive change".

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 on 9th March 2017. This was presented to the Clinical Quality Safety and Patient Experience committee on 25th April 2017.

Nine recommendations were identified for the Trust. Of the 9 actions that remain in progress 3 actions are in green and have been completed and there are 6 actions in amber. These have progressed but are still in progress. Revised action dates have been identified. These are being monitored at the Trust's Children's Services Group in June 2017.

The Trust is also working collaboratively with the Clinical Commissioning Group and other health providers to implement an action plan across the health economy to address the recommendations identified in the review.

3. LEARNING DISABILITY STRATEGY

The Learning Disability Strategy action plan has been updated and presented to the Clinical Quality and Patient Experience Committee on 25th April 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 within the green actions are:

- Internal Learning Disability Mortality review panel completed – reviewing all death against the identified criteria of premature death in the Confidential Enquiry (CIPOLD).
- Process developed to record on OASIS patients preferred method of communication; easy read information available on request.
- Initial 'Shout up Parents' meetings held with parents. Walk through of Emergency Department to review pathway for admission for children with a disability.

Progress to note within the amber actions are:

- Learning Disability Champion training on going. Further training sessions scheduled for June, September and December 2017.
- Trust has transferred to the Disability Confident scheme. Disability Confident aims to improve the recruitment process for people with disabilities – meeting planned with the Director of Human Resources to review.
-

A report of the findings of the Internal Learning Disability Mortality review panel has been scheduled to be presented to the Clinical Quality, Safety and Patient Experience committee in May 2017.

4. TRAINING COMPLIANCE

4.1 Safeguarding Children compliance

Foundation Level 1 & 2 training compliance (as 28th February 2017) is at 84.1%. This is a decrease of 0.8%.
Intermediate Level 3 training compliance (as at 28th February 2017) is at 63.5%. This is a decrease of 1%. 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 28th February 2017) is 80.24%. This is a decrease of 1.99%. 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 28th February 2017) is 76.95%. This is an increase of 1.14%. 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.

Timetabled sessions are currently fully booked so work is in progress to check that the percentage compliance is accurate

4.4 Safeguarding Maternity Compliance

Safeguarding Maternity compliance level 1 and 2 is 84.23%.
Safeguarding Maternity compliance level 3 is 84.18%. 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

Training for Learning Disability champions training dates have been identified for March, June, September and December 2017.

4.6 Prevent Training compliance

Level 1 and 2 - Training compliance is 84.29%.

Level 3 WRAP (Workshop to Raise Awareness of Prevent) - Training compliance is at 24%. This is on track to meet 30% training compliance level within the first year of training in July 2017.

The Dudley Group
NHS Foundation Trust

5. ACCESS TO CAMHS TIER 4 BEDS

2016/17 saw an increase in activity from 145 to 197 patients who required assessment by the CAMHS team. The number of patients referred for tier 4 placement was similar (9 and 8 respectively) however, the total number of days length of stay reduced. The CAMHS database is being adjusted to capture the length of stay for tier 4 patients from the point of decision to referral to tier 4.

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 to ensure that the actions are being implemented. The Trust attended a section 11 audit challenge day implemented by Dudley Safeguarding Adults Board in March 2017.

7. VULNERABLE ADULTS SAFEGUARDING TEAM

The Named Consultant for Safeguarding Adults has attended a conference where a Vulnerable Adult Safeguarding Team (VAST) had been introduced in the Emergency Department in Southampton. The team had made good progress in reducing the number of frequent attenders. A meeting has been held between the senior ED team and the safeguarding team to explore this further.

Pam Smith
Deputy Chief Nurse
26th April 2017

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 4th May, 2017

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

SUMMARY OF KEY ISSUES:

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

Strategic Objective	**RAG rating**			
	Red	Amber	Green	No Status
Deliver a great patient experience	2	2	2	0
Deliver safe and caring services	3	5	9	0
Drive service improvement, innovation and transformation	2	3	3	0
Be the place people choose to work	1	4	2	1
Make the best use of what we have	3	1	4	0
Plan for a viable future	0	1	3	0
Total	11	16	23	1

The change in position in Quarter Four when compared to Quarter Three is:

- 1 more green compared to Quarter Three
- 3 more reds compared to Quarter Three

Five measures of achievement are rated as red for the first time:

- Deliver a great patient experience
  - Improved National Patient Survey results
  - Cancer treatment standards
- Deliver safe and caring services
  - Nursing care indicators: omissions codes
  - Delivery of CQUIN schemes
- Be the place people choose to work
  - Sickness absence

Six measures of achievement have improved such that they are now rated green in quarter four:

- Safe and Caring Services
  - Nursing care indicators: zero avoidable stage 4 pressure ulcers
  - Deliver inspection action plans
- Be the place people choose to work
  - Information governance training target met

- Make the best use of what we have
  - Deliver agreed financial plan
  - Deliver the Lord Carter targets

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 Four 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 red at the end of Quarter Four.

The Dudley Group NHS
NHS Foundation Trust

Operational Plan 2016/17 Corporate Annual Goals: Quarter Four Outturn

Key to RAG rating:

	Achieved within timescale.
	Not quite achieved fully
	Not 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	RAG				Year end position
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	This rating has been given based on projected national benchmarking figures for January 2017 which indicate that this will not be achieved for at least one month of the quarter in four out of eight areas (inpatients, A&E, Maternity antenatal and community).
➢ Ensure patients, carers & public fully engaged & involved	✓ Improved National Patient Survey results	On-going	Chief Executive	Q1	Q2	Q3	Q4	Compared to our performance in the 2015 survey, we have scored significantly worse on 13 questions compared to two questions in the 2015 survey. The score relating to the question which asks patients to give the trust an overall rating decreased from 17 in 2015 to 20 in 2016 (a lower score is better).

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
	✓ Demonstrate engagement through feedback	Annual	Chief Executive	Q1	Q2	Q3	Q4	
➢ Achieve key performance standards	✓ 95% emergency access standard met	Monthly	Chief Operating Officer	Q1	Q2	Q3	Q4 Jan – 87.7% Feb – 92.31% Mar – 95.59%	Issues relating to delivery included: • Delayed Transfers of Care • Ability to deliver ward rounds over the 7 days by senior medical staff • Sustained increase in ED attendance / emergency admission/WMAS conveyances A Patient Flow Improvement Plan is in place which is being overseen by the A&E Delivery Board. A programme management approach is being undertaken, chaired by the Chief Operating Officer.
	✓ 18 weeks RTT met	Monthly		Q1	Q2	Q3	Q4 Jan – 94.16% Feb – 93.27% Mar – 92.81%	
	✓ Cancer treatment standards met	Monthly		Q1	Q2	Q3	Q4 Jan – 85.2% Feb - 73.7% Mar - 86.2%	A decrease in performance in month eleven has meant that Quarter Four has not met target. Improved escalation processes have been introduced, including improved divisional attendance at the cancer performance and patient tracker meetings. RCAs have been undertaken on all breaches in February to identify themes / rectifying action plans for diagnostics and urology.

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
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 86% 16/17 90%	This has not been achieved due to staffing vacancies and the use of bank and agency staff as well as under-recording of actual care given. Documentation is being reviewed to support recording of the actual care given.
	✓ Achievement of nursing care indicators: Efficacy of Analgesia (Target ≥95%)			Q1 92%	Q2 95%	Q3 97%	Q4 99% 16/17 96%	
	✓ Achievement of nursing care indicators: MUST (Hospital) (Target ≥95%)			Q1 88%	Q2 89%	Q3 85%	Q4 79% 16/17 85%	This has not been achieved due to staffing vacancies and the use of bank and agency staff. A specific project is being developed and implemented to focus on improving the MUST (hospital) score. The escalation process is being reviewed by the Chief Nurse to ensure improved performance. Documentation is being reviewed to support better recording of the actual care given.
	✓ Achievement of nursing care indicators: MUST (Community) (Target ≥95%)			Q1 100%	Q2 94%	Q3 96%	Q4 97% 16/17 96%	
	✓ Achievement of nursing care indicators: Medications Signed and Dated (Target ≥98%)			Q1 94%	Q2 95%	Q3 91%	Q4 88% 16/17 92%	This has not been achieved due to staffing vacancies and the use of bank and agency staff as well as under-recording of actual care given. As there has been some misinterpretation of this indicator, which has contributed to the missing of the target, the wording has been changed and clarified

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
	✓ Achievement of nursing care indicators: Omission codes (Target ≥95%)			Q1 92%	Q2 93%	Q3 85%	Q4 83% 16/17 88%	This has not been achieved due to staffing vacancies and the use of bank and agency staff as well as under-recording of actual care given. As there has been some misinterpretation of this indicator, which has contributed to the missing of the target, the wording has been changed and clarified.
	✓ Zero avoidable stage 4 pressure ulcers	Monthly		Q1	Q2	Q3	Q4	
	✓ Reduction in stage 3 pressure ulcers from 15/16	Monthly		Q1	Q2	Q3	Q4 Hospital 15/16= 36 16/17= 19 Community 15/16= 15 16/17= 8	2016/17 figures are incomplete as a number of ulcers are still being investigated to ascertain whether they were avoidable or not.
	✓ Zero post 48 hour MRSA cases	Monthly		Q1	Q2	Q3	Q4	
	✓ No more than 29 post 48 hour *Clostridium difficile* lapses in care	Monthly		Q1	Q2	Q3	Q4 2016/17= 13 cases	
	✓ Achievement of improvement trajectory in nutritional audit ending year in all wards as green (95%).	Monthly		Q1	Q2 96%	Q3 96%	Q4 95% 16/17 year end 96% 7 of 21 wards less than 95%	Individual wards did not achieve 95% even though hospital average is 95%. The escalation process is being reviewed by the Chief Nurse to ensure improved performance across the Trust.

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
✓ Deliver agreed CQUIN requirements	✓ Deliver CQUIN schemes to expected levels	On-going	Director of Strategy & Performance	Q1	Q2	Q3	Q4	The forecast outturn is £5.69m which is 14% less than the target of £6.46m Therefore, 14% of CQUIN monies was not achieved during the year as a result of non-delivery of targets within the following schemes: • Health and Wellbeing staff survey and flu • Sepsis identification and treatment • Consultant in community clinic in Respiratory.
✓ Maintain good mortality performance	✓ SHMI/HSMR within expected range	On-going	Medical Director	Q1	Q2	Q3	Q4	
	✓ 85% of in hospital deaths have a multidisciplinary review within 12 weeks	On-going	Medical Director	Q1	Q2	Q3	Q4	The Trust is MDT reviewing >97% of all deaths in the hospital but only 80.7% within 12 weeks.
✓ 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	

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
✓ 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	
✓ Safe staffing levels	✓ Deliver safe staffing	Monthly	Chief Nurse	Q1	Q2	Q3	Q4	This has not been achieved due to on-going recruitment challenges, continual winter pressures and capacity issues. A dashboard is being used to monitor staffing levels. Staffs are moved to support patient safety and mitigate any risks.
Strategic objective: drive service improvement, innovation and transformation								
➢ Develop integrated services & redesigned community provision	✓ Introduce case load management systems	June 2016	Chief Operating Officer	Q1	Q2	Q3	Q4	
	✓ Introduce SPA	June 2016		Q1	Q2	Q3	Q4	

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
➢ 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	This has not been achieved because of: • Lack of 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.
➢ Continued improvement in key services	✓ Improvements in service performance delivered for: Theatres	Review quarterly	Chief Operating Officer	Q1	Q2	Q3	Q4	Utilisation performance was affected detrimentally by the volume of elective cancellations. A Theatre Utilisation Programme is being implemented in Trauma & Orthopaedics and Ophthalmology.
	✓ Improvements in service performance delivered for: Out Patients			Q1	Q2	Q3	Q4	There have been issues relating to capacity to deliver changes and meet service demand. Phase two of improving the Out Patient Department is underway which focusses on individual directorate transformation work, Did Not Attend delivery, friends and family increases.

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
	✓ Improvements in service performance delivered for: Renal			Q1	Q2	Q3	Q4	
	✓ Improvements in service performance delivered for: Imaging			Q1	Q2	Q3	Q4	Capacity issues in ultrasound availability due to workforce shortages have led to DMO1 not being achieved. Limited capacity in MRI / CT results in delays when there are surges in demand. A plan is in place for recruitment which will deliver additional capacity from late summer 2017. A business case for additional CT / MRI capacity will take effect from late Autumn which will allow for sustained delivery of DM01.
➢ Expand Research & Development / Academic Health Sciences Network role	✓ Demonstrate greater involvement & engagement	On-going	Medical Director	Q1	Q2	Q3	Q4	AHSN membership is not considered cost effective (£30K PA membership fee) and the BCA work stream for R&D regional engagement has taken priority.
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	
	✓ Improved scores in National Staff Survey	Annually	Chief Executive	Q1	Q2	Q3	Q4	There has been an improved response rate (4,431 staff eligible to complete the survey, 2,004 returned a completed questionnaire – 45.2% compared to 45% in 2015). Overall, the staff engagement score remained almost stable (3.83% which is a minor decrease compared 3.86% (out of 5)).
➢ 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 4.16%	Winter period brought an increase in absence levels to 4.16%. The Trust's Sickness Absence Policy has been applied.

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
	✓ Mandatory training target of 90% met by end of year	Data collected monthly		Q1	Q2	Q3	Q4 84%	This has not been achieved due to lack of planning alongside capacity issues that stopped staff attending. This also resulted in training being cancelled. Enhanced levels of support and performance management have led to significant increase in performance for mandatory training with demonstration of highest performance for over 12 months and continuing improving trajectory towards 90%.
	✓ Appraisal target of 90% met by end of year	Data collected monthly		Q1	Q2	Q3	Q4 83%	Lack of planning and capacity issues resulting in appraisals being cancelled. Enhanced levels of support and performance management have led to significant increase in performance for appraisal with demonstration of highest performance for over 12 months and continuing improving trajectory towards 90%.
	✓ Information Governance training target of 95% met by end of the year	Data collected monthly		Q1	Q2	Q3	Q4	
➢ 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	The target is based on staff survey results. Further understanding of staff survey results is being obtained by developing staff survey focus groups and action plans alongside a staff well-being strategy.

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
➢ 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	The business case for Leadership Development has been postponed whilst the needs of the organisation are assessed further. 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	
	✓ Leverage from clinical systems & increasing orders from order comms. 5% each quarter	March 2017		Q1	Q2	Q3	Q4	
➢ Match capacity to demand	✓ Optimise capacity to match demand	Quarterly	Chief Operating Officer	Q1	Q2	Q3	Q4	There are national workforce challenges in certain specialties (e.g. Ophthalmology, Paediatrics). Physical space in the Ophthalmology outpatient department is also an issue.
➢ Deliver agreed financial plan	✓ Effective plans in place & monitored	Monthly	Director of Finance	Q1	Q2	Q3	Q4	The Control Total will be met following year end reconciliation. Additional year end income will be received from HEE and Dudley CCG.

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
➢ Deliver the agency threshold targets	✓ Meet the trajectory	Monthly	Chief Nurse	Q1	Q2	Q3	Q4	On-going recruitment challenges, capacity issues and impact of sickness and maternity leave have impacted on this despite regular recruitment initiatives, introduction of trainee nursing associates, improved management of sickness.
➢ Deliver the CIP	✓ Deliver CIP & financial target of £11.9m	Monthly	Director Strategy & Performance	Q1	Q2	Q3	Q4	The yearend forecast is approximately £10m which is a shortfall of £1.9m. 81% of the target has been achieved.
➢ Deliver the Lord Carter targets	✓ Deliver against the agreed targets	Annual	Director of Strategy & Performance	Q1	Q2	Q3	Q4	Information through the Model Hospital Portal was delayed until Quarter 4. The phased release of information was used to develop 2017/18 Cost Improvement Programme schemes. Key work streams on the bank office and pathology is underway within the BCA/STP structure. Procurement and Pharmacy transformation Plans were submitted on time at the end of March 2017 in line with requirements.
➢ Review the Clinical Strategy	✓ Revised plans in place	December 2016	Director of Strategy & Performance	Q1	Q2	Q3	Q4	The work on the Clinical Strategy was initially deferred so that it reflected MCP developments. In Autumn 2016, the Board reviewed the position and work began to develop the strategy. Clinical engagement has taken place. The strategy is due to be completed by June 2017.
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	

Annual Goal	Measures of Achievement	Timescale	Lead	RAG				Year end position
➢ 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	
➢ Dudley Partnership – ensure that the new care model works in the best interest of the Trust	✓ An agreed position in place regarding the shadow contract.	June 2016	Chief Executive	Q1	Q2	Q3	Q4	Discussions are still taking place with Dudley GPs as to their preferred partner in the MCP.
	✓ 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	

Enclosure 7

The Dudley Group NHS Foundation Trust

Report to the Board 4th May 2017

TITLE:	**Complaints and claims report for the year ending 31 March 2017**		
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: Key aspects from this report are – figures in [ ] refer to year ending 31/3/2016

There has been a small reduction in the total complaints received during this financial year, although many continue to be complex.

Complaints for year ending 31 March 2017

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

87% [38%] The revised timescale for a reply (within 40 working days) has shown a big improvement in response times during year. ***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. Many complainants are opting for a meeting before a formal response is provided***

49% [59%] of complaints received and closed were upheld/partially upheld

26 [11] complainants expressed dissatisfaction with their response (received and investigated). **In Qtrs 1,2 & 3 all further correspondence from complainants was incorrectly categorised as 'dissatisfied' when many were actually seeking additional information and were not therefore dissatisfied with *t*heir response. This was remedied in Q4 hence a reported reduction in actual dissatisfied complainants in that quarter.**

115 [101] local resolution meetings held with complainants

23 [12] Inquests held and closed

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

5 [4] Complaints accepted for investigation by the PHSO in year ending 31/3/17

Claims for year ending 31 March 2017

We continue to work with NHS Resolution (formally called NHS Litigation Authority) to settle swiftly appropriate claims and defend strongly those that are not appropriate. We have settled 38% of clinical claims within 2016/17 with no damages awarded against the Trust. In respect of personal injury we have settled 45% of these claims closed in the year with no damages awarded against the Trust (note this category of claim has a low number of claims logged against the Trust in any one year).

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Domains** **Safe, effective and caring**
	NHS Improvement	**Y**	**Details: supports effective governance**
	Other	**Y**	**The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 No. 309**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS:

To note level of complaints activity during year ending 31 March 2017 continues to reduce, that the Trust is committed to learning from each complaint. Also note that the Trust continues to work proactively with NHS Resolution to settle claims in a timely manner.

Key Facts – Complaints, Inquests & Ombudsman

Key facts During qtr/year	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	Qtr 4 Ending 31/3/2017	Year ending 31/3/2017
Total number of complaints rec'd within qtr/year	**66**	**294**	**81**	**64**	**66**	**68**	**279**
% Complaints ack'd within 3 working days	100%	100%	100%	100%	100%	100%	100%
% Complaints rec'd and replied within 40 working days	**38%**** [see note below]	**38% **** [see note below]	**95%**** [see note below]	**85%**** [see note below]	**83%**** [see note below]	86%** [see note below]	87% ** [see note below]
Number of upheld/ partially upheld complaints replied within qtr/year	**36***	**173*** (59%)	**54*** (67%)	**22** 34%	**38** (57%)	**22** (67%)	**136** (49%)
Complaints accepted for investigation by PHSO	2	4	0	2	2	1	5
Privacy/dignity incl as a concern in complaint	3	4	3	0	4	0	**7**
Complaints referring to shared accommodation	0	0	0	0	0	0	**0**
Complaints incl safeguarding issue	2	3	1	1	0	0	**2**
Number of meetings held with complainants (% of complaints rec'd)	**37** (56%)	**101** (34%)	**36** (44%)	**31** 48%	**24** (36%)	**24** (35%)	**115** (41%)
Total number and % of dissatisfied complaints rec'd	2	11 (4%	**9** (11%)	**7** (11%)	**7** (13%)	**3** (4%)	**26** (9%)
Total CCG/DWMH led complaints	3	7	3	4	3	1	**11**
New Coroner's cases opened	7	16	8	6	7	8	**29**
Coroner's Inquests held/closed	3	12	6	3	7	7	**23**
Coroner's Rule 28 (was rule 43)	0	1	0	0	1	0	**1**

Note

* Includes c/fwd from previous quarters for those in progress at the period end

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

Category * [see note below]	Qtr 4 ending 31/3/16	Year ending 31/3/16	Qtr 1 ending 30/06/16	Qtr 2 ending 30/9/16	Qtr 3 ending 31/12/16	Qtr 4 Ending 31/3/17	Year ending 31/3/17
Clinical Care (Assessment/Monitoring)	20 (31%)	**124 (42%)**	**30 (37%)**	**23 (36%)**	**23 (35%)**	**32 (47%)**	**108 (39%)**
Diagnosis & Tests	3 (5%)	**30 (10%)**	**4 (5%)**	**4 (6%)**	**4 (6%)**	**2 (3%)**	**14 (5%)**
Records, comms, Information or appts (incl delay)	17 (26%)	**56 (19%)**	**20 (25%)**	**10 (16%)**	**12 (18%)**	**14 (21%)**	**56 (20%)**
Admission, discharge & transfers	6 (10%)	**27 (9%)**	**7 (9%)**	**10 (16%)**	**11 (17%)**	**7 (10%)**	**35 (12%)**
Values & behaviour of staff (prev 'staff attitude')	4 (6%)	**15 (5%)**	**5 (6%)**	**5 (8%)**	**3 (5%)**	**2 (3%)**	**15 (5%)**
Obstetrics	7 (11%)	**16 (5%)**	**1 (1%)**	**3 (5%)**	**3 (5%)**	**2 (3%)**	**9 (3%)**
Nursing care (incl District Nurses)	1 (1%)	**2 (1%)**	**3 (4%)**	**2 (3%)**	**3 (5%)**	**6 (9%)**	**14 (5%)**
Medication	4 (6%)	**7 (2%)**	**2 (2%)**	**3 (5%)**	**0**	**0**	**5 (2%)**
Patient Falls, Injuries or Accidents	0	**5 (2%)**	**0**	**0**	**0**	**2 (3%)**	**2 (1%)**
Aids, appliances, equipment,	1	**4 (1%)**	**2 (2%)**	**2 (3%)**	**1 (1%)**	**0**	**5 (2%)**
Safeguarding	0	**1 (1%)**	**0**	**0**	**0**	**0**	**0**
Theatres	1 (1%)	**1 (1%)**	**0**	**0**	**0**	**0**	**0**
Privacy & dignity	1 (1%)	**2 (1%)**	**1 (1%)**	**1 (1%)**	**1 (1%)**	**0**	**3 (1%)**
Pressure ulcer	0	**0**	**0**	**0**	**0**	**0**	**0**
Violence, aggression	0	**0**	**0**	**0**	**0**	**0**	**0**
Other (incl security, workforce, catering)	1 (1%)	**4 (1%)**	**6 (6%)**	**1 (1%)**	**5 (7%)**	**1 (1%)**	**13 (5%)**
Total:	**66 (100%)**	**294 (100%)**	**81 (100%)**	**64 (100%)**	**66 (100%)**	**68 (100%)**	**279 (100%)**

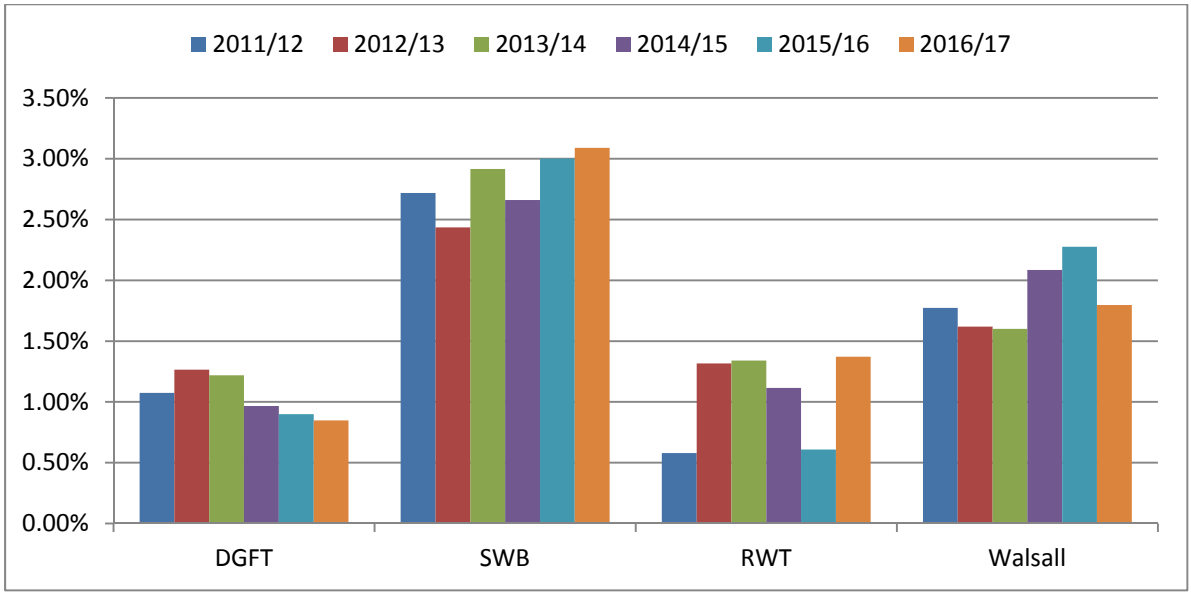
Note

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

Complaints received in Q4 within 2016/17 were slightly higher than those in the same quarter in the previous year, also they were slightly higher than the previous quarter (Q3) within 2016/17 although overall the number of complaints were lower than the total in the previous year. , the issue of 'communication' continuing to feature significantly within complaints and the Trust's

concerns, complaints and incidents group has asked for a plan to be developed to support and develop our staff to develop better communication skills.

Complaints as % of admissions - benchmarked to other Trusts



NOTE Data for Dudley Group shows whole year for 2016/7; remainder show Q1 & Q2 for 2016/7 only

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

	Complaints Yr ending 31/03/16	Pt Safety Incidents	% complaints against incidents
The Dudley Group NHS Foundation Trust	294	12575	2%
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%

*2016/17 data not available for other Trusts yet (expected for next quarter)

Complaints as % of patient safety incidents – Dudley Group – year ending 31/3/17

	Complaints	Pt Safety Incidents	% complaints against incidents
Year ending 31 March 2016	294	12575	2%
Q1 ending 30 June 3016	81	2927	3%
Q2 ending 30 September 2016	64	3008	2%
Q3 ending 31 December 2016	66	3942	2%
Q4 ending 31 March 2017	68	3802	2%
Year ending 31 March 2017	279	14679	2%

Complaints as % total hospital activity

ACTIVITY	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 Qtr 4 Ending 31/3/17	TOTAL Year ending 31/3/17
Total pt activity	188840	745455	198194	189578	188952	192902	769626
% Complaints against activity	0.03%	0.03%	0.04%	0.03%	0.03%	0.03%	0.03%

Compliments received during year ending 31/3/17

Q1 Ending 30/6/16	Q2 Ending 30/9/16	Q3 Ending 31/12/16	Q4 Ending 31/3/17	TOTAL Year ending 31/3/17
1647	1480	1915	1344	6386

Note this represent 0.8% of patient activity for the year

Senior Coroner – Inquests opened/closed during year ending 31 March 2017

	Q1 Ending 30/6/16	Q2 Ending 30/9/16	Q3 Ending 31/12/16	Q4 Ending 31/3/17	TOTAL Yr ending 31/3/17
Inquests opened	8	6	7	8	29
Inquests closed	6	3	7	7	23
Rule 28 (PFD) report	0	1	0	0	1

The one rule 28 (Preventing further deaths – PFD report) from the Coroner has resulted in a detailed action plan having been drawn up between ourselves and the other NHS FT involved in this case. We continue to work with that party to implement the agreed changes as a result of this very tragic case.

Claims logged and closed within the year ending 31 March 2017

We continue to work with NHS Resolution (formally called NHS Litigation Authority) to settle swiftly appropriate claims and defend strongly those that are not appropriate. We have settled 38% of clinical claims within 2016/17 with no damages awarded against the Trust. In respect of personal injury we have settled 45% of these claims closed in the year with no damages awarded against the Trust (note this category of claim has a low number of claims logged against the Trust in any one year).

Enclosure 8

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 4th May 2017

TITLE:	**End of Life and Palliative Care Strategy Group meeting on the 11 April 2017**		
AUTHOR:	Glen Palethorpe –Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES

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

SUMMARY OF KEY ISSUES:

The last meeting of the End of Life and Palliative care Strategy Group was unfortunately not quorate. However the Group still meet to discuss the actively of the reporting groups and to offer support should any of the sub groups need this to progress their actions. At this meeting a small number of items were referred to the relevant Group members to take back to their originations to progress, none were significant enough to warrant formal escalation to any member board or indeed the parent committee to this Group, that being the Clinical Strategic Board as relevant member representation was at this meeting to take responsibility to progress these few items.

The main meeting item was the launch of the economy wide developed end of life and palliative care strategy (the strategy on a page is attached for information to this paper). The Group agreed that a sub set of its members from the CCG, Trust and GP lead would work together on a project plan to have this strategy launched before April of next year.

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 caring domian**
	NHS Improvement	**N**	**Details:**
	Other	**N**	**Details:**

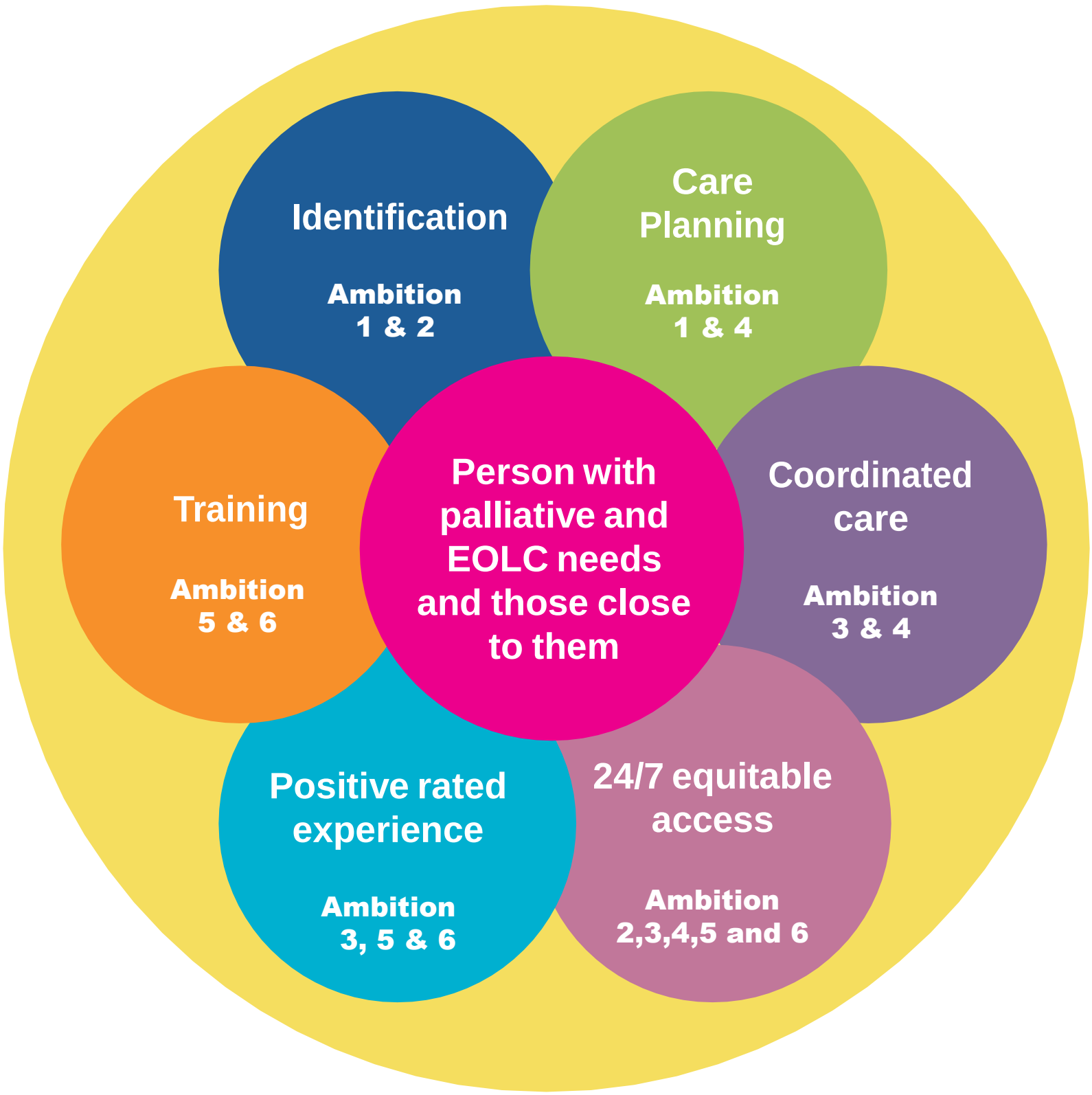
ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD
To note the work being led by this Group to secure an effective launch of the developed end of life and palliative care strategy by the end of the year.

Our vision for Dudley

All people with palliative and end of life care (EOLC) needs, irrespective of their diagnosis, together with those closest to them, are able to express their needs and wishes; and that as far as clinically appropriate and practically possible, these needs and wishes are met.



Ambition 1	Ambition 2	Ambition 3	Ambition 4	Ambition 5	Ambition 6
Each person is seen as individual	Each person gets fair access to care	Maximising comfort and wellbeing	Care is coordinated	All staff are prepared to care	Each community is prepared to help

Outcomes

Identification:
To ensure all patients and families with palliative care needs regardless of diagnosis or setting are identified in a timely manner.

Care planning:
To ensure patients and families with palliative care needs are offered the chance to create a personalised care plan.

Coordinated care:
To ensure the individual plans and care needs of patients & families are fully understood and coordinated effectively by and amongst all supporting agencies. This will involve provision of an effective system to enable shared records.

Equitable access 24/7:
To ensure all patients and families with palliative care needs regardless of diagnosis or setting can access the right help at the right time.

Positive rated experience:
To ensure effective data collection including person centred outcome measurement, patient and families experiences. Data collection to support team learning and reflection and policy improvement initiatives.

Education and training:
To develop and implement a framework for education, training, competency and Continuing Professional Development to ensure all staff have the necessary skills, knowledge and attitude to care for palliative patients.

Partnership working between The Dudley Group NHS Foundation Trust, Dudley Clinical Commissioning Group, Dudley Council and Mary Stevens Hospice.

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 4th May 2017

TITLE:	**Staff Survey Actions**		
AUTHOR:	**Rachel Andrew, Head of Learning & Development – Liz Abbiss, Head of Communications**	**PRESENTER**	**Andrew McMenemy, Director of Human Resources**

CORPORATE OBJECTIVE:

SO3: **Drive service improvements, innovation and transformation**
SO4: **Be the place people choose to work**

SUMMARY OF KEY ISSUES:

The results of the Staff Survey from 2016 were published on 7th March 2017. After initial review and analysis of key outcomes, a series of focus groups were held to engage with staff across the Trust to gain better understanding of the key issues, to explore solutions and get the opportunity to understand any other challenges or areas of good work.

Eight focus groups were held during April with a total of 40 attendees. Groups were selected according to areas of work and to represent a cross section of staff. Each group was provided with a summary of the key outcomes for the Trust in terms of improvements since the 2015 survey and the overall picture of the top 5 strengths and top 5 areas for improvement. Both summaries have been widely circulated throughout the organisation to share the results of the report with staff.

The focus groups were then given a summary of the results for their respective work area. This outlined the overall staff engagement scores for that area and how they compare to the rest of the Trust. Participants were also given the top four positive scores and the bottom four areas for improvement. An example of the summaries is enclosed at Appendix 1.

Taking consideration of the survey and additional feedback from the focus groups, the action plan below describes the key actions for focused activity during 2017/18. The first part of the plan outlines actions that will be delivered at a Trust level as these were referenced in all focus groups or were the areas specifically requiring improvement from the 2015 survey. The second section outlines some key areas from each of the staff groups or service areas.

In relation to the Action Plan below, each activity has a lead, outcomes/evidence and a review of progress will be initially undertaken at the end of Quarter 1. Further staff engagement will be undertaken and another round of focus groups will be held during Quarter 2 to assess the impact of changes and seek the views of those in the areas affected prior to the Survey for 2017 being launched.

It is also expected that the questions within the current FFT staff framework will be extended to provide more regular feedback from staff in the future.

IMPLICATIONS OF PAPER: ***(Please complete risk and compliance details below)***			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Well Led**
	Monitor	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
N	**Y**	**Y**	**N**

RECOMMENDATIONS FOR THE BOARD:

To review the action plan and be assured that this provides a credible plan to support the feedback received from staff based on the Staff Survey and subsequent focus groups.

Appendix 1: Example Focus Group Summary

Staff Survey Summary

Corporate

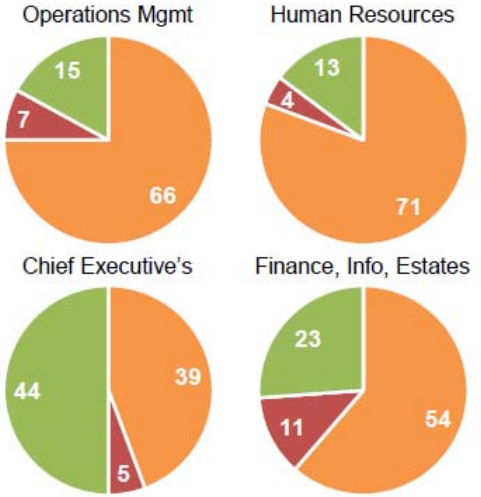
Response rates

86.7%	82.9%	78.3%	71.8%	84.6%
Finance, Information and Estates Dir	Human Resources Dir	Chief Executive's Dir. (Comms, Gov, IT, Strag&Perf)	Medical Director's Dir.	Operations Management Dir.

Internal benchmarking comparisons with Trust average and corporate areas	Trust	Chief Executive	Finance Information Estates	Human Resources	Medical Director	Operations Management
Overall staff engagement score	**3.83**	**4.06**	**3.86**	**3.94**	**4.11**	**3.99**
I would recommend my organisation as a place to work.	**3.66**	3.98	3.87	3.79	3.96	3.68
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	**3.81**	4.09	4	4	4.02	4.09
Care of patients / service users is my organisation's top priority.	**3.86**	4.17	4.13	4.21	4.14	4.23
I am able to make suggestions to improve the work of my team / department.	**3.89**	4.11	3.96	4.03	4.29	4.18
There are frequent opportunities for me to show initiative in my role.	**3.87**	4.14	3.71	3.91	4.18	4
I am able to make improvements happen in my area of work.	**3.49**	3.92	3.64	3.71	3.94	4
I look forward to going to work.	**3.61**	3.73	3.52	3.56	3.86	3.09
I am enthusiastic about my job.	**4.07**	4.13	3.79	4.03	4.28	4
Time passes quickly when I am working.	**4.21**	4.24	4.15	4.18	4.31	4.68

Directorates compared to Trust average

- Questions significantly better than average
- Questions significantly worse than average
- Questions on average



Top four positive areas

- ✓ Not experienced **physical violence, harassment, bullying or abuse** from patients, their relatives or members of the public
- ✓ Don't work any **additional paid hours** over and above contracted hours
- ✓ Have **adequate materials, supplies and equipment** to do my work
- ✓ Feedback from patients is used to make **informed decisions**

Bottom four negative areas for action

- × Don't work **additional unpaid hours** over and above contracted hours
- × Appraisal/performance review: **training, learning or development needs** identified
- × Had **training, learning or development** in the last 12 months
- × **Patient/service user feedback** collected within department
- × Feel my **role makes a difference** to patients/service users

The Dudley Group NHS
NHS Foundation Trust

Appendix 2: Staff Survey Actions

Trust Level					
No.	**You said:**	**We will:**	**Lead**	**Timescales**	**Impact/Evidence**
1.	We want you to do more engagement/continue engagement activities to give the opportunity to be heard and for our job roles to be valued and understood	Publish a quarterly programme of events to give staff the chance to talk, see and experience a range of views in the Trust including: CEO Team Briefings (monthly) open to all, Back to the Floor, Breakfast with the boss, Blogs and 'staff stories' to compliment patient stories showcased	Liz Abbiss	Events planned for Q2	Diary of events Follow up with focus groups on impact at the end of Q2/before staff survey
2.	We want to understand how our role fits into the Trust vision and values and connect clearly with Trust, Divisional and Department objectives	Publish a clear annual plan on a page giving staff the Trust aims and strategy and cascade this through the HUB, Divisional Management structures and connect with individual appraisals. We will work towards appraisals being timetabled to meet the annual review of Trust objectives and service plans in April each year.	Directors Line Managers Rachel Andrew to lead Appraisals work	2018/19 for appraisal changes. Annual Plan by the end of Q1	Annual Plan available Hub messages Appraisal documents Feedback from focus groups
3.	We need to keep staff here and promote the good things about the Trust.	Develop activities to recognise existing staff for their work and explore how we retain staff including using more effective communication/opportunities to listen and learn from existing staff, offering a more comprehensive training and development programme for all, further develop and promote staff health initiatives and conducting exit interviews to learn more about what would help people stay.	Recruitment and Retention Group	Q1 for L&D Strategy Q2 for further work on retention Q1 for promotion of exit interviews	Learning and Development Strategy Retention activities Exit interviews
4.	We need to ensure that people are reporting their experiences of physical violence	Promote awareness of the importance of staff reporting incidences to help protect them and ensure that Datix reports are followed up in a positive way when incidents are reported	Trust Security Management Specialist	Communications during Quarter 2/3	Increased Datix reports

5.	We need to improve how we communicate patient feedback to wards and departments so they can listen to the messages and use the information to recognise staff, develop services, and make improvements based on patient feedback.	Review and refresh what departments receive - asking what they want and how it will be used. Follow up the 'you said, we have done' review and ensure wards/departments see the results.	Liz Abbiss	Q1	Improved staff survey results Staff reporting knowledge of patient feedback improvements

Division	You said:	We will	Lead	Timescales	Impact/Evidence
Corporate:	We need to review our working practices to see if we can reduce work/utilise IT more	Liaise with IT to explore where they can support changes to work – for example, with online forms.	Mark Stanton	Q2 for review. Timescale for change depends on outcomes.	Review of services New process in place
Medicine and Integrated Care	We want managers to ask us what they can do to help when its busy so that they support us in the most effective way.	Cascade the messages from the staff survey to managers.	Liz Abbiss with Paul Bytheway	Q1/Q2	Feedback from focus groups
	There needs to be more investment in learning and development	Publish a learning and development strategy, linking in appraisals with development plans and coordinate better access to learning and development for all staff this year.	Rachel Andrew	Q1 –Q3	Learning Strategy in place Learning opportunities promoted
Nursing – Medicine	Capacity has a big impact – but it doesn't feel like everyone 'gets it', or gets involved in supporting patient activity when the Trust under times of pressure	Develop clear guidance for all staff about their role during peaks in demand and explain how all staff can support/contribute.	Paul Bytheway	Q3	Guidance available
	Review when you ask us to do training – avoid peak times.	Work with divisions to explore areas we can change timescales for training activity to reduce impact.	Rachel Andrew	Q2	Changes to requirements
Nursing – Surgery	Staff health and wellbeing is important – especially hydration. Can we promote this and help patients value it	Include promoting Hydration as a key workstream in the Health and Wellbeing Action Plan for this year.	Maudie McHardy	Q2	Promotion activities CQUIN plan/progress reports

Division	You said:	We will	Lead	Timescales	Impact/Evidence
	too?				
Surgery, Womens and Childrens	It sometimes takes a long time for people's concerns to be heard and addressed.	Ensure it is clear for all staff on how to report concerns about patient care and staff concerns around bullying and harassment including how to escalate issues. We will promote the roles of Speak Up Guardian, Guardian of Safe Working and Raising Concerns policy.	HR Business Partners	Q1-Q2	Feedback from focus groups
Clinical Support	Make it easier for us to access mandatory training.	Liaise with teams to explore how we make it easier to access training and offer solutions that work for teams.	Rachel Andrew	Q1/2	A range of more accessible learning options. Increased compliance
	There are big changes – EPR and MCP as examples. People are worried and don't understand the impact.	Publish regular updates about changes and keep messages simple. This will include Q&A opportunities so staff can ask questions	Liz Abbiss Peter Lowe for EPR	Q1-Q4	Updates available EPR engagement activities Engagement events
Midwifery	It seems that we are doing things to meet inspections rather than patient needs. We want to focus on the patient's needs and their experience.	Give you the opportunity to implement key guidelines with patient care and service needs in mind and be clear about how changes benefit services and patients.	Governance	Q1/Q2	Clear guidelines about what is inspected and why changes are made.
Community	We would like to be better connected to the wider Trust and access more information	Explore how we implement key mechanisms such as a service directory, community newsletter and revised HUB pages. Implement a CEO team brief monthly in community,	Liz Abbiss/Jo Newens	Q1 for CEO Brief Q2/3 for other elements	CEO Briefs in place HUB pages revised Service Directory available Community Newsletter in place
	Retaining staff is an issue for community teams.	Work with teams to understand what the issues are that are pertinent to them and work on a specific retention plan for community teams.	Recruitment and Retention Group	Q2	Retention activities implemented. Turnover figures

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 5 April 2016

TITLE:	**Annual Certifications**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary
CORPORATE OBJECTIVE SO 6 – Plan for a viable future			

Introduction

The Board is required to make a number of declarations at the year end, in respect of its annual plan the following self-certification is required.

For this year the NHS Improvement have adjusted the template declarations slightly to those required last year. General Condition 6 has been added to declaration 1 and the declaration that was not applicable for us about the Academic Heath Science Centers has been removed from declaration 2.

Certifications

Declaration 1 relating to General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts) and Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

Declaration 2 relating to Condition FT4 – Corporate Governance and Training for Governors

Conclusion

The Trust has maintained its systems for compliance with its License conditions and many of these processes and their effectiveness are described within the Trust's Annual Report and Annual Governance Statement. The work undertaken by the Board and the respective Committees of the Board have not identified any failure to comply with these conditions and therefore the Trust based on the summary provided within this paper are recommended to certify, as it did last year, that it is compliant with these conditions.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: N/A**
	Risk Register: N		**Risk Score: N/A**
	CQC	**Y**	**Details: well led**

COMPLIANCE and/or LEGAL REQUIREMENTS	**NHS improvement**	**Y**	**Details: License requirement**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATION FOR THE BOARD

That the Board approves the Trust self certification as complaint for each element within the required annual declarations.

Introduction

The Board is required to make a number of declarations at the year end, in respect of its annual plan the following self-certification is required.

For this year the NHS Improvement have adjusted the template declarations slightly to those required last year. General Condition 6 has been added to declaration 1 and the declaration that was not applicable for us about the Academic Heath Science Centers has been removed from declaration 2.

Certifications

Declaration 1 relating to General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts) and Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

Declaration 2 relating to Condition FT4 – Corporate Governance and Training for Governors

Trust Position

Declaration 1

General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

The Board is required to confirm it is compliant with the following certification, or explain why it can't certify itself as complaint.

Following a review for the purpose of paragraph 2(b) of license condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the license, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

It is recommended the Board a positive "confirmed" declaration is made. This is supported by the view of NHS Improvement within their regular meetings and that the Trust is segmented in segment 2 where only segments 3 & 4 indicate a risk or actual breech of the License.

Continuity of service condition 7 – Availability of Resources

The Board is required to make one of the following three declarations

1a After making enquires the Directors of the Licensee have reasonable expectations that the Licensee will have the Required Resources available to it

after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

1b After making enquires the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking account in particular (but without limitation) and distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 3 below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested services

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

It is recommended that declaration 1a is made. This is supported by the fact the Trust has achieved its control total for 2016/17 and set a positive control total for 2017/18. This is coupled with the Executive assessment of the Trust's going concern which reported positively that the Executives could make this declaration as part of recommending the accounts for audit (this was reported vial the Audit Committee)

Declaration 2

Condition FT4 - Corporate Governance Statement

The Board is required to indicate it is complaint with the following statements or if not state why it is non complaint.

1) The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

It is recommended the Board signify its compliance as the Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. The Trust has also been rated as "good" by the CQC within the domain of well led This is reflected in the Trust's Annual Governance Statement.

2) The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

It is recommended the Board signify its compliance as the Trust Board Secretary has made the Board, Audit Committee and Executives aware of monitor guidance and any impact / improvements to be made within Trust systems as a result.

3) The Board is satisfied that the Trust implements:
(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

It is recommended the Board signify its compliance as these processes were referred to and their effectiveness was considered by the Accountable Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair.

4) The Board is satisfied that the Trust effectively implements systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

It is recommended the Board signify its compliance as the Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas. Assurance is routinely and regularly obtained as to the quality of the data supporting the Trust's performance reporting and decisions being taken. The Board has approved the Trust's longer term strategy and annual plan. Key risks and associated assurance has been reported to the Audit Committee and Board during the year and the process has been subject to Internal Audit review which concluded positively over the Trust corporate risk and assurance processes.

5) The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

It is recommended the Board signify its compliance as there is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Quality Account and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. The Trust's quality priorities continue to be set in consultation with the Governors and other stakeholders with regular reporting of the delivery against these priorities provided to the Board and the Council of Governors and our Commissioners. The effectiveness of these processes was again considered by the Accountable Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report.

6) The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

It is recommended the Board signify its compliance as the Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year with the outcome of this reported to the Board's Remuneration and Nominations Committee as part of the relevant appointment process. An annual review of all Board Members continuation as fit and proper persons was also reported to the Board at the end of the year. The Board through its Workforce and Staff Engagement Committee has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention. Regular reporting is provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed

quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services.

Training of Governors

The Board is required to indicate it is complaint with the following statement or if not state why it is non complaint.

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

It is recommended the Board signify its compliance as the Trust has established a programme of training for the Governors, which includes training as part of their induction supplemented by workshops where new information on developments are discussed. The Trust's training package was reviewed in 2016/17 against NHS Providers govern well modular training package to ensure the breadth of the Trust's programme remained comprehensive. This review found no issues with the breadth of training provided. Also at each Council of Governors meeting, including the Annual Members Meeting, a presentation is made by an area of the Trust on its work thus allowing Governors to knowledge to be enhanced. These sessions have included information on Mortality, End of Life and Outpatients Transformation.

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 4th May 2017

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

CORPORATE OBJECTIVES

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

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: COR85, NO32 and COR109.**
	Risk Register: Y		**Risk Score: 20, 16 and 20.**
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 and the decisions taken in accordance with the Committee's terms of reference.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	25th April 2017	Julian Atkins	**yes**	**no**
			Yes	

Declarations of Interest Made

Andy Whallet declared his other role associated to Health Education West Midlands.

Assurances received

Workforce Assurance

1. The Committee received an update on the Workforce Business Plan that gave assurance that agreed objectives are on track at this time. The area brought to the attention of the Committee, subject to agreement by the Executive Team and Trust Board, to go smoke free from 1st January 2018. It was suggested that resources to support the initiative could be made available from the Charitable Funds Committee.
2. The Committee were provided with assurance that policies were either compliant or in the process of being reviewed in order that they would be compliant within the required timescales.

Workforce Education

3. An update of EDS2 was provided which developed into a wider discussion regarding the provisions at the Trust to support the Equality & Diversity agenda for both patient care and staff. It was concluded that there should be further review of our current support to determine if this should be clarified and/or extended. It was agreed that the Director of HR would raise this particular matter within the Executive Team.
4. The Committee received the outline Learning & Development Strategy paper for consideration. It was agreed that this formed a relevant basis to develop this into a full strategy document. It was also agreed that a detailed outline of training costs, as far as possible, should be included to support the strategy.
5. An update was provided on progress and plans to support the optimum use of the apprenticeship levy. The Trust narrowly missed the target of 100 apprentices for 2016/17 as we achieved the appointment of 97 apprentices. We were advised that the Levy contributions took effect from 1st April 2017 and equate to a figure around £900,000 (based on the total Pay Bill), (deducted monthly). The funding remains available for 2 years from the date it enters the account and money can only be spent on approved providers of apprenticeships. A range of qualifications are available and they vary in value depending on type and level In order to utilise

as much of the Trusts' contribution as possible, a range of apprenticeships will need to be offered including higher value degree-level qualifications.

Workforce Performance

6. The Workforce Key Performance Indicators were presented with the Committee pleased with the level of detail provided. The discussion focused on the new format of the report and the information associated the establishment and staffing arrangements for nursing.
7. The new recruitment key performance indicators were presented to the Committee for the first time providing good insight into the timescales and performance at each stage of the process. This highlighted concerns regarding the time taken to shortlist and interview by departments.
8. The Q4 Staff Friends and Family Test score were presented to the Committee. In Q4 we received 170 responses to the Staff Friends and Family Test. Efforts to improve the response rate are planned for the new financial year. 81% of staff were likely or extremely likely to recommend the Trust as a place to receive care or treatment. 73% of staff were likely or extremely likely to recommend the Trust as a place to work. The scores for Q4 were an improvement from Q3. We do expect a fall in score in Q3 as it conflicts with the period of the national staff survey. However, the overall scores for the year indicate an improvement from the previous year.

Workforce Projects

9. The Committee were provided an overview of the new reporting system to support recording and performance for Mandatory Training and Appraisals. The Committee were advised how the system was developed in consultation with end users and that it has been well received by managers.

Workforce Change

10. The Committee were provided confirmation that the MTI recruitment process has now been approved by the Deanery and therefore a working group has been established at the Trust to support the recruitment process alongside the Royal College of Physicians.

Decisions Made / Items Approved

1. The Committee ratified the following policies:
    - Study Leave Policy
    - Clinical Excellence Awards Policy
    - Mandatory Training Policy
    - Clinical Skills Training Policy
    - Safeguarding Staff Training Policy

Actions to come back to Committee (items the Committee is keeping an eye on)
1. The Committee requires further feedback regarding progress on the implementation of the following: • Junior Doctor Contract Implementation • Workforce Strategy (Business Plan) • Staff Survey Action Plans • Equality & Diversity support in the Trust. • Nurse Staff in post alongside establishment.
Items referred to the Board for decision or action
There were no items requiring Board decision or action.

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for Submission to the Board of Directors on 4th May 2017

TITLE:	**Medical Revalidation Update**		
AUTHOR:	**Paul Stonelake Responsible Officer**	**PRESENTER**	**Paul Stonelake Responsible Officer**

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

SUMMARY OF KEY ISSUES:

Revalidation for medical staff commenced in December 2012 and is required by all doctors to be given a licence to practice every five years. In order to be revalidated doctors require five satisfactory annual strengthened appraisals which form the basis of a recommendation for revalidation by the Responsible Officer (RO) to the General Medical Council. The RO was formerly the Medical Director (MD) but to address the risk of potential conflict of interest these roles have now been separated since September 2016.

There has been a temporary shortfall in staffing to support appraisal and revalidation which has now been addressed with the appointment of a replacement Directorate Manager and a Medical Revalidation Support Officer.

Recent circulation of medical appraisal rates through the mandatory training reports has been found to have some inaccuracies. New reporting systems are now being introduced by the Appraisal and Revalidation Team, who will assume responsibility for distributing this information with data sourced directly from the medical appraisal software. Verified compliance with medical appraisal for 2016/7 was 90%, which is in line with national figures.

IMPLICATIONS OF PAPER:

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

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

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of this report as the basis for the 2016/7 Annual Organisational Audit return to NHS England, and to support plans for direct internal reporting of medical appraisal rates by the Appraisal and Revalidation Team as reflects their existing responsibility for reporting this information externally.

REPORT OF THE RESONSIBLE OFFICER TO THE BOARD OF DIRECTORS

April 2017

1. Executive Summary

This report represents the status of medical revalidation and appraisals at The Dudley Group NHS Foundation Trust as of 31st March 2017. It represents the performance of the organisation with regards to the Framework for Quality Assurance for Medical Revalidation (FQA) and the Responsible Officer Regulations and related guidance from the General Medical Council (GMC) which will form the basis of the Annual Organisational Audit for 2016/2017 to be returned to NHS England.

As of 31st March 2017 there were 287 doctors with a prescribed connection to The Dudley Group NHS Foundation Trust as a designated body. The Trust has a good overall appraisal rate of 90% which compares favourably with the national figures. Timely recommendations to the GMC for revalidation are carried out with no missed recommendations and no referrals for non-engagement in the last financial year.

Improved internal reporting of medical appraisal has been identified as a priority and the Appraisal and Revalidation Team propose to circulate the relevant information direct rather than this being processed via Learning and Development.

2. Background

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

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards will oversee compliance by:

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

The Board has directly, and via the Workforce and Engagement Committee, received assurance for the last 4 years from the Responsible Officer and Medical Director that the organisation meets the above duties and responsibilities as set out in the Regulations.

As of 1st September 2016, Mr Paul Stonelake, Consultant Surgeon, was appointed by the Board as Responsible Officer, separating the role from that of the Medical Director. Along with many Trusts where a similar separation has taken place, this removes potential for conflict of interest between the employee / employer relationship versus the appraisal requirements to receive a license to practise through revalidation. The

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

Medical Director via the management structure is responsible for doctors being 'fit for purpose', whereas the Responsible Officer makes recommendations for revalidation to the GMC in relation to doctors being 'fit for practise'.

3. Governance

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

Assurance is provided by reporting to the Workforce and Engagement Committee quarterly and annually to the Board. The Medical Revalidation Group consisting of the Responsible Officer, Appraisal Lead, Directorate Manager and Medical Revalidation Support Officer will meet fortnightly to review progress with appraisal, recommendations for revalidation, and discuss escalation of any issues in relation to this to the GMC.

A separate 'Medical Concerns Group', consisting of the Responsible Officer, Medical Director, Deputy Medical Director and HR Director also meet fortnightly to discuss concerns arising from medical appraisal, complaints/adverse incidents, performance related issues, GMC contact etc. This Group functions as a senior decision making group in relation to whether to investigate further and if so under which process this should be carried out. It also reviews the outcome of any ongoing investigations and the implementation of any resultant recommendations.

4. Medical Appraisal Performance

4.1 Appraisal and Revalidation Performance Data

As of 31st March 2017, there were 287 doctors connected to The Dudley Group for the purpose of Medical Revalidation; 203 consultants, 54 Trust Grade doctors (Staff Grade, Associate Specialist etc) and 30 temporary or short term contract holders.

As of that date 257 (90%) had a compete appraisal as defined by NHS England within the previous year; a further 30 doctors had not had a complete annual appraisal within this time period. It is to be noted that the 'window' recommended by the GMC for obtaining appraisal is between 9 and15 months from the last appraisal and consequently many of the doctors failing the NHS England measure will nonetheless fulfil the GMC requirements. We estimate that 16 doctors will be in this category; a further 2 have left the Trust, 2 are new starters, 5 had agreed reasons for postponing appraisal (e.g. illness, gaps in employment, maternity leave etc) and 5 required escalation to the Appraisal Lead and/or Responsible Officer because of delays but are now engaging with the process.

The internal reporting of medial appraisal rates for Directorates/Divisions has been subject to scrutiny recently and inaccuracies have been identified in the processes used to circulate such information by the Learning and Development Department. This is partly due to methods for acquiring this information from the PREP medical appraisal software, and partly due to the database itself being in need of updating. As a

consequence of a temporary absence of support staff in the Appraisal and Revalidation Team there have been difficulties taking over maintaining the database from the Human Resources Department where this was formerly carried out. Vacancies have now been appointed to and it is now proposed that the Appraisal and Revalidation Team take responsibility for maintaining the database and using this to circulate reports both externally and internally as required.

4.2 Appraisers

There are a total of 68 Medical Appraisers within the Trust. The new Appraisal & Revalidation Lead holds quarterly appraisal drop in and development sessions supported by the General Medical Council (GMC).; Training and Development such as Duty of Candour, Consent and Mental Capacity Act training is mandatory for appraisers. Additionally, some appraisers have undergone enhanced mentorship training. This should allow the Trust to draw from this same pool of doctors suitable mentors for newly appointed consultants and other doctors where mentorship is required.

4.3 Quality Assurance

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

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

The Responsible Officer is exploring mutual external peer review of our appraisal processes and outcomes with neighbouring Trusts to independently quality assure the systems in place.

4.4 Access, Security and Confidentiality

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

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

4.5 Clinical Governance

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

5. Revalidation Recommendations

The Trust has made timely recommendations to the GMC for all doctors due 2016/2017. All deferrals were made due to insufficient information being contained within appraisal portfolios. Deferral is neutral and doctors are given between 4 to 12 months to meet the required standards.

Revalidation Recommendations	Total
Recommendation for revalidation	14
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
Referral for non-engagement	0
Deferrals (total)	8
Deferrals followed by recommendation for revalidation	5
Deferral (doctor left the Trust)	2
Deferral (submission date not due)	1

6. Recommendations

The Board is asked to note the contents of this report as the basis for the 2016/7 Annual Organisational Audit return to NHS England, and to support plans for direct internal reporting of medical appraisal rates by the Appraisal and Revalidation Team as reflects their existing responsibility for reporting this information externally.

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 4th May 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:

The Trust has identified schemes totalling **£11,431k** against a 2016/17 Full Year (FY) target of **£11,908k**, leaving a shortfall against the target of **£476k**.

The Trust is forecasting to deliver £10,046k of the £11,431k it has identified to date.

This creates a shortfall of **£1,385k** against identified schemes. As a result, the Trust is forecasting an overall shortfall of **£1,861K** for 2016/17.

Transformation Executive Committee (TEC) met on 20th April 2017 to discuss:

- Review overall CIP delivery status and progress for 2016/17.
- Review 2017/18 CIP planning progress

2017/18 CIP planning has identified schemes to deliver a full year effect of £12.5m .This is in line with the CIP target agreed in the Financial Annual Plan approved in April Board meeting. £1.3m has already been achieved through contract negotiations or budget setting.

The schemes included in the Baseline Budget 2017-18 are shown within the Financial Budget Package 2017-18. Whilst some of these schemes have agreed PIDs, a number still need to be developed in terms of detail and approved. It has also been agreed that the Programme be reconfigured to reflect more directly the Divisional structure and leadership of schemes. Executive Directors will no longer take the lead for thematic areas and the line of sight to delivery will be more transparent.

Transformation Executive Committee, now chaired by the Chief Executive, will continue to oversee schemes in 2017-18 and report back to Finance and Performance Committee and Board. Project leads will also attend the meeting to report on delivery. Work is underway to enact these changes and further detail will be available next month.

IMPLICATIONS OF PAPER:

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

			ST002 – Delivery of the Programme negatively impacting on Quality of Care or Patient Experience COR080 – Failure to deliver 2016/17 CIP
	Risk Register: **Y**		**Risk Score:** 4, 4, 16 (respectively)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	Monitor	**Y**	**Details:** Non delivery of CIP
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y	Y	

RECOMMENDATIONS FOR THE BOARD

a. **Note the year end position for 2016/17 and the progress made regarding the 2017/18 Programme**
b. **Note the proposal to revise the Programme structure.**

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 Programme Management Office Update

4th May 2017

Executive Summary – 2016/17

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

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

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

A summary of CIP performance as at Month 12 is provided below (with supporting detail overleaf):

	Full Year (FY)			YTD Performance against identified Plans			Y/E Forecast of identified Plans	
CIP Project Plans	FY Target	FY Identified	Shortfall against FY Target	YTD Plan (from identified schemes)	YTD Actual	YTD Variance (against identified schemes)	Y/E FYE of identified schemes	Y/E FYE Variance of identified schemes
TOTAL	£11,908k	£11,431k	-£476k	£11,431K	£9,314k	-£2,117k	£10,046k	-£1,385k

Based on the Month 12 position, the Trust 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 delivered £10,046k of the £11,431k it identified, creating a shortfall of **£1,385k** against identified schemes. As a result, the Trust finished the 2016/17 year with a shortfall of **£1,861k**.

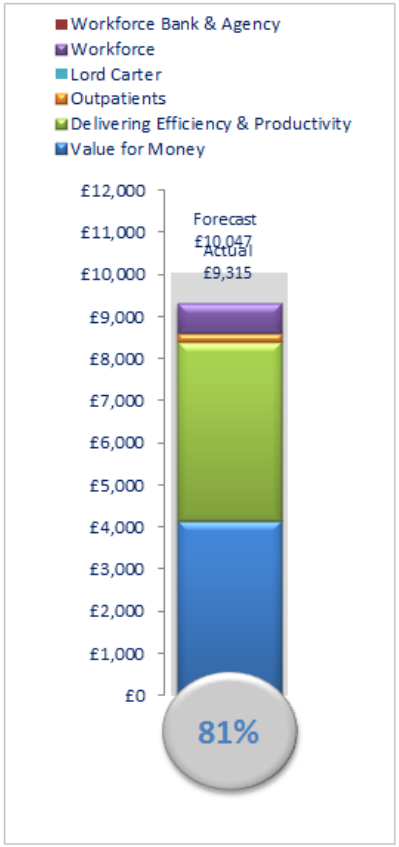
The following projects finished the year with a shortfall against the original target;

CIP	Plan	Forecast	Forecasted Shortfall against original plan
WORK013 Bank and Agency	£592k	£0k	**£592k**
DEP-KPCH002 Creating an Integrated Service	£1,450k	£955k	**£495k**
VFM002 Managed Service Contract Pathology	£300k	£0k	**£300k**
DEP-SUR003 Theatres Operational Management	£900k	£643k	**£257k**
WORK002 Consultant Job Planning	£200k	£86k	**£113k**
OUT003 IT Efficiencies	£103k	£14k	**£90k**

Executive Summary – 2016/17

	YTD	FYE
Planned	£11,431,963	£11,431,963
Actual	£9,314,888	£9,314,888
Forecast		£10,046,927
Variance	-£2,117,076	-£1,385,036

	Submitted Plan	Overall Shortfall
Identified	£11,431,963	
Target	£11,907,990	
Variance	-£476,027	-£1,861,063



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	£4,249,910	£4,690,059	£4,243,726	-£440,149	£2,993,347
Value for Money Infrastructure	Paul Taylor	£4,895,783	£4,506,240	£4,895,783	£4,137,800	-£389,544	£1,343,000
Workforce	Andrew McMenemy	£950,321	£775,825	£950,321	£724,092	-£174,496	£300,004
Outpatients	Anne Baines	£303,800	£214,952	£303,800	£209,270	-£88,848	£303,800
Lord Carter	Anne Baines	£0	£0	£0	£0	£0	£0
Workforce Bank & Agency	Paul Taylor	£592,000	£300,000	£592,000	£0	-£292,000	£592,000
View all Projects	Total	£11,431,963	£10,046,927	£11,431,963	£9,314,888	-£1,385,036	£5,532,151

2016/17 Forecast Non Recurrent	£2,646k	% of Total CIP Forecast as Non Recurrent	26.34%

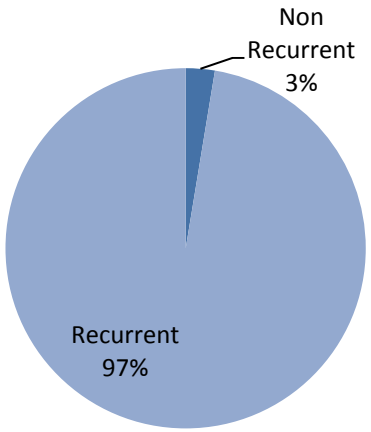
Executive Summary – 2017/18

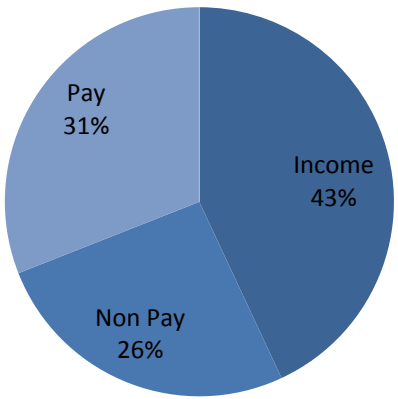
A CIP target of £12.5m as agreed at Trust Board on 6th April has been fully identified in ideas and plans. The work programme includes CIP plans at varying stages of the project management cycle and have varying levels of risk attached to them

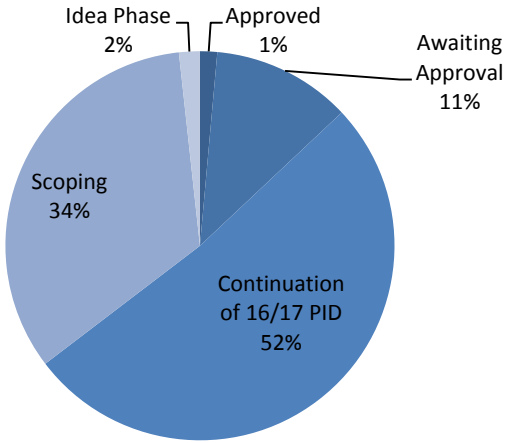
Of the £12.5m identified, £1.3m has already been achieved through budget setting or contract negotiations.

42 of 67 schemes currently on the work programme contribute to the £12.5m identified, and 3% of the CIP has currently been identified as non recurrent savings.

Row Labels	Agreed CIP 17/18 (Financial Plan)
Delivering Efficiency and Productivity	£5,005,409
Workforce B&A	£3,647,725
Value for Money Infrastructure	£3,201,099
Outpatients	£655,602
Workforce	£0
Grand Total	**£12,509,834**







Lessons Learnt from 2016/17 slippage against original CIP

- In year identification of CIP - There's a need to collect CIP ideas during the year as slippage during the year in many cases is not mitigated against
- - Robust Programme Management - Ensuring CIP schemes are developed in a robust way that mean clear milestones are identified linked to when the CIP is expected to be delivered.
- - Risk management - Early identification of risks that will have a detrimental impact on CIP delivery and ensuring sufficient mitigation is taken against these key risks
- - CIP Targets - Where additional CIP can be generated above original targets this is encouraged, so we move away from areas stopping when the target has been achieved
- Increased focus on Division responsibility to deliver savings
- No targeting beyond themes. Move to more equitable target setting across all areas including Corporate Directorates

Enclosure 14

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 4 May 2017

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Paul Taylor Director of Finance and Information	**PRESENTER**	J Fellows Non-Executive Director
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: Summary reports from the Finance and Performance Committee meeting held on 27 April 2017.			

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

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

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**27 April 2017**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- Plans are in place by the senior nurses of the Trust to significantly reduce agency spending in 2017-18 on qualified and un-qualified staff through staff retention, recruitment and control of rotas and shifts booked externally
- The out-turn for 2016-17 was confirmed (subject to audit) to be a deficit of £496,000 (excluding STF) which, when incorporating Dudley Clinical Services and accounting for donated asset adjustments was £390,000 better than the control total deficit of £726,000
- It was confirmed verbally that an additional STF premium of £1.445 had been notified to the Trust on 24th April 2017 resulting in a year-end surplus after STF of £11.584m

Decisions Made / Items Approved

- The Cost Improvement Programme for 2017-18 of £12.51m was agreed, although it was noted that this was heavily reliant on a quantum reduction in agency spending and a reduction in bed capacity owing to a reduction in beds which are currently occupied by patients whose discharge has been delayed through social care funding restraints (Delayed Transfers of Care)

Actions to come back to Committee

- None

Performance Issues to be referred into Executive Performance Management Process

- The work being undertaken on the information collection for RTT
- The external audit recommendations for the calculation of the ED standard
- The spending position on medical agency and the part played my medical workforce rotas

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

- The risk that contract income will be further reduced through a worsening of the re-admission rate, or the application of the Marginal Rate for Emergency Admissions
- The income risk to the Trust through a combination of CIP and contract over-performance
- The risk to liquidity of not receiving the £8.5m STF in 2017-18 given the size of the capital programme
- The level of delayed transfers of care does not free up significant bed capacity in 2017-18
- Continued high level of agency spend

Items referred to the Board for decision or action

- The business case for Hybrid Mail was reviewed and recommended for approval by the Board subject to a paper being submitted to Finance and Performance

Committee in 6 months' time on the potential for staff savings, and confirmation that the preferred supplier is the only supplier on the framework who can meet the Accessible Information Standard

- To note the Year –End position for 2016-17 and the non-recurrent steps taken to achieve it
- To note the proposed change to the membership of the Finance and Performance Committee to widen the membership to include representatives of the 3 new Divisions and the Director of IT

THE DUDLEY GROUP NHS FOUNDATION TRUST

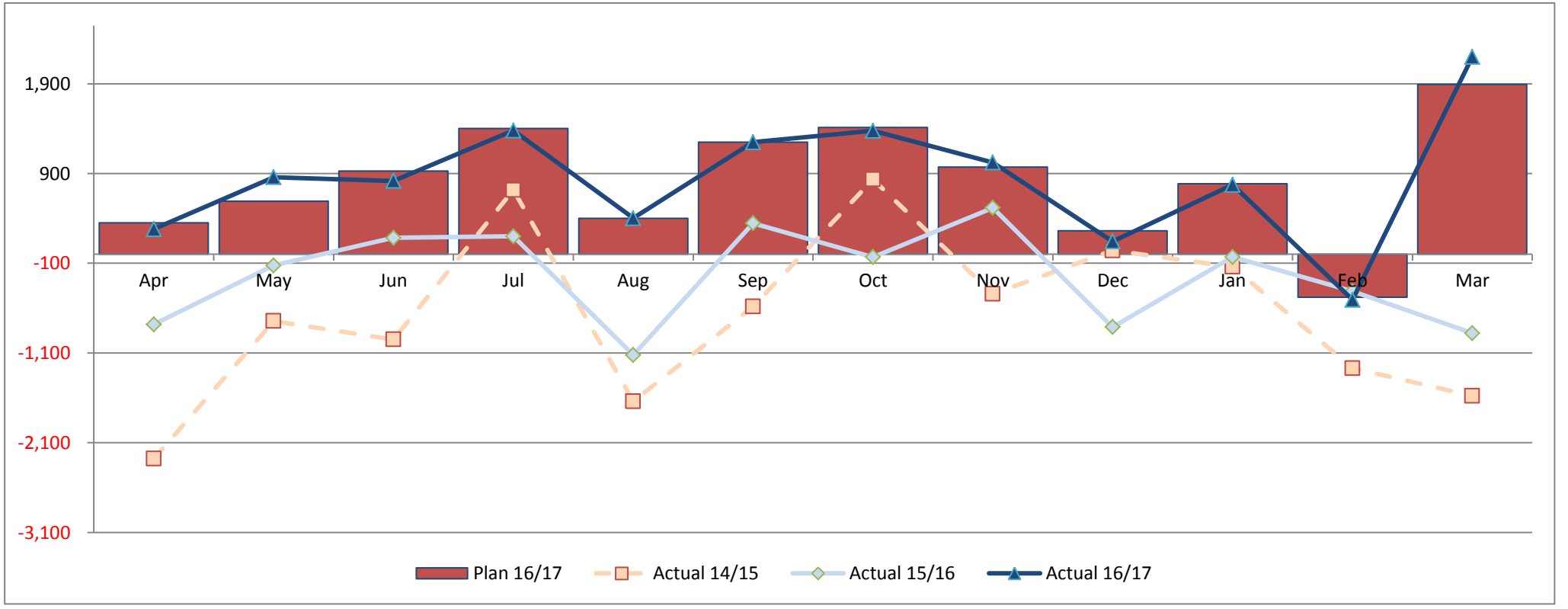
FINANCIAL SUMMARY **MARCH 2017**

	CURRENT MONTH		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£30,001	£31,925	£1,924
PAY	-£16,625	-£16,981	-£357
NON PAY	-£9,512	-£10,543	-£1,032
EBITDA	**£3,865**	**£4,401**	**£536**
OTHER	-£1,971	-£2,201	-£230
NET	**£1,894**	**£2,200**	**£306**

	CUMULATIVE TO DATE		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£345,993	£350,554	£4,561
PAY	-£199,207	-£203,095	-£3,888
NON PAY	-£113,360	-£114,683	-£1,323
EBITDA	**£33,426**	**£32,776**	**-£650**
OTHER	-£23,652	-£22,771	£881
NET	**£9,774**	**£10,004**	**£230**

	YEAR END FORECAST		
	BUDGET £000	ACTUAL £000	VARIANCE £000
INCOME	£345,993	£350,555	£4,561
PAY	-£199,207	-£203,095	-£3,888
NON PAY	-£113,360	-£114,684	-£1,323
EBITDA	**£33,426**	**£32,776**	**-£650**
OTHER	-£23,652	-£22,771	£881
NET	**£9,774**	**£10,004**	**£230**

NET SURPLUS/(DEFICIT) 16/17 PLAN & ACTUAL **MARCH 2017**



APPENDIX 2

Finance & Performance Report - March 2017

Quality & Risk			2016									2017				
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
Friends & Family – Community – Footfall		1%	1.4%	1.1%	1.5%	1.1%	1.3%	1.1%	0.6%	1.3%	1.3%	1.5%	1.2%	1.2%	1.2%	
Friends & Family – Community – Recommended %		96.4%	96.8%	94.7%	94.4%	97.3%	96.1%	96.1%	95.1%	95.5%	94%	94.4%	97.8%	97.3%	95.8%	
Friends & Family – ED – Footfall		7.5%	5%	3.8%	1.6%	8.4%	10.7%	5%	5%	3.7%	4.3%	13.1%	15.4%	18.6%	7.9%	
Friends & Family – ED – Recommended %		92.3%	91.4%	91.3%	88.2%	91.7%	91.8%	91.9%	93.8%	93.1%	90.1%	75.3%	76%	81%	85.1%	
Friends & Family – Inpatients – Footfall		25.7%	17.7%	15.8%	13.9%	17.9%	18.6%	20.5%	19.2%	19.2%	17%	17.9%	18.1%	18.3%	17.8%	
Friends & Family – Inpatients – Recommended %		97%	96.8%	96.7%	97%	94.6%	96.6%	96.6%	97.9%	95%	97.9%	95.8%	97.3%	97.3%	96.6%	
Friends & Family – Maternity – Footfall		21.6%	17.6%	33.2%	16.6%	33.8%	32.7%	32.3%	27.6%	36.5%	33.9%	34.5%	29.5%	32.7%	30.1%	
Friends & Family – Maternity – Recommended %		98.2%	97.5%	97.3%	98.9%	96%	98.6%	98.8%	98.8%	99.5%	99.4%	97.6%	98.2%	99%	98.3%	
Friends & Family – Outpatients – Footfall		-	1.2%	1.1%	1%	1.7%	1.5%	1.4%	1.5%	2.5%	1.5%	2.4%	1.9%	1.7%	1.6%	
Friends & Family – Outpatients – Recommended %		87.6%	85%	82.2%	93.1%	91.7%	92.4%	92.4%	93.2%	94.9%	93.1%	95%	94.1%	96.2%	92.6%	
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		-	2	3	2	2	-	-	-	-	-	-	-	-	-	
Incidents - Pressure Ulcer		2,047	253	240	194	193	196	188	192	202	212	233	216	254	2,573	
Mixed Sex Sleeping Accommodation Breaches		4	0	0	0	0	0	0	4	4	7	26	14	7	62	
Never Events		1	0	0	0	0	1	0	0	0	0	0	0	0	1	
Serious Incidents – Not Pressure Ulcer		104	7	6	4	12	11	6	7	9	8	12	8	10	100	
Serious Incidents - Pressure Ulcer		228	13	9	8	10	17	16	14	8	9	19	10	17	150	
Stroke Admissions : Swallowing Screen		80.58%	89.36%	88.37%	85.11%	78.72%	73.91%	62.5%	75.68%	73.33%	77.55%	66.67%	67.31%	76.32%	76.46%	
Stroke Admissions to Thrombolysis Time		56.31%	60%	50%	83.33%	36.36%	54.55%	50%	66.67%	37.5%	30%	83.33%	33.33%	50%	51.25%	

Finance & Performance Report - March 2017

Quality & Risk			2016									2017				
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)		89.16%	82.76%	91.11%	91.53%	90.2%	88.64%	89.36%	97.5%	86.54%	89.8%	79.03%	83.64%	86.27%	87.6%	
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation		85.35%	84.62%	78.57%	36.36%	63.64%	66.67%	83.33%	93.33%	80%	100%	66.67%	93.75%	100%	79.72%	
VTE Assessment Indicator (CQN01)		95.96%	94.65%	95.5%	95.09%	93.91%	94.5%	93.91%	95.65%	95.64%	94.64%	93.92%	92.58%	95.97%	94.68%	

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

Finance & Performance Report - March 2017

Finance			2016													
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
Budgetary Performance		£773k	(£71)k	£266k	(£110)k	(£23)k	£3k	(£1)k	(£35)k	£52k	(£118)k	(£11)k	(£28)k	£306k	£230k	
Capital v Forecast		-	61.8%	66.5%	76.2%	76.4%	73.9%	72.1%	69.6%	57.4%	88.4%	75.5%	64.1%	-	-	
Cash v Forecast		-	94.8%	93.2%	96.2%	74.9%	89%	93.7%	80.4%	93%	92.7%	68.4%	84.2%	-	-	
Debt Service Cover		-	1.4	1.58	1.63	1.74	1.69	1.72	1.77	1.77	1.71	1.71	1.63	-	-	
EBITDA		£20,460k	£2,228k	£2,820k	£2,755k	£3,321k	£2,358k	£2,550k	£3,221k	£2,835k	£2,299k	£2,657k	£1,330k	£4,401k	£32,776k	
I&E (After Financing)		(£2,945)k	£280k	£859k	£818k	£1,380k	£403k	£1,249k	£1,378k	£1,023k	£144k	£775k	(£507)k	£2,200k	£10,004k	
Liquidity		-	7.1	8	8.84	10.39	10.93	11.94	13.23	14.14	12.51	13.38	12.57	-	-	
SLA Performance		£1,031k	(£122)k	£316k	£138k	£0k	£221k	(£220)k	(£28)k	£256k	£42k	£340k	£548k	£447k	£1,937k	
SLR Performance		(£2,945)k	£281k	£859k	£819k	£1,381k	£403k	£1,249k	£1,378k	£1,024k	£144k	£775k	(£507)k	£2,201k	£10,007k	

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

Finance & Performance Report - March 2017

Performance			2016									2017				
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
A&E - 4 Hour A&E Dept Only % (Type 1)		96.79%	93.24%	92.88%	94.48%	93.34%	92.97%	92.14%	92.3%	86.08%	82.86%	77.85%	86.3%	92.46%	89.77%	
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%	96.3%	96.06%	96.76%	96.21%	95.81%	95.29%	95.51%	91.97%	90.78%	87.7%	92.31%	95.59%	94.16%	
Activity - A&E Attendances		96,141	7,807	8,801	8,433	8,973	8,579	8,594	8,929	8,477	8,718	8,607	7,758	9,020	102,696	
Activity - Community Attendances		407,248	32,681	32,631	32,846	31,673	33,863	33,078	32,365	34,044	33,676	33,404	29,912	34,208	394,381	
Activity - Elective Day Case Spells		45,020	3,801	3,720	3,998	3,798	3,895	3,911	3,721	3,888	3,428	3,761	3,748	4,313	45,982	
Activity - Elective Inpatients Spells		6,394	514	523	549	561	482	506	540	518	454	414	440	528	6,029	
Activity - Emergency Inpatient Spells		52,037	4,824	5,246	5,077	5,054	5,002	4,933	5,038	5,119	5,171	5,107	4,765	5,412	60,748	
Activity - Outpatient First Attendances		130,956	10,245	10,527	10,560	9,890	10,006	10,799	10,445	11,007	9,158	10,610	10,450	12,172	125,869	
Activity - Outpatient Follow Up Attendances		313,888	26,366	26,733	26,893	25,084	25,384	26,492	25,427	27,159	23,292	26,406	24,567	26,804	310,607	
Activity - Outpatient Procedure Attendances		52,451	4,976	4,951	5,210	5,090	4,898	4,992	4,845	4,985	4,067	5,163	5,133	5,311	59,621	
RTT - Admitted Pathways within 18 weeks %		94.2%	92.5%	93.5%	94.2%	94.2%	95%	93.2%	93.9%	92.6%	92.9%	91.4%	88%	88.5%	92.4%	
RTT - Incomplete Waits within 18 weeks %		95.1%	97.1%	96.8%	97.1%	97.1%	96.6%	96.1%	95.6%	95%	94.5%	94.2%	93.3%	92.8%	95.4%	
RTT - Non-Admitted Pathways within 18 weeks %		97.7%	96.7%	97.7%	98.1%	98%	98.4%	97.1%	95.9%	96.3%	96.3%	94.2%	94.3%	95%	96.5%	
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)		98.97%	98.04%	99.39%	99.16%	98.96%	97.69%	98.12%	98.59%	97.38%	93.5%	92.25%	97.09%	99.29%	97.41%	

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

Finance & Performance Report - March 2017

Staff/HR			2016									2017				
Description		LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	YEF
Appraisals		77.5%	80.9%	80.5%	81%	78.1%	78.3%	77.4%	77%	77.1%	73.9%	71.7%	75.9%	82.9%	82.9%	
Mandatory Training (Professional Requirements)		-	-	71.3%	72.8%	72.5%	72.4%	70.1%	69.7%	70.7%	69.9%	68.8%	69.9%	71.8%	71.8%	
Mandatory Training (Substantive)		83.3%	83.8%	75.4%	76.3%	77.4%	78.6%	77%	78.5%	79.6%	79.4%	78.6%	80.2%	83.9%	83.9%	
Sickness Rate (Performance Dashboard)		3.80%	3.86%	4.17%	4.04%	4.07%	3.73%	4.04%	4.38%	4.29%	4.30%	4.57%	4.37%	4.16%	4.17%	
Staff In Post (Contracted WTE)		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	4,240.77	4,280.54	4,278.19	4,278.19	
Vacancy Rate		9.41%	10.24%	10.53%	10.78%	10.75%	10.31%	9.61%	9.18%	9.09%	9.18%	8.77%	7.93%	7.90%	7.90%	

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

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Description	Target	All Tumour Sites	Brain	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Paediatric	Skin	Upper GI	Urology	Total
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	93%	-	100%	95.7%	98.6%	92%	100%	98.2%	88.2%	100%	93%	96.9%	98.4%	**96.1%**
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	93%	-	-	96%	-	-	-	-	-	-	-	-	-	**96%**
Cancer - 31 day - from diagnosis to treatment for all cancers	96%	-	-	100%	100%	100%	100%	100%	100%	-	100%	100%	90.9%	**98%**
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%	25%	100%	100%	75%	-	100%	100%	100%	**89.1%**
Cancer - 62 day - From Referral for Treatment following national screening referral	90%	-	-	100%	-	-	-	-	-	-	-	-	-	**100%**
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85%	-	-	100%	83.3%	25%	100%	0%	100%	-	100%	0%	91.4%	**86.2%**

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