The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 12th October, 2017 at 9.30am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	9.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	9.30
3.	**Announcements**		J Ord	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 6 September 2017	Enclosure 1	J Ord	To Approve	9.30
	4.2 Action Sheet 6 September 2017	Enclosure 2	J Ord	To Action	9.35
5.	**Staff Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	9.50
7.	**Safe and Caring**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 4	D Wulff	To note assurances & discuss any actions	10.00
	7.2 Quality Improvement Board report	Enclosure 5	D Wake	To note its contents	10.10
	7.3 Chief Nurse Report – Infection Prevention and Control	Enclosure 6	S Jordan	To note assurances & discuss any actions	10.20
	7.4 Nurse/Midwife Staffing Report	Enclosure 7	S Jordan	To note assurances	10.30
	7.5 Revalidation Report	Enclosure 8	Paul Stonelake	To discuss and note assurances	10.40

8	**Responsive and Effective**				
	8.1 Finance and Performance Committee Exception report	Enclosure 9	J Fellows	To note assurances & discuss any actions	10.50
	8.2 Performance Report	Enclosure 10	D Wake	To note assurances & discuss any actions	11.00
	8.3 Cost Improvement Programme and Transformation Overview Report	Enclosure 11	P Taylor	To note assurances & discuss any actions	11.10
9.	**Well Led**				
	9.1 Workforce Committee Exception Report including workforce strategy update	Enclosure 12	J Atkins / A McMenemy	To note assurances & discuss any actions	11.20
	9.2 Emergency Planning Report including Core Standards submission	Enclosure 13	D Wake	To note & Approve return	11.30
	9.3 Charitable Funds Committee Exception Report	Enclosure 14	J Atkins	To note assurances & discuss any actions	11.40
	9.4 Digital Trust Committee Exception Report	Enclosure 15	A Becke/ M Stanton / J Dale	To note assurances & discuss any actions	11.50
10.	**Any other Business**		J Ord		12.00
11.	**Date of Next Board of Directors Meeting** 9.30am 2 November, 2017 Clinical Education Centre		J Ord		12.00
12.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		12.00

Quorum: One Third of Total Board Members to include One Executive Director and One Non Executive Director

Enclosure 1

The Dudley
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 7th September, 2017 at 8:45am in the Clinical Education Centre.

Present:

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

In Attendance:

Helen Forrester, EA
Glen Palethorpe, Director of Governance/Board Secretary
Mark Stanton, Chief Information Officer
Dr Mark Hopkin, Associate Non Executive Director
Patient presenting Patient Story (Item 5)
Elizabeth Rees, Director of Infection Prevention and Control (Item 7.5)
Dr Babar Elahi, Guardian of Safe Working (Item 7.6)
Derek Eaves, Speak Up Guardian (Item 7.7)
Ned Hobbs, Director of Operations (Item 8.3)
Lisa Peaty, Deputy Director of Strategy (Item 9.3)
Jane Dale, Chief Clinical Information Officer (Item 9.5)
Emma Foreman, Deloitte, External Board Observation Review
Tom Berry, Deloitte, External Board Observation Review

17/089 Note of Apologies and Welcome
8.50am

Andrew McMenemy, Director of Human Resources and Liz Abbiss, Head of Communications, had sent apologies.

The Chairman welcomed Jo Marshall who was attending to present the patient story along with staff from Ward B4.

The Chairman welcomed Amrit Lochab, Deputy Director of Human Resources who was observing the Board to take note of any actions for the Director of HR who had sent apologies.

17/090 Declarations of Interest
8.52 am

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

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

There were no other declarations of interest.

17/091 Announcements
8.52 am

The Chair confirmed that Paul Harrison will be moving back into his Clinical role and stepping down as medical director over the course of the next few months. The Board thanked him for his work in the role of Medical Director.

17/092 Minutes of the previous Board meeting held on 3rd August, 2017 (Enclosure 1)
8.53am

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

17/093 Action Sheet, 3rd August, 2017 (Enclosure 2)
8.54am

17/093.1 Trust Annual Plan Objectives 2017-18

The Chairman confirmed that within the later item that she would ask that the Deputy Director of Strategy draws out where in the Annual Plan the stated amendments had been made. As such it was agreed that this action could be considered closed

17/093.2 Health, Safety and Fire Assurance

The Chairman asked that the Fire Safety item later on in the agenda updated the Board on the actions that had been taken to satisfy the regulators, as with the previous action the Board agreed with that update this action could be considered closed.

17/093.3 Organ Donation Report

Organ Donation week was noted to be progressing and had been successful with a stand in main reception, people registering to become organ donors, tweeting and blogs on the Trust website. Dr Hopkin confirmed that communications had also gone out to Primary Care and the staff at his practice had all signed up to be donors. The Board agreed that this action could be considered closed.

17/093.4 Clinical Strategy

The Medical Director confirmed that a meeting had taken place on 4th September where the draft Strategy had been finalised and it will be launched the following week. The Board agreed with that update, this action could be considered closed.

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

17/094 Patient Story
8.59am

Jo Marshall presented her patient story.

Jo had been diagnosed with Bowel cancer and described to the Board her treatment journey. She had a generally very positive story particularly in respect of the care on Ward B4, staff from the Ward were present to hear the story.

Jo detailed 5 challenges that she faced during her treatment including functioning bed side table equipment and the general environment, food and car parking, test results, cancelled appointments and the waits for results and treatment.

Jo highlighted to the Board 8 positive aspects of her journey including the care on Ward B4, the Trust's volunteers, the diligence of support staff, especially the cleaners, the way she had been treated with dignity and respect, how she had been provided with choice, that she had received good care in respect of her emotional wellbeing, there had been a smooth discharge and she had experienced easy access to her treatment teams, communication had been good and how she valued the access to wifi to enable her to remain connected to her social media when in the hospital .

The Chairman and Board noted the story and thanked Jo for being brave enough to share her experiences personally with the Trust and wished her well in completing her journey. The Board also thanked the staff representatives from Ward B4 who had clearly had such a positive influence on Jo's experience with the Trust. . The Medical Director stated that sometimes the importance of the little things in a patient's journey sometimes pass staff by and it is good to be reminded of these. The Chief Operating Officer commented that the use of social media is a very important tool for patients as in this case it enabled him to meet Jo and speak with her whilst she was with us about her positive experiences as they happened. The Chief Nurse asked about free wifi and the Chief Information Officer confirmed that this would be in place before the end of the year. The Chief Nurse also confirmed that the student nurse, cleaner and volunteer will all be contacted to thank them for their contribution to Jo's experience of the Trust. The Chairman and Chief Executive both thanked Jo and the staff from Ward B4 and confirmed that the Trust was aware of some of the areas that needed improvement.

The Chairman asked for a formal thank you to go to Jo, the Ward staff, volunteer, cleaner and student from the Board.

Thank you letters to be sent to Jo Marshall, the ward staff, volunteer, cleaner and student nurse.

17/095 Chief Executive's Overview Report (Enclosure 3)
9.28am

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

- Performance: The Board noted the challenges around the emergency access standard. The Trust was doing everything possible to get back to a favourable position and was working with partners in the Health Economy and particularly with patient transport where there had been some significant challenges.

- Cancer Performance: After some poor performance the Trust was now back on track to achieve 62 day performance target.

- Healthcare Heroes: This initiative had only just been recently launched and the first award had been presented the previous day. The staff receiving this award were all grateful for the recognition this provided over the work they had done

- Capital Projects: The Trust's two major projects, were both running slightly behind schedule but the Trust is working with its contractors to try and get each scheme back on track.

- Nursing Times Awards: The Trust had been shortlisted which was a testament to the work of the nursing staff at the Trust.

- CQC: The Trust was due a CQC inspection in quarter 3. The CQC had been supportive of the work the Trust is doing following a recent visit by our local CQC engagement inspector.

- Fire Safety: The Trust had received a positive draft report from the external inspection.

Mr Miner, Non Executive Director, asked about the new style quality review visits. The Chief Nurse outlined the changes including an increased frequency to the visits and changes to the rating system to mirror the CQC ratings. Mr Miner stated that the Board would not want to lose the opportunity to speak to staff within this process. The Chief Nurse confirmed that this would still be a key element of these visits along with other opportunities such as executive / non executive walk arounds. The Chairman confirmed that she had undertaken 2 such walk arounds and it was useful to see the area through a patients eyes. The Chairman asked the Non Executive Directors to put dates in their diaries if they wished.

Mr Atkins, Non Executive Director, asked about the process for follow up from the visits. The Chief Nurse confirmed that this will be done within a month where concerns were raised.

Mrs Becke, Non Executive Director, stated that it would be more useful to be provided with dates.

The Chief Executive stated that it was very positive to have structured walkrounds and encouraged Non Executive Directors to visit hospital areas and feedback.

Mr Fellows, Non Executive Director, asked where feedback would be reported. The Chief Executive confirmed that this would be to Clinical Quality, Safety, Patient Experience Committee and Non Executive Directors will be able to access this information.

The Medical Director stated that staff and patients appreciate Board members taking a direct interest in the clinical areas.

The Chairman asked the Chief Nurse to supply dates to Mrs Becke and the other Non Executive Directors. Mr Miner confirmed that evening sessions would also be helpful.

The Chairman confirmed that there had been a lot of good nominations for Healthcare Heroes and urged colleagues to continue to nominate people.

In response to the request of the Chair in respect of fire safety, the Chief Operating Officer stated that there was minimal risk to the site and no major concerns regarding fire safety following external review of our premises, there were just some minimal corrective actions noted as you may expect from any survey. There was no requirement to report to the regulator as the Trust was not classed as high risk and the report confirmed that assessment. Actions will be picked up through the Health and Safety Group and then through Clinical Quality, Safety, Patient Experience Committee and the Finance and Performance Committee dealing with the more minor issues from the inspection

The Chairman and Board noted the report.

Walkround dates to be supplied to the Non Executive Directors.

17/096 Safe and Caring

17/096.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
9.46am

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

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

Executive Management assurance was provided in respect of the Trust's processes for receiving, disseminating and assessing NICE guidance. The Committee were informed of the enhanced role the Clinical Audit team were taking over the next three months to work with Divisions and specialty leads to improve the Trust's assessment processes and therefore mitigate the local divisional risks in relation to compliance with NICE guidance. A further report showing the improvement to the Trust's processes to be brought back to the Committee the following month.

- The Committee had tasked the Quality and Safety Group to secure assurance over compliance with the recently received national Open Systems Alert.

The Committee had also agreed a schedule of deep dives across the next five months in respect of three corporate risks the Committee has oversight for, one being ophthalmology which was an area discussed at the Committee previously.

The Chief Executive stated that the good assurance had been received at the Committee in respect of the Ophthalmology planned actions and this was also monitored closely by Directors.

The Medical Director confirmed that he had recently had cause to be a mystery shopper in Ophthalmology and received good service.

The Chair had recently undertaken a walkround in Ophthalmology and had noted issues with clutter and cleaning standards which was fed back for action to be taken.

The Chief Nurse confirmed that Grade 4 pressure ulcers in the Community was a focus of attention. The Chief Executive added that this was not a new problem but it had not previously been reported and the Trust was trying to make rapid improvements.

Mrs Becke, Non Executive Director asked if the Trust could identify where there was a higher incidence of non compliance with best practice. The Chief Executive confirmed that this would be picked up through the RCA process.

The Board noted that the Trust had appointed a Community Tissue Viability nurse which will strengthen the support provided to pressure care in the community.

Dr Hopkin, Associate Non Executive Director, asked about if there had been any non-reporting. The Chief Nurse confirmed that staff had previously felt discouraged from reporting but now feel able to speak up. Dr Hopkin welcomed the cultural change.

Mr Miner, Non Executive Director, asked if disciplinary action was taking place where reporting had been discouraged. The Chief Executive confirmed that there was a potential for this and if required would be taken.

The Chairman and Board noted the report, assurances received, decisions made and areas the Committee were keeping close oversight of.

17/096.2 Audit Committee Exception Report (Enclosure 5)
10.16am

Mr Miner, Committee Chair, presented the Audit Committee Exception Report, given as Enclosure 5.

The Board noted the following key issues:

- Assurances had been received from the Risk and Assurance Group as to the completeness and appropriate representation of the Trust's corporate risks.

- Internal Audit advisory reports had been received for appraisals and mandatory training.

- The Committee had approved the outcome of a comprehensive review of the Standards of Business Conduct Policy.

- The Committee had requested a further deep dive into workforce issues be undertaken by the Workforce Committee, particularly concerning appraisals and mandatory training actions, as identified in the internal audit reports. This will culminate in Rachel Andrew reporting back to the Audit Committee at its next meeting later this year.

The Chairman and Board noted the report and the importance of cross-referral of work between Committees and supported the Committee request that appraisals be a focus at the Workforce Committee at its next meeting.

Appraisals to be a focus of the Workforce Committee at its next meeting.

.

17/096.3 Chief Nurse Report – Infection Prevention and Control Update (Enclosure 6) 10.18am

The Chief Nurse presented her report, given as Enclosure 6.

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

- MRSA: The Board noted the positive performance in this area.

- CDiff: The Trust continued to do well with 10 cases to date. Of these 8 were noted to be a lapse in care. The target for the year was 29 compared to 33 for last year. The Chief Nurse stated that mandatory training must be a focus for the organisation along with the environment.

The Chief Executive confirmed that the Trust is also mandated to focus on the control of other infections and the Board will be sighted on these in future reports. An Environment Group has been established and will be run by the Deputy Director of Finance and the Group would look at the cost of further enhancing cleaning across the Trust.

The Board noted that MRSA screening in maternity is a key focus of the Infection Prevention and Control Committee.

Mr Fellows, Non Executive Director, commented that last year the Trust had 33 cases in total and accepted 13 as lapses in care. There was double this number of lapses accepted to date in the current year. The Chief Nurse commented that this was due to the lack of training within the areas and that the criteria for allocating lapses had changed this year and any failure in training was an automatic apportionment against the Trust. There had only been 2 comparable lapses in care to those reported last year, all the other lapses this year related to the Trust not meeting the training standard.

Mrs Becke, Non Executive Director, commented that mandatory training had been an ongoing issue and asked how the Trust was addressing this. The Chief Executive confirmed that a number of actions are in place and numbers are improving week on week.

The Medical Director stated that there is more work to do around how training is offered to make it more accessible to staff.

The Chairman and Board noted the report and the actions being taken. The Board noted the positive performance in relation to MRSA and actions around mandatory training and the effect this should have on apportioned C.Diff lapses in care.

17/096.4 Monthly Nurse/Midwife Staffing Report (Enclosure 7)
10.28am

The Chief Nurse, presented the monthly Nurse/Midwife Staffing Report given as Enclosure 7.

The Board noted the following key issues:

- Staffing: The Trust was achieving safe staffing levels.
- Ongoing staffing review: Phase 3 of the review was underway. The Community review will commence in the next few weeks and this will be followed by Outpatients.
- The Trust was still focussing on recruitment and retention.

The Chief Executive commented that the Trust was focused on learning from exit interviews.

The Chairman and Board noted the report and the ongoing work in respect of recruitment and retention.

17/096.5 Annual Infection Prevention and Control Report (Enclosure 8)
9.58am

Dr Rees, Director of Infection Prevention and Control, presented the Annual Infection Prevention and Control Report given as Enclosure 8.

The Chairman commented on the apparent late timing of the report.

The Board noted the following key issues:

- Compliance criteria was listed on the first page.
- Systems in place/Risk assessments: The Board noted the assurance process in place over infection prevention and control.

- Providing/maintaining clean and appropriate environment: The Board noted the systems in place to monitor delivery.

- Antimicrobial Prescribing: The report provided assurance that clear processes are in place.

- Information around infections: The Information gathered and issues identified.

- Problems identified: The report provided information on the process whereby issues are flagged and responded to.

- Adequate isolation: The report confirmed that 25% of Trust beds are provided in side rooms.

- Adhering to policies: the report provided information on the audits undertaken to check compliance.

- MRSA: The report restated that there had been no Trust apportioned cases since September 2015.

- C:Diff: the report confirmed that all cases are subject to review to identify whether there were any lapses in care and the Trust falls well within trajectory.

Dr Wulff, Non Executive Director asked about the future role of the Trust's Infection Prevention and Control Forum and how the Trust mitigates the Anti-Microbial Pharmacist risk. The Trust had reviewed the Forum agenda and membership and was increasing the meeting frequency. There was no one available to fill the role of the Anti-Microbial Pharmacist and this is a highly sought after role, however, the Trust is currently out to advert to recuit. The Board noted that the Trust had enhanced the band and noted the risk around the vacant post. The Chairman asked that the risk is included on the Divisional Risk Register. The Chief Executive confirmed that this was already on the Risk Register and the Principle Pharmacist regularly attends the Directors meetings to update them on the plan. Mr Atkins, Non Executive Director, asked if there were any areas where the Trust was looking to target improvement. The Chief Executive confirmed that changes had been made to the scope of the cleaning provided by the PFI provider and that a cleaning policy is being produced to codify this .

The Chairman and Board noted the report and that this will be presented to the Clinical Quality, Safety, Patient Experience Committee next year ahead of a presentation to Board and asked that the report is presented earlier in the cycle of business. The Director of Governance confirmed this would be the case for 2017/18. The Chairman commended the good performance reflected in the report but recognised the challenges associated with the current year as described in the chief nurse's report on this area earlier in the agenda.

17/096.6 Guardian of Safe Working Report (Enclosure 9)
10.33am
Dr Babar Elahi, Guardian of Safe Working presented his Report given as Enclosure 9. The report covered the period 15 May 2017 to 17August, 2017.

The Board noted the following key issues:

- 165 junior doctors in training are already on the new contract.
- The Trust is continuing to fully engage with junior doctors.
- The previous issue with poor engagement with supervisors was now been resolved and all pending issues are closed within a week.
- The draft report had been finalised for the Trust Exception policy.
- The issues with the Allocate software was noted to be a National problem and the Trust continues to seek a resolution.
- Regular data is received from HR and Finance which support Dr Elahi deliver this role.
- The previous delay in payments was noted to be a teething issue and there was confidence that this should not be an issue going forward.
- Only 2 exception issues were reported in the period, which is comparably low to others.
- There were no immediate safety concerns or fines levied in this period, which again was another positive the Trust Board should recognise.
- Dr Elahi assured the Board around the system of compliance.

Mrs Becke, Non Executive Director asked how many doctors were not yet on the new contract. Dr Elahi confirmed that 199 doctors were coming onto the contract in October, which was as planned. All doctors must be on the contract by the end of year.

The Chief Executive confirmed that the Trust was looking at implementing Hospital at Night in the organisation which would support juniors overnight.

Mr Fellows, Non Executive Director, stated that this was an encouraging report and asked if junior doctors were positive about how the contract is working and how does the Trust gather feedback. Dr Elahi confirmed that there had been low morale nationally and work was ongoing to improve this. Feedback is gathered from various forums.

The Medical Director confirmed that vacancies had reduced to 27 and the Trust was taking some MTI doctors from Pakistan all of which helps support the junior doctors.

The Chairman and Board noted the report and actions underway to alleviate pressure on junior doctor colleagues.

17/096.7 Freedom to Speak Up Guardian Report (Enclosure 10)
10.48am

Derek Eaves, Freedom to Speak up Guardian presented his report given as Enclosure 10.

The Board noted the following key issues:

- Numbers of contacts: there had been 6 in the this period, there had been only 2 in the previous reported period..

- Videos were now available on the hub on how to raise concerns.

- The Trust was undertaking a number of initiatives to continue to raise awareness of this role and a fact sheet for staff and managers will be available on the hub shortly.

- The Trust was speaking to Interserve staff who have contact with patients to ensure they are aware of the Trust two Freedom to Speak up Guardians in the Trust

- The National Guardians Office was now producing statistics in respect of Trust contacts. The majority of Trusts had less than ten contacts in the period, which was comparable to this Trust.

Dr Wulff, Non Executive Director, confirmed that he had met with Carol Love-Mecrow, the more established guardian, frequently and would establish meetings with Derek Eaves the newly appointed second guardian. Both guardians also have monthly meetings with the Chief Executive.

Mr Miner, Non Executive Director asked about concerns raised and confirmed that it would be helpful to see the follow up undertaken. Derek confirmed that more detail could be included within future reports but reminded the Board that some concerns were anonymous so follow up with the specific reporter was not possible so general communication was undertaken in that area.

Mr Atkins, Non Executive Director, confirmed that it was positive that the Trust had a link with Interserve.

The Chairman and Board noted the report and impact of the extra resource was making on the Trust.

17/097 Responsive and Effective

17/097.1 Complaints Report (Enclosure 11)
11.26am

- The Chief Nurse presented the Complaints Report given as Enclosure 11 and reminded the Board that Jill Faulkner had been appointed as Head of Patient Experience which now incorporates complaints.

- The report covered the 1st quarter of the year.

The Board noted the following key developments:

- 100% of all complaints were acknowledged within 3 working days.
- The Trust had taken up to 60 days to respond to some complaints due to capacity issues but this was being addressed.
- PALS, Complaints and Patient Experience had been merged into one Department which was proving to be beneficial for resolving concerns quickly.
- Complaints will now be responded to within Divisions and there will be an action plan with every complaint letter.

Dr Wulff, Non Executive Director, asked if the Trust will be able to reduce the length of time taken to respond to complaints. The Chief Nurse confirmed that this will be reduced and information will be provided to the Clinical Q uality, Safety, Patient Experience Committee.

Mr Miner, Non Executive Director, raised issues relating to the attitude of staff and communications and added that they still form a large proportion of the number of complaints and this gives a risk to the reputation of the Trust. The Chief Nurse stated that we need to highlight to Divisions that this is a recurring theme and ask what actions are being taken. The Trust is looking to introduce 'always events' for example apologising for keeping patients waiting.

The Chairman asked how many complaints were outstanding. The Chief Nurse confirmed that there were 76 letters to respond to in October.

The Chief Nurse suggested that a monthly complaints briefing be presented to the Clinical Quality, Safety, Patient Experience Committee. The Board agreed this would be useful.

The Chairman and Board noted the report,

Monthly complaints briefing including information on the length of time taken to respond to complaints to be presented to the Clinical Quality, Safety, Patient Experience Committee.

17/097.2 Learning from Deaths Policy (Enclosure 12)
11.36am

The Medical Director presented the Learning from Deaths Policy given as Enclosure 12.

The Board noted the following key issues:

- There was a 2 stage process on reviewing deaths at the Trust.

- National guidance was included in the Trust policy, however the Medical Director intends to review this policy again in April 2018 when additional guidance is expected. The Policy had been approved by the Clinical Quality, Safety, Patient Experience Committee.

- Dr Wulff is the nominated Non Executive Director lead for this area.

- The Trust is using the Royal College of Physicians guidance for second stage reviews which is built into the Trust's audit tool.

- Reports on the learning from these reviews will start to be available from October 2017.

Some issues were noted with the first stage reviews around doctors who do not work at the Trust and how these elements are captured. There was also an issue with CCG representation on the reviews, discussions with the CCG continue to secure GP input within the case reviews.

The Policy and guidance will be placed on the Trust website in accordance with the national requirements placed on all Trusts.

The Chairman and Board noted the report.

17/097.3 Winter Plan Presentation (Enclosure 13)
10.54am

The Director of Operations for Surgery, Women and Children presented the Trust's outline Winter Plan, given as Enclosure 13.

The Board noted the following key issues:

- Construction of Plan:
  - Internal analysis of historical demand had informed the plan
  - Actions to reflect the requirements of NHSI/NHSE winter review of 2016/17 had also been incorporated

- Key Elements of 2017/18 Plan:
  - Expansion of Acute Medicine bed base following the relocation of EAU
  - Additional Social Workers for ED/EAU
  - Additional 50 CCG commissioned community beds
  - New Urgent Care Centre co-located to ED through the ongoing building works
  - Command and control arrangements strengthened during Christmas, New Year and January
  - Increased emphasis on clinically urgent and daycase admissions to minimise elective overnight patients during the expected peak in demand

- Testing of Plan:
  - Testing of the Plan is in place and lessons learnt will inform and update the Plan.
  - Exercise OLAF, mulit-agency event in October will again test the plan.

Mr Miner, Non Executive Director, asked about changes to workforce during the winter. The Director of Operations confirmed that Nurses and Doctors will manage the emergency workload as a priority.

Mr Miner asked if the Director of Operations saw the current plan as being more successful than that deployed in previous winters. He confirmed that the Trust was going into winter in a better position.

Mr Fellows, Non Executive Director, confirmed that an item needed to be included around the patient perspective and making waits more comfortable and this should include the role of Interserve and volunteers. The Chairman stated that communications and use of targeted information should also be included. The Chief Operating Officer confirmed that this was included in the Dudley Health Economy plan of which this plan is our operational delivery plan.

The Chief Nurse asked how many additional beds will be moving to the Emergency Assessment Unit.

The Board noted that Acute Medical beds will increase from 35 to 40 and the Emergency Care footprint will also increase.

Medicine will lose 14 beds and community will gain an additional 50 beds.

The Chief Nurse asked whether there were enough actions in place to manage winter in the plan.

Dr Hopkin, Associate Non Executive Director, asked if work had been done on admission prevention in the community. The Chief Operating Officer confirmed that there were a number of plans in place to bolster specialist teams to deliver this.

The Chief Executive confirmed that funds had been allocated to appoint a manager to bring together the community resource to focus on avoidance.

The Medical Director added that the Trust must make best use of the resource available, noting that there had been an increase in conveyancing to Trust.

Mr Atkins, Non Executive Director, stated that the Trust needs to get the daily management correct. The Director of Operations confirmed that there was a command and control structure in place and each division has a bronze command and overall site management from the capacity hub for silver command. The Trust was strengthening its on call arrangements and will be testing how this is working in September.

The Chairman asked about Support Services. The Divisional Director of Operations for Support Services confirmed that a 7 day services business case for Pharmacy had been approved and changes will commence in November and that a number of key roles were being filled in Pharmacy during October. These changes provide greater support to the wards and clinical areas. The Divisional Director confirmed that for these measures the Trust would be testing their plans during September with the Divisions.

The Board noted that the Guest Imaging project was progressing well, with just a one week delay. The start date had been confirmed as 8th November, 2017, when elective work will move to the Guest to free up capacity at Russells Hall. Reporting Radiographers will be based in the Emergency Department.

The Chairman stated that communications with the workforce were key, and asked if plans included converting staff from part time to full time if necessary during the winter period and managing expectations across the hospital. The Chief Operating Officer confirmed that workforce flexibility was considered and achieved through the use of the staff bank.

The Board noted the Flu jab CQUIN 75% achievement rate. Board members will be vaccinated after the October Board.

The Head of Communications and Patient Experience confirmed that the "Winter is Coming" slogan had been recognised as a landmark campaign.

The Chairman asked to see the results of the September stress testing of the winter plan and the alignment with the Health Economy plan.

The Chairman and Board noted the report and the actions identified.

The Board to see the results of the September stress testing and alignment with the Health Economy Plan.

17/097.4 Finance and Performance Committee Exception Report (Enclosure 14)
11.41am

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 14.

The Board noted the following key issues:

- The Trust's delivery of its CIP was slightly ahead of the year to date position and on track to finish the year ahead of target.
- The Trust's overall financial cumulative performance was however slightly behind plan.
- The full year control total delivery was challenging and actions had been identified. A meeting will take place after September, results are available.

The Chairman and Board noted the report.

17/097.5 Performance Report (Enclosure 15)
11.47am

The Chief Operating Officer presented the Performance Report given as Enclosure 15.

The Board noted the following key issues:

- 3 trajectories required improvement: Cancer, DM01 and VTE. The Trust was currently meeting its improvement trajectories in these areas.

- The Trust had missed the target for cancer 2 week waits but was aiming to meet the quarterly target.

- The ED target remains the Trust's biggest challenge. A new system is in place from this week and had seen performance improve significantly. The main reasons for the poor performance were capacity issues and staffing resources to meet demand over the holidays.

- Friends and Family results provided mixed results and ED continues to be a challenge. Teams are trying to increase the footfall which will give a better representation of the patients real perceptions of the Trust.

- For Paediatric Outpatients, all outstanding follow ups had been seen and actions were in place for this year's appointments to be seen.

Mrs Becke, Non Executive Director, asked if there was any metric that the divisions could report on to show the longest waiting patients. This assurance was provided by the Divisions at their respective performance meetings.

The Chairman stated that information needed to be more visible around delays.

The Chief Executive confirmed that the Trust would have a new integrated performance report available for October. The Chairman asked that the new report is presented to the Board as soon as possible.

The Chairman confirmed that Non Executive Directors had been invited to attend performance meetings and dates would be shared which would allow them to see the context of the reported performance at the Committees and Board.

The Chairman and Board noted the report.

17/097.6 Cost Improvement Programme and Transformation Overview Report (Enclosure 16)
12.01am

The Director of Finance and Information presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 16.

The Board noted the following key highlights:

- The main proportion of CIP savings are non-recurrent.

- Divisions are working hard delivering their plans.

- The agency spend scheme remains the biggest challenge within the programme.

The Chairman and Board noted the report

17/098 Well Lead

17/098.1 Corporate Risk Register and Assurance Report (Enclosure 17)
12.02pm

The Director of Governance/Board Secretary presented the Corporate Risk Register and Assurance Report, given as Enclosure 17.

The Board noted the following key highlights:

- The risk around the 3 core standards had been split into separate risks, which supported the discussion held in respect of the corporate performance report as each indicator had differing risks.

- New and escalated risks were listed in the report and had been discussed at the Audit Committee.

- There would be a further review of Ophthalmology risk by the Clinical Quality, Safety, Patient Experience Committee before it would be considered for de-escalation.

- Increased risks in the first quarter were identified including CIP, financial sustainability, income and pressure ulcers. There was 1 risk where the score has decreased this was in respect of ITDR.

The Chairman said that it would be good to receive a strategic report on risk trajectories and asked if this could be presented in the next quarterly report. Mrs Becke, Non Executive Director, asked about why the issue on learning from deaths had become a new risk. The Director of Governance confirmed that it was because it is a new policy and is based on a national untested process which may have a reputational issue.

The Chairman and Board noted the report and risks as identified.

Strategic detail on trajectories to be included in the next quarterly report

17/098.2 Corporate Calendar Report (Enclosure 18)
12.15pm

The Director of Governance/Board Secretary presented the Corporate Calendar Report, given as Enclosure 18.

The Board noted the following key highlights:

- There had been a change to the Board dates for quarter 4. For the first 3 months of 2018 the Board would meet on the 2nd Thursday of the month.

- The Workforce Committee were looking at including additional meetings.

Mr Fellows, Non Executive Director, confirmed that the Governors Governance Committee (GGC) normally meets on a Finance and Performance Committee day but this was not reflected for April and June. The Director of Governance to discuss dates with the Chair.

The Chairman and Board noted the report and approved the calendar, subject to any required changes to the GGC.

The Director of Governance to look at Governors Governance Committee dates with the Chair.

17/098.3 Annual Plan Quarterly Monitoring Report (Enclosure 19)
12.18am

The Deputy Director of Strategy presented the Annual Plan Monitoring Report, given as Enclosure 19.

The Board noted the following key highlights:

- Positive picture of performance with only 8 reds and a positive number of greens and some ambers that will turn green in quarter 2.

- Two measures of achievement had been rated red that do not appear on the risk register. The Trust will monitor mitigations and level of risk.

- The Clinical Strategy was approved by the Board in August. The proposed bullet points will be added to the Annual Plan.

The Deputy Director of Strategy also drew the Board's attention to the annual goals that link back to the Trust's approved clinical strategy and confirmed that this transparency would remain in future updates to the Board

The Director of Governance confirmed that both risks highlighted are now on the divisional risk registers.

Mr Atkins, Non Executive Director asked about pressure ulcers and stated that the wording needed to be amended to reflect different community/hospital arrangements.

The Chairman and Board noted the report and recognised the progress being made and noted the risks.

17/098.4 Smoke Free Update Report (Enclosure 20)
12.24noon

The Head of Communications and Patient Experience presented the Smoke Free Update Report, given as Enclosure 20.

The Board noted the following key highlights:

- The Trust had hosted a survey on its hub and website. There had been 700 responses. 200 responses were noted to be from smokers and 13% had said that they would not want the Trust to go smoke free.

- The survey asked if people would expect support in giving up smoking and 28% had said yes.

- The report sought approval that the Charitable Funds Committee support 2 extra posts for smoking cessation workers. and confirm its support to continue with the plans identified.

The Chief Executive asked if the number was correct in that only 2 local Trusts were currently smoke free. The Head of Communications and Patient Experience confirmed that she would check this information.

Mr Fellows, Non Executive Director, asked how far off-site staff would have to go to smoke and how this would be applied to Interserve staff and how breaches would be dealt with.

The Chief Executive stated that staff could use break times to smoke and go off site but acutely ill patients should not be leaving the ward to smoke.

There was a need for a strong communications campaign as the Trust needs to win the hearts and minds of staff and patients.

The Board thought that a more robust business case taking into account the existing resource and justifying further the need for extra resource.

The Chairman and Board noted the report. An update report would be presented to the Board in Quarter 4.

Smoke Free update report to be presented to the Board in Quarter 4.

17/098.5 Digital Trust Committee Exception Report (Enclosure 21)
12.38pm

Mrs Becke, Committee Chair and the Chief Clinical Information Officer both presented the Digital Trust Committee Exception Report, given as Enclosure 21.

The Board noted the following key highlights:

- That the Partnerships Board's approval for the population health project had been received and the project was on track.

- Point of care testing devices had been approved and support for their training had been secured following discussion at a previous CQSPE committee meeting.

- The overall project is rated as green and engagement across the Trust was excellent.

- Shadow IT resource remains unresolved. Pharmacy had been a challenge. The Chief Information Officer confirmed that agreement had now been reached and they were part of corporate IT removing this concern for Pharmacy.

- The Sunrise device strategy will bring a requirement for additional funding as part of the device refresh programme.

The Chief Executive asked that the Chief Nurse's comments also be included within future updates as nurses were the largest workforce within the Trust and the project had been structured to have their voice represented.

The Chairman and Board noted the report

17/099 Any Other Business
12.43pm

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

17/100 Date of Next Meeting
12.43am

The next Board meeting will be held on Thursday, 5th October, 2017, at 9.30am in the Clinical Education Centre. {Post meeting note: The October Board will now take place on 12th October, 2017}

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 3 August 2017

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/074.4	Workforce Committee	Improvements to be seen in relation to timescales for shortlisting for interview by the next Workforce Committee meeting.	AM/JA	26/9/17	See Board Report.
17/096.2	Audit Committee Exception Report	Appraisals to be a focus of the Workforce Committee at its next meeting.	AM/JA	26/9/17	See Board Report.
17/097.1	Complaints Report	Monthly complaints briefing including information on the length of time take to respond to complaints to be presented to the Clinical Quality, Safety, Patient Experience Committee.	SJ	26/9/17	To October Clinical Quality, Safety, Patient Experience Committee.
17/094	Patient Story	Thank you letters to be sent to Jo Marshall, the ward staff, cleaner and student nurse.	LA	12/10/17	Done
17/095	Chief Executive's Report	Walkround dates to be supplied to the Non Executive Directors.	SJ	12/10/17	Done
17/097.3	Winter Plan Presentation	The Board to see the results of the September stress testing and alignment with the Health Economy Plan.	COO	12/10/17	To November Board.
17/098.2	Corporate Calendar Report	The Director of Governance to look at Governors Governance Committee dates with the Chair.	GP	12/10/17	Revised calendar circulated to the Board.
17/063.3	Research and Development Report	Research and Development Strategy to be produced and presented to Board. R&D newsletter to be made available to Community staff.	JN JN	7/12/17 7/12/17	
17/063.9	Organ Donation Report	Tissue and organ donation data to be included in future OD Annual Reports.	JN/RE/RU	7/12/17	

		The Chief Nurse to join the Organ Donation Committee. NHSBT to facilitate contacts with the Tissue Donation team.	SJ	November Donation Committee Meeting	
17/098.1	Corporate Risk Register and Assurance Report	Strategic detail on trajectories to be included in the next quarterly report.	GP	7/12/17	
17/098.4	Smoke Free Update Report	Smoke free update report to be presented to the Board in Quarter 4.	AM	11/1/18	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 12th October 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:

- Visits and Events
- Staff Survey
- Flu Campaign
- Welcome to New Faces
- Healthcare Heroes
- Long Service Awards
- National NHS News
- Regional NHS News

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 – October 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.

Visits and Events

7th September	Board of Directors
	Council of Governors
12th September	Black Country STP Meeting
13th September	STP Quarter 2 Meeting
18th September	STP Partnership Meeting
20th September	A&E Delivery Board
21st September	Consultant Radiologist Interviews
27th September	Partnership Board
	Black Country Maternity Meeting
28th September	Trust/Summit Board to Board Meeting
	Visit from the President of the Royal College of Physicians and Surgeons, Pakistan
6th September	Black Country Chief Executive and Medical Directors Meeting
9th September	NHS Improvement Performance Review Meeting

Staff Survey 2017

The Trust is encouraged by the overall positive response to our recent staff survey results. Since the publication of the 2016 survey an action plan has been developed alongside the implementation of some exciting developments. This is based on the concept of 'You said, we Did'. The areas of focus have been on staff development and better engagement.

The staff survey for this year became available for all staff from 2nd October and is available until the beginning of December. We expect to exceed or response rate from last year and continue to improve on the positive and constructive feedback from our staff.

Flu Campaign

The flu campaign commenced on 2nd October 2017, with an expectation that all staff are vaccinated. There is a target of 75% of patient focused staff that are to be vaccinated and this is associated to our CQUIN. However, more importantly it is encouraged that all staff are vaccinated to protect themselves, their colleagues and their patients. Last year the Trust was one of the worst performing in the Midlands and East with only 49% of patient focused staff being vaccinated. We expect to achieve and exceed our target of 75% in 2017 and have therefore supported the campaign with appropriate levels of resource.

Welcome to New Faces

Julian Hobbs joined the Trust on 2nd October 2017, as Operational Medical Director. Julian has joined us from Royal Liverpool where he had been Deputy Medical Director, since 2013. Julian is also a Deputy Medical Director and leads on Mortality for Cheshire and Merseyside area team at NHS England. Julian is a Consultant Cardiologist by background and has worked at Liverpool Heart and Chest Hospital alongside his current roles.

The Trust is delighted to welcome our new Director of Strategy and Business Development, Natalie Younes, who recently joined the Trust. Natalie has joined us from Lincolnshire and District Medical Services (LADMS) where she held a joint role of Commercial Director with the GP Federation and Mental Health Trust since 2011. Natalie originally started her career working within social welfare, housing benefits and family liaison and moved into Local Authority working with Enterprise. Natalie entered the NHS in 2010.

Michael Woods has joined us as Interim Chief Operating Officer and will be working on a number of key priorities for the Trust supported by the Chief Executive and Interim Chief Nurse whilst he settles into the post.

We have also had a change of Associate Chief Nurse for Medicine effective from 1st November. Jenny Bree has been appointed to allow Julie Walklate to return to her role as matron

Healthcare Heroes

Our new monthly staff awards continue to be really well received by staff and we are getting lots of nominations. This month's winners were Ward C3 for the team award and, Clinical Lead Physio for Community Rehab and Falls Ed Tank, bagged the individual award.

Congratulations to all our staff who continue to go above and beyond to help our patients have a good experience of their care.

Long Service Awards

We have also refreshed our Long Service Awards and now celebrate the milestones of 10, 25 and 40 years' service. T he event, which will recognise staff who have reached 25 years' and 40 years' milestones, will take place on Thursday 2nd November 2017, from 3.30pm until 5pm in the Clinical Education Centre at Russells Hall Hospital.

National NHS news

Almost 10,000 EU health workers have quit NHS since Brexit vote
NHS Digital, the agency that collects data on the health service, found that in the 12 months to June 2017, 9,832 EU doctors, nurses and support staff had left, with more believed to have followed in the past three months.
The Guardian

Public sector pay cap: NHS staff real income cut by almost £2,000 over seven years of wage squeeze
The damage inflicted on the living standards of NHS staff by the Government's pay freezes and caps has been underlined by new figures, which show the average health worker enduring a real terms cut of almost £2,000 over the past seven years.
The Independent

NHS chiefs read the riot act over poor A&E performance
NHS hospital chiefs have been hauled in by Jeremy Hunt over poor performance, in a desperate bid to head off an Accident & Emergency crisis. It follows warnings that the NHS could be facing the worst flu season in its history, and orders to all NHS trusts to empty thousands of beds.
The Telegraph

Mental health staff on long-term stress leave up 22%
The number of NHS mental health staff who have had to take sick leave because of their own mental health issues has risen by 22% in the past five years. Those taking long-term leave of a month or more rose from 7,580 in 2012-13 to 9,285 in 2016-17, BBC freedom of information requests found.
BBC News online

Gloucestershire and Herefordshire NHS trusts to merge
Two NHS Trusts which serve Gloucestershire and Herefordshire are set to merge into one organisation. The 2gether NHS Foundation Trust and Gloucestershire Care Services (GCS) will begin by appointing a joint Chair and Chief Executive.
BBC News online

Life-extending lung cancer drug will be made available on the NHS
A drug that can prolong the life of some patients suffering from lung cancer has now been approved on the NHS. Nivolumab, which has the brand name Opdivo and is manufactured by Bristol-Myers Squibb, should be made available to around 1,300 patients with lung cancer through the CDF, Nice's draft guidance said.

Bristol-Myers Squibb will fund the drug at a discounted price whilst more evidence is gathered on its use.

NHS to spend £100m bringing in up to 3,000 GPs from abroad
The NHS plans to spend £100m bringing in up to 3,000 GPs from abroad to help alleviate serious shortages that have left surgeries struggling to run properly.

The most recent NHS Digital figures show that the number of full-time equivalent GPs is falling, from 29,862 in September 2015 to 29,423 in June – a decline of 439.
The Guardian

Up to 8,000 deaths a year may be caused by rising bed-blocking
Researchers examined the biggest surge in deaths for 50 years, which was seen in 2014/15, with almost 40,000 more casualties than normal. The study linked the higher mortality rates with soaring levels of bed blocking - which has risen by 50 per cent since 2014 for acute patients.
The Telegraph

Spire shares dive as NHS referrals fall and £27m is paid out to victims of rogue surgeon
Spire Healthcare shares have dived on a double blow for the private hospitals group, with NHS referrals down and £27m having to be set aside for compensating victims of rogue breast cancer surgeon Ian Paterson.
The Telegraph

One in three GP surgeries found to be failing patients on safety
Visits to all 7,365 practices across the country found out-of-date and contaminated medicines, and mounting backlogs of test results, including cancer referrals, left for weeks.
The Telegraph

Written complaints about NHS nursing staff have increased by 9.8% in a year
The nursing profession received 36,800 written complaints during 2016-17, representing 22.7% of all complaints involving a healthcare profession. It is an increase of 9.8% on last year's total of 33,500. The areas with the highest overall percentage increases in all written complaints were Lancashire, the West Midlands, the North Midlands, and Yorkshire and Humber.
Nursing Times

Regional NHS News

Which West Midlands NHS Trust is the most complained about?
Heart of England NHS Foundation Trust, which had 1,1268 complaints from May last year to May this year.
University Hospitals Birmingham Foundation Trust, which runs Queen Elizabeth Hospital in Birmingham. That trust received 821 complaints.
West Midlands Ambulance Service, which had 425 complaints.
The Dudley Group NHS Foundation Trust, which had 296 complaints.
Burton Hospitals NHS Foundation Trust with 255 complaints.
Black Country Partnership NHS Foundation Trust with 116 complaints.
Birmingham and Solihull Mental Health NHS Foundation Trust with 161 complaints.
Express and Star

Complaints about NHS in the Midlands on the rise
Nationally there were 208,400 written complaints received by the NHS during last year– up 4.9 per cent on the previous year, NHS Digital figures released today show.
The figures mean on average 571 written complaints were made every day.
The West Midlands had 14,400 complaints compared with 13,000 the previous year – an 11.1 per cent increase.
Shropshire Star

Women sue NHS after claiming they were abused by Birmingham doctor who later killed himself
Two women who claim they were abused by a Birmingham GP who killed himself after being told he was under investigation for sexual assault are launching legal action against the NHS. The pair were both patients of Dr Philip Schuppler at Swanswell Medical Centre, in Acocks Green, and claim they were abused by him at his surgery over a number of years.
Birmingham Mail

Trust warned by regulator over 'oppressive' culture
Walsall Healthcare NHS Trust has been issued with enforcement action by the Care Quality Commission following concerns about an “oppressive” culture in its maternity department.

Revealed: Triple Trust merger delayed
A merger between three West Midlands trusts to create one of the biggest community and mental health providers in the county has been delayed, HSJ can reveal. (Birmingham Community, Black Country Partnership, Dudley and Walsall).

Exclusive: Consultant backlash over patient record system 'disaster'
Nottingham University Hospitals NHS Trust: Outcry from dozens of senior consultants has forced one of the country’s largest teaching hospitals to review its £14m digital patient record system amid fears over patient safety.

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 12 October 2017

TITLE:	**26 September 2017 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe – Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

CLINICAL STRATEGIC AIMS		
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

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, specifically :- .

- In respect of assurance received over the actions taken in respect of ophthalmology which supports the view that this risk is being managed and should reduce in accordance with the planned timescale of November 2017.
- The endorsement of the work of the clinical audit team to develop better reporting of clinical audit outcomes to the Committee over the next three months.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	29 August 2017	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- The outcome of the continued weekly audits on compliance with the National Patient Safety Agency Alert in respect of Naso Gastric Tube placements was received by the Committee. The Chief Nurse confirmed that from next month compliance with this alert will form part of the routine Nursing Care Indicator audit programme.
- As requested at the last meeting an update was provided to the Committee on the assessment of NICE guidance. The report showed significant progress since the last report following the introduction of enhanced support from the corporate clinical audit team. The Division's confirmed to the Committee that they planned to have the residual guidance assessed shortly with the oversight of this delivery reported at their respective divisional governance meetings.
- Executive Management assurance was provided on the quality aspects of the Trust performance in respect of its key quality indicators. The Committee noted that there had been improvement within the Friends and Family recommended scores for all areas except for the Emergency Department, Maternity and Outpatients. The report also reflected that there had been 4 cases of *C diff* and that due to a lack of compliance with mandatory training in those areas there were attributed to lapses in care at the Trust. The Committee was updated as to the improved performance in respect of Stroke TIA assessed and treated within 24 hours after a reduction in the previous month and the Trust had met the performance target for VTE assessments being undertaken this month after a number of months failing this target.
- The Committee received a report on the Trust performance against its quality priority with regards to stage 4 avoidable pressure ulcers and the actions being undertaken as a result of the increased number reported in the last six months. The Committee agreed to keep this matter under review.
- The Committee received assurance from the Chair of the Trust Thrombolysis Group about the review of hospital acquired thrombolysis incidents and the rigor these are considered to extract learning. The Committee sought support from the Executive Team to assist in ensuring that the learning will be shared into the organsation. The Director of Governance confirmed the corporate incident team

would provide this support.

- The Committee was presented with the Maternity Dashboard which provided information on a wider spread of quality indicators for this service. The Committee were updated on a national project to look at a standard maternity dashboard that would allow meaningful comparisons to be made.
- An update was provided in respect of the Maternity Service Improvement Plan. The report provided assurance in respect of progress and the executive oversight of the action tracking process which has and will continue to take place within the Division and the Directorate.
- The Surgery, Women and Children Division provided assurance in respect of actions taken in respect of ophthalmology (the positive impact the extra resources were having on seeing patients who had been waiting and that the risk is on track to be reduced by November) and fractured neck of femur (the latest audit confirmed the positive impact the previously reported actions have had on the mortality rate for this cohort of patients).
- The Committee received a detailed report on the Trust self assessment against the CQC domains for each core standard and the oversight being applied by the Executive Team to the identified improvement actions. The report confirmed that for a number of the core services improvement was still warranted. The report also confirmed that the CQC view of the areas for improvement at the Trust were already recognised by the Trust and in a number of areas, for example fractured neck of femur, improvement could be demonstrated.
- The Committee received a report on incident management. The report provided assurance on the SI process being applied and now included information on the Trust position in respect of wider incidents. The report documented the continued focus on learning and improvement. The report provided assurance that the Trust has complied with the reporting requirement timescales in respect of initially reporting of Serious Incidents (SIs) within two days and the engagement with families when a serious incident occurs through the application of the duty of candour. The Committee was informed of the number of open incidents, many of these being of no harm, which require formal closure at a divisional level and the focus the divisions were putting on this work.
- The Committee was informed of the proposed changes to the reporting of advisory pharmacy “p-notes” going forward and enhancing the use of Datix to focus on learning from pharmacy advice provided.
- The Committee was updated on the outcomes from the Medicines Management Group.
- The Committee was updated on the actions being undertaken to strengthen clinical audit and a further report will be provided.
- The Committee was updated on the NHS Resolution activity over the first half of the year. The report also provided information on the lessons learnt from this activity.
- The Committee received a report on the qualitative aspects of the estates contract management processes in respect of both estates and facilities. The report provided information on actions taken in respect of it remit for water safety,

decontamination and the medical devices asset register.

- The Committee received the first monthly report on learning from deaths and agreed that the focus of the report needs to draw out the learning identified and how these had driven improvements within the Trust.
- The Committee received a report from the Quality and Safety Group and noted the focus on falls management, nutrition (MUST) and VTE (noting that VTE was the subject of a report directly to this meeting).
- The Committee received a report in respect of the activity of the Internal Safeguarding Board. The Committee was updated as to the actions being taken in respect of the issue of compliance with safeguarding training and a review into the staffing resources available within the Trust to ensure they are supported by the recruitment of a Head of Safeguarding.
- The Committee received a report from the Patient Experience Group which provided an update on the actions being taken by the group in respect of the outcomes from various surveys.
- The Clinical Chief Information Officer provided an update on the Digital Trust project and the work of the Clinical Approvals Group and the Committee gave its support to the work on the digital trust project.
- The Committee received a report from the Infection Prevention and Control Forum which supported the debate at the Committee in respect of the reported number of *C diff* cases

Decisions Made/Items Approved

- The Committee supported the closure of 11 SI Root Cause Analyses (RCA) action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.
- The Committee approved 3 policies one of which was new policy with the other two being subject to a comprehensive rewrite.
- The Committee approved the work of the clinical audit team to develop better reporting of clinical audit outcomes to the Committee over the next three months.

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

Further feedback on the learning from the Thrombolysis Group review of incidents.

The continued oversight of pressure ulcer care.

Safeguarding processes within the Trust especially within children's services.

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, specifically :- .

- In respect of assurance received over the actions taken in respect of

ophthalmology which supports the view that this risk is being managed and should reduce in accordance with the planned timescale of November 2017.

- The endorsement of the work of the clinical audit team to develop better reporting of clinical audit outcomes to the Committee over the next three months.

Enclosure 5

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on Thursday 12th October 2017

TITLE:	**Maternity**		
AUTHOR:	**Dudley Quality Improvement Board**	**PRESENTER**	**Siobhan Jordan, Interim Chief Nurse**

CLINICAL STRATEGIC AIMS

Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.		*Provide specialist services to patients from the Black Country and further afield.*

CORPORATE OBJECTIVE: SO1,SO2,SO3, SO4, SO5, SO6

The Dudley Maternity Services Quality Improvement Board

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Safe, Effective, Caring, Well lead, Responsive**
	NHSI	**Y**	**Details: Links to Well Led**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	√		

RECOMMENDATIONS FOR THE BOARD

To note the formal outcome of the Dudley Maternity Services Quality Improvement Board.
Seek formal confirmation from the Clinical Quality Safety and Patient Experience Committee of ongoing monitoring of the enhanced maternity performance plan.

NHS

Report

of the Dudley Maternity Services Quality Improvement Board

Published October 2017

Contents

1. Foreword

Early in 2016, NHS England alerted Dudley Clinical Commissioning Group (DCCG) to concerns about the high number of serious incidents in Maternity Services at The Dudley Group Foundation Trust (DGFT).

This report summarises the outcomes of the work of the Quality Improvement Board (QIB) which was established to look into those concerns.

It highlights the importance of strong clinical leadership and effective governance procedures. It emphasises the importance of understanding why things happen, of learning effectively from issues, and of sharing that learning widely to improve services. And it demonstrates the added value that external advice and support can offer to the improvement process. It also reinforces the importance of communicating with and involving patients and their families in their care.

During the course of the QIB's work, DGFT have introduced a comprehensive improvement plan for maternity services. This addresses the issues identified and provides assurance about the safety and effectiveness of the maternity services in Dudley.

The many improvements that have been made to DGFT Maternity Services as a result of the QIB's work are a tribute to the diligence and hard work of everyone involved, and I would like to thank them for their efforts and offer specific thanks to the families who contributed to the process.

Mr Steve Wellings
Chair, Quality Improvement Board

2. Context

Maternity Services at DGFT are responsible for the delivery of around 4,600 babies each year. The unit is well-regarded in the local community and serves not just Dudley and the Black Country area, but also parts of Worcestershire and Staffordshire.

Within the maternity unit, there is a triage area with four beds, a delivery suite with 10 rooms and a maternity ward with 22 beds. A co-located Midwifery Led Unit (MLU) has five rooms where 608 babies were born last year. The maternity unit has two dedicated obstetric theatres.

Currently the maternity unit is staffed by 168 midwives, which allows for the provision of one-to-one midwifery care in labour. The number of midwives required is assessed using the midwifery establishment Birth Rate Plus Staffing Tool that is recommended by the National Institute for Clinical Excellence (NICE) in the safer staffing guidance. The unit meets these recommendations. There are 32 doctors within the unit, 10 of which are consultant obstetricians and gynaecologists. This enables the service to comply with the Royal College of Obstetrician and Gynaecologists (RCOG) recommendations of 98 hours per week of consultant obstetric cover for the delivery suite.

DGFT has a level two neonatal unit, which has 18 cots, three of which are used to provide intensive care and two for high dependency care. Babies requiring neonatal intensive care that meet defined criteria, are transferred to a level three neonatal unit. These arrangements reflect the British Association of Perinatal Medicine recommendations.

One of the measures used to compare the outcomes for babies is the neonatal and stillbirth mortality rates. This is the number of babies that regrettably die compared to the total number of births. DGFT maternity unit's early neonatal mortality rate in 2014/2015 was 1.8 which meant that for approximately every 1,000 births, fewer than two babies died. This was below the national average of 2.68 per 1,000 births. DGFT maternity unit's stillbirth rate was 3.14 which means that for every 1,000 births fewer than four babies were stillborn. This figure compared favourably with a national figure of 4.64 per 1,000.

DGFT Maternity Services were last inspected by the Care Quality Commission (CQC) as part of an overall review of the Hospital Group in 2014. At that time, the CQC praised the caring nature of maternity staff and the environment in which women and babies were cared for. However, they expressed concerns about staffing levels and felt that the categorisation of incidents and recording of data were, at times, inaccurate. They reported that this prevented the service from fully analysing incidents and learning from these.

The CQC report summarised Maternity Services as 'Good' in relation to the assessments of 'Effective', 'Caring' and 'Responsive' domains, but as 'Requiring Improvement' in the areas of 'Safety and Well Led'. Overall, the CQC assessed the Maternity and Family Services as 'Requiring Improvement'. (The full CQC report can be found at www.cqc.org.uk).

3. Introduction

In January 2016, Dudley Clinical Commissioning Group (DCCG) were informed by NHS England West Midlands (NHSE) that The Dudley Group NHS Foundation Trust (DGFT) had reported a higher number of Serious Incidents (SIs) than for comparable maternity units in the West Midlands between April 2014 to December 2015.

In addition to this, it was identified by NHSE that there was limited learning associated with these Serious Incidents.

When a Serious Incident[1] happens, it is necessary to objectively establish what happened; what went well and what didn't, alongside what actions should be taken to avoid a similar occurrence in the future. This process should involve the patient and, where appropriate, their family. If incidents happen and are not adequately investigated, the same mistake and harm can be repeated; this is unacceptable. If lessons are not learned, the risk of recurrent harm increases. In maternity services where the health and wellbeing of women and babies is at the heart of care, the processes for investigating incidents are central to ensuring safe high quality care.

Following an initial assessment of the SI Root Cause Analysis[2] (RCA) reports from this period, by the DCCG, and the support of independent reviewers to provide objectivity and challenge, it was confirmed that DGFT maternity Serious Incident investigations were inadequate, that learning was not identified appropriately, and that there was harm in some cases. The DCCG subsequently led the establishment of a Maternity QIB as this was agreed as an open and transparent approach to investigating and addressing the concerns raised. The Maternity QIB commenced in April 2016 and the purpose of this report is to provide an overview of its work.

[1] Serious Incident (SI) - "…events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response";
[2] Root Cause Analysis (RCA) - defined by the NHS as: "a useful tool for thoroughly investigating reoccurring problems of a similar nature …in order to identify the common problems (the what?), contributing factors (the how?) and root causes (the why?). This allows one comprehensive action plan to be developed and monitored and, if used effectively, moves the focus from repeated investigation to learning and improvement".

Both definitions taken from NHS England (March 2015) Serious Incident Framework

4. Scope of the Maternity Quality Improvement Board

From the 43 cases reported as Serious Incidents between April 2014 and December 2015 the Maternity QIB agreed to initially review 25. Of the 25, 19 related to care that affected the baby and 6 cases related to care of the woman. These 25 presented the most opportunity for learning.

The objectives of the QIB were to:

- work openly and collectively to review and enhance maternity services;
- gain assurance that maternity services provided by DGFT are safe and effective and that processes to manage risk are robust;
- ensure those families whose cases formed part of the review were given opportunities to actively engage in the process and contribute towards any lessons learned, keeping them informed throughout;
- review DGFT system wide Serious Incident processes between April 2014 and December 2015 - addressing governance and reporting; and
- ensure lessons are learned and actions are taken to address issues that were identified.

The work of the QIB was allocated to three sub groups.

Each sub-group was given a set of tasks to ensure the QIB achieved its aims. The main work of each group is explained on the following pages.

A. Clinical Review Group (CRG)

The Clinical Review Group (CRG) was clinically led and included clinical representatives from both DCCG and DGFT, supported by an independent external consultant obstetrician. The purpose of the CRG was to provide assurance that the maternity service provided by DGFT was clinically safe and effective and involved detailed reviews of the 25 cases. In addition, the CRG was to identify improvements in care and service delivery and to ensure that learning is implemented for the benefit of women who receive maternity services from DGFT in future, their babies and their families.

Each of the 25 cases was clinically reviewed separately and thoroughly. The clinicians challenged decisions made throughout each case, and considered possible links between these decisions and outcomes for women and babies. There were five cases where there was avoidable harm and one death. DGFT have been open with all of the families affected. Where care and service delivery issues affected the outcome for women and babies, this was identified and led to recognition of themes which have been addressed within the DGFT maternity improvement plan.

All families were written to by DGFT and informed of the review into their care. They were offered the opportunity of a meeting with senior staff from DGFT. The point of this letter was to provide the 25 families with the opportunity to share their views on the care they received and to raise any questions they would like answered as part of the review process. Five families responded to the initial letter requesting a meeting. These families met with senior staff and were provided with the outcome of the review of their case by DGFT. Following the review of all the cases, the remaining 20 families were contacted for a second time. Six families were informed there was additional information regarding the care they had received and they were invited to a meeting with DGFT; of these, three families took up this offer. The remaining 14 families were informed that the review had concluded and it did not identify any findings that had not been shared with them previously.

During the review, DGFT identified that due to a disconnection between the DGFT clinicians and the maternity risk management processes, there were missed opportunities to prevent further recurrence of service and care delivery problems that may cause harm.

The CRG acknowledged that DGFT had not systematically investigated maternity Serious Incidents, identified root causes and embedded appropriate learning. The QIB were assured by the Governance Group that by providing training for staff on conducting systematic and objective investigations and redesigning the risk and governance systems within maternity and across the wider organisation, future governance would be robust. The CRG also had oversight of and monitored the maternity clinical improvement plan, to ensure that care and service delivery issues that had been identified, were addressed.

The CRG concluded that the 25 cases demonstrated common themes and opportunities for learning, as detailed in Section 5. The review of further cases was considered, however the CRG consensus was that they would not reveal anything that was not already captured within the improvement plan.

B. Governance Group

The Governance Group built on the work already underway across DGFT. It comprised clinical and managerial representatives from DGFT, the DCCG and Local Authority Public Health, and focused on improving the management and oversight of SIs across the system as a whole.

The Group:

- reviewed action plans to improve governance and reporting including ensuring clarity of roles of responsibility for assurance across DGFT, DCCG and NHSE. These actions included training for DGFT and DCCG staff and revisions to templates used for Root Cause Analysis reporting;

- agreed measures that could be used to show progress and monitor Serious Incidents on an on-going basis.

The Governance Group were assured that DGFT has taken positive steps to develop its incident, risk management and governance frameworks, with specific assurance gained in respect of maternity services. Oversight of maternity governance has now transitioned to a DCCG-led monthly Maternity Performance and Assurance Group. This provides a forum for ongoing dialogue in relation to the quality and safety of care in maternity services.

Two subsequent external reviews, reported via the DCCG Quality and Safety Committee, have both indicated that they were significantly assured of the improvements made in managing Serious Incidents which have been reported.

C. Communications Group

The Communication Group membership included communications leads from both DCCG and DGFT and from each of the QIB organisations. The role of Healthwatch Dudley was to be assured that the process was transparent and that Duty of Candour was followed throughout.

The group was instrumental in agreeing an engagement plan and communication concordat which was put in place and signed by all but the independent organisations of the QIB.

The communications group followed the principle of putting those most affected by the review first. They played a key role in the way that families affected were informed of the case review and insisted that the families were the first to receive this report prior to wider publication. Further detail on the involvement of families is included in the CRG section of this report, as it was right that the conversations with families happened at a clinical level.

5. Findings of the Maternity Quality Improvement Board

5.1. The review identified that Serious Incidents were not routinely reviewed by a Multidisciplinary team of professionals.

While DGFT Root Cause Analysis documentation indicated that clinicians within a Multidisciplinary Team (MDT) were responsible for investigating cases, the review identified that this was not happening. The Root Cause Analysis' were largely undertaken in isolation with limited input from clinicians; there was rarely a connection between the clinical conversations which happened with families, the risk and governance processes and midwifery supervision. This meant that when there were care and/or service delivery issues within individual cases, there was limited learning to help prevent further recurrence and potential harm to women and babies.

DGFT's process for the review of Serious Incidents now mandates that this is always done with input from obstetricians as well as midwives and includes anesthetists, cardiologists, paediatricians and other professionals as required. There is a process for the review of unexpected admissions to the Neonatal unit and that always includes paediatric staff input. There is also increased clinical leadership through the greater involvement of senior medical staff associated with risk management and governance processes.

A senior consultant obstetrician from Birmingham Women's Hospital NHS Foundation Trust attended DGFT's Maternity Governance Meeting on two occasions, to provide an expert independent review of cases and to enable sharing of clinical guidelines as appropriate.

In addition, a consultant midwife with specific expertise in governance, worked with the maternity team to further provide an independent review and assurance of Serious Incident processes being delivered. She has provided DGFT and the DCCG with positive feedback, confirming there has been a significant level of improvement and a clear commitment demonstrated by the DGFT maternity team to address the areas of weakness in governance and risk management.

The sharing of learning is now a priority in the maternity unit. The midwives, doctors and support staff train together with professionals from other disciplines who frequently work in maternity; this includes staff from the neonatal unit, anesthetics and theatres. Numerous methods are used to ensure everyone is informed and kept up to date.

Meetings are held regularly to discuss the care of women and babies. These meetings are attended by a range of clinicians including midwives, paediatricians and anesthetists to discuss cases and learn together on how they can improve care.

5.2. The review identified that DGFT assurance processes were not robust and DGFT were being over reliant on, and falsely assured by, the feedback from external organisations

The CCG requested support from an NHS England Midwife in reviewing the Serious Incident RCA's. They had accepted assurance on these from the stated level of MDT investigation.

DCCG has since changed the process of assurance for Serious Incident Root Cause Analysis documentation. This new process has been independently audited on two occasions to validate the improvements in this area.

However, as highlighted in 5.1, the documentation did not reflect the processes that were taking place and this could not have been known to the external agencies. DGFT were also falsely reassured by the fact that their Root Cause Analysis documentation was being produced in a timely way and this was misinterpreted as an indication of thoroughness.

DGFT established a Task and Finish Group in the summer of 2015, chaired by the Chief Executive Officer; to examine six serious incidents. The group met three times to review whether there were any themes or commonalities across those cases which would warrant further investigation and found none. The QIB identified on reflection that had the Task and Finish Group worked differently, it could have identified earlier the issues which have subsequently been highlighted elsewhere in this report. While the Task and Finish Group's actions and findings were taken as internal assurance by DGFT, it represented a key missed opportunity by the Trust to have identified maternity governance issues earlier.

DGFT have recognised the importance of clinical perspective when reviewing cases and they have changed their internal ways of working to ensure the clinical voice is heard.

5.3. The review identified fragmentation of governance systems and processes across the organisation and single points of failure across DGFT

DGFT has recognised multiple governance weaknesses which had contributed to the failings in maternity care. There were also wider governance issues identified such as the delayed application of the revised national Serious Incident framework released in March 2015; this was identified during the review in April 2016.

In response to this, DGFT has implemented a new training programme for staff in Serious Incident processes.

There was also a disconnect between the DGFT maternity investigatory and midwifery supervisory processes; this was subsequently investigated by the LSAMO and further case reviews took place.

The governance group monitored that the DGFT system assurance issues were addressed; however the supervisory issues were discussed and assured within the CRG.

Significant national changes of Supervision of Midwifery processes has resulted in the opportunity to ensure that the links between investigations and midwifery practice are strengthened in DGFT.

5.4. The review identified that Cardiotocography (CTG) heart rate monitoring was, in some cases, misinterpreted and therefore the wellbeing of the unborn baby was, in some cases, compromised

The CRG reviewed cases where the fetal heart monitoring was interpreted incorrectly and actions were delayed or not taken to avoid the potential of the baby being harmed.

To address this learning, DGFT undertook a thorough review of CTG training, sought advice from a tertiary maternity unit on best practice and has increased the frequency and breadth of training to all staff on CTG use and analysis.

There were also cases where CTG assessment of a baby's wellbeing was not completed before an epidural was sited. Midwifery, obstetric and anaesthetic staff are all now aware and compliant with this requirement. This process is audited on a monthly basis from 1st August 2016 and has shown 100% compliance with this improvement.

The documentation of a structured assessment of the fetal heart recording during a CTG was reviewed and rewritten in April 2016, and is used systematically across all areas of antenatal and labour care. There is also a system by which hourly reviews by senior staff, called 'Fresh Eyes', is used to ensure an objective review of a fetal heart tracing. Although well used there were times when this was not documented, and again the group emphasised the importance of this process being systematically undertaken by all staff. DGFT has been assured by monthly audits of these improvements demonstrating consistent compliance.

A competency assessment based on best practice has been developed and introduced in September 2016, for midwives and doctors regarding the interpretation of CTGs and documentation of the assessments made. Of the 168 midwives employed at the Trust, 158 have attended the fetal monitoring training session within the past 12 months and the remaining 10 have attended within the past 14 months, with dates to attend again within the next two months. All of the doctors employed in obstetrics at the Trust have attended a training session within the past 12 months.

There is now an identified lead consultant obstetrician who, together with a lead Midwife, delivers the training to mixed groups of staff. These sessions are multidisciplinary, attended by both midwifery and medical staff, to promote team working and this has the advantage of encouraging greater discussion of CTGs which are often complex and open to different interpretations.

In addition to the internal training, all staff are encouraged to attend external training courses, such as those run by the Royal College of Obstetricians and Gynaecologists (RCOG) and Baby Lifeline. Training packages provided by K2 and the RCOG, both online training and simulation systems, are available and obstetricians and midwives are required to complete these as part of their mandatory training every two years.

In December 2016, the maternity unit was successful in its bid for additional funding from the Department of Health for maternity safety training. Additional external training courses on fetal monitoring are being accessed by midwives and obstetricians via Baby Lifeline and the Maternity Network.

5.5. The review identified that there were, on occasions, delays in concerns being escalated in a timely manner to senior obstetricians

Despite there being a daily ward round where complex and/or high risk cases were discussed, the review identified a lack of documentation reflecting appropriate consultant involvement in decision-making for women under obstetric management. A review of the involvement of senior obstetricians has been undertaken and a revised procedure has been reinforced and monitored; this has improved, and now ensures, a more structured multidisciplinary ward round. The unit has introduced an audit to assure itself that there is early identification of high risk cases, and that senior obstetricians are involved and obstetric support is available when required. The support and involvement in routine care and escalation when required is to be documented in the patient records.

To ensure the Trust meets the RCOG recommendation to have 98 hours consultant cover for the labour ward each week, a further two obstetric consultants have been appointed. The vacancies in the midwifery workforce were addressed with a recruitment drive and concerted effort to improve midwifery staffing, to comply with Birth Rate Plus recommendations. A total of 21 midwives were appointed and all commenced employment between September and December 2016.

5.6. The review identified that there was concern regarding the use of drugs to induce labour and coordinate contractions

The review considered DGFT's use of induction agents, particularly in the management of vaginal births after caesarean (VBAC) cases, and the use of syntocinon, a drug used for induction and to coordinate and increase contractions in labour.

Although DGFT guidance for induction of labour reflected normal and acceptable practices, the guidance was reviewed and changes have been made to differentiate the types of induction agents (prostaglandins) used when women have had a previous birth by caesarean section. Specific education was provided for staff regarding the impact of the use of syntocinon on fetal wellbeing in labour.

5.7. The review identified that there were concerns that senior paediatric support was not available to assist with baby resuscitation at complex births

The review of cases raised questions about whether the most appropriate senior support was readily available, to support the immediate and ongoing resuscitation of a baby when difficulties arose. Local guidance was reviewed and updated to ensure a clear escalation process is in place to secure senior support when needed.

Subsequent audits have provided assurance that the right seniority of staff have been called and were available. It has been emphasised to staff the ongoing importance of ensuring the process is followed and documented.

The successful maternity safety training fund bid is now enabling DGFT to send an additional 72 midwives on enhanced training in Neonatal Life Support.

5.8. The review identified that there was concern that staff, on occasion, were slow to respond in a timely way to urgent situations and in some cases appreciate the deterioration of a woman's condition

External reviewers and members of the CRG identified a theme that staff, on occasion, were slow to respond to urgent situations and, in some cases, did not recognise deterioration in a woman's condition in a timely way.

A review of guidelines relating to care of the deteriorating patient was completed and a midwife lead was identified to participate in the DGFT Deteriorating Patient Group.

Reviews of the care pathways for women with severe pre-eclampsia and eclampsia, sepsis and existing long-term medical conditions were completed and updated to reflect the most up-to-date national guidance where necessary.

Multidisciplinary emergency skill drills study days, which staff attend annually, uses the DGFT Simulation Laboratory - a simulated ward or delivery suite environment. All staff can then practice the skills they need to use in an emergency situation and are given feedback on their performance. This allows for individual support to improve knowledge and skills.

A maternity acute illness management (AIM) course has been established within DGFT and all midwifery staff are attending.

5.9. The CRG review supported the importance of DGFT maternity services working with other maternity services, to share good practice and be involved in national initiatives to improve outcomes for women and their babies

As a consequence of the QIB process, DGFT have established a joint working relationship with The Royal Wolverhampton NHS Trust and midwives have shared learning and good practice. There is an effective programme of visiting each other's units, to share good practice across a wider network within the Black Country and more widely across the country.

DGFT contributes to NHS England's quarterly audit, based on the Saving Babies Lives Care Bundle, which aims to reduce the rate of stillbirths from 4.7 per thousand to 2.3 per thousand by 2030. The initial care bundle was launched in March 2016 and implemented by DGFT.

6. Conclusion

The QIB process has demonstrated that where systems work together, they are more effective.

The Quality Improvement Board met its terms of reference and was assured:

- that after the detailed clinical review, and by the subsequent improvement plan, that the maternity services at DGFT are safer and more clinically effective;
- by DGFT that families have been appropriately engaged in the investigation of these cases;
- through the focused work of the governance sub group, that significant improvement has been made to both the Serious Incident reporting processes within DGFT and DCCG, and that these improvements are being embedded across the Trust
- through the active monitoring of the action plans developed, that the lessons learnt have been adopted and the learning is enhancing day-to-day practice at DGFT.

This QIB review has identified that the level of investigation of Serious Incidents in the maternity unit at The Dudley Group Foundation Trust (DGFT) was poor. The absence of effective investigations into cases where there were care and service delivery issues resulted in missed opportunities to share learning from problems and prevent them re-occurring. During the review of multiple cases, clear themes emerged that have been referenced in this report. These have been addressed by the maternity service. Having identified the lack of learning, DGFT has worked to actively involve families directly affected by this review and communicate with them regarding the findings.

The systems and processes have now been strengthened across NHSE, DCCG and DGFT. The organisations have worked closely on the improvement agenda and we have mutual confidence that incidents are now being investigated thoroughly, that all relevant learning is being identified, and the required changes are being made to optimise the safety of women and babies.

A wider benefit of the QIB has been to enhance clinical and managerial working relationships and act as a catalyst to enable DGFT to forge partnerships with other maternity units, to allow the learning at Dudley to be cascaded to others, as well as offering a conduit for DGFT to proactively seek opportunities to further learn and improve.

Dudley Maternity Quality Improvement Board
Published October 2017

7. Membership of the Maternity Quality Improvement Board

Chair - Mr Steve Wellings, Non-Executive Director, Dudley Clinical Commissioning Group

Vice Chair - Dr Doug Wulff, Non-Executive Director, Dudley Group NHS Foundation Trust

Dudley Group NHS Foundation Trust (DGFT)

Dr Paul Harrison - Medical Director, DGFT
Mrs Dawn Wardell - Chief Nurse (until April 2017), DGFT
Mr Adrian Warwick - Consultant Obstetrician, Clinical Director, DGFT
Mrs Steph Mansell - Head of Midwifery (Retired June 2016), DGFT
Mrs Yvonne O'Connor - Head of Midwifery (June 2016 - December 2016)
Ms Siobhan Jordan - Interim Chief Nurse

Dudley Clinical Commissioning Group (DCCG)

Mrs Caroline Brunt - Chief Nurse & Quality Officer, Dudley CCG
Dr Ruth Edwards - Clinical Executive, Dudley CCG
Dr Tim Horsburgh - Clinical Executive, Dudley CCG
Dr Steve Mann - Clinical Executive, Dudley CCG

Care Quality Commission (CQC)

Ms Angela Martin - Inspection Manager, CQC

NHS Improvement

Ms Zena Young - Senior Clinical Lead

NHS England (NHSE) West Midlands

Ms Alison Tennant - Deputy Director Nursing & Quality, NHS England (West Midlands) (left October 2016)
Ms Helen English - (Quality Lead, joined QIB July 2016)
Ms Barbara Kuypers - Local Supervisory Authority Midwifery Officer (until April 2017)
Ms Jacqueline Barnes - Director of Nursing & Quality (joined QIB June 2017)

Healthwatch Dudley

Ms Jayne Emery - Chief Officer, Dudley Healthwatch Dudley
Ms Pam Bradbury - Chair, Healthwatch Dudley

8. Glossary

Abbreviation	Meaning
AIM Course	Acute Illness Management Course
BAPM	British Association of Perinatal Medicine
BWNHSFT	Birmingham Women's Hospital NHS Foundation Trust
CQC	Care Quality Commission
CRG	Clinical Review Group The purpose of the group was to provide assurance that the service was clinically safe and effective and involved detailed reviews
CTG	Cardiotocography Is a technical way to monitor a baby's heart rate alongside a woman's contraction during pregnancy and labour
DCCG	Dudley Clinical Commissioning Group
DGFT	Dudley Group NHS Foundation Trust
DoC	Duty of Candour The Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm
Eclampsia	Is a life-threatening complication of pregnancy. Eclampsia is a condition that causes a pregnant woman, usually previously diagnosed with pre-eclampsia (high blood pressure and protein in the urine), to develop seizures or coma
MDT	Multidisciplinary team Multidisciplinary and Multi-agency working involves appropriately utilising knowledge, skills and best practice from multiple disciplines and across service provider boundaries, e.g. health, social care or voluntary and private sector providers, to redefine, rescope and reframe health and social care delivery issues and reach solutions based on an improved collective understanding of complex patient need(s)
MLU	Midwifery Led Unit
MPAG	Maternity Performance and Assurance Group Provides a forum for ongoing dialogue in relation to the quality and safety of care in maternity services
NHSE	NHS England (West Midlands)
NHSE LSAMO	NHS England (West Midlands) Local Supervisory Midwifery Office
NIC	Neonatal Intensive Care
NICE	National Institute for Clinical Excellence

8. Glossary

Abbreviation	Meaning
Pre-eclampsia	Is a condition that typically occurs after 20 weeks of pregnancy. Signs of pre-eclampsia include high blood pressure (hypertension) and protein in urine (proteinuria). Symptoms of pre-eclampsia may include headache, visual disturbances, swelling of face hands and feet and upper abdominal pain. However often there are no symptoms and it may be picked up at a routine antenatal appointment by the results of the blood pressure and urine checks.
Prostaglandins	Induction agents Is a hormone-like substance that causes your cervix to ripen, and which may stimulate contractions
QIB	Quality Improvement Board
RCA	Root Cause Analysis Defined by the NHS as: 'a useful tool for thoroughly investigating reoccurring problems of a similar nature in order to identify the common problems (the what?), contributing factors (the how?), and root causes (the why?). This allows one comprehensive action plan to be developed and monitored and, if used effectively, moves the focus from repeated investigation to learning and improvement'
RCOG	Royal College of Obstetrician and Gynaecologists
RWT	The Royal Wolverhampton NHS Trust
Sepsis	Also referred to as blood poisoning or septicaemia, this is a potentially life-threatening condition, triggered by an infection or injury. In sepsis, the body's immune system goes into overdrive as it tries to fight an infection. This can reduce the blood supply to vital organs
SIF	Serious Incident Framework (released in March 2015)
SIs	Serious Incidents Defined by the NHS as: 'events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response'
Syntocinon	A drug used for induction and to co-ordinate an increase of contractions in labour
T&FG	Task & Finish Group Group established to assure themselves and providers of internal governance
VBAC	Vaginal births after caesarean

Notes

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12th October 2017 - PUBLIC

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

CLINICAL STRATEGIC AIMS

Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

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

SUMMARY OF KEY ISSUES:

For the month of September

- The Trust has had 16 cases of post 48 hr *Clostridium difficile*, 6 cases occurred in month.
- There have been 7 MSSA bacteraemia identified in the Trust of which 0 are post 48 hour cases.
- No post 48 hour MRSA bacteraemia cases since September 2015.
- There have been 18 E. coli bacteraemia identified in the Trust of which 0 are post 48 hour cases.
- There have been 2 Klebsiella bacteraemia cases of which 0 are post 48 hours.
- There have been 0 Pseudomonas bacteraemia cases.

IMPLICATIONS OF PAPER:

RISK	Yes		**Risk Description:** Failing to meet minimum standards
	Risk Register: Yes		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Yes	**Details:** Safe and effective care
	Monitor	Yes	**Details:** MRSA and C. difficile targets
	Other	Yes	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		√	

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

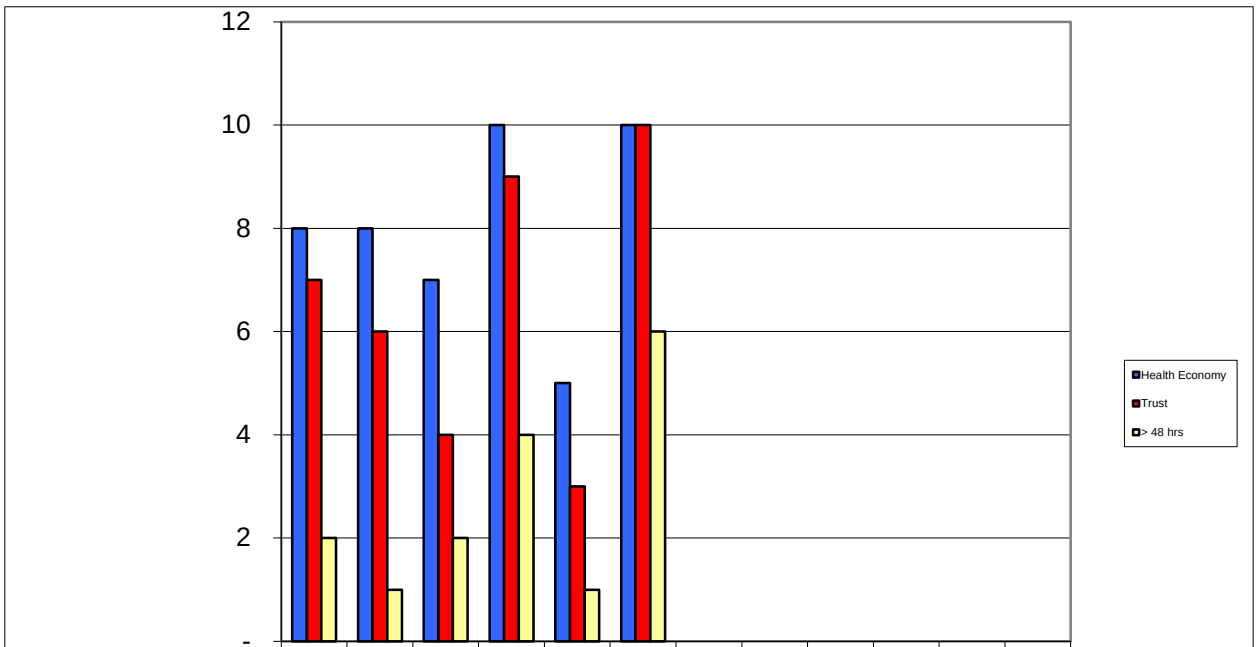
Clostridium Difficile – The target for 2017/18 is no more than 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. Penalties will be associated with exceeding 29 cases associated with lapses in care. We have had 6 post 48 hour case recorded in September 2017.

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

For the financial period 2017/18 there has so far been 16 post 48 hour case identified since 1st April 2017. There are 6 cases for September 2017 to date. Of these 16 cases 8 are lapses in care and the remaining 7 are under review. Of the 9 apportioned cases the lapses in care associated are: failure by areas to meet their mandatory IC training targets, cleaning score below the required standard and failure to complete a stool chart on admission of the patient.

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

Clostridium difficile **cases 2017/18**



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

MSSA bacteraemia (Post 48 hrs) – 0 post 48 hr cases for September to date.

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

MRSA screening – The Trust screens emergency admissions as well as appropriate elective surgical cases. The percentage of emergency admissions for August is 91.7%.

The percentage of elective admissions for August is 92%. There has been further work identifying areas where patients who should be screened have not been screened. This has now been

scoped. The Chief Nurse has requested the MRSA screening policy to be reviewed by the end of October 2017 to ensure there is absolute clarity on which groups of patients should be screened in order that accurate data can be generated against the baseline.

E. coli bacteraemia – For the post 48 hr cases an enhanced surveillance module has been commenced in April 2017 in order to ascertain themes and trends within the acute Trust to see where lessons may be learnt. There are 0 post 48 hr cases for September.

Klebsiella* and Pseudomonas* bacteraemia – Public Health England has asked Trusts to begin to report their Klebsiella oxytoca/pneumoniae and Pseudomonas aeruginosa cases on the mandatory HCAI system and so this information will be reported within the Board report from now on. For September there were 2 Trust identified Klebsiella bacteraemia cases of which 0 are post 48 hrs. There are 0 Pseudomonas bacteraemia cases for September to date.

Infection Control Mandatory Training – Percentage compliance as at 31.8.17 against a target of 90%, training is required 3 yearly.

Area	Clinical	Non Clinical
Corporate/Management	86%	92%
Medicine and Integrated Care	91%	93%
Surgery	90%	96%

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

Environment and Hand Hygiene – ICT are working with the Trust's PFI partner to scope the impact of the new Cleaning Policy. The Trust has also awarded the contract to a new provider to deliver the hand decontamination and hand care products required in the Trust. In the last week the company have visited the site to scope the clinical areas to ensure that the implementation planned for the end of September can be delivered. There has been a delay in addressing this issue and we expect it to be in by the middle of November at the latest.

The work to identify where the carpeted areas in the Trust are has been completed. The information has been RAG rated with red being clinical areas, amber being public areas and green being staff areas. The Facilities Department has been asked to arrange for the red and amber areas to be replaced with vinyl by December 2017 and for a further review to be undertaken around the staff areas.

Infection Prevention and Control Forum – The next forum is due to take place on Wednesday 27th September 2017. An update of that meeting will be included in next month's report.

Reference

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

* Klebsiella includes *Klebsiella oxytoca* and *Klebsiella pneumoniae* species and Pseudomonas includes only *Pseudomonas aeruginosa* species.

Enclosure 7

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th October 2017

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

CLINICAL STRATEGIC AIMS

Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.

CORPORATE OBJECTIVE: Deliver a great patient experience, Safe and Caring Services, Be the place people choose to work, Make the best use of what we have

SUMMARY OF KEY ISSUES:

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

With regards to the staffing review:

- Phase 1 covered the Surgical Wards and is now complete.
- Phase 2 covered Paediatrics and the Neonatal Unit. The Neonatal Unit review is complete while the Paediatric review is undergoing amendments as requested by the Executive Director meeting.
- Phase 2a covered the Critical Care Unit and is complete.
- Phase 3 covering the Medical Wards is being finalised with a paper being taken shortly to the Executive Director meeting.
- Phase 4 will consist of the other areas within the hospital.
- Phase 5 will consist of the Community which will commence in October 2017.

Following the completion of the initial phases the Chief Nurse and the Human Resources Director have drawn up an implementation plan to ensure effective recruitment and retention in order to have a substantive workforce providing high quality patient care.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Safe Staffing
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, Effective, Caring, Responsive Well Led
	NHSI	**Y**	**Details: Safe Staffing**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To note and consider the safe staffing data and the position with the ongoing staffing review.

Monthly Nurse/Midwife Staffing Position

October 2017 Report containing August 2017 data

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

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

It can be seen that for individual wards the fill rates vary although in the main they are close to 100%. On occasion, the fill rate is over 100%. C2, the paediatric ward, is a particular exception with regards to this as the planned hours are derived from the RCN dependency tool. Each shift the planned hours are determined by the acuity of the children actually on the ward. Also, sometimes there are occasions when the fill rate of unqualified staff goes above 100%. This occurs when it is recognised that there will be a reduction in qualified staff (e.g. C5 at night). The low fill rate during the days in CCU/PCCU reflects the problems in recruiting staff to this particular area. A new recruitment drive by the department has commenced and as well as appointing four of the recent graduates a further two individuals have been offered posts and two more are being interviewed shortly.

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

Table 1. Percentage fill rates January 2017 to the present

	Qualified Day	Unqualified Day	Qualified Night	Unqualified Night
Jan	94%	96%	94%	99%
Feb	93%	95%	96%	99%
Mar	95%	97%	97%	100%
Apr	97%	96%	98%	98%
May	97%	97%	99%	98%
June	96%	96%	98%	99%
July	96%	97%	98%	100%
August	96%	97%	97%	101%

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

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

2017 Month	TRUST Nurse & Midwife	Midlands & East Median	National Median	TRUST Care Support Workers	Midlands & East Median	National Median	TRUST Total number	Midlands & East Median	National Median
January	4.30	4.7	4.7	3.50	2.9	2.9	7.8	7.7	7.6
February	4.34	N/A	N/A	3.63	N/A	N/A	7.97	N/A	N/A
March	4.44	N/A	N/A	3.74	N/A	N/A	8.18	N/A	N/A
April	4.55	4.8	4.8	3.73	3.1	3.1	8.28	7.8	7.9
May	4.4	4.9	4.8	3.8	3.1	3.1	8.2	7.9	7.9
June	4.36	N/A	N/A	3.58	N/A	N/A	7.95	N/A	N/A
July	4.23	N/A	N/A	3.65	N/A	N/A	7.88	N/A	N/A

N/A = Data not available

The latest published regional and national average figures for May indicate that the Trust is below these averages for qualified staff but higher for care support workers (these figures were provided in last month's report and no more recent data is available).

As part of the staffing review being undertaken the comparative data in the Model Hospital has been considered. The examples from surgery and NNU/paediatrics/ITU that were in this paper in the last two months provided useful comparative information when formulating proposed staffing levels for those areas. The next stage of the staffing review has looked at medicine. In Table 3 below, example data of some of these wards is outlined.

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

Speciality/ Staffing Type			
Nephrology	**C1**	**Peer Median**	**National Median**
Total	7.21	7.59	7.13
Registered	***2.62***	4.13	3.96
HCSW	4.59	3.01	2.72
Respiratory	**C5**	**Peer Median**	**National Median**
Total	***6.33***	6.35	6.36
Registered	***2.43***	3.60	3.46
HCSW	3.90	2.68	2.87
Haematology	**C4**	**Peer Median**	**National Median**
Total	7.31	7.04	7.31
Registered	***4.01***	4.72	5.09
HCSW	3.30	2.23	2.30
Cardiology	**CCU**	**Peer Median**	**National Median**
Total	***6.26***	7.05	8.00
Registered	5.66	4.86	5.80
HCSW	0.60	2.20	2.14

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

It is not possible to include all of the wards in the above table due to the nature of some areas not being comparable to other Trusts e.g. due to MHDU having the flex beds and the Stroke Unit having a mixture of Hyperacute/Acute/Rehabilitation beds.

All Trust figures that are less than both the peer and national median have been put into bold and italics and it can be seen that for three areas qualified staffing is less than both medians. For one of these areas and the fourth area, the total staffing is less than both medians. The review findings have confirmed staff to patient ratios less than national standards.

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

Conclusion

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

The staffing review which commenced in May is using data from a wide variety of sources to inform and ensure the required outcome. As well as considering the above data, the review is structured discussions with senior nurses from each area together with their managers using information on establishments, staffing ratios and vacancy, sickness and temporary staffing rates. It is also considering the outcome of the most recent six monthly Safer Nursing Tool exercise. The outcome of the five phases of the review (1 Surgery, 2 Neonates and Paediatrics, 2a Critical Care, 3 Medicine, 4 Rest of the Hospital and 5 Community) will be reported, as agreed, to the Board of Directors as each phase is completed. The first phase outcome has been agreed at the Finance and Performance Committee in July and at the Board of Directors in August. An element of the second phase requires amendment (paediatrics), but both critical care and neonates has been agreed. The third phase is now nearing completion.

APPENDIX 1

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

Ward	Day RN Day RM Plan	Day RN Day RM Actual	Day CSW Day MSW Plan	Day CSW Day MSW Actual	Night RN Night RM Plan	Night RN Night RM Actual	Night CSW Night MSW Plan	Night CSW Night MSW Actual	Qual Day	UnQual Day	Qual N	UnQual N	Actual CHPPD Sum 24:00 Occ	Registered	Care staff	Total
Evergreen																
A2	248	232	217	217	155	145	186	181	94%	100%	94%	97%	1,130	3.90	4.23	8.13
A3																
A4																
B1	123	120	70	67	69	68	70	69	97%	96%	99%	99%	591	3.71	2.76	6.48
B2(H)	124	112	231	213	93	91	201	199	90%	92%	98%	99%	891	2.73	5.54	8.27
B2(T)	92	88	144	140	62	61	113	112	96%	97%	98%	99%	694	2.51	4.35	6.86
B3	189	172	167	155	158	148	135	135	91%	93%	94%	100%	999	3.75	3.40	7.15
B4	186	170	218	207	155	146	148	144	91%	95%	94%	97%	1,364	2.78	3.09	5.87
B5	185	178	124	119	155	151	93	95	96%	96%	97%	102%	1,008	3.83	2.55	6.38
B6																
C1	186	173	340	305	155	144	228	220	93%	90%	93%	96%	1,418	2.62	4.44	7.06
C2	146	223	81	79	127	155	46	44	153%	98%	122%	96%	710	6.23	1.86	8.09
C3	188	182	347	337	159	152	387	386	97%	97%	96%	100%	1,587	2.53	5.47	7.99
C4	155	130	78	78	93	93	93	93	84%	100%	100%	100%	665	3.83	3.09	6.91
C5	186	175	240	257	155	126	174	200	94%	107%	81%	115%	1,393	2.47	3.94	6.40
C6	94	91	65	60	62	62	64	62	97%	92%	100%	97%	506	3.54	2.89	6.43
C7	186	177	129	129	124	122	127	127	95%	100%	98%	100%	1,109	3.16	2.77	5.93
C8	205	185	217	246	186	181	217	262	90%	113%	97%	121%	2,510	1.68	2.43	4.10
CCU_PCCU	217	168	54	54	155	151	17	19	77%	100%	97%	112%	671	5.70	1.31	7.01
Critical Care	303	303	68	67	295	295	-	-	100%	99%	100%		284	24.74	2.48	27.21
EAU	186	167	155	149	155	149	155	150	90%	96%	96%	97%	710	5.22	5.05	10.28
Maternity	550	535	217	199	527	506	155	141	97%	92%	96%	91%	576	17.51	6.91	24.42
MHDU	124	113	39	31	119	109	7	8	91%	78%	92%	114%	222	11.75	2.01	13.76
NNU	183	182	-	-	180	184	-	-	99%		102%		493	8.72	0.00	8.72
TOTAL	**4,056**	**3,875**	**3,201**	**3,107**	**3,339**	**3,239**	**2,616**	**2,647**	**96%**	**97%**	**97%**	**101%**	**19,531**	**4.17**	**3.51**	**7.68**

Enclosure 8

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 12 October 2017

TITLE:	**Medical Revalidation Update**		
AUTHOR:	**Victoria Quinn** **Directorate Manager**	**PRESENTER**	**Mr Paul Stonelake** **Responsible Officer**

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

SUMMARY OF KEY ISSUES:

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 had previously been a temporary shortfall in staffing to support appraisal and revalidation which has now been addressed with the appointment of a replacement Directorate Manager (commenced August 2017) and a Medical Revalidation Support Officer (commenced January 2017).

This paper seeks to set out future plans for improving the quality assurance of the current Revalidation process and to update the Board on the data to be reported externally to NHS England.

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**

The Dudley Group
NHS Foundation Trust

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the contents of this report and to support plans for improved quality assurance of Revalidation processes.

The Dudley Group
NHS Foundation Trust

REPORT OF THE RESONSIBLE OFFICER TO THE BOARD OF DIRECTORS

October 2017

1. Executive Summary

This report represents the status of medical revalidation and appraisals at The Dudley Group NHS Foundation Trust as of 30 September 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 formed the basis of the Annual Organisational Audit (AOA) for 2016/2017 returned to NHS England.

Since that return was made a request was made by the regional Revalidation team (NHS England - Midlands and East Office) for further information about a discrepancy between the 2015/16 and 2016/17 AOA returned data. A response including action points has since been provided to the regional team see Appendix 1.

As of 30 September 2017 there were 324 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 have been carried out with no missed recommendations and no referrals for non-engagement in the last financial year.

Areas for development are highlighted within the report, most significantly:

- the commencement of a process of peer review and best practice sharing with neighbouring Trusts
- ratification of the previous proposed change to the process of quarterly update reporting
- a refreshed programme of training for appraisers
- a regular newsletter to update medical staff of any new developments e.g. changes in the Revalidation / Appraisal process being introduced by the GMC in response to the Pearson report, and also to feedback current appraisal performance.

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;

[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'

- 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 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 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, Victoria Quinn who has been in post since August 2017. 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 also necessary. In accordance with best practice amongst Trusts within the NHS England Midlands & East network, the Team recruited a Medical Revalidation Support Officer, Polly Moreton, who has now been in post since January 2017.

Assurance is currently provided by reporting to the Board quarterly. It was previously proposed and agreed by the Board that this quarterly report could be presented to the Workforce and Engagement Committee, with the annual update then presented to the Board. The Board is asked to agree that going forwards this is the reporting arrangement that will take place.

The Medical Revalidation Group consisting of the Responsible Officer, Appraisal Lead, Directorate Manager and Medical Revalidation Support Officer meet weekly or 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, Directorate Manager 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. Matters arising are reported separately and privately to the Board in a Medical Staffing update paper, provided by the Medical Director.

4. Medical Appraisal Performance

4.1 Appraisal and Revalidation Performance Data

As of 30 September 2017, there were 324 doctors connected to The Dudley Group for the purpose of Medical Revalidation.

As of that date 87 were due an appraisal within Q2 and 78 (90%) were compliant as defined by the GMC. The issues preventing 9 doctors completing appraisal are being addressed; in three cases this was due to external factors (e.g. recent employees) and in the remaining cases further reminders have been issued. It is expected that the majority of these will fulfil their appraisal shortly, though they have been made aware of the possibility of being reported to the GMC for lack of engagement if there are further delays, and also that the anniversary of their next appraisal will need to be kept at the original date.

The Revalidation team are in the process of producing a newsletter to go out to our connected doctors and the plan is to repeat this quarterly. The newsletter will contain a reminder about the Revalidation policy requirements plus other updates on revalidation as well as the figures that the Responsible Officer must report for compliance purposes. It is hoped that this will encourage engagement with the Revalidation process, plus an awareness of the external requirements that must be adhered to.

Previously the internal reporting of medial appraisal rates for Directorates/Divisions had been subject to scrutiny and inaccuracies had been identified in the processes used to circulate such information by the Learning and Development Department. This was 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 had 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 therefore the Appraisal and Revalidation Team now 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 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.

The Revalidation team have begun to explore a programme of training for appraisers and are currently considering the options in respect of hosting an in-house training session rather than expecting appraisers to go off site and at their own cost to undertake this. It is felt that this is a more consistent way of offering appraiser training, which needs to be undertaken every three years to maintain skills and

knowledge. It is also likely to encourage attendance if training can be provided on-site at no cost. The Team intend to use the quarterly Newsletter to invite new doctors to appraisal training so as to expand the available pool of appraisers.

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.

All appraisers should receive feedback from appraisees as a software prompt after the appraisal meeting. The Appraisal and Revalidation Lead will be formalising analysis of this and ensuring it is included in the Appraisers own appraisal.

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. We have contacted The Royal Wolverhampton NHS Trust and Sandwell and West NHS Trust to commence this process of mutual peer review and the sharing of best practice. A meeting is due to be arranged shortly with view to completing external Quality Assurance before April 2018.

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

Only two submitted recommendations were required July - Sept 2017. In one case recommendation for revalidation was submitted, in the other a recommendation for 4 month deferral was made due to insufficient evidence.

6. Recommendations

The Board is asked to note the contents of this report and to support plans for improving the quality assurance of our Revalidation processes.

The Dudley Group
NHS Foundation Trust

Appendix 1: AOA 2016/17 Follow Up

The NHS England - Midlands and East Office informed us that following their review of the AOA 2016/17 return they had noted an increase in the number of Category 3 unapproved missed in this year's figures compared to the 2015/16 AOA return. They requested a response as to why unapproved missed appraisals had increased (from none in 2015/16 to 8.71%) and what action plan was in place to address this.

We responded on 15 September 2017 as follows, setting out the reasons for the increase, and appropriate action to be taken (or already taken):

As indicated in the original submission made earlier in the year, the Revalidation team have had a gap in resource that has now been resolved, with the commencement of a Revalidation Manager in August 2017. In addition, the appointment of a permanent Revalidation Support Officer in January 2017 has provided support in managing the system used to facilitate the Revalidation process. While the previous lack of resource led to some slippage in the monitoring of appraisals, this has now been addressed and going forwards there is a robust team in place to manage the process in the round. In particular, the Revalidation Support Officer has become more experienced over the course of the last 9 months, increasing our understanding of how we can manipulate the information we hold to ensure that we have a 'live' picture of what is actually happening. The Appraisal Lead, Dr Helga Becker has been in post now since April 2016, and as such the team is now at full complement.

As a result of this additional, and now structured, resource, the team have been able to spend time drilling down into the detail of the data and reconcile any inconsistencies that were previously 'hidden' at first glance. More searching of the data has enabled us to become knowledgeable about specific issues, such as ensuring that the Doctors connecting to us via GMC Connect, should be connected to us, and not another appraiser. For example, we have found through manual auditing of our data that a number of Deanery trainees had been connected to us when in fact they should be connected to the Deanery. We are now monitoring GMC Connect daily. This improved practice in our systems management has increased our data quality and has helped us to develop a practice of quality assuring the data that exists in our system, and also changes to that data.

Our Revalidation Support Officer now holds monthly meetings with the Workforce Information Analyst which ensures that we have a regular audit of who is on our system, and monitor what changes need to be made such as the prompt archiving of Doctors who have left our Trust. This regular cleanse of our data ensures that our reporting is as accurate as can it can be.

Overall we have made good progress on the improvement of accuracy and validity of our data base. We are confident that this will robustly improve our appraisal rates quarter on quarter from now on. The work that we have undertaken has also allowed us to identify what underpinned the slippage from a data perspective - detecting missed appraisals which were not obvious previously.

We are a team who is passionate about having a robust, efficient and reliable Revalidation process and have worked hard to understand how we can improve month by month. While the slippage was regrettable, we would hope that it was the result of an unfortunate set of circumstances. We were also comforted by the fact that although there had been an increase in unapproved missed appraisals (by 8.7%)

this is only in fact 2.5% greater than Trusts in the same sector. Ultimately, we have worked incredibly hard to remedy this issue, and are committed to maintaining accurate and meaningful data that allows us to fulfil our Revalidation obligations.

We have also programmed in, and started work on, future projects to enhance what we have achieved to date. This includes initiating a more formal process of sharing best practice and mutual peer review - to quality assure our appraisers and our processes - with two neighbouring Trusts; Sandwell and West Birmingham Hospitals NHS Trust and The Royal Wolverhampton NHS Trust. We have also started internal work on the review of our incumbent Revalidation policy, with the aim of tightening the advertised timescales for the appraisal process. Our current policy stipulates that within 4 weeks of the appraisal due date, the process should be completed, with the output form completed by the appraiser, and the feedback form by doctor. We are hoping that by bringing forward some of the other advertised timescales that this will allow us to expect that the entire process is concluded by the appraisal due date. Our existing policy will be circulated to all Doctors in advance of us making the necessary revisions, advertising that in due course the timescales will be amended and that Doctors should be aware of these future proposed changes.

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 12 October 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 28 September 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	**28 September 2017**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- Corporate risk COR102 to be removed from the corporate risk register as the junior doctor implementation has gone more smoothly than anticipated.
- Good progress is being made with the Pharmacy Transformation Plan in line with the recommendations in the Model Hospital portal.
- The trend analysis of income and expenditure shows a gradual rise in spending and a flattening of income over the 3 year period.
- The Transformation Plan showed for the first time that the CIP plan was forecast to be £1.6m behind its planned savings of £12.5m in 2017-18 owing to a recalculation of the impact of agency savings. Whilst agency costs have reduced compared to 2016-17 out-turn they remain un-affordably high, and behind our planned reductions.
- A special meeting of the Committee has been established on 20th October 2017 to review the month 6 forecast out-turn in some detail and to show what additional savings schemes can alleviate the current forecast deficit position.
- The cash-flow implications of not receiving the STF funding if the control total was not achieved in 2017-18 was discussed together with the impact on the proposed capital programme.
- The anticipated recruitment of 3 cohorts on graduate nurses in short order (September 30; November 30; January 40) should lead to the eradication of the need for registered agency nurses in year.
- It was confirmed that the revised ward establishments for the medical wards was nearing completion, and similarly to the surgical wards. The additional posts would not lead to an increase in agency or premium rate bank costs as they would only be filled with substantive staff.
- Progress on reducing premium pay costs for medical staff were reviewed including the recruitment of 20 MTI staff from Pakistan and the harmonisation of additional payment rates.
- The latest position on PFI deficiency points was discussed in advance of the meeting with Summit which followed that day.

Decisions Made / Items Approved

- None

Actions to come back to Committee

- Written paper on the financial implications of the MCP to be received by the Committee at its next meeting

Performance Issues to be referred into Executive Performance Management Process

- The progress on Consultants' job planning to be reviewed and reported back to the Committee

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

- None

Items referred to the Board for decision or action
• The Trust's financial position in 2017-18 took a turn for the worse at Month 5 – both in the year to date and the year-end forecast. This was due to clinical activity in A&E and emergency admissions being at an unprecedentedly low level, and expenditure continuing to rise gradually, with agency spending not reducing as much as was planned. A review of forecast spending plans, additional savings schemes and the Month 6 position will be undertaken by a special Finance and Performance Committee meeting on 20th October 2017 and a challenging but realistic year-end financial forecast be agreed. At this point detailed conversations with NHS Improvement will be required so that the risk of not meeting the Trust's control total figure can be assessed. The cash-flow implications of not receiving STF funding should also be considered alongside the capital programme.

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12th October 2017

TITLE:	Key Performance Targets Report for Month 05 (Aug) 2017/18		
AUTHOR:	Andy Troth Head of Informatics	**PRESENTER:**	Siobhan Jordan Interim Chief Nurse

CLINICAL STRATEGIC AIMS

Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience
SO2: Safe and Caring Services
SO4: Be the place people choose to work
SO5: Make the best use of what we have
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

A&E target

Performance in August with of 87.16**%** for combined Type 1 and Type 3 down from 89.1% in July. The Trust's ED department (Type 1) was 80.2% down from 82.7%. There has been an 11.4% reduction in attendances to ED and UCC however, ambulance numbers remain similar to July. An improvement programme has commenced. The focus is on managing length of stay, timely clinical decision making and delayed transfers of care.

Cancer 2 Week Wait (2ww)

For the first time since the current suspected cancer waiting time standards were launched in 2009, the Trust failed to achieve the suspected cancer 2ww target in August 2017. During this period a total of 1,123 patients attended a 2ww appointment with 170 patients attending their appointments outside of the 2 week standard, achieving a performance 84.9% against the 93% target. Of the 170 2ww breaches, 146 were on a suspected skin cancer pathway, and it is this performance that was unprecedented and resulted in the overall Trust failure of this target. The Trust will fail the 2WW standard for Quarter 2 however, is on track to deliver the standard for the month of September.

Cancer 62 day

The performance figures for Cancer 62 day wait for August is 83.2%. The Weekly Cancer Performance meeting continues to meet and a Cancer Sustainability Plan has been formulated that reviews our processes and delivery systems against the best practice guidance. The trust has a plan to achieve 85% from September 2017. This is on track.

Referral to Treatment (18 week)

Incomplete pathways were achieved in month with a performance of 94.19% against a target of 92%, although performance in two specialities fell below the expected.

Urology (90.84%) – slightly up from last month
Ophthalmology (83.38%) – down from last month

DM01 Diagnostic Performance

The performance for August was 97.70% against a national target of 99%. The internal improvement trajectory has not been achieved in month (original trajectory was 98.4%).
The plan of reaching 99% for the end of September is now back on track.

Mixed sex accommodation

There were 2 MSA breaches in month relating to ITU and capacity to move patients out.

Never Events

There were 0 never events recorded in month.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** High levels of activity could impact on the delivery of KPIs – particularly the emergency access target and RTT. The latter would be impacted by increased levels of outliers resulting in cancelled operations**.**
	Risk Register: Y		**Risk Score:** 20 (COR079)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**Y**	**Details:** A sustained reduction in performance could result in the Trust being found in breach of licence.
	Other	**N**	**Details:**

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

RECOMMENDATIONS FOR THE BOARD:

To note the performance against the national mandated performance targets and where there has been non achievement to seek assurance on the plans to recover the expected position.

Report of the Interim Chief Nurse to the Board of Directors

Key Performance Targets Report for Month 05 (Aug) 2017/18

1. Introduction

This paper aims to present to the Committee performance against key areas, highlighting good performance and identifying areas of exception, together with the actions in place to address them.

2. Key Issues

a) A&E 4 hour wait – Page 4

The combined Trust and UCC performance was below target in August 2017 at **87.16**%. Whilst, the Trust only (Type 1) performance was **80.20**%

The split between the type 1 and 3 activity for August was:

	Attendances	Breaches	Performance
A&E Dept. Type 1	8115	1607	**80.19%**
UCC Type 3	4607	27	**99.41%**

There has been a marked reduction in activity in August compared to July. We noted deterioration in the Emergency Access Standard for August. Whilst ambulance attendances are approximately the same as July, overall attendances to the Trust are down from 9056 to 8115 (10%), UCC down from 5297 to 4607 (13%), combined reduction overall of 11.4%. The reduction in walk-in attendances has had a significant impact on the denominator of the indicator and that they are less likely to be breaches. The main reason for failure are delayed transfers of care, bed availability and increasing length of stay.

b) Cancer Waits

The Committee is reminded that due to the time required to validate individual pathways, the cancer waiting times in this report are **provisional only**. In addition, the reporting of patients breaching 104 days is provided 1 month retrospectively.

Cancer – 62 Day from Urgent GP Referral to Treatment performed below target for August at **83.2%.** The Trust has a plan to achieve **85%** from September 2017.

Cancer - 104 days - Number of people who have breached beyond 104 days (July)

No. of Patients treated on or over 104 days (DGFT)	5
No. of Patients treated on or over 104 days (Tertiary Centre)	0
Total No. of Patients treated on or over 104 days (Combined)	5

c) 2 Week Wait (2ww)

For the first time since the current suspected cancer waiting time standards were launched in 2009, the Trust failed to achieve the suspected cancer 2ww target in August 2017. During this period a total of 1,123 patients attended a 2ww appointment with 170 patients attending their appointments outside of the 2 week standard, achieving a performance **84.9%** against the **93%** target**.**

Of the 170 2ww breaches, 146 were on a suspected skin cancer pathway, and it is this performance that was unprecedented and resulted in the overall Trust failure of this target.

The number of suspected skin cancer referrals increased significantly received between May and August with an average of 321 for these four months against an average of 254 for the preceding four months. Most notably and a contributing factor a total of 378 referrals were received in June, creating the start of a cumulative effect that was eventually to be realised in August. It is disappointing that this is consistent with known seasonal variation experienced by the Trust in previous years and therefore with better planning could have been mitigated.

In addition to the increased demand, the level of 'normal' 2ww appointment capacity provided during the months of July and August was reduced with a total of 16 out of a possible 32 clinics being cancelled in July and a further 16 from a possible 40 clinics cancelled in August. These clinic cancellations were all associated with planned annual leave.

Actions Taken

1. Improved monitoring of 2ww referral levels and 2ww capacity via the new weekly Cancer Performance meeting (commenced w/c 21st August 2017) with tracked actions for the Directorate Managers, Cancer Management Team and any support services.

2. More effective management of annual leave within specialties via the Directorate Managers and contingency plans put to put in place well in advance of the summer months to mitigate the same issue occurring next year.

3. Escalation, management and resolution of capacity issues to be achieved via the weekly Cancer Performance management meeting, with action owners and timescales specified. Any concerns around these actions to be formally raised at Executive level performance meeting and new template produced to raise awareness of and flag such issues has been drafted.

   Review of the suspected skin pathway to be conducted with all 3 divisions present to discuss and agree:

   - The appropriateness of 2ww clinics only being held on a Tuesday.
   - Pathway distinction between Dermatology and Plastics.
   - Capacity and Demand.

d) Referral To Treatment (RTT)

The performance of the key target RTT Incomplete Waiting Time indicator remained at **94.19%** in month against a target of **92%**, a slight decrease in performance from 94.39% in July. Urology did not meet the target in month at **90.84%,** however was up slightly from **89.78%** in previous month. Ophthalmology is at 83.38%, down from 85.21% in July.

There were no 52-week Non-admitted Waiting Time breaches in month.

e) Diagnostic waits

The diagnostic wait target was not achieved in August with a performance of **97.70%** (against a trajectory of **98.40%**). This was an Improvement from the July position of 97.1%. The number of patients waiting over 6 weeks has fallen again from the previous month, 158 to 152.

Of the 152 waiting more than 6 weeks:

- Non-obstetric Ultrasound accounted for 103
- MRI 35 and Cardiology
- Electrophysiology 6

A diagnostic trajectory plan has been put in place that supports month on month improved performance, returning to delivery by September 2017. The trajectory is outlined below and is expected to deliver.

	Aug Actual	Sep Forecast	Oct Forecast	Nov Forecast
MRI Breaches	35	30	30	28
MRI Extra Capacity		6	6	6
CT Breaches	2	2	2	2
CT Extra Capacity		180	180	180
US Breaches	103	30	30	30
US Extra Capacity		345	345	345
Others	12	5	5	5
Total Breaches	152	67	67	65
Total Activity (denominator)	6611	7200	7200	7200
DM01 %	97.70%	99.02%	99.06%	99.10%

f) Mixed Sex Sleeping Accommodation Breaches (MSA)

There were 2 breaches reported in month related to ITU and capacity to move patients out within 4 hours.

g) VTE Assessment on Admission: Indicator

The indicator achieved the target in month with **provisional** performance at **95.17%** against a target of **95%.** This is an increase on July's performance of **94.29%.**

h) Stroke Medicine - Suspected High Risk TIA Assessed and Treated < 24hrs from Presentation

This KPI was met in month with a **provisional** figure of **90.9%** (10/11) against a local target of **85%.** For 2017/18 the guidance and requirements for seeing TIAs are changing, with all TIAs to be seen within 24hrs (except where the event is over 7 days prior to referral), however requirements for further assessment and treatment vary. The Indicator will be retitled to TIAs Seen within 24hrs.

i) Stroke Medicine – Swallowing Screen

This KPI was not met in month with a **provisional** figure for August **73.8%** (31/42) against a local target of 75%. It is to be noted that after validation the July final figure rose from **75%** to **82.7%.**

j) Finance

The month 5 financial position has been characterised by a significant reduction against income (largely A&E, Emergency spells, Outpatient and Community attendances) whilst pay costs have remained high. This has resulted in an adverse variance of £2.185m in August leading to a cumulative position that is £2.348m behind plan. Consolidation of Dudley Clinical Services Ltd and technical changes relating to donated assets reduce the adverse variance to £2.240m. Agency costs continue to exceed the NHSI cap and pay costs were further increased by a high bank spend (normal for the summer months) and highest WLI spend this financial year (linked to a positive Day Case/Elective performance). The unmitigated forecast position has now deteriorated to a deficit of just under £6m which is approximately £8.5m short of the control total. This excludes the risk

regarding the potential removal of £1.2m CQUIN funds for a national risk reserve. A series of plans have been developed to reduce the current forecast and bring the Trust back into line with plan although this still falls some way short. An in-depth review will commence post month 06 figures with a report back to an extraordinary Finance & Performance Committee session. The September income performance will be pivotal as this will help determine whether August was a one-off anomaly or whether the plan has been inadequately phased. If the Trust fails to recover the financial position, the remaining STF monies of £7.288m will not be received.

Liquidity is above plan at month 05 with a rating of 13.2 against a plan of 10.1. This is as a result of the stronger net current assets position compared to plan. Capital service cover is lower than plan as a result of the Income and Expenditure adverse variance compared to plan the Trust has reported at month 05.

k) Workforce

Appraisals:

August has seen the position remain static in the percentage of appraisals undertaken, from at 83.93%. Clinical Support Division is red at **64.9%** (below 90%). Corporate/Management, Surgery and Medicine and Integrated Care are amber at **86.21%, 87.11%** and **86.25%** respectively **(>80% <90%).**

Performance meetings have been undertaken with the divisions and expectations are that **90%** will be achieved by all for October 2017.

Mandatory Training:

Mandatory Training has risen slightly from **85%** in July to **85.47%** in month. The Director of HR is working with respective Divisions based on the feedback from a series of forums that were held to identify issues within the mandatory training system. The Clinical Support Division is red at **78.25%.** Within this division Imaging and Pathology are red at **75.24%** and **74.80%** respectively.

Only the Urgent Care Directorate in the other Divisions is red with **73.77%.** The Chief Executive has signalled that for the year of 2017/18 that the Trust's targets need to be met.

Performance meetings have been undertaken with the divisions and expectations are that **90%** will be achieved by all for October 2017.

Sickness:

Sickness rate overall has risen from **4.14%** in July to **4.21%** in month. Medicine & Integrated Care are red with **4.49%** and Surgery Division red at **4.81%.** Within the Medicine & Integrated Care Division, Integrated Care and Nursing Medicine Directorates are red with **4.30%** and **5.85%** respectively. Within the Surgery Division; Nursing Surgery, Theatres & Critical Care, OPD and Health Records, Surgery Division Management Directorates are red with **6.13%, 5.64%, 4.94%** and **14.48%** respectively.

l) Single Oversight Framework (SOF)

The Trust's self-assessment against NHSI's single oversight framework is included at Appendix 1 to this report. We are awaiting the formal NHSI assessment confirmation. However, we consider we would remain within segment 2.

m) Electronic Discharge Letters to Primary Care

This indicator relating to electronic discharge letters from inpatient and ED remains below target at **90%** at **82.47%**.

A Contract Notice has been issued by the CCG. In addition, the Trust is currently reporting an under-achievement against the requirement to communicate outpatient information within 10 days where the GP is required to take action and a performance notice has been issued by the CCG. However, it has become apparent that the Trust is reporting all outpatient letters, as opposed to only those requiring GP action and this is being reviewed.

3. Recommendation

The Board of Directors is asked to: Note the contents of the report and approve.

Siobhan Jordan
Interim Chief Nurse

Appendix 1

Appendix 1: Single Oversight Framework

Finance & use of resources.

Single Oversight Framework (Finance and Use of Resources)							
Area	Weighting	Metric	Definition	Score			
				1	2	3	4
Financial Sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75 - 2.5x	1.25 - 1.75x	<1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly commtted lines of credit available for withdrawal	>0	(7)-0	(14) - (7)	<(14)
Financial Efficiency	0.2	I&E Margin	I&E surplus or deficit/total revenue	>1%	1-0%	0-(1)%	<=(1%)
Financial Controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/deficit	>=0%	(1)-0%	(2)-(1)%	<=(2%)
	0.2	Agency spend	Distance from provider's cap	<=0%	0%-25%	25%-50%	>50%

Single Oversight Framework (Finance and Use of Resources)								
Area	Weighting	Metric	Mar	Apr	May	Jun	Jul	Aug
Financial Sustainability	0.2	Capital service capacity	3	4	4	3	3	3
	0.2	Liquidity (days)	1	1	1	1	1	1
Financial Efficiency	0.2	I&E Margin	1	4	3	1	1	2
Financial Controls	0.2	Distance from financial plan	1	2	2	1	2	3
	0.2	Agency spend	4	4	4	4	4	4

Quality of Care (safe, effective, caring &responsive) and Operational performance:

Measure	June Trust Position	July Trust Position	August Trust Position	VAR	Latest National Position	Latest National Reporting period	Ranking if Applicable
Quality Indicators							
Organisational Health Indicators - all Providers							
Staff Sickness	3.93%	4.04%		▼	4.01%	Jul-16	54/105
Staff Turnover	9.26%	9.30%		▼	N/A	N/A	
Executive Team Turnover							
NHS Staff Survey	Annual Report				3.83	2016	This is for Overall Staff engagement, calendar year 2015 was 3.86.
Proportion of Temporary Staff							
Aggressive Cost Reduction Plans							
Written Complaints - Rate							
Staff F & F % Recommneded - Care							
Ocurrence of any Never Event	1	0	0	▬	0	July	
NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	0	0	▬	0	July	
Acute Providers							
Mixed Sex Accommodation Breaches	0	0	2	▼	0	July	
Inpatient Scores F & F - % Positive	97%	96%	96%	▬	96%	July	101/173
A & E Scores F & F - % Positive	79%	77%	73%	▼	77%	July	128/140
Emergency C - Section Rate	22%	20%	20%	▬	17%	2015/16	95/129
CQC Inpatient / MH and Community Survey							
Maternity Scores F & F - % Positive							
Antenatal	96%	99%	100%	▲	99%	July	41/111
Birth	98%	99%	99%	▬	99%		45/129
Postnatal Community	100%	100%	97%	▼	100%		1st with 58 other trusts
Postnatal Ward	99%	98%	96%	▼	98%		35/124
VTE Risk Assessment							
C Diff - Variance from plan					TBC	TBC	
C Diff - infection rate	2	4	1	▲	4	July	
MRSA Bacteraemias	0	0	0	▬	0	July	
HSMR (DFI)				▬	107	Mar 16 to Feb 17	As expected
HSMR (DFI) - Weekend				▬	98	Mar 16 to Feb 17	As expected
SHMI					0.98	Oct 15 - Sep 16	As expected
Potential under-reporting of patient safety incidents							
Emergency Re-admissions within 30 days	6.3%	6.5%	6.5%	▬	National Reporting Suspended - Last 2 months will be provisional		
Community Providers							
CQC Inpatient / MH and Community Survey							
Community Scores F & F - % Positive	97%	98%	98%	▬	98%	July	39/143
Operational Performance Metrics							
Acute and Specialist Providers							
A & E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	93.5%	89.1%	87.4%	▼	89.1%	July	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	95.0%	94.4%	94.2%	▼	94.4%	July	
All Cancers - maximum 62-day wait for first treatment from: - urgent GP referral for suspected cancer	78.1%	83.1%	83.0%	▼	82.9%	July	89/160
- NHS Cancer screening service referral	100.0%	95.0%	90.5%	▼	95.0%	July	59/136
Maximum 6-week wait for diagnostic procedures	96.9%	97.8%	97.7%	▼	97.80%	July	139/176

Enclosure 11

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board Committee on 5th October 2017

TITLE:	Transformation and Cost Improvement Programme (CIP) Summary Report		
AUTHOR:	Lisa Peaty Deputy Director: Strategy & Performance	**PRESENTER**	Paul Taylor Director of Finance

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 an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18.

To support this, the Trust has identified 57 schemes currently on the work programme which contribute to the £12.5m identified. 3% of the CIP has currently been identified as non recurrent savings.

Based on the Month 5 position, the Trust has achieved £5,044k against the year to date (YTD) plan of £3,526k. However, the full year effect variance is forecast by to under-deliver by £1,599K (i.e. delivery of £10.9m against a target of £12.5m). .

Transformation Executive Committee (TEC) met on 25th September to discuss:

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

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details: (*Please select from the list on the reverse of sheet)***
	Monitor	**N**	**Details:**
	Other	**N**	**Details:**

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

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COMMITTEE:
Note delivery of CIP to date and the end of year forecast.

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

Board Committee

Programme Management Office

Summary Report

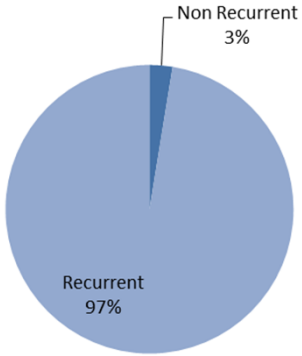
5th October 2017

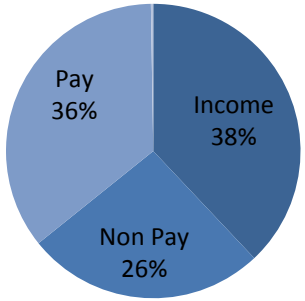
Executive Summary – 2017/18

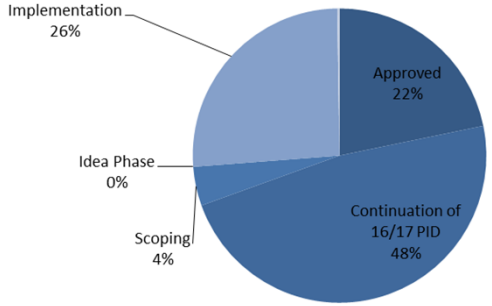
The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18. To support this there are 57 schemes on the work programme which contribute to the £12.5m identified, and 3% of the CIP has currently been identified as non recurrent savings.

A summary of CIP performance as at Month 5 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	Variance against FY Target	YTD Plan (from identified schemes)	YTD Actual	YTD Variance (against identified schemes)	FYE forecast of identified schemes	FYE Variance of identified schemes
TOTAL	£12.5m	£12.6m	£165k	£3,526k	£5,044k	£1,517k	£10,900k	-£1,599k







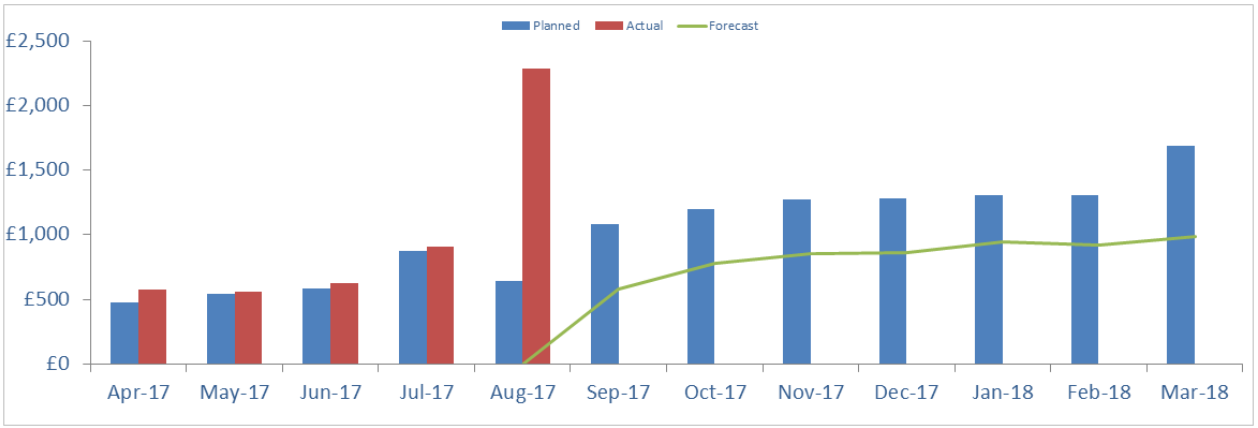
Based on the Month 5 position, the Trust has identified schemes totalling **£12.6m** against a Full Year (FY) target of **£12.5m.**
As at Month 5 the Trust is forecasting to deliver **£10.90m.**

For the 17/18 programme of work, 32 Quality Impact Assessments (QIAs) have now been approved by the panel, 1 QIA remains in Amber (Phase 2 of Cardiology redesign) and 20 QIAs have been deemed not applicable. QIAs for pipeline schemes continue to be worked up.

Executive Summary – 2017/18

	YTD	FYE			Submitted Plan
Planned	£3,526,970			Identified	£12,665,556
Actual	£5,044,125			Target	£12,500,000
Forecast		£10,900,803			
Variance	£1,517,156	-£1,599,197			£165,556

Programme (Click for details)	YTD Plan	YTD Actual	YTD Variance	FYE Plan	FYE Forecast	FYE Variance
Surgery Women and Children's	£1,346,927	£1,305,202	-£41,724	£3,247,324	£3,296,906	£49,582
Medicine and Integrated Care	£482,845	£582,613	£99,768	£1,470,365	£1,489,070	£18,705
Clinical support Services	£380,199	£494,294	£114,094	£998,746	£1,296,172	£297,426
Corporate Directorates	£716,206	£653,945	-£62,261	£2,027,916	£1,878,998	-£148,918
Cross Workstream	£600,793	£2,008,072	£1,407,279	£4,921,205	£2,939,658	-£1,981,547
View all Projects	£3,526,970	£5,044,125	£1,517,156	£12,665,556	£10,900,803	-£1,764,753



The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 12th October 2017

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

CORPORATE OBJECTIVES

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

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: COR105, COR109, COR 083, COR102, COR110 & COR 119.**
	Risk Register: Y		**Risk Score: 20, 20, 16, 16, 15 & 12.**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
Y	Y		Y

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	26th September 2017	Julian Atkins	**yes**	**no**
			Yes	

Declarations of Interest Made

No declarations registered.

Assurances received

Presentations to Committee

1. The Committee were presented with the latest staff story from Liz Slevin, Lead Nurse in Emergency Medicine. The story was well received and gave interesting insight to some of the continuing developments within ED Department from a senior nurse perspective.
2. The Committee received a presentation from Andrew McMenemy and Darren Leech, NHS Elect regarding their proposal for a senior management development programme. It is proposed that NHS Elect work alongside the Trust for the latter part of this year to develop and deliver a programme that includes cohorts of our senior leaders already identified within the new Leadership Forum. The proposal was well received and the Committee were looking forward to the delivery of the development programme in the near future.

Matters Arising

3. The Committee received feedback on two separate workforce audits associated to Mandatory Training and Appraisal. The senior Workforce Team provided assurance that the recommended actions were underway and would be completed within the designated timescales. The Committee were assured of the actions required as part of recommendations and requested further feedback following full implementation.

Workforce Governance

4. The standard report highlighting risks associated with the workforce was presented. It was agreed that the risk associated to the Junior Doctor contract implementation should be closed and replaced with a risk associated to gaps in the medical rotas. It was also recommended that a risk regarding recruitment should also be provided within the corporate Risk register.
5. The Committee received a policy update with ratification of the Work Experience Policy and the Dignity at Work Policy were ratified and ready for publication.

Workforce Performance

6. The Workforce Key Performance Indicators were presented with the Committee pleased with the level of detail provided. As requested by the Committee there were supplementary deep dive presentations regarding Absence, Employee Relations, Mandatory Training, Appraisals and Vacancies. The additional reports provided detail regarding departments and staff groups as well as mitigation plans to improve performance. There continues to be concerns regarding Divisional Performance regarding timescales associated with recruitment. This is being addressed at the monthly performance meetings. In addition, it is expected that e-mail alerts will shortly be sent to individuals and their line manager when they are 3 months and 1 month prior to compliance and on the day of non-compliance for appraisal and mandatory training.

7. The Trust received a report from the Head of Learning and OD alongside the Deputy Chief Nurse regarding incentives to support nurse recruitment. This included a £200 reward for recommending someone into a role as well as free parking or gym membership for 3 months for new appointments. The Committee indicated that if incentives were to be provided that they should include other hard to fill areas. It was therefore agreed to provide the incentives for a trial period of 6 months for clinical professionals under band 7.

Workforce Strategy

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

9. The Committee received an update regarding the Staff Survey that is due to be launched on 2nd October 2017 for a period of 2 months.

10. Rachel Andrew, Head of Learning and OD provided a detailed report on Workforce Race Equality Scheme. The WRES submission is attached to this report as an Appendix as it is a requirement for the Trust Board to receive this information annually. (Appendix Two) The Committee asked that further work was developed alongside other protected characteristics to show a full picture of how the Trust supported Equality & Diversity across all domains.

Workforce Change

11. The Committee were provided confirmation that the MTI recruitment process has now been initiated alongside our colleagues in Pakistan with the excellent news that 23 doctors had been appointed and are currently going through the pre-employment checking process. It is expected that the first candidates will start in the Trust as soon as 3 months' time.

Decisions Made / Items Approved

The Committee ratified the following policies:

- Work Experience Policy
- Dignity at Work Policy

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

1. The Committee requires further feedback regarding:
   - Update on Leadership Programme;
   - Feedback on recruitment incentives.

Items referred to the Board for decision or action

The Committee is asking the Trust Board to consider the proposal for recruitment incentives and the information that support the Workforce Race Equality Scheme paper.

Workforce Strategy for Dudley Group NHS Foundation Trust 2017-2018

Strategic priority areas	Leadership, Development & Values	Staff Well-Being and Engagement	Innovation & Change	Workforce Capacity	Recruitment & Retention	Performance & Productivity
Aims	***Our staff will have access to relevant education that meets the needs of the service within a culture of continuous development.***	***We will be a well led and engaged organisation with an inclusive culture that demonstrates our values.***	***We will be a Trust that excels in innovation through our workforce.***	***We will ensure that our workforce capacity is efficient and flexible to support patient and service needs.***	***We will have the right people in the right place within the framework of a sustainable workforce model.***	***We will support and expect the achievement of the highest level of workforce standards.***
Enablers	Develop systems that record employee skills and aspirations alongside options for developing learning and career ambitions.	To actively listen and engage with staff allowing opportunities for two way communication.	Better utilise information and information systems to support innovation with the workforce.	Plan for the skills that the Trust needs now and for the future to meet the needs of changing demands of our service.	Strengthen the brand for DG to attract people to the Trust and retain the people and skills within the Trust.	Provide a consistent reporting mechanism that aligns workforce performance with other areas of Trust performance.
	Develop a coordinated approach that supports staff development and education.	To actively support health & well-being initiatives for staff that support both physical and mental health.	Develop opportunities for new ways of working across professional boundaries in order to support a sustainable workforce.	Develop partnership arrangements with local stakeholders to support our sustainable workforce plan.	Enhance and streamline the processes for recruitment to bring the right people in at the right time in a cost effective manner.	Ensure managers fully understand how best to utilise workforce information to mitigate risk and enhance performance.
	Design, launch and manage a comprehensive employee development programme.	Work more closely with our local stakeholders in order to support engagement and well-being initiatives.	Develop an environment that supports, recognises and rewards innovation.	Ensure workforce plans are aligned to service plans and are supported by credible workforce information.	To listen to the workforce and provide tangible feedback that demonstrates listening in action.	To provide clear expectations regarding performance and behaviour within a clear accountability framework.

Workforce Business Plan to support the Workforce Strategy

Strategic Priority One – Leadership, Development and Values

Objective What do you need to do to achieve this?	How will this outcome be measured?	Timescale (by when)	Current Level of Performance	Any support/action by other teams.
To develop a training needs analysis using the information from our PDR system. This will be broken down by Directorates and staff groups to provide an indication of main development needs.	Development of new appraisal paperwork. Integrated system to record PDP outcomes centrally.	Q3	The new appraisal paperwork is completed and available from 1st April 2016. The training needs analysis is outstanding.	Divisional Management Teams Clinical Education Teams Professional Heads
To create an appropriate employee development programme, underpinned by the development of a Learning & Development Strategy and aligned to serivce priorties and linked directly to our strategy, service plans and training needs analysis.	To work with STP colleagues to develop core areas of employee development programme alongside Trust specific developments.	Q3	Scoping exercise being undertaken to support options around a leadership programme across the Black Country. Prposal presented to Workforce Committee on 26th September 2017.	STP Colleagues Procurement Colleagues Divisional Management Teams Professional Heads
To implement a dedicated period for appraisals for non-medical staff, to be undertaken in order to provide consistency with corporate and local objectives and support the training needs analysis.	To implement phased approach to changing the appraisal calendar.	Q2-4	This will be integrated and implemented from April 2018. Plans on the process to be provided at the November Workforce Committee.	Divisional Management Teams
To develop an Organisational Development Programme that supports better integration between staff and services while aligning to Trust values.	To use the feedback from staff survey alongside priorities of Trust strategy to develop an appropriate OD programme.	Q4		Communication Team Divsional Management Teams Executive Team

Strategic Priority Two – Staff Well-Being and Engagement

Objective - What do you need to do to achieve this?	How will this outcome be measured?	Timescale (by when)	Current Level of Performance	Any support/action by other teams.
To work with our partners in Action Heart to extend Gym opening hours in order to encourage physical activity within the workforce.	The opening of the Gym.	Q1	The gym is expected to open on 3rd July 2017 with extended opening times.	Action Heart Communications Team
To extend the remit of the well-being strategy group in order that regular staff well-being events are held at least four times a year focsing on physical and mental health.	Terms of reference and regular work programme developed.	Q1	The new well being forum is established with the first well being event completed and well received by staff.	Professional Leads Public Health CCG Action Heart Smoking Cessation
To develop a forum across the STP that develops best practice initiatives for staff well-being and supports the associated CQUINN.	Terms of reference and regular work programme developed.	Q2	PIDs completed with actions to support well being initiaves and fulfil the requirements for the CQUIN.	STP Colleagues
To commence consultation on implementing a smoke free site with the proposal for a six month lead in time from July 2017 and formal initiation from 1st Jan 2018.	Option appraisal to be developed and determined at Board.	Q2	Conusltation will commence in July with extended FFT questions for staff and opportunity for feedback from the public.	Executive Team Smoking Cessations Estates Dept

Strategic Priority Three – Innovation & Change

Objective What do you need to do to achieve this?	How will this outcome be measured?	Timescale (by when)	Current Level of Performance	Any support/action by other teams.
To review our electronic workforce systems to understand if ESR Management and Employee Self Service is benefical going forward and will create efficiences and support managers and staff.	The development of new mandatory training and appraisal system as interim measure and option appraisal for future use.	Q3	Review has taken place with opportunities to develop functionality around Employee Relations information recording and reports.	Information Team BCA Colleagues
Develop innovative new ways of working by developing areas of good practice from within and outside the NHS. This will be supported by effective workforce plans.	Establishment of recruitment & retention working group with an agreed R & R strategy.	Q2	Recruitment & Retention group is established. An audit is planned to determine outcome and measure effectiveness.	Professional Leads Divisional Management Teams
To develop an effective Workforce Directorate that delivers effective support to staff and managers while supporting innovative practice.	Implementation of new Workforce Directorate structure alongside achievement of objectives and feedback using survey from stakeholders.	Q4	New structure and new appointees in place by end of June 2017.	Divisional Management Teams Executive Team
To support effective change management and engagement alongside our partners with the introduction of the MCP.	Effective application of management of change best practice principles during MCP transition for our staff.	Q3-4	Engagement meetings have occurred with Community staff and will develop alongside the tendering process and outcome.	MCP Partners CCG Trade Union Colleagues

Strategic Priority Four – Workforce Capacity

How will this outcome be measured?	How will this outcome be measured?	Timescale (by when)	Current Level of Performance	Any support/action by other teams.
To develop detailed workforce plans based on 1-3 years for the Trust and then have this cascaded by each Division and split between the main staff groups. For these plans to be directly linked to service/business planning process and developed within a set period each year.	To establish a template and process to support workforce plans that can be used by the Trust and management teams to plan their workforce alongside service developments.	Q3	New templates to support workforce planning being developed with the first stages being developed in September 2017.	Information Team Divisional Management Teams Professional Leads
To use the information generated from the service and workforce plans to create a link between the assumptions in the workforce plans to the recruitment strategy and the employee development programme. This will also support succession/talent management plans for particular posts or departments.	Completed recruitment plan and development plan that informs the following year's activity.	Q4	This will follow from the templates being developed.	Divisional Management Teams Professional Leads
To develop formal partnership links with local education providers in Dudley to support career opportunities and sustainable workforce planning at the Trust.	To establish an agreed link to relevant educational establishments to support career development programme.	Q2	Letters have been written to relevant local Head Teachers to understand the appetite for paretnership working.	Local Schools & Colleges
To develop career pathways that support prospective employees to understand the opportunities within their local NHS Trust.	Set out established career pathways where demand is low or turnover is high.	Q3	The new recruitment events for hard to fill areas have commenced.	Local Schools & Colleges Recruitment & Retention Group Professional Leads

Strategic Priority Five – Recruitment & Retention

Objective What do you need to do to achieve this?	How will this outcome be measured?	Timescale (by when)	Current Level of Performance	Any support/action by other teams.
To work alongside colleagues in our Communications Team to support brand development at Dudley for the specific purpose of attracting the highest quality candidates to the Trust and retain our current workforce.	Review our marketing and communications strategy to ensure we develop the brand for Dudley.	Q2	This has been developed as part of the corporate recruitment plans and supported the recruitment events.	Communications Team Executive Team
To better understand the reasons for staff turnover by holding listening events that allow positive interventions to take place to support retention.	Developing breakfast with the boss sessions and create a listening environment for staff to provide regular feedback.	Q3	Breakfast with Boss sessions now established alongside staff survey focus groups, back to floor initiavies, a revised CEO briefing and Director blogs.	Communications Team Executive Team
To create an efficient and appropriately centralised system for recruiting staff that has identifiable performance indicators for each stage of the process.	Implement the actions from the Recruitment Process Review.	Q2	The review on recruitment processes are complete with some centralisation in place such as contracts and production of KPIs.	Local Management Teams where recruitment has been decentralised.
To implement a Recruitment and Retention group in the Trust involving professional groups that creates opportunities for best practice initiatives for recruiting staff.	Agree terms of reference and diarise meetings for 2017 and report achievements to Workforce Committee.	Q1	The group has been established with terms of reference. We now need to look at output from this group and positive impact on recruitment.	Profesional Leads Divsional Management Teams

Strategic Priority Six – Performance & Productivity

Objective - What do you need to do to achieve this?	How will this outcome be measured?	Timescale (by when)	Current Level of Performance	Any support/action by other teams.
To create and implement a set of workforce key performance indicators that provide one version of the truth and support managers in managing performance within an integrated performance mechanism.	A new template for workforce KPIs that is produced monthly with accurate information and integrated alongside wider performance report.	Q1	The new workforce performance report was produced in April 2017. Further minor amendments may be required.	Information Team Divsional Management Teams Strategy and Performance Team
To establish a set of supportive and regular training programmes around absence management, staff capability and employee relations to support enhanced performance.	Provide a training programme published on the HUB with nominations through respective HRBPs.	Q3	This has been reviewed alongside the Leadership Development proposals.	Divisional Management Teams
To support the attainment of all targets agreed within our workforce key performance indicators alongside trajectories to achieve the target where there are instances of under performance.	Establish new key performance indicator template alongside integration into Divisional team meetings and performance meeting cycle.	Q4	The new KPI report is aligned to the Performance meetings with targets set.	Information Team Divsional Management Teams Strategy and Performance Team
To provide quarterly workforce performance reports to the Trust Board highlighting areas of risk and good practice alongside trend analysis.	To establish a Board Report.	Q1		Governance Team

Performance Indicator Key: Green = Completed or on Target
Amber = Working Towards Target
Red = Not completed with designated Timescale

The Dudley Group
NHS Foundation Trust

WRES Actions and Equality Update

This report outlines two key elements of work. The first, an outline of findings from the Workforce Race Equality data submission for 2017 and an associated action plan to address findings. The second part is an update on equality work within the Trust including actions following engagement with NHS Employers through their Diversity Partner programme.

WRES

The Workforce Race Equality Standard is a national requirement for all NHS Trusts to submit their workforce data annually. As a new requirement for 2017, Trusts are now also expected to publish an action plan alongside their data, outlining key areas for action on the 9 elements of the WRES return.

The WRES data was submitted in August as per the national timeline. Data for 2017 is attached at Appendix 1. Some of the data is directly captured through the Trust's ESR system, other data such as experiences of harassment and perceptions about career advancement are taken from the result of the annual Staff Survey.

In addition to the local data, nationally the WRES team at NHS England has reviewed the submissions and collated data and produced a report which outlines the key areas for action across all NHS Trusts for future focus.

The areas identified nationally were:

- A higher percentage of BAME staff reported the experience of harassment, bullying or abuse from staff.
- BAME are less likely to believe there is equality in relation to access to career progression/promotion
- BAME are more likely to report that they are experiencing discrimination at work

From our 2017 data, they key areas for reflection and action are similar to those found nationally:

- There are some gaps in our information on ethnicity so a significant number of staff are reported as not known or not declared
- There are fewer BAME employees in non-clinical senior leadership posts
- According to the information, the likelihood of entry in to the formal disciplinary process is higher for BAME employees
- BAME employees report less access to training – this may be linked to the point above about fewer people in leadership roles as current development opportunities are more available to those in senior leadership roles.

In response to the information above, the following actions are proposed:

- Undertake an update of staff information in ESR. Additional work has highlighted that there are also high numbers of staff who have not completed information on disability and sexual orientation. This forms a key objective for this year and will initially be complete by 31st March and annually following that.

- Consider reviewing the specific development of BAME as part of the revised leadership development strategy.
- Review the disciplinary process and cases that contributed to the data to understand what is impacting on the likelihood of BAME entering the disciplinary process. Act upon any findings where the process is identified as unequal.
- Review the training offer (this is already underway as part of a wider review) and monitor uptake on a more regular basis.
- Equality and Diversity training is currently being reviewed to ensure it meets the staff and patient requirements; additional information to be included about access to development and progression opportunities as well as discrimination and harassment
- Undertake a specific listening/engagement activity with BAME staff to understand they views in more detail and suggestions for improvements. This has already been requested for the Medical Staff.
- Ensure that BAME staff representatives are recruited to the Staff Inclusion Network planned for 2017/18.

An action plan outlining more detailed activities and timelines will be developed to provide assurance on addressing the gaps identified through the WRES submission this year.

Equality, Diversity and Inclusion Update
Further to previous updates, the element of the report is an update on activity around the NHS Diversity Partner Programme for 2017/18. The Trust has been selected as an NHS Employers Partner which means we are able to access additional support to implement work on equality and diversity this year. The programme consists of a number of events focussed on themes – and provides an opportunity to learn from good practice in place at other Trusts and to also access a range of expertise and resources to support the development of our own equality and diversity activities.

The first two events have been held. These initially focussed on the legislative requirements which include EDS2 and WRES which the Committee has received reports on. The second workshop was focussed on capacity building and leadership on equality matters.

As a result of the workshops, and the wider work being undertaken, a work-plan is being developed to take forward the priority work for 2017/18. This includes:

- Appointment of an Equality, Diversity and Inclusion Coordinator to support better engagement with patients on equality and diversity
- Re-launching the Diversity Management/Steering Group to coordinate activities on equality and diversity
- Reviewing and gathering improved data on patient and staff experiences to inform where we need to focus attention for improvement
- Review of Equality and Diversity training for all staff to include disability awareness and autism awareness

- Identifying key theme leads within the Trust to focus activity on improvements in patient access, patient experience, workforce engagement and development
- Engagement with senior leaders is essential to making progress on equality, diversity and inclusion. This will form part of the activity around inclusive leadership.

Work will continue to be undertaken and regular reports will be provided to the Workforce Committee for assurance on activities being completed. The next NHS Employers event is in December.

The Dudley Group NHS Foundation Trust

Appendix 1 – WRES submission 2017

	1a) Non Clinical workforce	White	BAME	Not known or not declared
Headcount of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Under Band 1	15	4	17
	Band 1	0	0	0
	Band 2	237	16	60
	Band 3	114	11	30
	Band 4	191	17	46
	Band 5	44	7	9
	Band 6	30	3	6
	Band 7	21	3	11
	Band 8A	12	4	6
	Band 8B	14	1	4
	Band 8C	6	0	5
	Band 8D	2	0	1
	Band 9	6	0	0
	VSM	1	0	1

The Dudley Group NHS Foundation Trust

	1b) Clinical workforce	White	BAME	Not known or not declared
Headcount of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	*of which Non Medical*			
	Under Band 1	0	3	17
	Band 1	0	0	0
	Band 2	643	74	123
	Band 3	135	8	24
	Band 4	78	14	12
	Band 5	645	180	166
	Band 6	622	103	96
	Band 7	302	27	25
	Band 8A	57	7	6
	Band 8B	18	1	2
	Band 8C	5	0	1
	Band 8D	5	3	0
	Band 9	0	0	0
	VSM	1	0	0
	Of which Medical & Dental			
	Consultants	90	84	34
	of which Senior medical manager	27	14	2
	Non-consultant career grade	12	35	7
	Trainee grades	81	133	26
	Other	0	0	0

		White	BAME	Not known or not declared
Relative likelihood of staff being appointed from shortlisting across all posts	Number of shortlisted applicants:	3363	1859	96
	Number appointed from shortlisting:	646	265	14
	Relative likelihood of shortlisting/appointed:	0.1920903955	0.1425497579	**0.1458333333**
	Relative likelihood of White staff being appointed from shortlisting compared to BME staff:	**1.35**		
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	Number of staff in workforce:	3414	738	739
	Number of staff entering the formal disciplinary process:	78	33	22
	Likelihood of staff entering the formal disciplinary process:	0.0228471002	0.0447154472	0.0297699594
	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff:		**1.96**	
Relative likelihood of staff accessing non-mandatory training and CPD	Number of staff in workforce (White):	3414	738	739
	Number of staff accessing non-mandatory training and CPD (White):	142	14	25
	Likelihood of staff accessing non-mandatory training and CPD:	0.0415934388	0.0189701897	0.0338294993
	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff:	**2.19**		

		White	BAME
KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**	24.49%	27.35%
KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**% of staff experiencing harassment, bullying or abuse from staff in last 12 months**	19.02%	20.92%
KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	**% staff believing that trust provides equal opportunities for career progression or promotion**	89.34%	76.82%
Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	**% staff personally experienced discrimination at work from Manager/team leader or other colleague**	4.64%	12.97%

The Dudley Group NHS Foundation Trust

		White	BAME	NK or Not declared
Percentage difference between the organisations' Board voting membership and its overall workforce **Note: Only voting members of the Board should be included when considering this indicator**	Total Board members	**12**	**0**	**3**
	of which: Voting Board members	6	0	1
	: Non Voting Board members	6	0	2
	Total Board members	**12**	**0**	**3**
	of which: Exec Board members	7	0	2
	: Non Executive Board members	5	0	1
	Number of staff in overall workforce	3414	738	739
	Total Board members - % by Ethnicity	**80.0%**	**0.0%**	**20.0%**
	Voting Board Member - % by Ethnicity	**85.7%**	**0.0%**	**14.3%**
	Non Voting Board Member - % by Ethnicity	**75.0%**	**0.0%**	**25.0%**
	Executive Board Member - % by Ethnicity	**77.8%**	**0.0%**	**22.2%**
	Non Executive Board Member - % by Ethnicity	**83.3%**	**0.0%**	**16.7%**
	Overall workforce - % by Ethnicity	**69.8%**	**15.1%**	**15.1%**
	Difference (Total Board -Overall workforce)	**10.2%**	**-15.1%**	**4.9%**

The Dudley Group
NHS Foundation Trust

Appendix 2

The action plan below summarises the key actions within the report to the WSEC with the addition of timelines for assurance monitoring.

Workforce Race Equality Standard Action Plan		
Action	Responsible	Due date
Undertake an update of staff information in ESR. Additional work has highlighted that there are also high numbers of staff who have not completed information on disability and sexual orientation. This forms a key objective for this year and will initially be complete by 31st March and annually following that.	ESR Systems Manager	Commence October 2017 Complete by 31st March 2017
Implement the specific development of BAME as part of the revised leadership development strategy.	Head of Learning and OD	Identify development opportunities Dec 2017 Commence delivery by 31st March 2017
Review the disciplinary process and cases that contributed to the data to understand what is impacting on the likelihood of BAME entering the disciplinary process. Act upon any findings where the process is identified as unequal.	HR Business Partners	Review by 31st December 2017 and report on actions.
Review the training offer (this is already underway as part of a wider review) and monitor uptake on a more regular basis.	Head of Learning and OD	Review by 31st December 2017. Monitor uptake quarterly
Equality and Diversity training is currently being reviewed to ensure it meets the staff and patient requirements; additional information to be included about access to development and progression opportunities as well as discrimination and harassment	Head of Learning and OD with support from Stat Training Lead	Revised training available November 2017
Undertake a specific listening/engagement activity with BAME staff to understand they views in more detail and suggestions for improvements. This has already been requested for the Medical Staff.	Head of Learning and OD	Undertake listening /engagement by 30th November 2017 and report on actions.
Ensure that BAME staff representatives are recruited to the Staff Inclusion Network planned for 2017/18.	HR Business Partner	Network in place by 31st March 2017

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 12th October 2017

TITLE:	**EPRR Core Standard Submission 2017**		
AUTHOR:	**S Walford – Emergency planning and capacity manager**	**PRESENTER**	**D Wake – Chief Executive**

CLINICAL STRATEGIC AIMS		
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*

CORPORATE OBJECTIVE: SO1, SO2 & SO6

SUMMARY OF KEY ISSUES:

- Every year the Trust is required to do a self-assessment for the compliance of a set of 'Core Standards' for Emergency Preparedness, Resilience and Response (EPRR).
- The Trust self-assessment for 2017 is 'Substantially' compliant.
- The Trust has identified 4 that require actions before it can declare 'Full' compliance with the EPRR Core Standard.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: The Trust is required to be compliant with a set of core standards for Emergency preparedness**
	Risk Register: Y/N		**Risk Score:** 10
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, responsive, effective & well led
	Monitor	**N/A**	**Details:**
	Other	**Y**	**Details: Civil Contingencies Act 2004**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR BOARD:

- The Board approves the submission of the Trust's 'self-assessment' status as 'Substantial' in accordance with the 2017 Core Standards.
- The Board endorse the management actions planned to progress to achieve the compliance level 'Full'.

The Dudley Group NHS
NHS Foundation Trust

NHS EPRR CORE STANDARDS SELF-ASSESSMENT 2017

1. INTRODUCTION

As a Category 1 Responders under the Civil Contingencies Act (CCA) 2004 and a provider of publicly funded healthcare services under Section 46 of the Health and Social Care Act 2012, Dudley Group NHS Foundation Trust (the Trust) is required to have appropriate arrangements in place to deal with service disruptions, local incidents and major emergencies.

To demonstrate the levels of preparedness, the Trust is required to complete an annual 'self-assessment, based upon the NHS England Emergency Preparedness Resilience and Response (EPRR) Core Standards.

As the threat spectrum has continued to diversify and the variety of perceived risks to service disruption increase, the Trust independently prompted an internal facilitated review of its current arrangements in June 2017. The approach focused upon several areas including:

- Statutory compliance.
- NHS EPRR Core Standards and Operating Framework.
- Specific Response Plans.
- Best Practice.

As a result, a significant and detailed programme of work to improve organisational resilience, commenced in July.

The Trust decision was justified with the receipt of the Core Standards question set for 2017, which included a significant increase in scrutiny across the EPRR agenda and an emphasis on corporate governance. The findings from the 'self-assessment' have not only endorsed the internal review findings but have also added further consideration and activities to the ongoing programme.

2. AIM

The aim of this report is to give assurance to the Board of the Trust's compliance level for the 2017 EPRR Core Standards submission, as well as outline the current improvement programme and associated activities.

3. OBJECTIVES

The objectives are to provide:

- An overview of the EPRR Core Standards requirements.
- Confirmation of the Trust's current declared position of 'Substantial'.
- A Summary of the current programme and ongoing high-level activities.

4. EXECUTIVE SUMMARY

Whilst the Trust position has been 'self-assessed' as Substantial, there is an ongoing programme of work to improve overall levels or preparedness and resilience to future incidents, emergencies and service disruptions.

5. RECOMMENDATION.

The recommendations include:

a) The Board acknowledges the Trust's 'self-assessment' status as 'Substantial' in accordance with the 2017 Core Standards.

b) The Board endorse the management actions planned to progress to achieve the compliance level 'Full'.

6. EPRR CORE STANDARDS

The EPRR Core Standards for 2017 comprised of 108 questions covering several elements focusing upon:

- Governance.
- Assessing risk.
- Developing and maintain emergency (generic and specific) and business continuity plans.
- Command and control.
- Communicating with the public.
- Information sharing and cooperation with other Responders.
- Training and exercising.
- Business continuity.
- Hazardous Materials (HAZMAT) and Chemical Biological Radiological and Nuclear (CBRN).
- HAZMAT and CBRN Equipment Checklist.

As a minimum, the Trust is also required to provide evidence of:

- A tabletop exercise, annually.
- A live exercise every 3 years.
- An internal test of escalation and cascade arrangements every 6 months.

The responses and underpinning evidence to each question are graded and aggregate to provide and overall Trust compliance level, based upon the table below.

Compliance Level	Evaluation & Testing Conclusion
Full	Arrangements are in place, the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place, however the organisation is not fully compliant with **one – five** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however the organisation is not fully compliant with **six to ten** of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-Compliant	Arrangements in place do not fully address **eleven** or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

7. PROGRAMME OF WORK

It is forecasted that with existing resources and commitments, that the current programme of work will continue until December 2017. The programme can be summarised as key achievements, ongoing improvement and future activities, including:

- The key achievements include the development and delivery of the:
    - EPRR Governance.
    - EPRR Policy.
    - EPRR Strategy.
    - EPRR Training and Exercising Strategy.
    - Scenario Workshops – Security, Mass Casualties and Pandemic Influenza.
    - Mass Casualties Planning.
    - Excess Deaths Planning.
    - Industrial Action Planning.
    - Strategic Incident Management Training.
    - Evacuation Planning.

- The ongoing improvements includes the review and improvement of the:
    - Major Incident Plan.
    - Communications/Media Handling.
    - Operational Business Continuity Plans.
    - Lockdown Policy.
    - Bomb Threats and Suspect Packages Policy.

- Fuel Shortage Policy.
- HAZMAT & CBRN Plans.
- Pandemic Influenza Plan.
- Internal Call Out/Cascade Lists.
- Multi-Agency Working Arrangements (Responders and Key Stakeholders).

- The future activities include the development and implementation of the:

  - Tactical Incident Management Training.
  - Business Continuity Training.
  - Tactical Business Continuity Plan.
  - Mass Countermeasure Plans.
  - Workshops – Evacuation, Fuel Shortage, HAZMAT/CBRN, Mass Countermeasures.

8. TRUST COMPLIANCE LEVEL

The A&E Delivery Board was appraised of Trust position and the programme in August, whilst the CCG and NHS England were provided with the 2017 Core Standards submission with underpinning evidence on the 13th September.

Based upon the responses, underpinning evidence and programme results so far, the Trust can confirm that the current compliance level of ***'Substantial'*** has been achieved for the 2017 reporting period.

9. SUMMARY

As a Category 1 Responder and Provider of NHS funded care, the Trust is expected to have the necessary arrangements in place to prepare for, respond to and recover from incidents, emergencies and service disruptions.

To meet the statutory and regulatory requirements, the Trust must be able to demonstrate its readiness through the annual EPRR Core Standards 'self-assessment submission to NHS England.

Whilst the Trust has met the requirements associated with the compliance level of 'Substantial' for 2017, it still has further work to attain the highest category within the EPRR Core Standards. To achieve this, the current programme of work is expected to continue until the end of this calendar year.

The Trust continues to demonstrate its cognisance of the ever-changing threat spectrum and will take appropriate proactive steps to improve organisational preparedness and resilience, therefore providing a safe environment to maintain the quality of care expected.

Enclosure 14

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 12 October 2017

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Summary of key issues discussed and approved at the Charitable Funds Committee on 31 August 2017.

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

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

FUNDRAISING UPDATE

Mrs Phillips informed the committee that her role has transferred to the Communications team and that her line manager is now Mrs Abbiss.

She reported that the 'Big Push Wheelchair campaign' is proving very successful and that £10,000 had been donated already. The Dudley News has been particularly supportive and has provided regularly press coverage.

She was also pleased to say that the income and expenditure report was showing a profit of £23,233.

Three grant applications had been submitted since the previous meeting and Mrs Phillips was encouraged to continue do this alongside seeking further corporate donations.

Mrs Abbiss reported that she has been asked to set up an appeal for the refurbishment of the ED Resus area and that she would be working with Mrs Phillips on this.

FINANCE UPDATE

Mr Walker presented the financial position of the Charity for the period ending 31 July 2017. He reported that the total fund balance stood at £2.4 million whilst the general funds balance was £54,000.

Income for the year to date was reported as £156,453 whilst expenditure was £129,061.

FUNDRAISING REQUESTS

Two bids from general funds were considered.

The first was in relation to improvements to the day case surgery waiting room and funding was requested for a wall mural, magazine subscriptions and electronic tablets - £4,520. Funding for the wall mural and electronic tablets was subsequently approved following a visit to the area by Mr Atkins and Mrs Abbiss.

The second bid was to provide furniture and equipment for wards across the Trust in the form of 'top up' payments where individual ward funds were insufficient to pay for everything needed – £25,600. This bid was approved at the meeting.

Meeting	**Meeting Date**	**Chair**	**Quorate**	
Charitable Funds Committee	**31 August 2017**	**Julian Atkins**	**yes**	**no**
			Yes	
Declarations of Interest Made				
None				
Assurances Received				
None				
Decisions Made / Items Approved				
One bid for funds was approved at the meeting and one subsequently.				
Actions to come back to Committee				
None				
Items referred to the Board for decision or action				
None				

Enclosure 15

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board
October 2017

TITLE:	**Digital Trust Programme Committee update**		
AUTHOR:	**Mark Stanton CIO**	**PRESENTER**	**Ann Beck**

CORPORATE OBJECTIVE:

SO3: **Drive service improvements, innovation and transformation**
SO5: **Make the best use of what we have**

SUMMARY OF KEY ISSUES: ***(please identify key issues arising from report or minutes)***

A summary of the Digital Trust Programme Committee (DTPC) September 2017

1. The Sunrise project is on-track against the project plan for the end delivery date although there are some slippages within phases that will be recovered. Enthusiasm from the Clinical teams is high but opposing priorities are impacting the level of engagement. This item will be taken to Executive Directors.
2. There are a number of Strategic risks to the Benefits case mainly around the interfacing to Pathology, ITU and pharmacy systems. Mitigation plans are in progress
3. Outside the Digital Trust Programme a number of projects are making good progress, Syntertec Hybrid mail is ahead of the plan, Big Hand enhancements are delivering value to the Consultant community's, TeraFirma are rolling out 8,000 mailboxes across the Trust and Commercial clients with over 1,200 Trust mailboxes complete.
4. Sunrise dBMotion has gone forward to the CCG as the proposed MCP population Health solution.

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/N**	**Details:** (***Please select from the list on the reverse of sheet)***
	Monitor	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

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

Decision	Approval	Discussion	Other
		X	

The Dudley Group NHS
NHS Foundation Trust

RECOMMENDATIONS FOR THE COMMITTEE

Demonstrate to the Board that the DTPC is providing governance for this project.

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

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

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

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

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Digital Trust Programme Committee	20th September 2017	Ann Becke	yes	no
			X	

Declarations of Interest Made

None

Assurances received

- Updates were given on the progress of the project rollout which currently has 3 stages in this delivery: -
    - Stage 1 – Complete
    - Stage 2 – 79% complete with test and training plans still to be delivered. Completion was due 18/8/17 but has been delayed due to the late recruitment of the Test Manager and Training Manager. Completion is forecast for the end of September and has no impact on the go-live date of 23/4/18.
    - Stage 3 – 9% complete with completion due 22/11/17 and currently on target.
- The Future state workshops for the first phase of the roll out are complete (4 Hour workshops where Stakeholders define at a high level how the system should work) were very well attended by Medics, Nurses and AHP's and in some instances had to switch to the lecture theatre to accommodate high numbers.
- The Scrum meetings which are weekly meetings over a 12-week period to define at detail the system configuration are not well resourced by clinician's due to conflicting priorities. The project has funding for backfill but scheduling within the Divisions is challenging. The risk is the system will be configured without the appropriate level of input, this will be taken to Directors for resolution.
- A launch event for the Digital Trust managed by Communications will take place 18th October on a creative digital theme.
- A Draft Paper was reviewed detailing some strategic risks to the project, these were mainly around integration into other systems
    - *Laboratory Information system (LIMS)* – We were aware at the outset the current LIMS system was legacy and had limited interface capability and was due to be upgraded, this is now on hold due to the BCA Pathology project where the likely outcome will be integration to the Wolverhampton LIMS. Full integration would be dependent upon Hub/spoke work practices.
    - *Real-time use of the PAS (oasis)*- The EPR process is initiated in the PAS which means that in order for Clinicians to have the relevant information the administration process needs to be real-time which is not the case today mainly due to process and the culture of retrospective use of systems.
    - *ITU Carevue system* – clinical care have invested 9 years into refining the current carevue system and there will be challenges in migrating to the EPR

for a number of reasons. However, integration between Carevue and the EPR is poor and running the two systems in parallel could result in introducing inefficiency and transposing errors into the process

- *Pharmacy Stock Management* – Integration between Pharmacy stock control system (JAC) and EPR is poor due to JAC reluctance to develop the system in line with NHS I guidelines, this could lead to clinical safety and efficiency issues.

Issues are all recorded in the project issues log and an action plan is being developed.

- The Cyber security Strategy was presented to the committee, the main points to note were :-
  - Our current level of protection is good in terms of process and policy, but better visibility of threats is required
  - A substantive IG/Cyber Security Manager is part of the IT Management team.
  - A robust patching regime has been implemented to ensure all devices and servers are at the correct level.
  - New firewall Technology in will go live in October 2017 to provide better defense and better visibility of threats
  - Advanced Malware Detection (AMD) and Intrusion Prevention Systems (IPS) is being reviewed and will be built into the proposals for the replacement of our device management software at the end of the current contract (January 2018)
  - In terms of process we are ISO2700 accredited, part of the NHS Digital CareCert programme and working towards Cyber Security Essentials plus which we should complete January 2018.
  - Cyber security will need ongoing investment to keep up with the evolving number of threats.
- A review took place of all IT projects, the significant points to note:-
  - The NHSmail2 programme is a combined programme managed by TeraFirma on a commercial basis covering 8,000 mailboxes across DGFT, DWMHT, CCG, GP's. It was noted the project is being carried out a fraction of the costs of other Trusts. DWMHT and the CCG are complete and around 1,200 DGFT mailboxes for heavy mail users are complete. The focus now is on the Medic community at the Trust to ensure continuity of mails
  - The Synertec mail project (centralised letter printing) is running ahead of programme and is nearly complete. This is the first enabler to move towards the Accessible information Standard (AIS) for electronic communication with patients. Scoping for the AIS phase is underway.
  - Enhancements to the big hand dictation software are complete which will improve efficiency in the Consultant letter process
  - An upgrade to the Oasis PAS will take place in October 2017, this is an enabler for the Sunrise EPR. The outage will involve downtime (to be scheduled with the division) and some level of user training.
- Sunrise DBMotion has gone forward to the CCG as the MCP population Health system and will be discussed in the Dialogue sessions. Adam Thomas (IT Digital Health Architect) is the IT lead on the MCP partner board

Decisions Made / Items Approved

- IT have now engaged in the BCA Pathology project IT sub group. Early indications suggest that we will use the Wolverhapmton LIMS system due to the End of life of Walsall and Dudley systems but retain local integration to GP's which is fully supported by DGFT IT.
- A discussion took place around the RHH telephony system which forms part of the PFI contract. Recent outages were caused by Capacity issues on the hardware. The Telephony system on site is a legacy Analogue system with PFI schedule payments high and perceived poor value. Previous attempts to terminate this part of the schedule and extend the Trusts own Digital telephony system have been turned down by Summit on several occasions. Given the current situation with Interserve it may be good timing to re-open this discussion.

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

- The committee will need to support the Project team in acquiring Onsite Training rooms (experience has shown people tend not to show up for offsite rooms), currently only 2 of the 10 required have been identified
- The project team will need support from the Executive Team to ensure the right level of Clinical attendance at the Scrum design meetings

Items referred to the Board for decision or action

None

Comments relating to the DTPC from the CCIO

- A key principle of the Sunrise system is that the design is clinically-led. Clinical engagement and enthusiasm for a new EPR remains very strong, but attendance at all levels of meetings needs to be protected. Winter pressures may impact on the project.
- In order to manage the transition from paper to electronic documentation, the Procedural Document Development Policy needs to reflect the new digital process. If new policies and guidelines require changes to clinical documentation, this must be identified in time to reconfigure the EPR.
- During the transition stage, new paper forms should not be created unless they are outside the current scope of the Digital Trust Project. The Trust needs to agree a deadline to stop creating or updating paper documents that are part of the EPR roll-out

The Dudley Group
NHS Foundation Trust

Comments relating to the DTPC from the CNIO

Development of the nursing documentation element in the new EPR is being developed with engagement from the trust senior nursing team, clinical nurse specialist teams and the subject matter experts (SME's), who have been nominated by both Director of Ops to support this process. Implementation of care plans/pathways had been highlighted as a concern but engagement with the Chief nurse and her senior team will give assurance of safe development during our weekly meetings.

- Attendance at senior nurse meetings, ward staff meetings and other forums has been essential to ensure that all nurses have an understanding of the impact of the EPR well before Go Live. Concerns regarding training are being fed-back to the training manager to ensure that nursing concerns are being taken into account in developing their training strategy.

· Project owner of Nursing documentation, ePMA and technology *scrums* ensures that nursing has a high profile within these meetings.