The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 2nd November, 2017 at 9.00am
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	9.00
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	9.00
3.	**Announcements**		J Ord	To Note	9.00
4.	**Minutes of the previous meeting**				
	4.1 Thursday 12 October 2017	Enclosure 1	J Ord	To Approve	9.00
	4.2 Action Sheet 12 October 2017	Enclosure 2	J Ord	To Action	9.05
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.10
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	9.20
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	9.30
	7.2 Chief Nurse Report – Infection Prevention and Control	Enclosure 5	S Jordan	To note its contents	9.40
	7.3 Nurse/Midwife Staffing Report	Enclosure 6	S Jordan	To note assurances & discuss any actions	9.50
	7.4 Safeguarding Report	Enclosure 7	S Jordan	To note assurances & discuss any actions	10.00

8	**Responsive and Effective**				
	8.1 Finance and Performance Committee Exception report	Enclosure 8	J Fellows	To note assurances & discuss any actions	10.10
	8.2 Performance Report	Enclosure 9	M Woods	To note assurances & discuss any actions	10.20
	8.3 Cost Improvement Programme and Transformation Overview Report	Enclosure 10	P Taylor	To note assurances & discuss any actions	10.30
	8.4 Black Country Pathology	Enclosure 11	D Wake	To note progress	10.40
9.	**Well Led**				
	9.1 Digital Trust Committee Exception Report	Enclosure 12	A Becke/ M Stanton / J Dale	To note assurances & discuss any actions	10.45
	9.2 Board Assurance Framework	Enclosure 13	G Palethorpe	To note assurances	10.55
	9.3 Annual Plan Quarterly Monitoring Report	Enclosure 14	L Peaty	To note assurances & discuss any actions	11.05
10.	**Any other Business**		J Ord		11.10
11.	**Date of Next Board of Directors Meeting** 9.30am 7 December, 2017 Clinical Education Centre		J Ord		11.10
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		11.10

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

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 12th October, 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
Jonathan Fellows, Non Executive Director
Diane Wake, Chief Executive

In Attendance:

Helen Forrester, EA
Andrew McMenemy, Director of HR
Mark Stanton, Chief Information Officer
Dr Mark Hopkin, Associate Non Executive Director
Liz Abbiss, Head of Communications
Julian Hobbs, Operational Medical Director
Dawn Lewis, Head of Midwifery (17/107.2)
Eric Watson, Clinical Director for Womens and Childrens (17/107.2)
Paul Stonelake, Responsible Officer (Item 17/107.5)

17/101 Note of Apologies and Welcome
9.30am

Glen Palethorpe, Director of Governance/Board Secretary and Natalie Younes, Director of Strategy and Business Development had sent apologies.

The Chairman welcomed Julian Hobbs, Operational Medical Director to his first Board meeting.

17/102 Declarations of Interest
9.32 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.

17/103 Announcements
9.34 am

Steve Wellings and Laura Broster from the CCG and Jeremy Vanes, Chair of The Royal Wolverhampton Hospitals NHS Trust who were in the audience were welcomed to the meeting.

17/104 Minutes of the previous Board meeting held on 6th September, 2017 (Enclosure 1)
9.33am

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

17/105 Action Sheet, 6th September, 2017 (Enclosure 2)
9.35am

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

17/106 Staff Story
9.38am

The Head of Communications presented the staff story.

The story was given by a Lead Nurse in ED. She described the challenges faced during the previous winter and was very enthusiastic about the building of the new treatment centre. She detailed some of the positive actions that had taken place over the previous 6 months and was looking forward to the results of the nursing review.

Dr Wulff, Non Executive Director, asked about the new build and what interventions had been put in place to make the area more comfortable for patients. The Chief Nurse confirmed that several changes had been made to facilities to make the environment more comfortable during the build.

Mr Fellows, Non Executive Director, asked if staff in the Department understood the importance of the 95% target. The Chief Nurse confirmed that staff in the Department are very good and many of the breaches were due to a lack of available beds in the hospital and the consequent impact on patient flow.

The Chief Executive agreed that improving patient flow was key to improving the position. Rotas also need to be scrutinised to ensure Consultant cover matched the peaks in demand.

Mr Miner, Non Executive Director, asked if previous work on patient flow had broken down. The Chief Executive stated that an escalation process needs to be put in place to anticipate issues earlier before they become a block to flow.

Dr Hopkin, Associate Non Executive Director, asked if Consultants were involved in the plans for the build. The Chief Executive confirmed that Consultants were heavily involved in the planning process.

The Chair asked when the extra Health Economy Community beds will become available through the Better Care Fund monies. The Chief Executive stated that this will be raised at the next A&E Delivery Board as only around 23 out of 50 beds had been identified. The Board noted that additional pressure was also being put on Social Care partners to ensure delayed discharges were kept to a minimum.

The Chairman and Board noted the story and congratulated staff in the Department for their hard work and also that the member of staff is thanked for her presentation.

Member of staff to be thanked for their presentation.

17/106 Chief Executive's Overview Report (Enclosure 3)
9.59am

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

The Board noted that the performance commentary will be picked up in the Performance Report later on the agenda.

- Staff Survey: All staff are encouraged to complete a survey; we were falling beind response rates of other Trusts.

- Flu Vaccination: The Chief Executive confirmed that she was delighted with the progress made towards meeting the 75% target. A "Jabathon" was taking place throughout the day and will be repeated over the forthcoming weeks. Board members would also be participating after the meeting.

- Health Care Heroes: This new initiative had been well received by the organisation and recent awards were identified.

Mr Fellows, Non Executive Director, asked how staff that have had the flu jab elsewhere other than at the hospital are tracked. The Director of HR confirmed that there is a mechanism in place for recording this information.

Dr Hopkin, Associate Non Executive Director, asked about the risk of people having the injection twice because they had been vaccinated at a Pharmacy. The Chief Executive confirmed that the Trust will remind its staff to tell their GPs that they have had a vaccination.

The Chairman and Board noted the report.

Staff to be reminded to notify their GPs that they have had the flu jab if invited for one at their Surgery.

17/107 Safe and Caring

17/107.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
10.05am

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:

- Delays in assurance around NICE guidance: The Committee noted the progress that had been made. The next meeting is expecting to see further improvement.

- Over the previous few months the Committee had been looking at the Maternity Dashboard. This will be incorporated into the integrated dashboard being presented to the November Board.

- Approval had been given regarding RCA closures and policies that had been reviewed.

- Further feedback on the learning from the Thrombolysis Group review of incidents, continued oversight of pressure ulcer care and safeguarding processes within the Trust especially within Children's Services would all be reported back to the next Committee meeting.

The Chairman and Board noted the report, assurances received, particularly with regard to Ophthalmology and the reduction of follow ups and to endorse the work of the clinical audit team, and items to come back to the Committee. The Chairman confirmed that it was good to see the focus on improvements and the actions being taken.

17/107.2 Maternity Quality Improvement Board Report (Enclosure 5)
10.10am

The meeting was joined by Dawn Lewis, Head of Midwifery and Eric Watson, Clinical Director for Womens and Childrens.

The Chief Nurse presented feedback from the Quality Improvement Board, including the following key issues:

- Why?: The Trust was identified as an outlier for the number of serious incidents reported.

- How?: The Trust established a Maternity Performance Assurance Group and contributed to a local Health Economy Clinical Reference Group and Improvement Board.

- Actions as a Result: The Trust is maintaining 1:28 midwife to birth ratio, had appointed an additional 4 Consultants, improved the Maternity Governance structure, provided external sourced RCA training support to staff and undertook a peer review of its processes with support from Birmingham Women's Hospital and New Cross Maternity Unit.

- Further Actions taken as a result of QIB discussions: Improved CTG training, teaching around oxytocin, review of prostaglandins particularly for VBAC and recognition of ill women and the application of appropriate escalation for appropriate cases.

- Oversight: The Quality Improvement Board (QIB) had met throughout 2016, and produced the QIB action plan which then became a service improvement and Maternity improvement plan. This was monitored through our Clinical Quality, Patient Experience and Safety Committee with reports flowing through to the Board.

Dr Wulff, Non Executive Director and Vice Chair of the QIB confirmed that the QIB had a true desire to ensure that all actions were addressed and improvements seen. Members of the group had a very good working relationship. Dr Wulff confirmed that RCA training was offered across the whole health economy and also system links had been strengthened for women across all specialties, not just paediatricians and obstetricians for the babies, but also gynaecologists and cardiologists for mothers.

The Chairman confirmed that it was pleasing to note that the peer review had been established and welcomed the whole root and branch look at maternity service provision and confirmed that the report had produced some excellent changes that had been implemented and would be sustained.

The Chairman thanked everyone involved in the process.

Mrs Becke, Non Executive Director, highlighted the positive patient experience experienced by mothers using the Unit and thanked the staff for their hard work. This was borne out in the recent national Maternity survey.

The Chief Nurse confirmed that the Trust had been a high reporter of Serious Incidents as it had previously been using out of date guidance from 2010 through to 2014/15.

Mr Miner, Non Executive Director, asked if the Clinical Quality, Patient Safety Committee, were content with assurance around future monitoring of the actions within the improvement plan. Dr Wulff, confirmed that the Committee were assured because of new processes and monitoring in place but further assurance can and will be requested if any concerns were identified though the maternity service dashboard which recorded important quality indicators.

Dr Hopkin, Associate Non Executive Director, asked about Root Cause Analysis and staff training. The Chief Nurse confirmed that there had been 2 serious incidents since she joined the Trust and confirmed that these were reviewed with forensic detail and improvement actions identified and implemented.

Dawn Lewis confirmed that the culture is changing within Maternity and the staff have lots of ideas to improve the service and this is a continuing process.

Dr Watson confirmed that he welcomed the appointment of the 4 new Consultants and this will ensure that all clinicians have more time for driving improvements.

The Chairman and Board noted the formal outcome of QIB and that the report was appended to the papers and noted the ongoing monitoring of the service improvement plan by the Clinical Quality, Safety, Patient Experience Committee.

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17/107.3 Chief Nurse Report – Infection Prevention and Control Update (Enclosure 6) 10.54am

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

There had been a comprehensive presentation prior to the Public Board and as such there were no further questions.

The Board received the report for information and noted the continuing focus on mandatory training.

17/107.4 Monthly Nurse/Midwife Staffing Report (Enclosure 7) 10.55am

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 across all services and using some agency staff to do this.

- Benchmarking is undertaken using the Model Hospital data. The ratio of qualified to unqualified nurses is slightly out of balance and this is being rectified through the nurse staffing review, which would see some adjustments. Recruitment of qualified nurses was a continuing endeavour.

- The format of the report will change after the staffing review has been completed for all areas.

The Chairman asked for a broad overview of when work will be complete in respect of the staffing review. The Chief Nurse confirmed that work in Surgery and Medicine had been completed and the review of Community had commenced. Theatres would also be reviewed shortly. The Chief Nurse confirmed that work will be complete by the end of the calendar year and a report presented to the January Board.

Mr Atkins, Non Executive Director, asked about new nurses not joining the Trust because of current registered nurse staffing levels. The Chief Nurse confirmed that this did have an impact and this position will improve as nursing positions are recruited to on a permanent basis.

The Director of Finance and Information stated that the Trust could not increase the number of substantive staff whilst continuing with current levels of agency staffing and that there would have to be a consequent reduction in the latter.

The Chairman and Board noted the report and the ongoing work and thanked the Chief Nurse for her work.

Outcome of Nurse Staffing Review to be presented to the January Board.

17/107.5 Medical Revalidation Report (Enclosure 8)
10.41am

Mr Stonelake, Responsible Officer, presented the Medical Revalidation Report given as Enclosure 8.

The Board noted the following key issues:

- Previous issues with vacancies within the team: A full team had been in place since August, 2017 so these issues had been resolved.

- Quarterly reports: These are now presented to the Workforce Committee so they can monitor compliance.

- Appraisal rate: Currently the Trust's rate is 89.7% for the target doctor population.

- Appraisals: 9 Doctors had not been appraised that should have been and these were all being followed up.

- Peer Review: The Trust is required to undertake an annual peer review of its processes and was planning a joint exercise with neighbouring Trusts to mutually peer review so that good practice could be shared.

- Appraiser Training: The Trust was refreshing the training programme for appraisers. There were currently 68 appraisers within the Trust.

Mr Atkins, Non Executive Director, asked if appraisers undertake the same number of appraisals. Mr Stonelake confirmed that numbers are variable and appraisers are monitored to ensure that they maintain their skills. Dr Wulff suggested including a minimum number of appraisals to be undertaken by each appraiser within the Revalidation policy, as this seemed to be normal in other organisations.

Mr Stonelake to consider a minimum level of appraisals to ensure expertise was retained.

The Chairman asked about the challenge undertaken in respect of the evidence that appraisees provide and the balance of input from other sources. Mr Stonelake confirmed that this is being currently reviewed but the Trust does try and triangulate evidence. The Chairman asked that consideration is given to how supporting information is reviewed. Dr Wulff, Non Executive Director confirmed that further guidance is expected to be released in due course, via the Pearson Review.

The Responsible Officer asked about the Board's expectation for future reporting. The Chairman confirmed that only an annual revalidation report was required to be presented to Board, given that regular reports are provided to the Workforce Committee.

The Chairman and Board noted the report and the improved detailed quality assurance process.

17/108 Responsive and Effective

17/108.1 Finance and Performance Committee Exception Report (Enclosure 9) 11.05am

Mr Fellows, Committee Chair, presented the Finance and Performance Committee Exception Report, given as Enclosure 9.

The Board noted the following key issues:

- Deficit in August and adverse variance to finance plan. There had been a fall in levels of activity for ED and non elective work.

- Agency staffing spend was not seen to be reducing in line with ambition.

- Risks in not achieving the control total. If this is not achieved the Trust will lose £7.5m of STF funding. The Trust is working with the Divisions to rectify the position. A special finance meeting has been arranged for 20th October, 2017, to consider options, including additional savings.

The Chief Nurse confirmed that the Trust had identified that a number of different practices have been taking place to fill shifts and work is being undertaken to ensure that there is equity across the whole organisation.

The Chairman and Board noted the report and risks identified and encouraged colleagues to attend the meeting on 20th October, 2017.

17/108.2 Performance Report (Enclosure 10)
11.09am

The Chief Executive presented the Performance Report given as Enclosure 10.

The Board noted the following key issues:

- Challenges with the Emergency access standard. The Trust was not currently meeting the target. August performance showed that the Trust is still in the top third of Trusts for its ED performance, but was adrift of target.

- There had been issues with delayed transfers of care and the Trust was working with partners to manage delays.

- Internal work was taking place to ensure that patients had optimum discharge dates.
- Co-location of Urgent Care Centre. The Trust was still hopeful that work would be completed by November but recognised that this may run into December or early January due to adjustments that have recently been made to the specification.

- The new centre would increase the number of cubicles within the Emergency Department and improve overall patient experience.

- There had been challenges in August for the cancer 2 week wait performance. Mostly this was due to capacity within Dermatology. The Trust was back on track for September but would not meet the quarterly target for 2 week waits which was disappointing as better scheduling of capacity might have prevented some of the downturn.

- 62 day cancer performance had been a challenge for a number of months but the Trust was delivering to target for September. Overall the Quarter 2 figure would be met. The Trust needs to ensure its provision was effective so the Tertiary Centre could also deliver a positive outcome, as this was a shared experience.

- The Trust was continuing to perform well for patients being Referred to Treatment within 18 weeks.

- Diagnostic wait performance. The Trust was on track to hit 99% performance, and had achieved 98% by September. Two additional scanners are to be available at the Guest Hospital shortly. A recovery plan has been shared with the Trust's regulator and was on track to deliver.

Mrs Becke, Non Executive Director, asked about mixed sex breaches on ITU. The Chief Executive confirmed that this relates to flow in the organisation as a result of capacity pressures. The work on patient flow and bed utilisation will eradicate this occurring in future.

The Chairman asked if patients are aware why this happens. The Chief Executive confirmed that patients are communicated with and are normally happy with the arrangement as their care is not compromised.

Dr Hopkin, Associate Non Executive Director asked if there were actions that GPs could take to help with Dermatology referrals. The Chief Executive confirmed that Dudley was not an exception for referral. More potential skin cancers were referred during the summer period.

The Chairman and Board noted the report and challenges to performance and improvements made in some areas and assurance provided with respect to ongoing action to support achievement of targets.

17/108.3 Cost Improvement Programme and Transformation Overview Report (Enclosure 11)
11.21am

The Director of Finance and Information presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 11.

The Board noted that the Trust had adjusted the forecast outturn to £10.9m due to agency costs not falling as anticipated.

The Chairman and Board noted the report and the adjusted forecast outturn and the work underway and overseen by the Finance and Performance Committee.

17/109 Well Lead

17/109.1 Workforce and Staff Engagement Committee Exception Report (Enclosure 12)
11.20am

Mr Atkins, Committee Chair, presented the Workforce and Staff Engagement Committee Exception Report, given as Enclosure 12.

The Director of Finance and Information declared an interest in this area, in respect of his association with the company who were supporting the Trust on Leadership Development. The Board confirmed the Director of Finance had no direct connection with the Trust and company arrangements. The matter was to note for information and as such there was no conflict of interest.

The Board noted the following key highlights from the Committee report:

- Presentation on development of a Senior Manager programme was well received by the Committee.

- Audits on Mandatory Training and Appraisals were received.

- The appraisal window will be reduced to a shorter period for next year so that achievement rates can improve.

- A more appropriate span of control for appraisals will be applied in some areas.

- Workforce risks had been reviewed and the committee considered they were correctly reflected within the Trust's risk register.

- The Committee received a report from the Deputy Chief Nurse regarding incentives for recruitment relating to all clinical professionals under pay band 7 which would apply for the next 6 months.

- The Committee received a report on the Workforce Race Equality Scheme (WRES) which was appended to the report. The Trust had appointed an Equality and Diversity lead.

Mrs Becke, Non Executive Director, asked if the Trust had seen an increase in racial discrimination incidents. The Director of HR confirmed that the Trust had not experienced any changes in respect and the Trust works hard to champion diversity.

Mr Miner, Non Executive Director, raised how outcomes will be measured within the Workforce Strategy as the measures were not specific enough. The Director of HR confirmed that the Strategy had been approved by the Board the previous November. Mr Miner stated that there needs to be more measurable outcomes. The Chairman noted that this was a repeat of the discussion in November that the strategy document was described in broad terms but supporting plans would provide detail. Linkages to demonstrate this connection might usefully be pursued outside the meeting.

Workforce Committee consider demonstrable measures with links to strategy.

Mr Atkins confirmed that 23 MTI doctors had been recruited from Pakistan and would join the Trust at various times throughout the year.

The Director of HR confirmed that issues around recruitment KPIs had not improved and this will be picked up with Divisions and the Workforce Committee.

The Chairman and Board noted the report, approved the proposal for recruitment incentives for all specialties for a period of 6 months. The WRES information was also noted along with the appointment of an Equality and Diversity Co-ordinator.

17/109.2 EPRR Core Standard Submission Report (Enclosure 13)
11.35pm

The Chief Executive presented the EPRR Core Standard Submission Report, given as Enclosure 13.

The Board noted the following key highlights:

- The Trust is mandated to undertake an annual self-assessment.
- Assessment is against 4 compliance levels.
- External support is being provided to give the Trust more resilience around emergency planning.
- The Trust has assessed itself as substantially compliant.

Mr Miner, Non Executive Director, confirmed that the Audit Committee took assurance that actions were being undertaken and gaps were being closed.

Mr Fellows, Non Executive Director, suggested that internal audit should do a further review in quarter 4.

The Chairman asked about the 5 areas where work was required for full compliance. The Chief Executive confirmed that business continuity was a key focus and work would continue to ensure all elements were fully covered.

The Chairman and Board noted the report and acknowledged the 5 areas that require focus and the suggestion of undertaking a further audit when work is completed. It also approved the submission of the Trust's self-assessment status as substantial. A further update will come to Board in due course, with Finance and Performance Committee confirming the position beforehand.

A further update on EPRR to be presented to the Board in Quarter 4.

17/109.3 Charitable Funds Committee Summary Report (Enclosure 14)
11.40am

Mr Atkins, Committee Chair, presented the Charitable Funds Committee Summary Report, given as Enclosure 14.

The Board noted the following key highlights:

- The Fundraising Manager had transferred to the Communications Team to enable a higher marketing profile.
- The 'Big Push' campaign had already raised £10k for additional wheelchairs in the hospital.
- The Deputy Director of Finance reported that the overall fund balance stood at £2.4m.
- General funds had reduced to £54k because of concerted efforts on expenditure.
- Bids: 2 bids had been considered at the last meeting - one for Day Case Surgery and one for Furniture and Equipment across the Trust. These had been approved.

The Chairman and Board noted the report and the good work on fundraising for the Big Push.

17/109.4 Digital Trust Programme Committee Summary Report (Enclosure 15) 11.44am

Mrs Becke, Committee Chair presented the Digital Trust Committee Exception Report, given as Enclosure 15.

The Board noted the following key highlights:

- 18th October was Digital Trust Awareness Day and all Board members were invited to attend.

- Sunrise Project is on track and enthusiasm for the outcome remains high, across all clinical areas. On-site rooms for training was a current issue but options to provide facilities that would enable full attendance were being actively considered.

- The Trust had identified some strategic risks to the benefits case, The Committee had taken assurance around mitigations. The Chief Information Officer highlighted that real time system working is a cultural change that needs organisational support on a sustained basis.

- Julian Hobbs to join the Committee.

- Tera Firma the in-house IT team, continues rolling out NHS mail and were to be congratulated on the successful adoption of 1200 of 8000 mailboxes in the Trust converted, but they had also fully completed rollout for external clients.

Mr Fellows, Non Executive Director, suggested raising the telephony system at the Interserve Board to Board meeting as the system was long overdue updating.

The Chairman and Board noted the report and asked that thanks were passed to both the Chief Clinical Information Officer and Chief Nursing Information Officer.

17/110 Any Other Business
11.50am

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

17/111 Date of Next Meeting
11.50am

The next Board meeting will be held on Thursday, 2nd November, 2017, at 9.00am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 12 October 2017

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
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. 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	Stress testing remains in progress.
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. The Chief Nurse to join the Organ Donation Committee. NHSBT to facilitate contacts with the Tissue Donation team.	JN/RE/RU SJ	7/12/17 November Organ 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	This is included within the Board Assurance Framework Report on the November agenda.
17/106	Staff Story	Member of staff to be thanked for their presentation.	LA	2/11/17	Done

17/106	Chief Executive's Overview Report	Staff to be reminded to notify their GPs that they have had the flu jab if invited for one at their Surgery.	AM	2/11/17	
17/107.5	Medical Revalidation Report	Mr Stonelake to consider a minimum level of appraisals to ensure expertise was retained.	PS	30/11/17	
17/109.1	Workforce and Staff Engagement Committee Exception Report	Workforce Committee consider demonstrable measures with links to strategy.	AM	30/11/17	
17/098.4	Smoke Free Update Report	Smoke free update report to be presented to the Board in Quarter 4.	AM	11/1/18	
17/107.4	Monthly Nurse/Midwife Staffing Report	Outcome of Nurse Staffing Review to be presented to the January Board.	SJ	11/1/18	
17/109.2	EPRR Core Standard Submission Report	A further update on EPRR to be presented to the Board in Quarter 4.	KK	Quarter 4	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 2nd November 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
- Welcome to New Faces
- Healthcare Heroes
- Digital Trust Launch
- Flu Update
- Staff Survey
- Charity Update
- 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 – November 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

12th October	Board of Directors
13th October	Colorectal Surgeon Interviews
16th October	Black Country STP Meeting
18th October	A&E Delivery Board
	Digital Trust Launch
	Overview and Scrutiny Committee Working Group
19th October	MCP Meeting
23rd October	NHS Transformation Support Meeting
25th October	Partnership Board
	MCP Meeting
26th October	Trust/Summit Board to Board Meeting
27th September	Visit by James Morris MP
31st October & 1st November	Transformational Change through System Leadership Programme

Welcome to New Faces

Karen Kelly has been appointed our substantive Chief Operating Officer and she will take up her new post in January 2018. Karen joins us from Barnsley Hospital NHS Foundation Trust.

I am pleased to announce that Siobhan Jordan, who joined as interim Chief Nurse in April, has been appointed to the permanent position of Chief Nurse. Siobhan brings with her a wealth of senior nurse leader experience from a career spanning almost 30 years. In her first six months with the Trust, she has undertaken a nurse staffing review which resulted in her refocusing the Trust's recruitment strategy to hire local, UK-based staff. Under her guidance, we have already recruited 72 nurses from two highly successful open days and the graduate nurse programme. A further 25 graduate nurses will be starting with us in January 2018. Siobhan is holding monthly recruitment days and hopes to attract even more home-grown talent. Siobhan's priority will continue to be on patients and their families and ensuring we listen and learn from their experiences.

Healthcare Heroes

Healthcare Heroes is attracting some very strong nominations and choosing winners this month was no easy task. I am very pleased to say that End of Life Facilitator Karen Lewis is our worthy winner for the individual award. This recognises her work ensuring we have competency trained Palliative Care Champions on all wards and departments.

The team award goes to Ward C8 Stroke for the wonderful care they are providing for our stroke patients. They stand out because their Sentinel Stroke National Audit programme figures have improved from level D to a green level B.

Digital Trust Launch

We had a very busy launch for our Digital Trust programme on 18th October. It is estimated that approximately 1000 members of staff took a few minutes out of their busy days to speak to the Digital Trust team in main reception at Russells Hall Hospital and at Brierley Hill Health and Social care Centre. Going paper-free really will transform the way we work and staff had the opportunity to ask how their working lives will change from 23rd April 2018. Their questions and answers were posted all over social media which received lots of hits on Facebook and Twitter from staff and members of the public.

Flu Update

To date 45% of staff have had their flu vaccine but our target is 70% so we need to keep pushing flu and reminding staff about the importance of having their vaccines. The latest breakdown of flu vaccine uptake figures by division is available on the Hub.

Vaccines are available at regular drop in clinics based at all three hospital sites and various locations in the community, as well as from more than 75 peer vaccinators across the Trust. A calendar of clinics is available on the Hub.

A letter from NHS and Public Health has also been distributed to staff areas across the Trust telling staff how important it is to have the vaccine to protect themselves and their patients but if staff are unsure about having the vaccine, please encourage them to speak to one of our peer vaccinators to find out more.

Staff Survey

We are currently at 17.4% for staff who have taken part in the National Staff Survey. For acute and community Trusts, the worst performing is 1.4% response rate and the best performing Trust is 27.8%. Our results are encouraging but we would encourage as many staff as possible to have their say. It is only by listening to our staff that we can act on their feedback and make improvements.

This year staff can part complete the survey and then pick up where they left off and can also forward their unique link to their home email address. If staff have not received their survey link, they should email luke.o'neill1@nhs.net with their full name, department and payroll number.

For any members of staff who struggle to access a computer, Staff Survey teams are able to visit their areas throughout the survey period with iPads and laptops.

Charity Update

Great Halloween Bake Off

There is still time for staff to get a cake sale organised for your department. Seven departments have registered so far. Everyone who hosts a cake sale can enter up to three cakes in the 'Showstopper' competition. The three best entries will get a prize. This is a great way for wards and departments to raise funds for the benefit of patients. Money raised can also be donated to one of the Trust's four charity appeals.

The Big Push Wheelchair Campaign

The campaign has so far raised more than £13,000, which equates to 21 brand new wheelchairs. The campaign is due to run until Christmas and I would like to say a huge thank you to local businesses who have supported this appeal.

Tesco Bags of Help

I would like to say a big thank you to everyone who voted for our Children's Appeal with blue tokens in the Tesco Bag for Help funding scheme. We are delighted to announce that we have been awarded the top grant of £4,000. Shoppers in Dudley voted for the Trust's children's appeal at local Tesco stores using blue tokens given to them once they a purchased a bag during their visit. The money will help our children's appeal.

London to Paris Bike Ride

Two brave members of staff have already agreed to test their stamina and registered for the 300 mile London to Paris bike ride. It's a great way for keen cyclists to test their stamina, get fit and raise funds for the Trust charity

National NHS news

Referring NHS patients to Weight Watchers classes cut their diabetes risk by half, study suggests (Daily Mail)

A new study suggests GPs should send patients who are at risk of developing type 2 Diabetes to Weight Watchers. Researchers found some 38 per cent of the patients, who had pre-diabetes returned to normal blood sugar levels after a year.

NHS Trust pays £600,000 to abuse victims of children's doctor (The Guardian)

A hospital Trust has paid more than £600,000 in compensation to victims of a children's doctor who abused 18 boys in his care, reports say. Myles Bradbury was jailed in December 2014 after carrying out medical examinations on boys "purely for his own sexual gratification" while working at Addenbrooke's hospital in Cambridge. The paediatric consultant haematologist used a spy pen to take photos of some of his victims and abused others behind a curtain while their parents were in the room.

List of treatments that may no longer be available on NHS prescription (The Guardian)

Some treatments patients are used to getting on the NHS may soon no longer be available. These include travel jabs, omega-3 supplements, painkillers and gluten-free foods. Reports say NHS England Chief Executive wants to slash the £128 million cost of 'low priority' items prescribed by GPs.

NHS patients to be asked about sexuality (BBC News)

Health professionals in England are to be told to ask patients aged 16 or over about their sexual orientation, under new NHS guidelines. NHS England said no-one would be forced to answer the question but recording the data would ensure that "no patient is discriminated against". The guidance applies to doctors and nurses, as well as local councils responsible for adult social care.

Outcry over the NHS asking about sexuality shows why it's necessary (New Statesman)

Those who object know that straightness is presumed when LGBT patients stay silent. NHS England has announced plans to record the sexual orientation of all patients over the age of 16. The new rules, which come as a response to research collated by the LGBT Foundation, will aim to ensure that people who do not identify as heterosexual are treated fairly. The data from lesbian, gay and bisexual patients who choose to answer the optional questions will be used to identify the specific health needs of LGB people.

Council and local NHS plan to work closer together for the benefit of B&NES (Bath Echo)

B&NES Council and NHS Bath and North East Somerset Clinical Commissioning Group (CCG) are set to take an important step forward to further join up the delivery of local health and care services. At November's Council Cabinet and CCG Board, health and social care commissioners will present plans to improve existing joint working arrangements.

Children waiting up to 18 months for mental health treatment – CQC (The Guardian)

NHS watchdog's report sounds alarm that accessing care for under-18s in England takes so long, amid self-harm concerns. Children with mental health problems are waiting up to 18 months to be treated, a government-ordered report reveals, in an indictment of the poor care many receive.

Dropping the Language Barrier (The Sun)
NHS English tests to get easier in bid to recruit more foreign nurses, watchdog rules

The Nursing and Midwifery Council is acting after hospitals complained that too many potential nurses have been turned away for poor language skills. They will be given a choice of English tests after hospitals complained too many were being turned away for poor language skills. They claimed the International English Language Test System was too academic and did not reflect the training of overseas staff. Officials said it will allow more nurses from countries such as the Philippines to pass.

NHS patients abused by Jimmy Savile received an average pay out of just £9,500 (The Express)

NHS PATIENTS abused by Jimmy Savile have received an average compensation pay-out of just £9,500. The health service has now settled all but three of the cases against it but has paid out less than £450,000. Savile's sickening behaviour included molesting a paralysed teenager in a wheelchair and preying on girls as young as five years old.

NHS staff urged to get flu jabs to protect patients (BBC News)

NHS leaders are urging nurses, doctors and other healthcare workers to have a flu vaccination to protect their patients this winter. Vulnerable groups, such as children, pregnant women and older people are also reminded to have their free jab. Sir Bruce Keogh, NHS England's Medical Director, told the BBC he was worried about how staff would cope with a major flu outbreak. He said the NHS was under "severe and unrelenting" pressure.

Rise in violent attacks by patients on NHS mental health staff (The Guardian)

Surveys find budget cuts leaving workforce struggling to cope. Staff said that the delays patients can face in accessing treatment can make them very frustrated.

Two out of five NHS mental health workers have been abused or attacked by a patient over the past year as services have become overstretched because of staff shortages, a new report has revealed.

Bill for urgent repairs at NHS hospitals reaches almost £1bn (The Guardian)

Hospitals are at growing risk of "catastrophic failure" because the bill for urgent repairs for problems that threaten staff and patient safety has soared to almost £1bn, an NHS report reveals. The cost of undertaking urgent "high-risk" maintenance in hospitals jumped last year from £775.5m to £947.1m – a rise of 22% – according to figures published by the NHS's statistical arm.

NHS data loss scandal deepens with further 162,000 files missing (The Guardian)

The scandal over the biggest ever loss of NHS medical correspondence has deepened with the revelation that a further 162,000 documents went missing, in addition to the 702,000 pieces of paperwork already known to have gone astray. MPs said they were "dumbstruck" to learn that even more material relating to patients' health had been mislaid, some of it by NHS Shared Business Services (SBS), the firm co-owned by the government that lost the documents.

NHS officials float idea of banning patients from going to A&E without prior permission (The Telegraph.co.uk)

NHS officials have held talks about banning patients from turning up at Accident & Emergency departments if they have not been referred by a doctor. The radical idea, discussed by officials at NHS England, would mean patients could only be treated in casualty units if they had been referred by their GP, or via 111 phone lines.

Overseas 'health tourists' will be charged upfront for NHS treatment (Metro)

The NHS will begin its crackdown on 'health tourism' by making overseas patients pay 'upfront' for their care. From Monday, hospital staff will ask patients for bank statements, utility bills and proof of employment. The new legislation will hope to expose those getting NHS treatment for free when they should be paying. 'Health tourism' costs the NHS an estimated £2bn each year.

NI has never met key NHS cancer target (BBC News)

Northern Ireland has never met a key NHS waiting times target for cancer treatment since it was introduced eight years ago. The target states that at least 95% of patients should begin treatment within 62 days of receiving an urgent cancer referral from their GP. It was introduced in April 2009 but has never been achieved. It was among a series of missed targets highlighted by a UK-wide BBC report into the performance of the NHS.

Patients left waiting as half of North East NHS Trusts miss key targets (Chronicle Live)

Half of the NHS Trusts in the North East failed to hit waiting time targets – figures have revealed. Newcastle NHS Trust, City Hospitals Sunderland, Northumbria Healthcare, and North Tees & Hartlepool all failed to hit key waiting time figures, according to the recently published statistics. Nationally North East Trusts performed well, with all eight being ranked within the top 20 of the UK's 134 NHS Trusts.

NHS patients urged to stop asking for antibiotics in television campaign (Telegraph.co.uk)

NHS patients will be urged to stop asking GPs for antibiotics in the first ever television campaign to prevent a bacterial 'apocalypse'. Around 5,000 people in England die each year because antibiotics have become resistant to some infections and experts predict resistance will kill more people than cancer and diabetes combined within 30 years.

Bed blocking costs Scottish NHS more than £100 million a year (Telegraph.co.uk)

Bed blocking by hospital patients, who are ready to go home, cost the Scottish NHS more than £100 million over the past year despite the SNP's promise to abolish the scourge, according to new figures. Labour published an analysis based on official figures showing 511,972 bed days were lost to "delayed discharge" in Scotland's hospitals between September 2016 and August this year.

Regional NHS news

999 workers attacked 30 times a day in West Midlands (Express and Star)

Police officers and NHS workers were attacked more than 30 times a day in the West Midlands last year, new official figures have revealed. Analysis of Government figures shows there were 11,466 assaults recorded in 2016 - an average of 31.41 a day. And only 1.55 per cent of the attacks on police and NHS staff led to any criminal prosecution.

Hospital hitting most national targets but failing on A&E wait times (Salisbury Journal)

Salisbury District Hospital is performing better than the majority of UK hospitals, but is still falling short on emergency waiting times. A report into hospital targets published by the BBC on Tuesday showed Salisbury NHS Trust is failing to meet targets in one category, on A&E waiting times, but still performing better than the majority of Trusts in the UK.

NHS Trusts to use connected tech for better mental health care (Med-Tech Innovation)

A group of four NHS mental health Trusts have created the Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT), to help healthcare professionals share access to crucial information from the patient's mental health record. The four Trusts cover a population of 3.4 million people and include Birmingham and Solihull Mental Health NHS Foundation Trust, Black Country Partnership NHS Foundation Trust, Dudley and Walsall Mental Health Partnership NHS Trust and Coventry and Warwickshire Partnership NHS Trust.

Badly-behaved surgeons are putting patients' lives in danger due to 'culture of bullying', report finds (Telegraph.co.uk)

Trainee surgeons are being assaulted during operations for raising safety concerns as part of an 'endemic culture of bullying' that causes patient deaths, the professions leadership has warned. Earlier this year West Midlands surgeon Ian Paterson was jailed for 20 years after being convicted of deliberately performing unnecessary and incompetent operations on 10 patients, although the true number of his victims is estimated to be several hundred.

West Midlands acute trust's 'outstanding' chief nurse announces retirement next year (Nursing Times)

Dr Cheryl Etches, Chief Nurse and Deputy Chief Executive of The Royal Wolverhampton NHS Trust, has announced that she will be retiring from the NHS at the end of March 2018. Dr Etches has been a nurse in the NHS for 38 years and she has held her current senior roles at the Midlands trust for the last 12 years.

Sandwell cancer patients face trips to Birmingham or Wolverhampton (Express and Star)

Cancer patients in Sandwell will have to travel to Birmingham or Wolverhampton for appointments as the borough's main hospital has lost its oncology services. Health officials were not able to reach an agreement to keep oncologists at Sandwell Hospital, where they had been allowed to work by the Queen Elizabeth Hospital in Birmingham. It means cancer outpatient care and chemotherapy will no longer be delivered in the borough – forcing patients to travel up to 11 miles out of their way in a move that has been criticised by families.

Campaign launched to recruit more nurses (Shropshire Star.com)

Shrewsbury and Telford Hospital NHS Trust (SaTH), which runs Royal Shrewsbury Hospital and Princess Royal Hospital in Telford, have launched one of their largest ever drives to attract nurses from across the West Midlands. The campaign includes adverts on the back of buses that travel along the main routes in Shrewsbury, Telford, Stoke and Wolverhampton, posters and banners throughout the hospitals, adverts in the local press and targeted email and social media activity.

RCN warns of a "dangerous blind-spot" in dealing with assaults on NHS staff (Nursing Notes)

Health ministers will no longer collect information on NHS staff assaults, the Government confirmed for the first time on the eve of a Commons debate. A decision stands in contrast to the Home Office, which monitors assaults on police officers. The Royal College of Nursing has warned that the move leaves the Government blind to the scale of the problem and risks a further deterioration. The news comes only a week after Unison said it had concerned that cuts to mental health service were leaving staff vulnerable to violence and aggression. MPs will today debate a Private Member's Bill to strengthen the law against people who assault emergency workers.

Nurses deliver 'scrap the cap' pay petition to Downing Street (Nursing Times)

Frontline nursing staff today handed a petition of 67,000 names to Downing Street, urging the Government to scrap the cap on public sector pay. Michael Coram (London), Kayleigh Peel (West Midlands), Jane Leighton (Northern Ireland), Julie Lambeth (Scotland) and Jean Richards (Wales) are RCN Pay Champions and spent the summer promoting the Scrap the Cap campaign, distributing campaign materials and organising events at hospitals and in public spaces.

Over a third of 10 to 11-year-olds in Worcestershire are overweight or obese, according to figures released by the NHS (Malvern Gazette)

A RISE in obesity among school pupils could put them more at risk of bullying, it was claimed, after new NHS figures revealed more than a third of the county's 10 to 11-year-olds are overweight or obese. It means nearly one in four reception year children in Worcestershire are now overweight or obese.

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 2 November 2017

TITLE:	**24 October 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.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

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

Declarations of Interest Made

None

Assurances received

- The Committee received a report, in response to its request at its last meeting, 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 report provided an update on the management tracking of actions being delivered in a timely manner to improve pressure ulcer care.
- The Surgery, Women and Children Division provided assurance on actions taken in respect of ophthalmology (the positive impact the extra resources were having on seeing patients who had been waiting and that the backlog of overdue appointments despite some internal resourcing challenges recently is on track to be cleared by November). The Division also provided an update on the work being undertaken in respect of paediatric outpatient waiting lists and whist the Division is ahead of its trajectory to clear these it is also doing work on reducing the time those with a booked appointment are waiting beyond their ideal appointment time. The Committee were informed that the Chief Executive is meeting with the Division about this issue to identify what else can be done to support the Division with this challenge.
- The Committee received an update from the Chief Nurse on the Trust quality account priorities and were informed of the risks associated with the delivery recognising that for pressure ulcer care the Trust had had more than one grade four pressure ulcer so had failed its zero target for the year.
- 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 to the structure of the report. The Committee asked that for future reports clear narrative is included in the report that alerts to the key areas of performance were the Committee should focus time within the meeting.
- The Committee was presented with the tabled Maternity Dashboard report which provided information on a wider spread of quality indicators for this service. The Committee was updated on the progress and reporting of three audits the outcomes of which will be reported back to this Committee within the clinical audit

report.

- An update was provided in respect of the Maternity Service Improvement Plan. The report provided assurance of progress and the continued executive oversight of the action tracking process which has and will continue to take place within the Division and the Directorate.
- The Committee received a report on incident management. The report provided assurance on the Serious Incident 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 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 work undertaken since the last meeting to close a number of open incidents, many of these being of no harm. The Committee noted that this remains a focus within the divisions and directorates. The Committee were updated on the actions being taken to close investigations in a timely manner and were asked to note that for two investigations action plans extensions of implementation dates had been made, one until the end of the month of October and one until the 1 November.
- The Committee was updated on the complaints activity over the first half of the year. The report provided information on the themes of the complaints and the progress being made on responding to them in a timely manner.
- 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 its remit for water safety, decontamination and the medical devices asset register. The Committee were informed that Summit had agreed to the proposed changes by the Trust in respect of the cleaning policy.
- The Committee received reports from the Quality and Safety Group; the Internal Safeguarding Board; the Mortality Surveillance Group; the Infection Prevention and Control Forum; the Medicines Management Group and the Clinical Approvals Group. These reports confirmed that the groups were quorate when meeting and were working in accordance with their terms of reference. The Clinical Chief Information Officer updated the Committee along with the Chief Executive on the work being undertaken to support the clinical engagement for the Digital Trust project whilst managing the competing prioirties on the clinicians time with the work on the MCP pathways as well as their patient facing work.

Decisions Made/Items Approved

- The Committee supported the closure of 9 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 6 policies, three of which had been the subject to a comprehensive rewrite with the other three having more minor changes to reflect process changes since their first drafting.

• The Committee recommended to the Executive that they consider whether a risk should be placed on the corporate risk register in respect of the challenge to clinical resources of dealing with the many competing priorities being put on their time.
Actions to come back to Committee (items the Committee is keeping an eye on)
Further feedback on the work being undertaken to resolve the waits within the paediatric service.
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.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors November 2017 - PUBLIC

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

CORPORATE OBJECTIVE:

SO1 – Deliver a great patient experience

SO2 – Safe and caring services

SO3 – Drive service improvements, innovation and transformation

SO4 – Be the place people chose to work

SO6 – Plan for a viable future

SUMMARY OF KEY ISSUES:

For the month of October (as at 24.10.17):

- As of this date the Trust has had 17 cases of post 48 hr C. difficile so far in 2017/18 and 1 case for this period. However we have identified during October a Period of Increased Incidence (PII) on C1.
- No post 48 hr MRSA bacteraemia cases since 27th September 2015
- There have been 4 MSSA bacteraemias identified in the Trust of which 1 is post 48 hr cases.
- There have been 17 E. coli bacteraemias identified in the Trust of which 2 are post 48 hr cases.
- There have been 4 Klebsiella bacteraemia cases of which 1 is post 48 hrs.
- There have been 2 Pseudomonas bacteraemia cases of which 1 is post 48 hrs.
- The Trust is registered as a laboratory user for the carbapenem resistant enterobacteriacae voluntary PHE reporting system. No cases have been reported.
- There was one confirmed case of norovirus on B2 on 19th October.

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

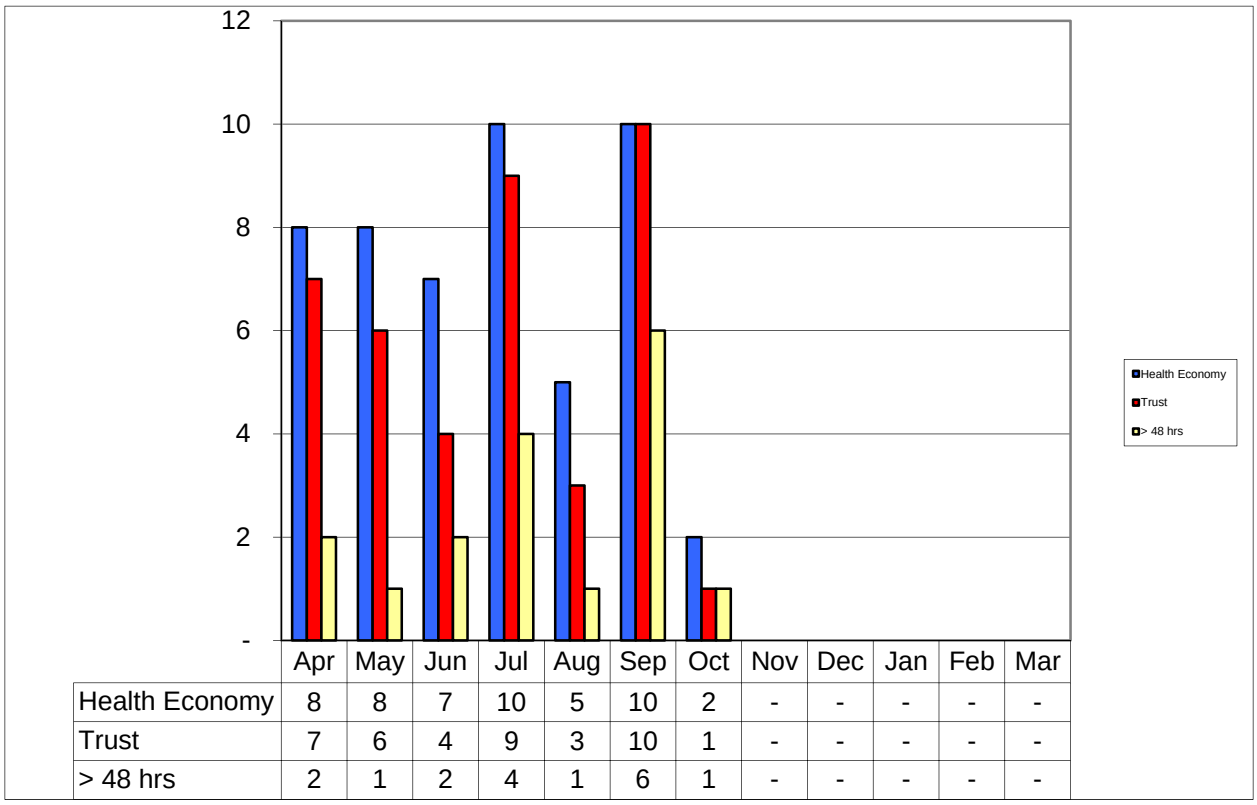
Decision	Approval	Discussion	Other
		√	

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

Summary:

Clostridium Difficile – The target for 2017/18 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. Penalties will be associated with exceeding 29 cases associated with lapses in care. At the time of writing (24.10.17) we have had 1 post 48 hour case recorded in October 2017.

C. DIFFICILE CASES 2017/18



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

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

For the financial period 2017/18 there has so far been 17 post 48 hour case identified since 1st April 2017. There is 1 case for October 2017 to date. Of the 17 cases 14 are lapses in care, of the remaining cases 1 is 'no lapse in case' and 2 are under review. Themes identified for the lapses in care include: failure by areas to meet their mandatory IC training targets, environmental scores, cleaning score below the required standard and failure to complete a stool chart on admission of the patient.

Following the RCA process issues identified are included in local plans for each individual case.

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

MSSA bacteraemia (Post 48 hrs) – 1 post 48 hr case for October to date.

MRSA screening – The Trust screens emergency admissions as well as appropriate elective surgical cases. The percentage of emergency admissions for September is 90% (last complete set of data available).

The percentage of elective admissions for September is 89%. Following work to identify patient groups who had not been screened a review of the MRSA Screening Policy to ensure clarity about the groups affected by this policy, is being undertaken.

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 2 post 48 hr cases for October to date. There is work with the CCG to enable all of the E. coli bacteraemias in the healthcare economy to be reviewed and the CCG are about to appoint a pharmacist to support this work after which a more detailed report will be available.

Klebsiella* and Pseudomonas* bacteraemias – 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 October there were 4 Trust identified Klebsiella bacteraemia cases of which 1 is post 48 hrs. 2 Pseudomonas bacteraemia cases for October to date, of which 1 is a post 48 hr case.

Norovirus – A case of norovirus was identified on ward B2 on the 19th October and further patients were affected with symptoms consistent with norovirus. The ward was closed to admissions and transfers to optimise patient care and reduce the risk of transmission to other parts of the hospital. The situation is improving with patients settling clinically and there have been no new cases within the last 24 hours.

Infection Control Mandatory Training – Percentage compliance as at 30.9.17 (target 90%)

Area	Total
Corporate/Management	90%
Medicine and Integrated Care	91%
Surgery	91%
Clinical Support	82%

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

Environment and Hand Hygiene – The revised Cleaning Policy will be presented to the Infection Prevention and Control Forum at the next meeting for initial approval. The Trust has also awarded the contract to one provider to deliver the hand decontamination and

hand care products required in the Trust. The implementation is due to commence on 30th October and will take 4 weeks to complete.

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 meeting of the forum is on 25th October 2017 – an update will follow.

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 6

The Dudley Group
NHS Foundation Trust

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

TITLE:	**a. Monthly Nurse/Midwife Staffing Position – November 2017 report containing September 2017 data b. Outcome of Safer Nursing Care Tool (SNCT) undertaken this financial year.**		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER**	Siobhan Jordan 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 based on the present establishments and having a significant reliance on temporary staff (bank and agency). 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 close to but less that 100 percent of the current establishment and there has been improvement in these figures from early in the year (January/February).

Under the guidance of the new Chief Nurse, the Trust has been undertaking a detailed, extensive staffing review of each of the wards and departments. To date all of the medical and surgical wards have been reviewed and the community and other specialised areas of the Trust e.g. out-patients are in the process of being reviewed. The completed review of the medical and surgical wards have taken into consideration the results of the Safer Nursing Care Tool (SNCT) that was undertaken earlier in the financial year. This paper contains the results of the SNCT tool (we are required to share them with the Board and publish them on the website) with a summary of the wider review that has been completed for both surgery and medical areas.

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 for September and the detail of the SNCT tool undertaken earlier in the financial year.

a) Monthly Nurse/Midwife Staffing Position

November 2017 Report containing September 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 is ongoing and a number of staff have already been recruited to the department.

The chart below shows that the percentage fill rates have generally 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%
September	96%	97%	98%	100%

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 (see over).

Table 2. Care Hours Per Patient Day (CHPPD) – Overall Trust and Regional/National 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
August	4.17	N/A	N/A	3.51	N/A	N/A	7.68	N/A	N/A
Sept.	4.67	N/A	N/A	3.86	N/A	N/A	8.52	N/A	N/A

N/A = Data not available

The latest published regional and national average figures are for May (as reported for the last two months). The Model Hospital site has had technical problems recently and access on 24th October shows that there has been no recent update. The available comparative figures indicate that the Trust is below these averages for qualified staff but higher for care support workers.

As part of the staffing review being undertaken the comparative data in the Model Hospital has been considered throughout.

The Trust has started to use this comparative data and this will continue and become more refined as time progresses. A visit from an NHSI specialist leading on safe staffing and this data is due to take place on November 1st.

Conclusion

This report demonstrates that we are achieving nearly 100% fill rate using the present establishments and a significant reliance on temporary staff (bank and agency). 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 Matrons and senior nurses from each area together with their managers using information on establishments, staffing ratios and vacancy, sickness and temporary staffing rates. It is considering the outcome of the most recent six monthly Safer Nursing Tool exercise (results below) and patient acuity. The outcome of the phases of the review (1. Surgery, 2. Neonates and Paediatrics, 2a. Critical Care, 3. Medicine, 3a. ED/EAU 4. Rest of the Hospital (e.g. OPD and Renal Unit) 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.

The whole review will be concluded and presented to the Board by January 2018.

APPENDIX 1

Safer Staffing Summary		Sep		Days in Month	30										
	Day RN	Day RN	Day CSW	Day CSW	Night RN	Night RN	Night CSW	Night CSW					Actual CHPPD		
	Day RM	Day RM	Day MSW	Day MSW	Night RM	Night RM	Night MSW	Night MSW		UnQual		UnQual	Sum		
Ward	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Qual Day	Day	Qual N	N	24:00 Occ	Registered	Care staff	Total
Evergreen																
A2	240	227	210	209	150	144	180	186	95%	100%	96%	103%	1,111	4.01	4.27	8.27
A3																
A4																
B1	119	116	60	60	64	64	61	60	97%	100%	100%	98%	584	3.59	2.47	6.05
B2(H)	124	112	231	213	93	91	201	199	90%	92%	98%	99%	852	2.79	5.80	8.58
B2(T)	92	88	144	140	62	61	113	112	96%	97%	98%	99%	608	2.87	4.96	7.83
B3	196	190	155	144	161	157	141	140	97%	93%	98%	99%	1,044	3.89	3.26	7.15
B4	180	174	226	209	150	144	170	164	97%	92%	96%	96%	1,338	2.79	3.34	6.13
B5	180	182	121	111	150	162	94	92	101%	92%	108%	98%	1,036	3.90	2.35	6.25
B6																
C1	169	165	306	280	132	132	208	206	97%	92%	100%	99%	1,402	2.54	4.16	6.70
C2	146	205	60	58	120	145	31	31	141%	97%	121%	100%	655	6.26	1.45	7.71
C3	180	172	362	359	151	149	373	370	95%	99%	99%	99%	1,504	2.56	5.81	8.37
C4	149	135	72	69	90	90	90	84	91%	96%	100%	93%	639	4.01	2.87	6.89
C5	180	167	240	261	150	124	177	198	93%	109%	83%	112%	1,415	2.40	3.89	6.29
C6	90	82	60	62	60	60	60	61	91%	103%	100%	102%	507	3.28	2.91	6.19
C7	180	170	134	127	120	117	136	136	94%	95%	98%	100%	1,059	3.09	2.92	6.01
C8	196	188	209	219	180	176	210	227	96%	105%	98%	108%	578	7.39	9.26	16.65
CCU_PCCU	210	165	40	40	150	148	-	-	78%	100%	99%		648	5.66	0.74	6.40
Critical Care	303	303	68	67	295	295	-	-	100%	99%	100%		285	24.65	2.59	27.24
EAU	180	170	150	141	150	148	150	141	94%	94%	99%	94%	703	5.31	4.81	10.12
Maternity	531	515	210	193	510	486	150	142	97%	92%	95%	95%	529	18.81	7.42	26.23
MHDU	120	109	39	35	120	110	8	7	91%	90%	92%	88%	241	10.68	2.00	12.68
NNU	184	175	-	-	179	170	-	-	95%		95%		429	9.24	0.00	9.24
TOTAL	**3,948**	**3,807**	**3,097**	**2,994**	**3,237**	**3,173**	**2,553**	**2,556**	**96%**	**97%**	**98%**	**100%**	**17,167**	**4.67**	**3.86**	**8.52**

b) Safer Nursing Care Tool (SNCT) undertaken this financial year

One of the recommendations of the national publications 'How to ensure the right people, with the right skills, are in the right place at the right time' and 'Hard Truths' is that Trusts undertake a review of their nurse staffing situation twice a year. The Trust has being doing this since 2014. April 2017, at the time of the last review using the SNCT, coincided with the appointment of the new Chief Nurse. It was recognised at the time the need for an extensive review of staffing levels to address both the quality of patient care and the significant reliance on a temporary workforce resulting in considerable financial impact. That extensive review is in progress with the Surgical Wards and the main Medical wards now completed. The reviews of community nursing and specialised areas of the Trust e.g. outpatients are now in process.

The Trust has an obligation to publish the results of a six monthly review and so the pages below show the results of the SNCT tool undertaken earlier in the year. The exercise requires ward staff to assess patient dependency (and place patients into 1 of 5 care groups) over a twenty day period (Monday to Friday over four weeks). As the descriptions of each category are open to interpretation, it does involve a professional judgement of which group every patient falls into. Therefore, there needs to be consistency of assessment.

As well as determining the level of acuity/dependency of all patients and calculating the nurse staffing required per ward based on the actual needs of those patients, the second element of the tool describes Nurse Sensitive Indicators (NSIs) such as care undertaken, patient feedback, complaints, pressure ulcers and falls. Monitoring NSIs is recommended to ensure that staffing levels deliver the patient outcomes that we aim to achieve. However, even with optimum staffing establishments poor patient outcomes may result due to other reasons such as high turnover, sickness, leave or unfilled vacancies.

It is recognised that the results of the SNCT need to be interpreted with caution as they do not take into consideration RN/patient ratios such as the national directives of having at least a 1:8 RN/patient ratio for day shifts and 1:10 nights shifts. The SNCT figures also do not take into account the workload associated with the numbers of admissions, discharges, transfers, escorts or deaths that occur on a ward and all of these activities take nursing time. Each ward is different in this respect with some wards having a fairly stable population of patients while others, particularly assessment type areas, having possibly more than one person in a bed space during a twenty four hour period. In addition, the SNCT tool is based purely on the patient types and numbers in the 20 day study periods which do not include weekends.

SNCT and Comparative Whole Time Establishments as at April 2017

Ward B1 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17
Patient Level	% of patients	% of patients	% of patients	% of patients
1	82	86	83	85
2	2	11	0	0
3	16	3	17	15
4	0	0	0	0
5	0	0	0	0
Beds	26	26	26	26
Av Pat	21.7	22.2	23.9	23.3

Required Staff April 17	SNCT	Establishment (WTE)
RNs required	15.5	18.35
HCAs required	10.3	10.96
Total FTE required	**25.8**	**29.31**

Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT				
	Aug 15	Feb 16	Oct 16	Apr 17
Patient Observations	94	98	93	96
Manual Handling	100	100	88	100
Falls Assessment	100	100	90	100
Tissue Viability Assessment	100	97	100	100
Nutritional Assessment	47	53	100	100
Medication Assessment	98	100	97	100
Nutrition (Total)	97	88	98	98
SL – Hand Hygiene	100	100	96	100
SL – Commode Audits	100	100	100	100
Incidents				
Minor Incidents	1	0	1	5
Moderate Incidents	0	0	0	0
Major/Tragic Incidents	0	0	0	0
Complaints	0	3	0	0

Commentary: Both the dependency and occupancy have increased over time. The increase in dependency can be accounted in part by more dependant outlier patients from ward B2 being placed on this ward to create capacity for T&O and general surgery. The SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges on a surgical ward.

Ward B2 Hip – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17
Patient Level	% of patients	% of patients	% of patients	% of patients
1	63	21	12	10
2	1	2	2	1
3	36	78	86	89
4	0	0	0	0
5	0	0	0	0
Beds	30	30	30	30
Av Pat	27.1	27.4	27.5	28.4

Required Staff April 17	SNCT	Establishment (WTE)
RNs required	28.2	20.32
HCAs required	18.8	30.14
Total FTE required	**46.9**	**50.46**

Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT				
	Aug 15	Feb 16	Oct 16	Apr 17
Patient Observations	94	98	100	97
Manual Handling	100	100	100	100
Falls Assessment	100	100	100	100
Tissue Viability Assessment	100	100	100	100
Nutritional Assessment	97	100	100	100
Medication Assessment	96	100	100	100
Nutrition (Total)	95	99	98	99
SL – Hand Hygiene	100	96	100	100
SL – Commode Audits	100	88	100	100
Incidents				
Minor Incidents	3	4	4	6
Moderate Incidents	0	0	0	0
Major/Tragic Incidents	0	0	0	0
Complaints	1	2	0	0

Commentary: The dependency of the patients on this ward has increased over time. This is likely due to the increasing number of patients with dementia that need require 1 to 1 care and 2-hourly intentional rounding as well as skin bundles, due to high risk of pressure damage. This contributes to the different actual skill mix requirement provided to this ward (as opposed to the SNCT calculation). The SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges on a surgical ward.

Ward B2 Trauma – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17	Required Staff	SNCT	Establishment (WTE)
Patient Level	% of patients	% of patients	% of patients	% of patients	RNs required	19.1	14.80
1	60	72	44	45	HCAs required	12.7	18.68
2	5	0	3	0	Total FTE required	**31.8**	**33.48**
3	35	28	53	55			
4	0	0	0	0			
5	0	0	0	0			
Beds	24	24	24	24			
Av Pat	19.8	21.6	22.6	22.7			

Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT				
	Aug 15	Feb 16	Oct 16	Apr 17
Patient Observations	98	100	90	97
Manual Handling	100	100	87	100
Falls Assessment	89	100	96	100
Tissue Viability Assessment	100	100	90	90
Nutritional Assessment	100	90	90	100
Medication Assessment	100	100	100	100
Nutrition (Total)	96	100	100	100
SL – Hand Hygiene	100	100	100	100
SL – Commode Audits	100	100	100	100
Minor Incidents	3	4	3	4
Moderate Incidents	0	0	0	0
Major/Tragic Incidents	0	0	0	0
Complaints	1	0	0	1

Commentary: Both occupancy and dependency have risen, the latter quite considerably, over time. The SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges on a surgical ward. Quality Indicators are good.

Ward B3 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17*
Patient Level	% of patients	% of patients	% of patients	% of patients
1	71	66	73	60
2	6	12	2	2
3	23	22	25	38
4	0	0	0	1
5	0	0	0	0
Beds	38+4HDU	38+4HDU	38 +4HDU	38 +4HDU
Av Pat	34.5	33.6	36.5	37.7
Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT				
	Aug 15	Feb 16	Oct 16	Apr 17
Patient Observations	99	97	100	96
Manual Handling	88	100	100	85
Falls Assessment	98	97	100	78
Tissue Viability Assessment	100	100	100	100
Nutritional Assessment	45	93	100	73
Medication Assessment	93	100	100	100
Nutrition (Total)	87	100	100	100
SL – Hand Hygiene	93	100	100	100
SL – Commode Audits	100	100	100	100
Incidents				
Minor Incidents	2	1	2	4
Moderate Incidents	1	1	0	0
Major/Tragic Incidents	0	0	2	0
Complaints	0	0	0	1

Required Staff	**SNCT**	**Establishment (WTE)**
RNs required	36.3	31.66
HCAs required	24.2	19.34
Total FTE required	**60.6**	**51.00**

Commentary: Both dependency and occupancy has increased over time, with the former due to an increase in HDU activity. With regards to the establishment, as noted previously, there is a large difference between the SNCT calculation and the actual establishment. B3 contains the VASCU unit which has a variable workload which contributes to this difference as does the fact that, as previously stated, the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges of a surgical ward.

Ward B4 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17	**Required Staff**	**SNCT**	**Establishment (WTE)**
Patient Level	% of patients	% of patients	% of patients	% of patients	RNs required	30.3	31.66
1	85	81	80	86	HCAs required	20.2	27.40
2	10	9	1	1	Total FTE required	**50.5**	**59.06**
3	4	9	19	13			
4	0	0	0	0			
5	0	0	0	0			
Beds	48	48	48	48			
Av Pat	46.8	46.9	46.8	46.1			
Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT							
	Aug 15	Feb 16	Oct 16	Apr 17			
Patient Observations	99	93	98	98			
Manual Handling	100	100	100	100			
Falls Assessment	100	100	100	100			
Tissue Viability Assessment	100	83	100	100			
Nutritional Assessment	96	38	95	100			
Medication Assessment	100	100	100	100			
Nutrition (Total)	100	100	100	96			
SL – Hand Hygiene	100	98	100	100			
SL – Commode Audits	100	100	100	100			
Incidents							
Minor Incidents	4	2	6	7			
Moderate Incidents	0	0	0	0			
Major/Tragic Incidents	1	0	0	0			
Complaints	1	2	2	1			

Commentary: Dependency and occupancy have reduced slightly at the last review. NSI results have improved. The SNCT study suggests a smaller FTE than the establishment, which is probably accounted for by the fact, as previously stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges of a surgical ward.

Ward B5 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17*
Patient Level	% of patients	% of patients	% of patients	% of patients
1	95	95	89	86
2	3	1	2	1
3	2	4	9	13
4	0	0	0	0
5	0	0	0	0
Av Pat	33.3	33.2	37.1	46.1

Required Staff	**SNCT**	**Establishment (WTE)**
RNs required	38.5	31.27
HCAs required	25.7	16.44
Total FTE required	**64.2**	**47.71**

Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT				
	Aug 15	Feb 16	Oct 16	Apr 17
Patient Observations	91	97	97	97
Manual Handling	100	75	94	100
Falls Assessment	100	53	90	100
Tissue Viability Assessment	90	100	95	100
Nutritional Assessment	97	43	37	100
Medication Assessment	100	98	100	100
Nutrition (Total)	100	100	100	92
SL – Hand Hygiene	100	100	100	100
SL – Commode Audits	100	100	100	100
Incidents				
Minor Incidents	1	0	1	1
Moderate Incidents	0	0	1	0
Major/Tragic Incidents	0	0	0	0
Complaints	0	1	2	1

Commentary: With an increase in activity over the last two years both occupancy and dependency have increased. This area as well as the in-patient numbers also has SAU which accounts in the difference between the SNCT tool results and the present establishment. NSIs have improved in April 2017.

Ward C6 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17	Required Staff	SNCT	Establishment (WTE)
Patient Level	% of patients	% of patients	% of patients	% of patients	RNs required	13.8	16.38
1	84	76	87	70	HCAs required	9.2	10.96
2	2	2	1	2	Total FTE required	**23.0**	**27.34**
3	13	22	12	28			
4	0	0	0	0			
5	0	0	0	0			
Beds	20	20	20	20			
Av Pat	16.9	17.5	18.7	19			
Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT							
	Aug 15	Feb 16	Oct 16	Apr 17			
Patient Observations	99	81	87	96			
Manual Handling	100	70	100	100			
Falls Assessment	100	86	84	91			
Tissue Viability Assessment	100	88	88	82			
Nutritional Assessment	100	87	89	83			
Medication Assessment	100	100	93	78			
Nutrition (Total)	100	100	90	100			
SL – Hand Hygiene	100	100	92	100			
SL – Commode Audits	100	100	100	100			
Incidents							
Minor Incidents	1	1	0	1			
Moderate Incidents	1	0	0	0			
Major/Tragic Incidents	0	0	0	0			
Complaints	0	0	0	0			

Commentary: Dependency has increased as have the patient numbers. Occupancy is at its highest since these studies began. The establishment has a slightly higher FTE than the SNCT results which is probably accounted for by the fact that, as previously stated, the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges on a surgical ward plus outpatient clinic work that occurs on the ward. NCIs have taken a considerably decrease in results recently and the ward is at Escalation Level 3 with an action plan in place. A contributing factor to the latter is the ward losing very experienced staff recently to work in other areas of the Trust.

WARD A2 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17	Required Staff	SNCT	Establishment (WTE)
Patient Level	% of patients	% of patients	% of patients	% of patients	RNs required	33.3	38.64^/36.89*
1	76	75	63	86	HCAs required	22.2	38.41^/35.67*
2	3	1	0	3	Total FTE required	**55.5**	**77.05^/72.56***
3	21	24	36	11			
4	0	0	0	0			
5	0	0	0	0			
Beds	42	42	42	42			
Av Pat	36.6	40.1	39	40.1			
	Aug 15	Feb 16	Oct 16	Apr 17			
Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT							
Patient Observations	96	88	91	95			
Manual Handling	100	100	100	100			
Falls Assessment	100	70	96	100			
Tissue Viability Assessment	100	90	92	92			
Nutritional Assessment	90	100	86	38			
Medication Assessment	100	98	95	100			
Nutrition (Total)	98	99	96	87			
SL – Hand Hygiene	100	100	95				
SL – Commode Audits	100	100	100				
Friends and Family Test Score	99	97	85	84.6			
Incidents							
Minor Incidents	10	5	8	6			
Moderate Incidents	0	2	1	0			
Major/Tragic Incidents	0	1	0	0			
Complaints	1	1	0	2			

^Figures are for March and Oct 2015 as the patient speciality of the ward changed after September 2014.
*Present establishment following a review after October 2015

Commentary: The Acute Medical Society indicates that such an area requires 1:6 qualified nurse to patient ratio. The high turnover area means there can be more that 30 transfers of patients a day while the SNCT study only looks at the situation at one time-point in the day. The usefulness of the tool in such circumstances is therefore questionable (just like it is not suitable for the Emergency Department). The dependency of patients has decreased since October 17 but the chart indicates the variability in the types of patients the area accommodates. NSI results have also been variable.

WARD C1 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17	Required Staff	SNCT	Establishment (WTE)
Patient Level	% of patients	% of patients	% of patients	% of patients	RNs required	37.6	31.36
1	56	51	50	57	HCAs required	25.1	32.93
2	3	4	0	1	Total FTE required	**62.7**	**64.29**
3	45	50	42	48			
4	0	0	0	1			
5	0	0	0	2			
Beds	48	48	48	48			
Av Pat	47.7	47.7	47.8	47.8			
Nursing Care Indicators (NCIs), Nutrition Audit, Saving Lives and FFT							
	Aug 15	Feb 16	Oct 16	Apr 17			
Patient Observations	93	97	96	92			
Manual Handling	76	100	94	89			
Falls Assessment	100	100	100	100			
Tissue Viability Assessment	100	100	100	100			
Nutritional Assessment	93	39	83	56			
Medication Assessment	100	98	100	100			
Nutrition (Total)	93	97	95	99			
SL – Hand Hygiene	97	97	100	100			
SL – Commode Audits	100	100	100	100			
Friends and Family Test Score	96	100	100	100			
Incidents							
Minor Incidents	6	3	6	4			
Moderate Incidents	0	0	0	0			
Major/Tragic Incidents	1	0	0	0			
Complaints	0	0	0	0			

Commentary: Occupancy remains constant at nearly 100%. The ward has had some very highly dependent patients at the last review. NCIs have deteriorated slightly in April 2017 compared to previously, but have improved again since then in the last few months.

WARD C3 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17	Required Staff	SNCT	Establishment (WTE)
Patient Level	% of patients	% of patients	% of patients	% of patients	RNs required	49.9	34.91
1	24	24	20	15	HCAs required	33.3	38.41
2	2	1	5	1	Total FTE required	**83.2**	**73.32**
3	74	75	75	84			
4	0	0	0	0			
5	0	0	0	0			
Beds	52	52	52	52			
Av Pat	51.5	52	50.3	51.3			
	Aug 15	Feb 16	Oct 16	Apr 17			
Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT							
Patient Observations	99	93	92	94			
Manual Handling	100	100	82	94			
Falls Assessment	100	100	84	87			
Tissue Viability Assessment	100	100	100	100			
Nutritional Assessment	100	73	62	88			
Medication Assessment	100	96	100	100			
Nutrition (Total)	100	98	95	100			
SL – Hand Hygiene	100	100	100				
SL – Commode Audits	100	100	80				
Friends and Family Test Score	100	100	100	100			
Incidents							
Minor Incidents	11	8	9	6			
Moderate Incidents	1	1	0	0			
Major/Tragic Incidents	0	0	0	0			
Complaints	0	1	0	1			

Commentary: The dependency of the patients has increased slightly compared to the previous reviews and occupancy remains high. The last three SNCT studies suggest there should be higher establishments on this ward but both the well-being workers, the acute confusion team and 1 to 1 additional staff give considerable assistance to this ward, which can balance out this difference. NCIs are very variable becoming worse in October 2016 and April 2017.

WARD C5 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 16	Required Staff	SNCT	Establishment (WTE)
Patient Level	% of patients	% of patients	% of patients	% of patients	RNs required	35.1	31.59
1	62	60	48	62	HCAs required	23.4	32.92
2	5	3	19	10	Total FTE required	**58.4**	**64.51**
3	26	33	31	23			
4	7	3	2	5			
5	0	0	0	0			
Beds	48	48	48	48			
Av Pat	47.9	47.9	47.5	46.5			

Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT				
	Aug 15	Feb 16	Oct 16	Apr 17
Patient Observations	98	97	87	96
Manual Handling	100	83	94	85
Falls Assessment	100	100	100	96
Tissue Viability Assessment	100	80	87	100
Nutritional Assessment	100	98	83	80
Medication Assessment	100	100	94	96
Nutrition (Total)	98	99	90	99
SL – Hand Hygiene	96	100	100	100
SL – Commode Audits	93	100	100	100
Friends and Family Test Score	100	93	100	100
Incidents				
Minor Incidents	3	8	8	6
Moderate Incidents	1	1	0	0
Major/Tragic Incidents	0	0	1	0
Complaints	1	0	1	0

Commentary: Occupancy remains high and dependency has fluctuated compared to the last studies. The number of NIV (non-invasive ventilation) and high flow oxygen patients account for the Category 4 patients. NCIs have generally improved since the previous study period.

WARD C7 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17	Required Staff	SNCT	Establishment (WTE)
Patient Level	% of patients	% of patients	% of patients	% of patients	RNs required	26.2	26.86/29.6*
1	61	52	62	62	HCAs required	17.5	21.92/21.94*
2	2	4	1	3	Total FTE required	**43.7**	**48.78/51.54***
3	37	44	37	35			
4	0	0	0	0			
5	0	0	0	0			
Beds	36	36	36	36			
Av Pat	36	35.9	35.8	34.6			

Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT				
	Aug 15	Feb 16	Oct 16	Apr 17
Patient Observations	78	76	89	97
Manual Handling	100	66	87	100
Falls Assessment	70	74	100	100
Tissue Viability Assessment	96	90	100	100
Nutritional Assessment	94	85	85	100
Medication Assessment	100	100	86	100
Nutrition (Total)	95	93	97	96
SL – Hand Hygiene	100	100	100	100
SL – Commode Audits	100	94	100	100
Friends and Family Test Score	92	100	100	88.2
Incidents				
Minor Incidents	5	6	10	3
Moderate Incidents	1	0	0	0
Major/Tragic Incidents	0	0	1	0
Complaints	0	2	2	0

*Following a review the skill mix on this ward was amended in early 2016.

Commentary: Occupancy remains high and dependency is similar to the last study. This period sees an improvement in the NSIs. Incident reports have decreased.

WARD C8 – QUALITY INDICATORS AND RESULTS OF SAFER NURSING TOOL

	Oct 15	Mar 16	Oct 16	Apr 17	Required Staff	SNCT	Establishment (WTE)
Patient Level	% of patients	% of patients	% of patients	% of patients	RNs required	39.2	37.79
1	23	13	27	23	HCAs required	26.1	38.41
2	26	22	5	4	Total FTE required	65.3	**76.2**
3	51	64	68	71			
4	0	0	0	1			
5	0	0	0	0			
Beds	44	44	44	44			
Av Pat	39	42.3	40.4	40.4			

Nursing Care Indicators, Nutrition Audit, Saving Lives and FFT				
	Aug 15	Feb 16	Oct 16	Apr 17
Patient Observations	94	66	78	89
Manual Handling	100	66	100	100
Falls Assessment	100	60	97	80
Tissue Viability Assessment	100	86	100	93
Nutritional Assessment	83	33	74	90
Medication Assessment	100	89	92	90
Nutrition (Total)	98	95	91	95
SL – Hand Hygiene	100	100	100	100
SL – Commode Audits	95	100	100	100
Friends and Family Test Score	97	100	88.8	100
Incidents				
Minor Incidents	13	8	6	2
Moderate Incidents	0	1	0	0
Major/Tragic Incidents	1	0	0	0
Complaints	2	2	0	1

Commentary: Occupancy has decreased slightly at the last two reviews with dependency being variable. Although there is a difference between the SNCT results and the establishment this is balanced out by the presence of the stroke bleep holder in the establishment (accounts for 5.45WTE). The NCIs have improved since April 2017.

Enclosure 8

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 2 November 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 26 October 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	**26 October 2017**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- A briefing on the current financial issues regarding the MCP procurement process was given – and a debate undertaken about the extent to which the challenging 18th December 2017 timetable for submission of a business case is possible
- The current performance on the major KPIs and the remedial steps being taken to improve them
- The Income and Expenditure position at Month 6 (September 2017) which showed that the Sustainability and Transformation Fund (STF) allocation of £3m would be earned from a financial perspective subject to an appeal on the performance element. This was finally achieved by bringing forward of £3.6m of contract income, in agreement with Dudley CCG, to better match income and expenditure plans.
- The updated position on registered nurse recruitment (both graduates and recruitment days) was presented which showed that 71.79 WTE qualified nurses are due to start working for the Trust in 2017-18 and another 8.72 WTE in 2018-19.
- Work is about to commence by the Operational Medical Director to reduce the requirement for agency medical staff

Decisions Made / Items Approved

- The revised forecast out-turn position for 2017-18 to be recommended to the Board to adopt
- The MHDU business case was approved and recommended for approval to the Board

Actions to come back to Committee

- The Back Office proposal to be worked up further in respect of risks and relative positions and be presented back to the November 2017 meeting
- The profile of anticipated savings in agency spending derived from the recruitment of 71.79 WTE registered nurses by month and division to be reported back to

Performance Issues to be referred into Executive Performance Management Process

- None

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

- None

Items referred to the Board for decision or action

- Recommendations regarding the proposed change to Forecast Out-turn financial position for 2017-18
- The current contractual position on the PFI contract to be discussed in private with the Board for reasons of commercial confidentiality

Enclosure 9

The Dudley Group NHS Foundation Trust

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

TITLE:	Integrated Performance Report for Month 06 (Sept) 2017/18		
AUTHOR:	Andy Troth Head of Informatics	**PRESENTER:**	Michael Woods Interim Chief Operating Officer

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

September performance off track at 87.73% for combined Type 1 and Type 3, which is slightly up on August's position of 87.16%.
Activity for September is up on August (Attendances by 5%, Ambulance conveyances 2%, Majors 5% & Minors 6%)

The operational team have agreed 5 key priorities for focus over the next two months

1. Development of Community response team at Front door
2. Full implementation of a sustainable Red2Green process
3. Review of escalation procedures and Capacity team function
4. Focussed effort in reducing delays / DTOC by improving discharge processes
5. Review of surgical pathways

In addition we will produce robust governance to ensure that the pending urgent care estate and clinical models are robustly implemented.

Activity analysis is showing that there has been an increase against the previous month and comparative month in 2016.

Cancer (provisional)

The provisional performance figure as at 26th October suggests delivery of the 2ww & 62 day targets for September:

- Cancer 62 day wait is 91.2%
- 2WW is 94.1%

Quarter 2 currently stands at 62 day (85.9%%) & 2WW (92.5%), which means that will not deliver the quarter due to the 2WW

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. A comparison of performance by tumour site is included in the backing pages of the report.

The predictive position for October currently indicates that the trust will achieve in October.

Referral to Treatment (18 week)
The incomplete pathway was achieved in month with a performance of 94.01% against a target of 92%, although performance in two specialities fell below the expected.

Urology(90.56%) – slightly down from last month
Ophthalmology (82.3%) – down from last month

The non-admitted measure of 95% was not achieved based on a provisional figure of 92.86%. The admitted measure was below its target of 90% at a provisional figure of 88.62%.

DM01 Diagnostic Performance
Despite improving on the August position, the performance for September was not achieved with a performance of 98.34% against a national target of 99%.

The internal improvement trajectory has not been achieved in month (original trajectory was 98.4%). The plan of delivering 99% for the end of October is also off track.
Two main areas of breach relate to specialist capacity in:

- Paediatric GA MRI
- Muscular-skeletal USS

The division is producing a recovery plan.

Mixed sex accommodation
There were 6 MSA breaches in month relating to ITU and capacity to move patients out, and MHDU.

Never Events
There were 0 never events recorded in month.

Finance
The Trust recorded a cumulative surplus of £1.188m (before STP) in September 2017 which was £0.032m better than plan. This position was achieved by bringing forward contract income into the first half of the year £3.6m in agreement with Dudley CCG, to better match income and expenditure profiles.

The Trusts Forecast out-turn target of £2.5m continues to be a challenge and a number of additional savings schemes are being considered by Finance and Performance Committee to see how far the current financial performance can be alleviated

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.

Performance - Key Performance Indicators

	Target	Sep-17	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)					
All Cancer 2 week waits	93%	94.1%	94.5%	↑	
2 week wait - Breast Symptomatic	93%	97.3%	98.1%	↑	
31 day diagnostic to 1st treatment	96%	99.3%	98.4%	↑	
31 day subsequent treatment - Surgery	94%	100.0%	98.5%	↑	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	↔	
62 day urgent GP referral to treatment	85%	90.3%	82.9%	↑	
62 day screening programme	90%	100.0%	97.1%	↑	
62 day consultant upgrades	85%	91.2%	92.8%	↑	
Referral to Treatment					
RTT Incomplete Pathways - % still waiting	92%	94.0%	94.4%	↓	
RTT Admitted - % treatment within 18 weeks	90%	88.6%	88.9%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	92.9%	93.2%	↑	
Wait from referral to 1st OPD	26	30	175	↔	
Wait from Add to Waiting List to Removal	39	41	251	↔	
ASI List		2095	0	↓	
% Missing Outcomes RTT		0.0%	0.2%	↓	
% Missing Outcomes Non-RTT		6.2%	3.3%	↑	
DM01					
No. of diagnostic tests waiting over 6 weeks	0	106	1368	↓	
% of diagnostic tests waiting less than 6 weeks	99%	98.3%	96.8%	↑	
ED - TRUST					
Patients treated < 4 hours Type 1 (Trust ED)	95%	81.5%	84.4%	↑	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	87.7%	90.3%	↑	
Emergency Department Attendances	N/A	8563	52260	↑	
12 Hours Trolley Waits	0	0	0	↔	
Ambulance to ED Handover Time - TRUST					
30-59 minute breaches		294	1525	↑	
60+ minute breaches		25	225	↓	
Cancelled Operations - TRUST					
% Cancelled Operations	1.0%	1.0%	1.1%	↓	
Cancelled operations - breaches of 28 day rule	0	1	6	↔	
Urgent operations - cancelled twice	0	0	0	↔	

Performance - Key Performance Indicators cont.

	Target	Sep-17	Actual YTD	Trend	Month Status
GP Discharge Letters					
GP Discharge Letters	90%	79.3%	77.4%	↑	
Theatre Utilisation - TRUST					
Theatre Utilisation - Day Case (RHH & Corbett)		76.5%	76.8%	↑	
Theatre Utilisation - Main		83.6%	86.4%	↓	
Theatre Utilisation - Trauma		92.3%	91.5%	↑	
GP Referrals (1 month in arrears)					
GP Written Referrals - made		6550	33043	↓	
GP Written Referrals - seen		5630	26986	↑	
Other Referrals - Made		2757	13545	↓	
Throughput					
Patients Discharged with a LoS >= 7 Days		7%	6%		
Patients Discharged with a LoS >= 14 Days		3%	3%		
7 Day Readmissions		3%	3%		
30 Day Readmissions - PbR		7%	7%		
Bed Occupancy - %		89%	90%		
Bed Occupancy - % Medicine & IC		95%	94%		
Bed Occupancy - % Surgery, W&C		84%	88%		
Bed Occupancy - Paediatric %		51%	57%		
Bed Occupancy - Orthopaedic Elective %		76%	80%		
Bed Occupancy - Trauma and Hip # %		94%	94%		
Number of Patient Moves between 8pm and 8am		104	575		
Discharged by Midday		15%	16%		
DNA Rates					
New outpatient appointment DNA rate	8%	7.0%	7.5%	↓	
Follow-up outpatient appointment DNA rate	8%	7.9%	7.9%	↑	
Total outpatient appointment DNA rate	8%	7.5%	8.4%	↑	
Average Length of stay (Quality Strategy Goal 3)					
Average Length of Stay - Elective	0.0	2.6	2.7	↑	
Average Length of Stay - Non-Elective	3.4	3.3	3.3	↓	

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Sep-17	Actual YTD	Trend	Month Status
Friends & Family Test - Footfall						
Friends & Family Test - ED	14.5%	21.3%	19.7%	16.2%	↑	
Friends & Family Test - Inpatients	26.0%	35.1%	27.8%	31.2%	↓	
Friends & Family Test - Maternity	21.7%	34.4%	39.6%	44.5%	↓	
Friends & Family Test - Outpatients	4.7%	14.5%	3.0%	2.7%	↓	
Friends & Family Test - Community	3.5%	9.1%	2.0%	2.2%	↓	
Friends & Family Test - Recommended						
Friends & Family Test - ED	89.9%	93.4%	75.9%	76.0%	↑	
Friends & Family Test - Inpatients	96.3%	97.4%	96.0%	96.2%	↓	
Friends & Family Test - Maternity	96.0%	98.1%	97.9%	97.6%	↑	
Friends & Family Test - Outpatients	94.6%	97.2%	92.3%	93.7%	↓	
Friends & Family Test - Community	96.4%	97.7%	97.1%	97.4%	↓	
Complaints						
Total no. of complaints		N/A	33	181	↓	
Complaints closed within target	90%	90%	100.0%	93.4%	↔	
Complaints re-opened			0	2	↔	
PALs Numbers			228	0	↓	
Ombudsman						
Dementia (1 month in arrears)						
Find/Assess		90%		97.4%	↑	
Investigate		90%		100.0%	↑	
Refer		90%		97.6%	↑	
Falls						
No. of Falls		0	71	502	↓	
No. of Multiple Falls		N/A	8	59	↑	
Falls resulting in moderate harm or above		10	1	8	↑	
Pressure Ulcers (Grades 3 & 4)						
Hospital Avoidable		0	3	12	↑	
Hospital Non-avoidable		0	2	6	↔	
Community Avoidable		0	6	19	↑	
Community Non-avoidable		0	8	15	↑	
Mixed Sex Accommodation Breaches						
Single Sex Breaches		0	6	16	↑	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Sep-17	Actual YTD	Trend	Month Status
Mortality (Quality Strategy Goal 3)						
HSMR Rolling 12 months (**Latest data March 17**)			0		↔	
SHMI Rolling 12 months (**Latest data December 16**)			0		↔	
HSMR Year to date (**Latest data March 17**)			0		↔	
Infections						
Cumulative C-Diff due to lapses in care		15	9	N/A		
MRSA Bacteraemia		0	0	0	↔	
MSSA Bacteraemia		0	0	5	↔	
E. Coli - Total hospital		0	1	21	↓	
Stroke Admissions - PROVISIONAL						
Stroke Admissions: Swallowing Screen		75%	92.7%	80.2%	↑	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	90.7%	94.7%	↓	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	93.8%	93.5%	↓	
VTE - PROVISIONAL						
VTE On Admission		95%	94.3%	93.5%	↓	
Incidents						
Total Incidents			1503	4194	↑	
Recorded Medication Incidents			287	1776	↑	
Never Events			0	1	↔	
Serious Incidents			26	159	↑	
of which, pressure ulcers			5	63	↓	
Incident Grading by Degree of Harm						
Death			1	4	↔	
Severe			2	12	↑	
Moderate			9	52	↓	
Low			204	1132	↔	
No Harm			981	6879	↓	
Percentage of incidents causing harm		28%	18.0%	14.9%	↑	
NQA Think Glucose						
NQA Think Glucose - EAU/SAU						
NQA Think Glucose - General Wards						

Performance - Financial Overview

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	581	493	-15.15%	-88	3,302	2,946	-10.78%	-356
Day Cases	4,186	4,259	1.74%	73	23,785	24,625	3.53%	840
Non-elective inpatients	5,237	4,923	-6.00%	-314	30,915	30,093	-2.66%	-822
Outpatients	39,903	37,728	-5.45%	-2,175	226,720	215,887	-4.78%	-10,833
A&E	8,610	8,115	-5.75%	-495	51,073	52,260	2.32%	1,187
Total activity	**58,517**	**55,518**	**-5.13%**	**-2,999**	**335,795**	**325,811**	**-2.97%**	**-9,984**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	128	122	-4.68%	-6	559	536	-4.08%	-23
Pay	590	-136	-123.04%	-726	2,433	2,905	19.36%	471
Non-Pay	366	685	87.14%	319	1,618	2,192	35.43%	573
Total CIP	**1,084**	**671**	**-38.13%**	**-413**	**4,611**	**5,633**	**22.16%**	**1,022**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	27,620	27,013	-2.20%	-607	163,295	161,624	-1.02%	-1,672
Other Clinical	130	-97	-174.68%	-227	779	621	-20.39%	-159
STF Funding	572	572	0.00%	0	3,001	3,001	0.00%	0
Other	1,418	5,157	263.62%	3,739	11,092	14,532	31.02%	3,441
Total income	**29,740**	**32,644**	**9.77%**	**2,904**	**178,167**	**179,778**	**0.90%**	**1,610**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-17,239	-17,653	2.40%	-414	-103,233	-105,141	1.85%	-1,908
Drugs	-609	-710	16.47%	-100	-3,562	-3,884	9.04%	-322
Non-Pay	-6,669	-6,912	3.65%	-243	-40,820	-40,697	-0.30%	123
Pass-through	**-2,521**	**-2,415**	**-4.19%**	**106**	**-15,006**	**-14,789**	**-1.45%**	**217**
Total Costs	**-27,038**	**-27,690**	**2.41%**	**-653**	**-162,620**	**-164,510**	**1.16%**	**-1,890**

Performance - Financial Overview - TRUST LEVEL ONLY

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
	£'000	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
EBITDA	**2,694**	**4,972**	**84.54%**	**2,278**	**15,503**	**15,374**	**-0.83%**	**-129**
Depreciation	-777	-762.1	-1.92%	15	-4661	-4464.77	-4.21%	196
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1112	-1002	-9.86%	110	-6729	-6634.31	-1.41%	95
SURPLUS/(DEFICIT)	**805**	**3,207**	**298.41%**	**2,402**	**4,113**	**4,275**	**3.94%**	**162**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	1,491	800	-46.34%	0	9,267	5,955	-35.74%	-3,312
Inventory					2,788	2,952	5.88%	164
Receivables & Prepayments					18,149	25,857	42.47%	7,708
Payables					-16,384	-19,932	21.66%	-3,548
Accruals							n/a	0
Deferred Income					-3,370	-1,630	-51.63%	1,740
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					16,278	16,074	-1.25%	0
Loan Funding							n/a	0
KPIs								
EBITDA %	9.06%	16.72%	7.66%		8.70%	8.55%	-0.15%	-0.15%
Deficit %	2.71%	10.78%	8.08%		2.31%	2.38%	0.07%	0.07%
Receivable Days					0.0	0.0	n/a	0.0
Payable (excluding accruals) Days					0.0	0.0	n/a	0.0
Payable (including accruals) Days					0.0	0.0	n/a	0
Use of Resource metric					1	3		

Enclosure 10

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board Committee on 2nd November 2017

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

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

SUMMARY OF KEY ISSUES:

The Trust has 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. 4% of the CIP has currently been identified as non recurrent savings.

Based on the Month 6 position, the Trust has achieved £5.6m against the year to date (YTD) plan of £4.6m. However, the full year effect variance is forecast by to under-deliver by £1.4m (i.e. delivery of £11.0m against a target of £12.5m). .

Transformation Executive Committee (TEC) met on 19th October 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

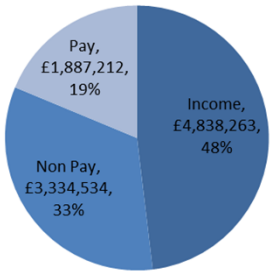
Summary Report

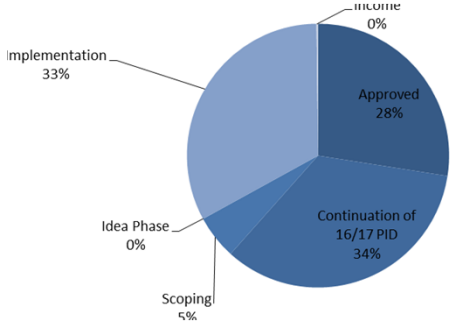
2nd November 2017

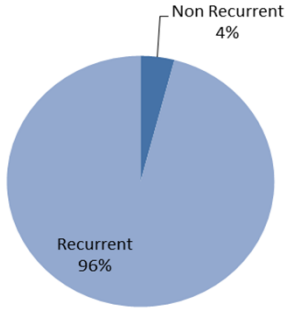
Executive Summary – 2017/18

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 4% of the CIP has currently been identified as non recurrent savings.
A summary of CIP performance as at Month 6 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	£4,609,121	£5,632,085	£1,022,964	£11,092,927	-£1,407,073







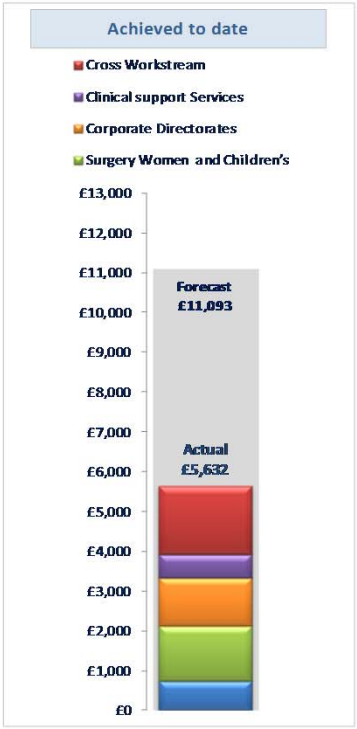
Based on the Month 6 position, the Trust has identified schemes totalling **£12.6m** against a Full Year (FY) target of **£12.5m.**
As at Month 6 the Trust is forecasting to deliver **£11.09m.**

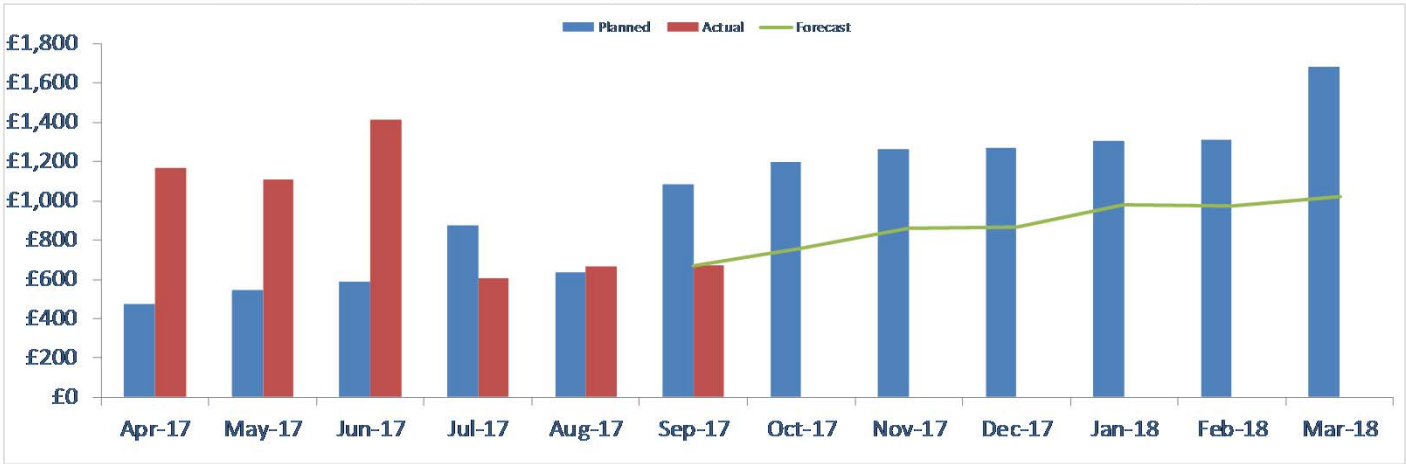
For the 17/18 programme of work, 32 Quality Impact Assessments (QIAs) have now been approved by the panel, 1 QIA remains in Amber (Phase 2 of Cardiology redesign) and 20 QIAs have been deemed not applicable. QIAs for pipeline schemes continue to be worked up.

Executive Summary – 2017/18

	YTD	FYE			Submitted Plan	
Planned	£4,609,121			Identified	£12,638,758	
Actual	£5,632,085			Target	£12,500,000	
Forecast		£11,092,927				
Variance	£1,022,964	-£1,407,073			£138,758	

Programme (Click for details)	YTD Plan	YTD Actual	YTD Variance	FYE Plan	FYE Forecast	FYE Variance
Surgery Women and Children's	£1,616,312	£1,382,015	-£234,297	£3,232,624	£3,245,571	£12,947
Medicine and Integrated Care	£619,370	£750,174	£130,804	£1,457,627	£1,461,052	£3,425
Clinical support Services	£459,989	£589,324	£129,335	£998,746	£1,281,128	£282,382
Corporate Directorates	£945,084	£1,195,953	£250,869	£2,028,556	£2,212,414	£183,858
Cross Workstream	£968,367	£1,714,621	£746,254	£4,921,205	£2,892,763	-£2,028,442
View all Projects	£4,609,121	£5,632,085	£1,022,964	£12,638,758	£11,092,927	-£1,545,831





2017/18 Forecast Non Recurrent	£410,041
% of Total CIP Forecast as Non Recurrent	3%

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 2nd November

TITLE:	**Black Country Pathology Service (BCPS)**		
AUTHOR:	**LTS on behalf of the Black Country Pathology Service**	**PRESENTER**	**Diane Wake Chief Executive Officer**

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:

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

The attached paper provides a update on the progress being made with the Black Country Pathology Services project.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** The risk log is being managed within the Clinical Support Division
	Risk Register: Y		**Risk Score:** Various within project risk log
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Links to the two domains of responsive and well led.
	NHSI	**Y**	**Details:** This supports the NHS I Pathology Network letter 7th September
	Other	**N**	**Details:**

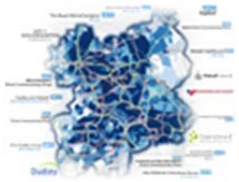
ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD:

- To note the progress being made in respect of this project.

NHS
The Dudley Group
NHS Foundation Trust



Walsall Healthcare NHS
NHS Trust

NHS
The Royal Wolverhampton
NHS Trust

Sandwell and West Birmingham Hospitals NHS
NHS Trust

In August the four Black Country Trust boards; The Royal Wolverhampton Trust, Sandwell and West Birmingham Hospitals NHS Trust, The Dudley Group Foundation Trust and Walsall Healthcare Trust, reviewed the Outline Business Case to form a Black Country Pathology Service (BCPS) and agreed to progress the development of a single pathology service with ownership shared across the four Trusts. The service model has a single large hub, supported by three Essential Service Laboratories, (ESLs) on the other acute hospital sites.

The proposal includes the Hub at New Cross Hospital with Essential Service Laboratories at Russells Hall, Walsall Manor and Midland Metropolitan Hospital and is planned to be operational by the end of 2018 to fit with the opening of the new Midland Metropolitan Hospital

The feedback from the boards highlighted the need to carry out detailed due diligence in a number of areas to provide assurance that key risks were being managed and that costs were accurate.

The requirements from the boards were:

1. Detailed analysis of staffing profiles in the Target Operational Model to reduce the risk to the delivery of the service;
2. Detailed analysis on IT and logistics costs to understand the extent of the investment required, IT infrastructure requirements, logistics routes, logistics costs and ability to improve quality and Turn Around Times;
3. Detailed analysis of capital investment required for the extension of the Hub and refurbishment of the Essential Service Laboratories;
4. Assessment on implementation timeline and key milestones for the construction and critical path to meet the needs.
5. Evaluation of key clinical and operational risks to ensure that these are addressed.

While this detailed work was being carried out in these areas, in early September 2017, all Chief Executives and Medical Directors in England received a letter from NHS Improvement. This highlighted the need to consolidate their pathology services into networks and through collaboration.

Their work outlined the identification of 29 potential pathology networks to be run as Hub and Spoke models, working with NHS Improvement to ensure an implementation of the proposed plans over the next three years. **The current proposals for a Black Country Pathology service fits with the direction set out by NHS Improvement.**

At the October meeting of the joint Black Country Pathology Service Oversight Group, a progress report was received. Extensive further work and testing of assumptions has been undertaken in conjunction with staff in each discipline of pathology. The Target Operating Model, Logistics, Estates and IT solutions have now been mostly agreed by the Oversight Group.

The full business case for the Black Country Pathology Service will be considered by Trust Boards at later this year. If the case is approved the four trusts will then move into the implementation stages of the project, which will include communication of progress with staff and service users.

Enclosure 12

The Dudley Gr
NHS Foundation Trust

Paper for submission to the Trust Board
November 2017

TITLE:	**Digital Trust Programme Committee Update**		
AUTHOR:	**Mark Stanton CIO**	**PRESENTER**	**Ann Becke**

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.
2. Additional Clinical and Project resources have been approved to recover some time lost around configuration, this is all within Budget.
3. Three Associate CCIO roles have been created to support the implementation and adoption.
4. Work is underway to look at improving adoption of real-time ADT across the Trust.
5. A proposal was made to change the DTPC Terms of reference around Quoracy to ensure that both Clinical and Operational staff were required to be quorate.

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	X	

RECOMMENDATIONS FOR THE COMMITTEE

1. **Be assured that the DTPC is providing governance for this project.**
2. **The DTPC recommends that the Board approve the new TOR, specific changes to section 4.1 Highlighted in the document.**

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	18th October 2017	Ann Becke	yes	no
				X

Declarations of Interest Made

None

Assurances received

Note: The Meeting was not quorate

- Updates were given on the progress of the project rollout which currently has 3 stages in this delivery: -
  - Stage 1 – Complete
  - Stage 2 – 87% 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 – 21% complete with completion due 30/11/17 and currently on target.
- The Clinical documents design is running around 3-4 weeks behind target, additional resource has been identified to bring this back on plan :-
  - Additional SME resource has been approved by the Executive Directors and discussions are underway on how to release this resource.
  - 2 Additional Business Analysts (BA's) are currently being contracted in to strengthen the Clinical documents team and process design.
  - Additional off-shore resource available to the configuration team.
- 3 Associate CCIO role have been approved by Executive Directors, these will be professional roles and cover each of the Divisions, it is envisaged these will be in place by January 2018 and will be focused initially around engagement and adoption activities.
- A launch event took place on 18th October at RHH and in the community which created a lot of interest and discussion. It was well attended with an estimated 600 Staff in RHH visiting.
- It was noted that real time ADT (presented at last DTPC meeting) had been discussed at a number of forums , in the Hospital this is specific to working patterns of Ward clerks which results in Oasis PAS entries' being made retrospectively, once the EPR is live this practice will delay the admission of patients. This risk is now being included in a review that is being undertaken by the HRD around ward clerks.
- Community ADT processes will not currently support EPR working due to culture of retrospective PAS updates, this issues will be added as a spate item to the strategic

risks with BA resource to review how this can be mitigated.
Decisions Made / Items Approved
Actions to come back to Committee (items Committee keeping an eye on)
Items referred to the Board for decision or action
None
Comments relating to the DTPC from the CCIO
Report from the Clinical Approvals Group 25/10/17 There was no nursing representation at the CAG, this has been escalated to the nursing directorate. Configured Sunrise content from the scrum groups was presented for the first time, including radiology ordering and process maps for ED, AEC, EAU and SAU There are ongoing DATIX issues relating problems with UHB uploading radiology images to support urgent referrals on NORSE, which have been escalated to the medical director at UHB. It was noted that there will be a new process for sharing images across Birmingham and the Black Country which may resolve the issue.
Comments relating to the DTPC from the CNIO
Work is progressing in the development of the nursing documentation element in the new EPR. The nursing admission document has been slow to complete due to the time engaging with the different specialist teams who were involved in the development of the paper document and ensuring national guidance is being adhered to. Weekly meetings continue with the nursing senior team to ensure full engagement in the safe development of the EPR.

The launch event on October 18th resulted in a lot of interest from nursing staff in regard to the nursing documents and the technology that they will be using. The training team took lots of questions about the support required pre and post launch. The importance of staff undertaking the skills assessment when it's launched on the Hub has been highlighted at senior nurse and staff meetings.

Project owner of Nursing documentation, ePMA and technology scrums ensures that nursing has a high profile within these meetings with support of senior nurses who attend as SME's.

The Dudley Group NHS
NHS Foundation Trust

Digital Trust Programme Committee

TERMS OF REFERENCE

The Programme will cover the delivery of the Digital Trust Programme along with Operational performance specifically:

1. ***Allscripts Sunrise EPR* – Oversight of the delivery of an Electronic Patient Records (EPR) solution as defined in the Full Business Case presented to the Trust Board November 2016**
2. ***Strategic projects* – The approval and oversight of Key IT projects across the Trust.**
3. **I*nfrastructure* – The oversight of Infrastructure (Datacentre, Desktop, Networks, cyber security) projects**
4. ***Review of IT Service Delivery***

1. Constitution

1.1 The Trust Board resolves to establish a reporting group to be known as The Digital Trust Programme Committee. The DTPC in its workings will be required to adhere to these Terms of Reference and has no delegated powers outside of these.

2. Membership

Non-Executive Director (Chair)
Non-Executive Director
Finance Director
Medical Director
Director of Strategy and Performance
Directors of Operations (Medicine, Surgery, clinical support)
Chief of Medicine
Chief of Surgery
Chief Nurse
IT Programme Director
Digital Health Architect
Chief Information Officer
Chief Clinical Information Officer
Caldecott Guardian

3. Attendance

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

3.2 It is expected that all members attend the Programme Committee meeting. Where this is not possible through annual leave, sickness or other circumstances an appropriate deputy or representative may be asked to attend.

3.2 Other managers/staff may be invited to attend meetings depending upon issues under discussion.

4. Quorum

4.1 A quorum shall be four members of the DTPC one of whom must be a Non-Executive Director, an Executive Director (other than the CIO), CIO or CCIO, A senior clinician, Director of Operations.

5. Frequency of Meetings

5.1 The DTPC will meet monthly.
5.2 Additional meetings may be required at short notice if urgent decisions are required. Under these circumstances, matters may be considered by email, tele-conference, or meetings as appropriate.
5.3 Papers will be issued at least a week before meetings.
5.4 The membership reserves the right to cancel or change the date of scheduled meetings.

6. Authority

6.1 The DTPC is authorised by the Trust Board to investigate any activity within its terms of reference.

7. Duties

7.1 A review of previous minutes and outstanding actions
7.2 Agree and recommend the IT strategy
7.3 Ensure all projects are aligned with the IT strategy
7.4 Project updates
7.5 Review of any issues that need DTPC Consideration
7.6 Review of any dependencies that need DTPC consideration
7.7 Review of change requests escalated from sub-groups that need DTPC consideration
7.8 Make any decisions and approve programme deliverables
7.9 Review Digital Trust risks and issues rated extreme and high, agree appropriate course of action and agree items to review at Trust Board
7.10 Provide guidance on priorities relating to project deliveries
7.11 Reconcile differences in opinion and approach from reporting sub-groups namely IT Clinical Approvals Group, IT Projects Group and Sunrise Project Group
7.12 Any other matters that require DTPC consideration

8. Reporting

8.1 The DTPB reports to the Trust Board and will produce a monthly report. The Sunrise Project Group, IT Projects Group and Medical Devices Group will report to the DTPC.

9. Review

9.1 The Terms of Reference of the Board shall be reviewed by The Trust Board at least annually.

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to Board 2 November 2017

TITLE:	**Board Assurance Framework**		
AUTHOR:	Sharon Phillips – Deputy Director of Governance (Risk and Standards	**PRESENTER**	Glen Palethorpe – Director of Governance

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: All Objectives

Attached is the Trust's Board Assurance Framework, which prior to the purchase of Datix was reported through its component parts (corporate risk and corporate assurance register).

The attached report now includes a forward projection as to the direction of risk over the next quarter and shows for two of the Trust objectives the executive team are predicting a reduction in the overall level of risk for those objectives and for the other four there is no predicted increase.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:** Full Risk Register
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** All Domains
	NHSI	**Y**	**Details:** Well led framework
	Other	**Y**	**Details:**

ACTION REQUIRED:

Decision	Approval	Discussion	Other
X		X	

ACTION FOR BOARD:

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

To note the projected direction of travel for the next quarter and that the progress towards the achievement of this will be reported to the Audit Committee in November 2017.

BOARD ASSURANCE FRAMEWORK

Introduction

The Board Assurance Framework (BAF) is both a process and a document which supports the Board's oversight of the key risks to the delivery of its objectives.

The process is made up of the systematic assessment and review of the key risks that impact on the Trust's objectives, the recording of assurances logged against these risks and their impact along with determined mitigating actions on these risks over the year. The application of these processes along with the oversight at the respective Committees, Groups and within the Executive risk, performance and governance structures culminates in the BAF document.

The Trust Board is used to seeing the components of the BAF in the Corporate Risk and Corporate Assurance Registers.

The BAF at Appendix 1 brings those components together focusing on those KEY risks, noting that for 2017/19 there are 6 new risks and 1 escalated risk.

Summary of the Trust's BAF profile against each of the Trust's objectives

	Total number of risks	Total inherent risk score	Total current value of risks	Expected movement in these risks by end of next quarter (Q3)	Total target risk score
Objective 1 – deliver a great patient experience	9	180	162	🡻	89
Objective 2 – safe and caring services	6	125	94	🡻	56
Objective 3 – drive service improvement, innovation and transformation	1	20	16	➲	15
Objective 4 – be the place people choose to work	There are no identifed key unmitgated risks for this objective (noting that a number of risks within the other objectives would also impact on this objective)				
Objective 5 – make the best of what we have	3	65	44	➲	31
Objective 6 – deliver a viable future	2	45	40	➲	20

The 2017/18 BAF reflects the level of increased risks facing the Trust's delivery of this year's annual plan. These risks cover all aspects

- Quality, with for example risks to new processes such as the publication of learning from deaths information, delays in ophthalmology outpatients clinic appointments;

- Performance, with for example the Trust's ability to meet the cancer and emergency access standards;
- Finance, with for example the increased risk at the start of this year in respect the Trust's ability to achieve its cost improvement plan and the risk in respect of our of main commissioner' ability to fund the activity that flows through the Trust; and
- Workforce whilst not increasing from last year, the risks remain a challenge, for example over the Trust's ability to reduce the reliance on agency staff.

Review of the BAF

The Trust's Executive Risk and Assurance Group met on the 11 October to consider the Trust's corporate risk register, divisional and directorate risk registers. The Group discussed the movement in risk through recorded assurances or completed actions from the first quarter to the second and then considered the projected movement in risk for the next quarter. The reformatted BAF document now records this projection allowing the Board to gauge the planned actions of the Executive to actively manage the Trust's risks.

The Audit Committee considers the Corporate Assurance Register a key component of the BAF at each of its meetings. In support of the work of the audit committee the various committees of the Board are undertaking a series of reviews into risks they have committee oversight for, where they do not get routine reports within their cycle of business. For Finance and Performance these specific deep dive reviews will cover for 2017/18 the risks in relation to Major Incident Planning and Delayed Transfer of Care, for Clinical Quality, Safety and Patient Experience they are considering the risks in relation to the new Learning from Deaths process, ophthalmology waiting times and the Trust's accessible information processes. The outcome of these risk reviews will be reported to the Board and to the Audit Committee supporting the Audit's year end assessment of the Trust's risk management processes alongside the outcome to the work of Internal Audit reviewing the underpinning BAF systems as well as the content of the document itself.

Anticipated movement in the next quarter

Executive management expect to see movement in a number of risks over the third quarter of the year, these include

Strategic Objective 1 – deliver a great patient experience

- COR099 in relation to the Trust's diagnostic standard. This has been at 20 but is expected to reduce based on the increase in capacity from the new community facilities coming on line in November / December 2017. Whilst staff sickness has seen the Trust's trajectory of achievement of the 99% target in September be missed this is expected to be achieved with the new capacity.
- COR377 in relation to the Trust's cancer targets. The Trust has received confirmation from an external review of its improvement plan that the plan is robust. The Trust in making progress in the delivery of this improvement plan and has seen the 62 day target achieved for the month of September and whilst the 2 week wait target was missed for the first time in August it has been again achieved for September.

- COR244 in relation to the Trust being prepared for the increased requirements in respect to the national learning from deaths programme. The Trust approved its learning from deaths policy ahead of the required deadline and has commenced on collating its information on learning and is on track to have this reported as required within quarter 3 of the year.
- COR121 in relation to ophthalmology outpatient capacity. The Trust has engaged with an third party to provide increased outpatient clinical resources and this has seen the Trust remain on target to deliver its trajectory to remove this back log by the end of November 2017.

Strategic Objective 2 – safe and caring services

- COR096 in relation to the prevention of avoidable patient deterioration. The Trust has adopted a new track and trigger tool, the national early warning system and the review of medical emergency triggered activity has shown that there has been less following the launch of the tool.
- COR100 in relation to fire safety requirements. The risk is to reduce following the receipt of the external report on the Trust's fire cladding which has not identified any issues that would mean this risk could not be reduced. Noting this risk was increased in recognition of the need for greater assurance post the Grenfell fire.

Conclusion

The Trust has revised its BAF document to clearly show the predicted direction of travel regarding the respective risks. The BAF and its component processes continue to be reviewed by the Risk and Assurance Group and the Audit Committee. The other Committees of the Board continue to undertake reviews into specific risks and these have been scheduled for 2017/18 to support the Audit Committee's annual report.

Appendix 1 Board Assurance Framework to 30/09/2017

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Past Risk Score 31/07/17	Current Risk Score 30/09/17	Movement in risk	Expected movement by next quarter	Target Risk Score
Objectives: SO1 Deliver a great patient experience									
F	COO	COR069	**Risk Title The Diagnostic Standard is at risk due to continuing demand for Imaging to support multiple pathways**	**20**	**20**	**20**	➲		8
			Key Controls • *Weekly PTL review* • *Regular maintenance of scanners* • *Use of external provider for review of scans over night*		+Pos level 1 New Capacity at Guest -Neg level 1 DMO1 report to F&P 1	+Pos level 1 New Capacity at Guest -Neg level 1 DMO1 report to F&P 1			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**		🕐	
F	COO	COR376	**Risk Title Failure to meet the key ED performance target**	**20**	**20**	**20**	➲		8
			Key Controls • *Capacity monitoring 4 times a day* • *Daily reviews of discharges* • *Weekly EAS assurance meeting*		-Neg level 2 failure to meet the ED Performance target discussed at F&P	-Neg level 2 nationally produced data confirms consitent failure to meet the ED Performance target discussed at F&P		➲	
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**			
F	COO	COR0377	**Risk Title Failure to meet the key cancer performance targets**	**20**	20	**20**	➲		8
			Key Controls • *Weekly PTL reviews*		+Pos level 1 Weekly PLT meetings -Neg level 2 Cancer performance targets not met, discuused at F&P	+Pos level 1 Weekly PLT meetings +Pos level 2 cancer targets now being met -Neg level 2 2 weekly waits not being achieved			
			Strength of assurance logged (L1 / L2 / L3)		**G** **A**	**G** **A**		🕐	
F	COO	COR378	**Risk Title Failure to meet the 18wk performance target**	**20**	**10**	**10**	➲		8
			Key Controls • *Review of theatre productivity* • *Review of performance*		+Pos level 2 Report to F&P	+Pos level 2 Report to F&P			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**G**		➲	
F	COO	COR099	**Risk Title Failure to reduce the number of delayed transfer of care may result in poor patient experience**	**20**	**20**	**20**	➲		16
			Key Controls • *Dudley economy MoU* • *Daily review of discharges* • *Application of Red 2 Green initiative*		+ Pos level 1 A&E delivery plan	+ Pos level 1 A&E delivery plan			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**G**		➲	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Past Risk Score 31/07/17	Current Risk Score 30/09/17	Movement in risk	Expected movement by next quarter	Target Risk Score
CQSPE	MD	COR244	**Risk Title Failure to Monitor and to Learn From Deaths** **Key Controls** • *Mortality review process* • *Mortality Surveillance Group* • *Learning from deaths policy* **Strength of assurance logged (L1 / L2 / L3)**	20	20 +Pos level 2 Policy approved and presented to CQSPE G	20 +Pos level 2 New report in line with national guidance. Policy approved and presented to CQSPE G	➲	🡻	8
CQSPE	CN	COR259	**Risk Title Friend and Family Testing Outcomes** **Key Controls** • *Review of real time surveys* • *Oversight of action plans through Patient Experience Improvement Group* **Strength of assurance logged (L1 / L2 / L3)**	20	20 +Pos level 1 Patient Experience Improvement group overseeing improvement plan. G	20 Pos level 1 Patient Experience Improvement group overseeing improvement plan. Positive engagement across Trust. +Pos level 2 FFT response rates improving. G G	➲	➲	9
CQSPE	COO	COR121 (OOS004)	**Risk Title Ophthalmology Outpatient Appointment Capacity** **Key Controls** • *Review of RAG rating for each appointment* • *Application of formal escalation for delayed appointments* • *Project management of procured extra resource to deal with backlog* **Strength of assurance logged (L1 / L2 / L3)**	20	20 +Pos level 2 External resources approved -Neg level 2 increase in delays reported to F&P A	20 +Pos level 2 Reduction in delayed FU appt. ASI extract confirms reduction -Neg level 2 May-Aug - increase in delayed FU appt. A	➲	🡻	16
F	DF	COR101	**Risk Title Capital Schemes fail to be delivered impacting on patient experience of the Trust** **Key Controls** • *Capital programme project management process* **Strength of assurance logged (L1 / L2 / L3)**	20	12 +Pos level 1Project Boards for Capital Programme for UCC and Guest imaging +Pos level 2 Capitol report to F&P G G	12 +Pos level 1 Project Boards for Capital Programme for UCC and Guest imaging +Pos level 2 Regular reports to F&P -Neg level 2 Report to F&P detailing UCC programme 5 weeks behind plan; review of plan due to be reported Oct 17 G A	➲	➲	8
			SUMMARY	180	162	162	➲	🡻	89

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Past Risk Score 31/07/17	Current Risk Score 30/09/17	Movement in risk	Expected movement by next quarter	Target Risk Score
Objectives: SO2 Safe and Caring services									
F	DF	COR241	**Risk Title Failure of the PFI provider to maintain the building in line with statutory requirements and to ensure a resilient estate**	**25**	**20**	**20**	➲		8
			Key Controls • *Board to Board meetings* • *Contract management processes*		+Pos level 2 Regular senior management meetings with provider, incorporating rigorous review of contract improvements	+Pos level 2 Quarterly Board to Board meetings; performance of estates discussed. Monthly reports to CQSPE and F&P Rigorus monitoring and reporting to continue until at least Dec -Neg level 2 Performance of estates improved but still requires improvement.			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**A**		➲	
CQSPE	CN	COR085	**Risk Title An inability to maintain the delivery of the safer staffing levels in relation to ward nurse staffing**	**20**	**20**	**20**	➲		10
			Key Controls • *Established staff banks* • *Review of staffing dashboards* • *Recruitment plan*		+Pos level 2 Approved recruitment for substantive staff Report to Board -Neg level 2 Attrition of staff higher than recruitment	+Pos level 2 Report to F&P; recruited 35 RNs. Approved recruitment for substantive staff -Neg level 2 Attrition of staff higher than recruitment			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**		➲	
CQSPE	CN	COR096	**Risk Title Failure to prevent avoidable deterioration of patients leading to cardiac arrests**	**20**	**15**	**15**	➲		10
			Key Controls • *Use of track and trigger tool* • *Mandatory training* • *Post MET call review of processes followed*		+Pos level 1 Launch of NEWS track & trigger	+Pos level 1 Launch of NEWS track & trigger			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**G**		🕐	
CQSPE	CN	COR093	**Risk Title Delays in the management of young people requiring section under the Mental Health Act (Tier 4)**	**20**	**12**	**12**	➲		8
			Key Controls • *CAMHS tier 3.5 service commissioned* • *Conflict resolution and safeguarding staff training programmes*		+Pos level 2 Report to Children's services group - improvement for children not requiring Tier 4 care. -Neg level 2 Report to Children's services group-no improvement for children requiring Tier 4 care	+Pos level 2 Report to Children's services group - improvement for children not requiring Tier 4 care. -Neg level 2 Report to Children's services group - no improvement for children requiring Tier 4 care			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**		➲	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Past Risk Score 31/07/17	Current Risk Score 30/09/17	Movement in risk	Expected movement by next quarter	Target Risk Score
F	DF	COR100	**Risk Title Failure to comply with fire safety requirements** **Key Controls** • *Fire Safety risk assessments* • *Electric fire detection system designed to provide early warnings of fire* • *Regular maintenance of the system* **Strength of assurance logged (L1 / L2 / L3)**	20	**12** +Pos level 1 Reviews of building cladding, verbal positive feedback – awaiting report **G**	**12** +Pos level 1 Reports received and reviewed, confirm cladding adheres to NHSI requirements. +Pos level 3 Independent report confirms cladding on PFI buidlings meets NHSI requirements - P **G**	➲	⬇	10
F	COO	COR032	**Risk Title Trust Major Incident Plan does not deliver intended business continuity** **Key Controls** • *Trust has developed a major incident plan and processes* • *Periodic test of the plan* **Strength of assurance logged (L1 / L2 / L3)**	20	**10** +Pos level 1 Action plan being monitored and reported **G**	**15** + Pos level 1 Awareness sessions for emergency preparedness and workshops for portering and security staff -Neg level 1 Several partners were unable to attend the sessions **A**	⬆	➲	10
			SUMMARY	**125**	**89**	**94**	⬆	⬇	**56**
Objectives: SO3 Drive Service improvements, innovation and transformation									
CQSPE	MD	COR083	**Risk Title Failure to have a workforce/infrastructure that supports the delivery of 7-day working** **Key Controls** • *Use of nerve centre to direct tasks out of hours* • *Delivery of 7/7 audit action plan* **Strength of assurance logged (L1 / L2 / L3)**	20	**16** +Pos level 1 Clinical audit shows positive delivery against standards in Medicine -Neg level 1 Clinical audit shows negative delivery against standards for surgery, T&O & O&G - N **A**	**16** +Pos level 1 Clinical audit shows positive delivery against standards in Medicine -Neg level 1 Clinical audit shows negative delivery against standards for surgery, T&O & O&G - N **A**	➲	➲	15
			SUMMARY	**20**	**16**	**16**	➲	➲	**15**
Objectives: SO4 Be the place people choose to work									
			NO INITIAL RISKS SCORING 20 or ABOVE						

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Past Risk Score 31/07/17	Current Risk Score 30/09/17	Movement in risk	Expected movement by next quarter	Target Risk Score
Objectives: SO5 Make the best use of what we have									
F	DF	COR080	**Risk Title Failure to deliver 2017/18 Cost Improvement Programme**	25	16	20	↑		12
			Key Controls • *Programme governance structure monitored by TEC* • *Programme PID and QIP process*		+Pos level 2 Report to F&P - achieving plan	+Pos level 2 Transformation and CIP report to F&P. Month 4 on track, forcast to deliver by year end -Neg level 2 F&P increased risk score to 20. September report identifies £2.5m shortfall due to agency spend		→	
			Strength of assurance logged (L1 / L2 / L3)		G	A			
F	DF	COR234	**Risk Title Trust plans assume a significant level of income at risk from commissioners**	20	20	20	→		15
			Key Controls • *Monthly reconciliations of activity and coding* • *Regular dialogue through formal meeting with CCGs*		+Pos level 2 Monthly report to CCG contract review meetings; agreed process with CCG	+Pos level 2 Monthly report to CCG contract review meetings; agreed process with CCG -Neg level 2 Month 5 income fell; reduced forecast outurn. Additional F&P meeting in Oct to review position			
			Strength of assurance logged (L1 / L2 / L3)		G	A		→	
F	DIT	COR091 (FI003)	**Risk Title The IT DR arrangements are not effective**	20	8	8	→		4
			Key Controls • *Established BC Plans* • *System back ups taken and tested* • *Patient Information back up system in operation*		+Pos level 1 Recovery time for top 5 systems would be 2-24 hrs +Pos level 2 Datacentre refresh programme approved by Board	Recovery time for top 5 systems would be 2-24 hrs Datacentre refresh programme approved by Board			
			Strength of assurance logged (L1 / L2 / L3)		G G	G G		→	
			SUMMARY	65	44	48	↑	→	31
Objectives: SO6 Deliver a viable future									
F	MD	COR116	**Risk Title High dependency on agency staff particularly in clinical areas**	25	20	20	→		4
			Key Controls • *Review of agency use by Executives* • *Nursing and Medic STAR chamber review and approval* • *VAR panel review and approval*		+Pos level 1 Recruitment of staff to ED +Pos level 2 Approved resources for substantive nurse recruitment -Neg level 2 Report to Workforce committee shows higher attrition to recruitment.	+Pos level 2 Approved resources for nurse recruitment -Neg level 2 Report to F&P – trajectory suggests full year target will not be met . -Neg level 2 Report to Workforce committee shows higher attrition to recruitment.			

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Past Risk Score 31/07/17	Current Risk Score 30/09/17	Movement in risk	Expected movement by next quarter	Target Risk Score
			Strength of assurance logged (L1 / L2 / L3)		G A	A		➲	
F	DF	COR061	**Risk Title Failure to remain financially sustainable in 2017-18 and beyond** **Key Controls** • *Trust's business planning and budget setting process* • *Regular up to date financial reporting reviewed* • *Developed CIP Programme* *Agency controls*	**20**	**20** +Pos level 2 Report to F&P include schemes to achieve control. Total surplus at month 4 above forecast. Report to F&P on achievemnet of Q1 STF money. -Neg level 2 Month 5 financial position below plan. Directorates asked to find addition CIP. Additional F&P meeting Oct to discuss remedial plan.	**20** +Pos level 2 Report to F&P include schemes to achieve control. Total surplus at month 4 above forecast. Report to F&P on achievemnet of Q1 STF money. -Neg level 2 Month 5 financial position below plan. Directorates asked to find addition CIP. Additional F&P meeting Oct to discuss remedial plan.	➲		16
			Strength of assurance logged (L1 / L2 / L3)		A	A		➲	
			SUMMARY	***45***	**40**	**40**	➲	➲	*20*

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

Enclosure 14

The Dudley Gr
NHS Foundation Trust

Paper for submission to Trust Board on
2nd November, 2017

TITLE:	**Trust Annual Plan 2017/18: Quarter Two Report**		
AUTHOR:	**Lisa Peaty** **Deputy Director: Strategy & Business Development**	**PRESENTER**	**Lisa Peaty** **Deputy Director: Strategy & Business Development**
CORPORATE OBJECTIVE: **All Objectives**			

SUMMARY OF KEY ISSUES:

The full performance report for the Trust's Annual Plan can be found in Appendix One. Five measures of achievement relating to the Clinical Strategy have been added to this quarter's report.

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

Strategic Objective	RAG rating			
	Red	Amber	Green	No Status
Deliver a great patient experience	2	6	2	5
Deliver safe and caring services	4	8	8	0
Drive service improvement, innovation and transformation	1	18	6	3
Be the place people choose to work	0	6	4	6
Make the best use of what we have	0	2	4	0
Plan for a viable future	0	1	3	8
Total	7	41	27	22

Seven measures of achievement are rated as red as outlined below, one fewer than in Quarter One.

The following were red in Quarter One, but are now green or amber:

- 62 day wait for first treatment for cancer (green);
- six week diagnostic wait (amber);
- recruitment and retention of theatre staff (amber);
- waiting time for Ophthalmology (amber);
- Pharmacy prescribers (amber).

The follow were amber in Quarter One but are now red:

- reduce delayed transfers of care;
- avoidable pressure ulcers (hospital & community);
- job plans in place for consultants;
- increased clinical pharmacy time.

The following remain red:

- 95% emergency access standard;
- serious incidents managed in line with national standards;

- monthly trajectory towards £3.73m cap on nursing agency spend.

Mitigating actions are in place for the measures of achievement rated as red, all which are also on either the Corporate or Divisional Risk Registers.

Deliver a great patient experience
- 95% emergency access standard met (Corporate Risk 376);
- reduce delayed transfers of care (Corporate Risk 099).

Safe and caring services
- serious incidents managed in line with national standards (CE379);
- monthly trajectory towards £3.73m cap on nursing agency spend (Corporate Risk 116);
- avoidable pressure ulcers (hospital & community) (Corporate Risk 087);
- job plans in place for consultants (COR083)

Service improvement, innovation and transformation
- increased clinical pharmacy time (CSS293).

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

Strategic Objective	**RAG rating**			
	Red	Amber	Green	No Status
Deliver a great patient experience	1	3	6	5
Deliver safe and caring services	2	3	15	0
Drive service improvement, innovation and transformation	0	16	9	3
Be the place people choose to work	0	1	11	4
Make the best use of what we have	0	2	4	0
Plan for a viable future	0	0	4	8
Total	3	25	49	20

The forecast Quarter Three position is an improvement when compared to Quarter Two.
- 22 more greens compared to Quarter Two
- 4 fewer reds compared to Quarter Two
- 16 fewer ambers compared to Quarter Two
- 2 fewer indicators are grey compared to Quarter Two

A trajectory of performance into Quarter Four can be found in Appendix Two. The forecasts for Quarters Three and Four are currently considered realistic, although will continue to be revised in light of progress.

IMPLICATIONS OF PAPER:

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

REQUIREMENTS			approved by NHSI

ACTION REQUIRED OF TRUST BOARD

Decision	Approval	Discussion	Other
	Y	**Y**	

RECOMMENDATIONS FOR TRUST BOARD:

- The outcome of Quarter Two and forecast outcome for subsequent quarters for each of the goals is noted.
- Confirm whether the proposed mitigating actions are sufficient to sustain and improve performance.

Appendix One

†† **- denotes initiatives contained in the Clinical Strategy**

The Dudley Group NHS
NHS Foundation Trust

Operational Plan 2017/18: Quarter Two Monitoring Report

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
Strategic aim one: deliver a great patient experience					
✓ **Improve engagement and involve patients, carers and the public in their care and the work of the Trust** ✓ Implement approaches that engage and involve patients, carers and the public in their care / service developments and provide opportunities for feedback ✓ Improve the FFT response rate trust-wide ✓ Further develop mechanisms to implement learning from	✓ *Percentage positive monthly FFT/patient survey scores equal to or better than the national average for all areas (Inpatients, Outpatients, Maternity, Emergency Department and Community).*	March 2018	Chief Nurse		**Progress update and risks to delivery**: This has been achieved in Maternity with a footfall score of 56.3%, Emergency Department with a footfall score of 16%, Outpatients 4.5% and Inpatients with a footfall score of 32.3% during August 2017. It has not been not been achieved in Community (footfall score 3.2%). **Mitigating actions**: Dedicated work is being undertaken with local and trust wide actions plans developed to deliver improvement actions which are monitored by the Patient Experience Improvement Group. Community Patient Experience Group established with nominated FFT champions.
	✓ *An agreed 6 month trajectory of improvement until the monthly FFT response rate is equal to national average.*				**Progress update and risks to delivery**: A six month trajectory has been agreed in quarter one. **Mitigating actions**: These include the: • Expansion of FFT SMS survey method across the trust in Q3 • Introduction of Feedback Friday and FFT champions nominated in community • Introduction of dedicated Patient Experience volunteers
	✓ *Annual National Patient Survey results equal to or better than the national average.*				**Progress update and risks to delivery**: This indicator is grey as the results of the survey are not due until quarter 4. Results for the last few years are poor and there is a risk that 2017/18 patients who are surveyed will not have experience positive changes yet. **Mitigating actions**: All areas have action plans in place to improve the results for next year. Local surveys will be introduced to demonstrate improvements.
	✓ *Undertake LIA with patients groups for example dementia, learning disability and end of life*				**Progress update and risks to delivery**: LIA events continue to be planned with information on user/support groups being collated and engagement monitored by the Patient Experience Improvement Group. Patient stories are shared at Board, with one patient attending in person. Head of Patient Experience was appointed in July 2017.

Appendix One

†† **- denotes initiatives contained in the Clinical Strategy**

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
feedback. ✓ Increase the use of Listening into Action (LIA) with Patient Groups					**Mitigating actions**: Other listening activities are scheduled for Quarter 3 (e.g. Shout up Parents Group, EOL focus Group, Mums with pregnancy loss, patient at Board meeting).
✓ **Maintain high performance in national operational performance standards:** • **Urgent care** • **Patient flow** • **Delayed transfers of care** • **Imaging** • **Cancer** • **Referral to treatment time** ✓ Rebuild and reconfigure the UCC to provide more effective front door streaming ✓ Deliver best practice models for discharge	✓ *95% emergency access standard met.*	March 2018	Chief Operating Officer	92.3 % 88.0 %	**Progress update and risks to delivery**: Improved substantive medical cover is in place in ED, Board rounds are happening but not consistently on medical wards with the aim of delivering plans for patients earlier in the day. Consistently high number of DTOCs (100 plus daily during Q2) has seen bed days lost. **Mitigating actions:** An external review of bed utilisation has highlighted internal delays in relation to decision making and clear communications around decisions. This audit will be discussed with the medical workforce and appropriate actions put into place. Better utilisation of the discharge lounge will be developed. Job planning reviews are underway so that plans can be made to ensure each ward has a daily consultant ward round.
	✓ *Best practice models for discharge delivered*				**Progress update and risks to delivery**: A DTOC Action Plan for the health economy is in place which included an agreement at A&E Delivery Board of planned spend for Better Care Fund monies. **Mitigating actions**. Increased capacity within Dudley social care will come on line in Q3 as part of the Better Care Fund and should reduce DTOCs**.**
	✓ *Additional Mental Health Crisis team support available*				**Progress update and risks to delivery**: Mental Health Crisis Team support is already available through A&E and plans are in place to develop this further through the A&E Delivery Plan. **Mitigating actions**: Work is ongoing with the Mental Health Team to expand service provision and to share breach data with them on a weekly basis.
	✓ *Reduce Delayed Transfers of Care from March 2017 baseline*				**Progress update and risks to delivery**: A DTOC Action Plan for the health economy is in place which included an agreement at A&E delivery board of planned spend for Better Care Fund monies. The local authority has agreed to provide 50 beds in the health economy for discharge to assess patients, but only 21 are on line. Local authorities surrounding Dudley are also failing to address DTOC issues for patients who are resident in those areas. **Mitigating actions** include an internal daily review to check ward-based assessments; review format of daily site meeting to inform decisions to progress on discharge; top 20 meeting re-initiated; iBCF funding to support

Appendix One

†† - denotes initiatives contained in the Clinical Strategy

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
✓ Work in partnership with Dudley and Walsall Mental Health (MCP) to improve 24 hour access to mental health services in A&E ✓ Deliver the Dudley Health Economy Delayed Transfers of Care Improvement Plan (High Impact Change Model) ✓ Develop and implement a demand and capacity plan to deliver definitive cancer diagnosis within 28 days ✓ Assess the potential impact of Rapid Diagnostic Centres on the Trust's activity in conjunction					community assessments rather than hospital based. Discharge to Assess is being discussed at the A&E Delivery Board. The Chief Executive is meeting with out of area Local Authority accountable officers to progress DTOCs. Issues have been escalated to NHSI and NHSE and an urgent health economy meeting is being convened.
	✓ *Maximum 62day wait for first treatment from: i) urgent GP referral for suspected cancer ii) NHS cancer screening service referral*				**Progress update and risks to delivery**: A Cancer Action Plan has been developed and is being progressed. Additional support monies from NHSI have been applied for and, in the case of Urology, agreed (a further bid is pending for short-term project management support and additional Histopathology capacity). **Mitigating actions** include an internal cancer action plan based on good practice tools; external review of processes being undertaken by IST; external Cancer Board meeting; weekly review of performance.
	✓ *National Cancer Dashboard in place*				**Progress update and risks to delivery**: The Trust already contributes to the current national cancer dashboard and will ensure that it complies with the implementation of the national dashboard as it is rolled out nationally. **Mitigating actions**
	✓ *Six week wait for diagnostic procedures (99%)*			95.7 % / 97.9 %	**Progress update and risks to delivery**: Currently, there is improved performance against trajectory in quarter 2 and it is anticipated that the target (99%) will be met by November 2017. An action plan has been produced with short, medium and longer term actions identified. Risks include breakdown of CT and MRI scanners and any increase in the number of emergency patients. **Mitigating actions** include ongoing implementation of actions associated with improvement trajectory; increased mobile working for some modalities; weekly performance meetings against target; implementation of Guest CT and MRI suite to provide additional elective capacity. A replacement programme for existing CT scanners will be in place from January 2018.
	✓ *RTT – 92% of incomplete pathways*			94.2 % / 93.1 %	**Progress update and risks to delivery**: On-going monitoring via RTT team. Target is 92%. **Mitigating actions**:

Appendix One

†† **- denotes initiatives contained in the Clinical Strategy**

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
with neighbouring trusts. ✓ Implement community imaging hub at The Guest Outpatients Centre to increase capacity ✓ Meet the 18 weeks referral to treatment standard across all specialties					
✓ **Redesign a number of integrated pathways and services as a partner in the MCP** †† ✓ Further develop the redesign of community nursing services to deliver MCP aims ✓ Implement community based consultant	✓ *To be determined on the outcome of procurement* ✓ *Clinics in place* ✓ *Regular discussion in place with practices and localities*	March 2018	Medical Director/ Chief Operating Officer		

Appendix One

†† **- denotes initiatives contained in the Clinical Strategy**

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
services in elderly care, respiratory, diabetes and paediatrics ✓ Work closely with primary care to optimise the outcomes of the MCP					
Strategic aim two: deliver safe and caring services					
➢ **Deliver the Trust's Quality Strategy Priorities** ✓ Implement the priorities within the Trust's Quality Strategy • Pressure ulcers • Infection control • Nutrition and hydration • Medication management ✓ Improve delivery in incident	✓ *Targets outlined in the Trust's Quality Strategy achieved: zero Pressure ulcers: hospital and community* • *Ensure that there are no avoidable stage 4 hospital and community acquired pressure ulcers throughout the year.* • *Ensure that the number of avoidable stage 3 hospital and community acquired pressure ulcers in 2017/18 reduces from the number in 2016/17.*	March 2018	Chief Nurse		**Progress update and risks to delivery**: A number of posts have been advertised and recruited to in the Tissue Viability Team. The Trust is out to recruitment for a band 7 tissue viability specialist. **Mitigating actions**: Additional training sessions have been set up. Full recruitment to the team will release additional time for bespoke training in areas with specific training needs.
	✓ *Targets outlined in the Trust's Quality Strategy achieved.* *i) Infection control* • *Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases*				**Progress update and risks to delivery**: Targets have been achieved. A risk surrounds the new national definition of 'lapse in care' which now includes staff being not compliant with mandatory training. **Mitigating actions**: Training methods are being diversified and availability of training increased. Continual monitoring of infection control processes are in place.

Appendix One

†† **- denotes initiatives contained in the Clinical Strategy**

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
management ✓ Review the use of National Early Warning Scores to identify deteriorating patients and minimising impact ✓ Deliver the action plan on the reduction in patient falls within the Trust	*will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.*				
	✓ *Targets outlined in the Trust's Quality Strategy achieved. Nutrition and hydration (CLM) - Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items):* • *is 95% or above in each of the first three quarters for the Trust as a whole* • *has a 'Green' rating (95% or above) in the final quarter for every ward in the hospital*				**Progress update and risks to delivery**: Two of the three targets were achieved in Quarter two. A risk includes the use of temporary staff and capacity issues. **Mitigating actions** include increased staffing onwards, increased focus in this area, close monitoring and action.
	✓ *Targets outlined in the Trust's Quality Strategy achieved. Pain and Medication management (CLM)* • *Ensure that in 95% or more cases, all prescribed medications will either be: a) signed and dated as administered or b) have an omission code recorded.*				**Progress update and risks to delivery**: Targets were close to being met in Quarter Two with year to date figures of: Pain (92%) and Medications (93%). A risk includes the use of temporary staff and capacity issues. **Mitigating actions** include increased staffing, increased focus in this area, close monitoring and action planning.
	✓ *Reduce the number of omitted medication errors by 50%*				**Progress update and risks to delivery**: Both two targets were missed this quarter with year to date figures of: Pain (92%) and Medications (93%). A

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast				Risks to Delivery & Mitigating Actions
								risk includes the use of temporary staff and capacity issues. **Mitigating actions** include increased staffing, increased focus in this area, close monitoring and action planning.
	✓ *Incident reporting rate increase by 10% each Quarter*							**Progress update and risks to delivery**: Latest comparative figures for October 2016 to March 2017 were published on 27th September 2017. The Trust reporting rate was 79th of 136 organisations which is an improvement of the previous six months when we were 97th. Risks include the time taken to achieve cultural change required to improve reporting. **Mitigating actions**: Publicity on ensuring that incidents are closed in a timely fashion. This is being monitored.
	✓ *Best practice (aligned with partner specialist provider) National Early Warning Systems (NEWS) in place including Paediatric Early Warning Systems (PEWS), Modified Obstetric Early Warning System (MOEWS)(CLM)*							**Progress update and risks to delivery**: Full implementation of NEWS was completed August 2017. A compliance audit is being undertaken for Q2. **Mitigating actions**: Training for staff on the use of NEWS continues for all new staff and forms part of the annual resus update for staff.
	✓ *Reduce the number of avoidable falls that result in harm in our inpatient services by a third (PS/JP)*			1	0			**Progress update and risks to delivery**: Q2 16/17 = 4 avoidable falls with harm. Q2 17/18 = 0 fall with harm. The target is for 7 or less in 2017/18. **Mitigating actions**: 50 high low beds in place since September 2017. Grab bags have been implemented in bathrooms and 'call don't fall' signs placed at each bed space. The '1:1 tag you're it' initiative has been launched and walking aids labelling is in place. The RITA therapy system is on the wards with the high number of dementia/falls risk patients.
	✓ *All serious incidents to be managed in line with national Standards: All Serious incidents, including Never Events, sent to commissioners within 60 days*	Director of Governance						**Progress update and risks to delivery**: In Q2 10 RCAs were in breach of the 60 day deadline. All have now been submitted. **Mitigating actions**: An escalation process from Governance team to Chief Nurse has been established. Serious Incidents are now discussed as part of regular divisional performance review meetings.
➢ **Deliver agreed CQUIN requirements**	✓ *CQUIN schemes are delivered to expected levels*	March 2018	Chief Operating Officer					**Progress update and risks to delivery**: All CQUIN schemes have appropriate project documentation completed. 8 of the 11 CQUINs are on track to fully deliver. Quarter 2 partial achievement only for Sepsis treatment within 1 hour which

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
✓ Develop and deliver all CQUIN schemes					achieved 74% against a target of 90%. There is some risk to delivery of the CQUINs relating to e-referrals, discharge and medicines optimisation due to national changes in timescales relating to IT systems. **Mitigating actions**: include a Sepsis ED recovery plan with regular monitoring and confirm and challenge meetings which should enable the trust to fully achieve targets from Quarter 3. Risks to the achievement of the discharge and medicines CQUINs have been escalated to NHS Digital and SpecCom. Risk relating to e-referrals relates to reducing ASIs to 4%. A staged plan for reduction is being developed.
➢ **Maintain good mortality performance** ✓ Continue to develop arrangements for learning from the death of patients in our care, including publication of data	✓ *SHMI/HSMR within expected range* ✓ *100% of hospital deaths have a multidisciplinary review*	March 2018	Medical Director		
Deliver Safe staffing levels ✓ Ensure all clinical areas are staffed to Best Practice Standards, including all ward and community teams ✓ Review of Allocate Rostering	✓ *50% Reduction in use of agency staff* ✓ *Monthly trajectory toward the full year target of £3.73m cap on maternity and nursing*	March 2018	Chief Nurse/ Medical Director/ Director of HR		**Progress update and risks to delivery**: A small reduction in agency usage has been noted since the implementation of the new control measures. The last couple of months have seen this plateau. Non recruitment of substantive staff remains the main risk. A nurse recruitment and retention lead post has now been appointed to. **Mitigating actions**: Use of the revised agency authorisation proforma continues., The Associate Chief Nurse risk assesses all agency requests ensuring patient safety is maintained whilst supporting overall reduction in agency use. The use of agency CSWs is no longer permitted. Tighter control on the use of non-framework agency for registered staff is in place. Monthly recruitment events are planned **Progress update and** risks to delivery: The trajectory for Quarter 2 is £2.817 m and total spend to end of Quarter 2 is £5.772m. The main risks are ongoing vacancies and non- recruitment of substantive staff.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
✓ System Review all of Trust's Clinical Nurse Specialists (CNS) ✓ Implementation of Job Planning for all Consultant posts	*agency spend is met*				**Mitigating actions**: A staffing review is in progress and a recruitment plan in place.
	✓ *Substantive staffing in place to cover agreed establishment requirements in both the community and hospital areas. Ensure that there is a reduction in vacancy rates.*				**Progress update and risks to delivery**: A staffing review is in progress. Surgical areas medical reviews was completed by August. Medical ward review to be presented to directors for approval October 2017. The main risk is non recruitment of substantive staff. **Mitigating actions**: : Recruitment and retention post filled, due to start October 2017. Additional recruitment events planned for October 2017.
	✓ *Job Plans in place for consultants and specialist doctors*				**Progress update and risks to delivery**: Policy has been updated and agreed, and a programme of work has been agreed. Data collection for job plans is being undertaken in divisions. **Mitigating actions**: Data collection for job plans is being undertaken in divisions.
➢ **Deliver improvements in maternity care** ✓ Develop and implement the Maternity Transformation Programme (Better Births) ✓ Deliver improved maternity dashboard	✓ *Reduce neonatal deaths*	March 2018	Chief Nurse		**Progress update and risks to delivery**: The draft 5 year plan for Maternity Transformation is being written by the Black Country LMS for submission to the National Maternity board in October 2017. **Mitigating actions**: There are three work streams currently in progress particularly the Infant Mortality work stream building on existing good practice across the Black Country.
	✓ *Reduce babies with brain injuries that occur at or soon after birth*				**Progress update and risks to delivery:** The draft 5 year plan for Maternity Transformation is being written by the Black Country LMS for submission to the National Maternity board in October 2017. **Mitigating Actions:** There are three work streams currently in progress particularly the Infant Mortality work stream building on existing good practice across the Black Country.
	✓ *Zero avoidable maternal deaths*				**Progress update and risks to delivery**: The draft 5 year plan for Maternity Transformation is being written by the Black Country LMS for submission to the National Maternity board in October 2017. **Mitigating actions**: There are three work streams currently in progress particularly the Infant Mortality work stream building on existing good practice across the Black Country.
	✓ *Progress towards key maternity dashboard*				**Progress update and risks to delivery**: Updated locally agreed dashboard in use **Mitigating actions**: Locally agreed dashboard completed. However there are plans for a nationally agreed dashboard to be implemented
Strategic aim three: drive service improvement, innovation and transformation					

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
➢ **Deliver effective medical research activities** ✓ West Midlands CRN Higher Level Objectives (HLO 1-3) achieved.	✓ *West Midlands CRN Higher Level Objectives (HLO 1-3) achieved*	March 2018	Medical Director		**Progress update and risks to delivery**: This action is being reviewed
✓ **Increase access to 7 day services** ††	✓ *Improve the position from the audit completed in April 2016 for:* • *first consultant review in 14 hours*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: Directorates have implemented a number of initiatives to secure review by a consultant in 14 hours though compliance cannot be confirmed until a further audit is undertaken. **Mitigating actions**: Directorates have submitted plans to improve 14 hour access and these are being reviewed by Medical Director and Chief Operating Officer.
✓ Implement plans to deliver key standards ✓ Actively contribute to appropriate clinical networks to deliver seven day services for emergency vascular surgery, stroke, major trauma, heart	✓ *Improve the position from the audit completed in April 2016 for:* • *Consultant directed intervention*				**Progress update and risks to delivery**: Many services are available already on site or through SLAs. **Mitigating actions**: A plan is in place for Interventional Radiology to be in place for December 2017; a plan is in place to extent MRI provision through the community imaging hub and a plan for interventional endoscopy is being developed.
	✓ *On-going review of high-dependency patients by consultants twice daily*				**Progress update and risks to delivery**: Delivered in most of high dependency areas, but more work is required in some with plans to support. **Mitigating actions**: Meetings are in place to support plans in these areas doe Vascular/Surgical/Medical HDU.
	✓ *Improve the position from the audit completed in April 2016 for:* • *Timely access to diagnostics*				**Progress update and risks to delivery**: with community imaging suite, the timescale for delivery should be March 2018 **Mitigating actions** include a current review of capacity and workforce to support delay of timescales to March 2018.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
attacks and paediatric intensive care					
	✓ *Trauma network peer review recommendations implemented*				**Progress update and risks to delivery**: All recommendations are being reviewed for implementation by the directorate. Some actions have been completed (e.g. governance structure). **Mitigating actions**: Work is taking place between Directorate Manager and clinical teams to implement the recommendations, including working towards an ED Level 2 trained Trauma nurse being on shift 24/7 and appointing a Trauma Coordinator.
✓ **Transform and re-organise services to drive efficiency and improve key services** ✓ Deliver phase two of Outpatients Transformation ✓ Implement theatres transformation plans ✓ Develop and implement plans for the hybrid theatre ✓ Address performance challenges in ophthalmology ✓ Implement the GIRFT recommendati	✓ *Referral and clinical management processes reviewed and new processes implemented*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: Progress has been made on letter review and a plan is in place to progress advice and guidance and delivery of e-referrals. **Mitigating actions**: Further work being undertaken through OPD performance meeting which includes reduced clinic cancellations and improved ASI performance, improved slot utilisation, and improved oversight of follow ups through partial booking implementation. A business case for 2-way text messaging has been improved approved.
	✓ *Records management processes reviewed and new processes implemented*				**Progress update and risks to delivery**: Processes internally have been reviewed and changed to support operational delivery. **Mitigating actions**: Further work is required on notes' delivery for theatres and OPD. A proposal for destruction of health records to be received at Directors by December 2017.
	✓ *Recruitment and retention strategy for theatre staff in place*				**Progress update and risks to delivery**: April/May- high level of Band 5 leavers for external opportunities at band 6 and above. External review has identified areas for focused improvement. **Mitigating actions** Analysis has concluded that the Recruitment and Retention strategy has had a positive effect, but has not yet addressed the vacancy issue. Further actions include increasing the geographical area for university graduates (which has resulted in recruitment from Stoke area) and a rolling advert on NHS Jobs for Band 5 Anaesthetics & Recovery Practitioners.
	✓ *Theatre scheduling undertaken using EPR*				**Progress update and risks to delivery**: EPR project is on-going. Vacancies now recruited. Improved delivery from August 2017. **Mitigating actions**: Action plan is now about to be delivered.
	✓ *Phase two of theatre reconfiguration complete*				**Progress update and risks to delivery**: Further work being undertaken with an external company. **Mitigating actions**: Action plan to improve as per external review.
	✓ *Hybrid Theatre business case*				**Progress update and risks to delivery**: The business case has been

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
ons for relevant specialities	*written and approved*				written and approved, plans in place to build within 2018/19. **Mitigating actions**: Progressing with architectural planning.
✓ Develop and deliver improved pathways for MSK, Respiratory and Neurology in line with the RightCare initiative to reduce unwarranted variation ††	✓ *Hybrid theatre implementation*				
	✓ *Reduced waiting time for ophthalmology*				**Progress update and risks to delivery**: Use of ODS and additional DGFT capacity have reduced overdue follow ups to <800. **Mitigating actions**: Nurse Injector in post, completion of building work, ODS capacity.
	✓ *Hip prosthesis rationalised*				**Progress update and risks to delivery**: Savings have been realised
	✓ *ENT day case rates improved*				**Progress update and risks to delivery**: Day case rates have been optimised within ENT and all clinically appropriate patients are admitted as day cases. **Mitigating actions**:
	✓ *Consultant physician input to vascular surgery in place*				**Progress update and risks to delivery**: Work is taking place with the Elderly Care department to secure locum. **Mitigating actions**: Employment of consultant locum for winter period being reviewed. Business case to Directors Oct ober 2017.
✓ Improvements in service performance delivered for Renal	✓ *Implement actions from Ophthalmology GIRFT Review*				**Progress update and risks to delivery**: Ophthalmology action plan developed and presented at CQSPE. **Mitigating actions**: Plans to engage with a private company to clear backlog of 100 new and 650 follow up patients.
✓ Implement the Hospital Pharmacy Transformation Plan (HPTP)	✓ *Improved pathways developed, agreed and implemented Ophthalmology*				**Progress update and risks to delivery**: In Ophthalmology a number of pathway improvements are already in place and the service is working to improve capacity further as below: • Nurse injector to start interdependent theatre sessions • Minor Eye Conditions to go out in the community • Virtual Glaucoma Pathway with Oct Cirrus
✓ Implement improvements to hospital discharge process					**Mitigating actions**: Consultants are doing extra clinics to mitigate risks and engaging with the private company.
	✓ *Improvement in efficiency (metrics to be approved once plan approved)*				**Progress update and risks to delivery**: The plan is in place to improve theatre efficiency and is linked with CIP
✓ Develop MSK Services††	✓ *Increase clinical pharmacy time by 80%*				**Progress update and risks to delivery**: Performance against this metric is deteriorating due to a number of people leaving, creating increased vacancies and pressure on the department. **Mitigating actions**: This will be addressed via the implementation of the
✓ Expansion of community					

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
ENT clinics (incl Audiology) ††					Pharmacy 7 day services business case, with the recruitment process now underway.
✓ Develop a model to support Acute Oncology Service ††	✓ *Increase pharmacy prescribers to 70%*				**Progress update and risks to delivery**: Currently limited with prescribing pharmacists and above mentioned vacancies adding pressure to the department. **Mitigating actions**: Refinement and approval of additional prescribing pharmacist business case should allow metric to be green by the end of this financial year.
✓ Review of provision of plastics/skin cancer services ††	✓ *Implement e-chemo prescribing system (October 2017)*				**Progress update and risks to delivery**: Resourcing and technology issues have been an issue however these are mostly resolved. **Mitigating actions**: Meetings are in process to agree implementation.
✓ Develop a more integrated clinical model for therapy services ††	✓ *Reduce number of patients with length of stay of 2 weeks or longer*				**Progress update and risks to delivery**: Work on the systematic management of 14 day length of stay continues. **Mitigating** actions include the implementation of red to green, introduction of an elderly care physician to support pre-operative optimisation and post-operative review.
✓ Expansion of orthodontics service ††	✓ *Improved pathways developed, agreed and implemented: MSK* ††				**Progress update and risks to delivery**: Options for a MSK triage service are being developed as part of the Right Care initiative and the MCP. **Mitigating actions**:
	✓ *Improved model in place for Oncology Service* ††				**Progress update and risks to delivery**: Changes to the cancer pathway at a neighbouring Trust may lead to a decrease in resource available to DGFT. **Mitigating actions**:
	✓ *Revision of plastics/skin cancer services undertaken and implemented* ††				**Progress update and risks to delivery**: The business case was approved in August 2017. Implementation is underway. **Mitigating actions**:
	✓ *Improved pathways developed, agreed and implemented: Therapies Services* ††				**Progress update and risks to delivery**: **Mitigating actions**:
	✓ *Increased capacity of orthodontics service* ††				**Progress update and risks to delivery**: Two consultants have been appointed and commenced in October 2017. The Orthodontics service will be operational. Limited orthodontics capacity across the Black Country may

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast				Risks to Delivery & Mitigating Actions
								mean that there is an increase in referrals to DGFT. **Mitigating actions**:
Strategic aim four: be the place people choose to work								
➢ **Enhance colleague engagement** ✓ Develop a programme to enhance colleague engagement ✓ Embed the Staff Survey as a tool to help managers share best practice and make improvements to staff engagement	✓ *Staff Survey embedded*	March 2018	Director of HR/ Chief Nurse					**Progress update and risks to delivery**: The survey went live in quarter two and closes 1st December 2017. The profile of the survey is being raised to improve engagement across the Trust. Results will be available in March 2018.
	✓ *Improvement in the national Staff Survey engagement score to 3.8%*							**Progress update and risks to delivery**: The survey takes place in October/November. Plans are in place to raise the profile and improve engagement across the Trust.
	✓ *Increase the response rate to 48%*							**Progress update and risks to delivery**: The survey takes place in October/November. Plans are in place to raise the profile and improve engagement across the Trust.
	✓ *Extend staff Friend and Family Test update*							
	✓ *Staff story presented at Board*							**Progress update and risks to delivery**: the staff story was presented by the Lead Nurse for ED.
➢ **Maximise workforce capacity and capability, undertaking workforce redesign where appropriate** ✓ Create an	✓ *Mandatory training target of 90% met be end of year*	March 2018		85%	85%			**Progress update and risks to delivery**: A new policy has been developed, agreed and is in place. **Mitigating actions:** HR is supporting managers to understand and implement the policy on level one and two mandatory training
	✓ *New roles in place i.e. Nursing Associate, clinical apprentice and nursing volunteers*							**Progress update and risks to delivery**: Clinical apprenticeships are now underway. **Mitigating actions:** A revised programme will commence in November 2017. New trainee Nursing Associates are being recruited for a second cohort starting in January 2018.
	✓ *Information Governance training target of 95% met by end of the year*			98%	83%			**Progress update and risks to delivery**: **Mitigating actions:**

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast				Risks to Delivery & Mitigating Actions
employee development programme underpinned by an employee training needs analysis ✓ Create an Organisational Development Programme ✓ Enhance mechanisms to identify potential to support succession planning opportunities ✓ Improve performance against recruitment key performance indicators (KPIs) ✓ Boost staff retention through structured support ✓ Introduce new nursing roles	✓ *Employee development programme in place*							**Progress update and risks to delivery:** This is due in December 2017.
	✓ *Leadership Forum commenced*							**Progress update and risks to delivery**: This will commence in November 2017. Invites have been issued.
	✓ *Appraisal target of 90% met by end of year*			85%	84%			**Progress update and risks to delivery**: Managers are being supported to implement the new policy and appraisal forms.
	✓ *Recruitment and retention KPIs delivered*							**Progress update and risks to delivery**: KPIs have been developed and introduced
➢ **Maximise employee-well being**	✓ *Sickness absence target 3.5% met by end of year.*			3.9 %	4.2%			**Mitigating actions:** Managers are being supported to manage sickness absence and to apply the sickness absence policy

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
✓ Improve workforce performance in sickness, mandatory training, appraisal ✓ Implement a smoke free site	✓ *Achieve 5% improvement in two of the 3 health & well-being staff survey questions*				**Progress update and risks to delivery**: The results of the survey will be available in March 2018.
	✓ *staff well-being events are held at least four times a year focusing on physical and mental health*				**Progress update and risks to delivery**: two have been delivered and two are planned.
	✓ *Site smoke free by January 2018*				**Progress update and risks to delivery**: A paper was discussed and approved at Trust Board in September 2017. Discussion is now taking place on how to implement this.
Strategic aim five: make the best use of what we have					
➢ **Implement the Digital Trust Programme** ✓ Implement the core foundation systems for the Digital Trust ✓ Deliver a Proof of Concept Shared Record between GP's and DGFT	✓ *Each phase of the Digital Trust plan delivered in line with project plan*	March 2018	Chief Information Officer		**Progress update and risks to delivery**: Timescale for EPR go live was moved to 23rd April to fit in with Divisions plans. **Mitigating actions:**
	✓ *Proof of Concept Shared Record developed*	Sept 2017			**Progress update and risks to delivery**: The shared record is now positioned as an MCP IT population Health solution so any proof of concept will be carried out with the GP partnership directly, rather than through the CCG **Mitigating actions:** The proof of concept date has moved to November 2018 to align with the MCP activities.
➢ **Match capacity to demand** ✓ Implement an operational	✓ *Operational demand/capacity management tool implemented*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: Demand and capacity modelling has been completed but not embedded within services. **Mitigating actions**: Further work is being undertaken until demand managed and appropriate capacity in place.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
demand/capacity management tool					
➢ **Deliver the agreed financial plan** ✓ Set budgets that will achieve a £2.45 m surplus and monitor progress. ✓ Deliver CIP of £12.5m and a financial control target of £2.45m surplus ✓ Identify and target specific areas of efficiency as identified through the Model Hospital Portal	✓ *Budgets set that achieve a £2.5m surplus* ✓ *£12.5m CIP and a £2.45m surplus control total achieved*	March 2018	Director of Finance/ Director of Strategy & Business Planning		**Progress update and risks to delivery**: The full year target is £12.5m of which £10.03m has been identified at the end of Quarter 2. However, year to date performance of CIP schemes is ahead of plan. Risks to delivery include schemes linked to medical bank and agency spend and theatre productivity (T&O and Ophthalmology day case). **Mitigating actions** include agency spend reduction plans, further capacity reductions, (perhaps linked to social care funding) and robust monitoring of existing plans. Progress pipeline schemes to ensure that there are contingency CIP schemes in place.
➢ **Develop a Clinical Strategy which ensures a sustainable clinical organisation**	✓ *Refreshed Clinical Strategy in place*	June 2017	Medical Director / Chief Nurse		**Progress update and risks to delivery**: The Clinical Strategy is in draft form following consultation with clinicians and managers from across the Trust. The draft reflects the potential impact of external initiatives. The draft strategy will be considered by Trust Board in August 2017.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
✓ Engage clinical workforce in the development of the strategy ✓ Reflect the impact of external initiatives within the strategy (i.e. STP, BCA, MCP).					
Strategic aim six: deliver a viable future					
➢ **Play an active part in the STP arrangements in the Black Country and West Birmingham** ✓ Implement the Sustainability and Transformation Plan	✓ *STP implemented*	March 2018	Chief Executive		
➢ **Play a part in the implement-ation of the Black Country Alliance initiatives.**	✓ *Savings identified achieved* ✓ *BCA procurement work stream implemented* ✓ *Implement the Black Country Pathology Review*	March 2018	Chief Executive		**Progress update and risks to delivery**: The full business case which includes identified risks is due to be presented to Board in November/December 2017. A Programme Manager is in place to work

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
✓ Deliver the aspirations of the BCA procurement work stream including the Nationally Contracted Products Programme. ✓ Work in partnership to develop a model for delivery of Black Country Pathology Services ✓ Develop opportunities for pharmacy benefits across Black Country Trusts ✓ Maximise back office opportunities					across the Black Country. Twenty work streams have been identified and are developing clinical models. **Mitigating actions**: DGFT is represented on each work stream. The Clinical Director is the lead for DGFT. A Non-Executive Director attends the BCA Pathology Board.
	✓ *Deliver identified pharmacy benefits*				**Progress update and risks to delivery**: Three projects are under way: • Pharmacy Aseptic Unit review and rationalisation – a paper has been produced to propose a review. • Medicines Safety – initial projects scoped by Chief Pharmacists to improve prescribing, dispensing and administration of high risk drugs. • Medicines administration Pharmacy Technician Project – each BCA Chief Pharmacist is meeting with exec leads to establish if pilots can be undertaken locally and then pool the learning to develop the posts.
	✓ *Back office opportunities identified and delivered*				**Progress update and risks to delivery**: The Trust is committed to progress shared back office function at an STP level. The Trust is working with Sandwell & West Birmingham Hospitals NHS Trust, Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust to review how the finance, procurement payroll and Human Resources function could be delivered in a collaborative model. An outline business case has been prepared which provides a number of options of how the services could be provided on a collaborative basis going forward. The Trust expects to progress with a preferred option during 2018-19 which will provide the Trust with more efficient back office functions to support our clinical services. **Mitigating actions**
✓ **Work proactively with BCHCare FT to become the provider of MCP services** †† ✓ Develop and submit a joint	✓ *Bid developed and submitted*	March 2018	Chief Executive		**Progress update and risks to delivery**: The outcome of the pre-qualification questionnaire was announced by the CCG on 08/08/2017, with DGFT and Birmingham Community Healthcare being identified as preferred provider. The outline response under Invitation to Participate in Dialogue was submitted on 20/08/2017. Work has commenced and will continue in Quarter 3 which includes clinical and financial modelling and development of organisational form and governance. There have been on-going dialogue sessions between the CCG procurement team and partners. Key risks include i) the impact of all workstreams on the trust ii) agreement of gain share and iii) utilisation of capacity created to the Trust's benefit. **Mitigating actions** include i) ensuring timescales and capacity to respond

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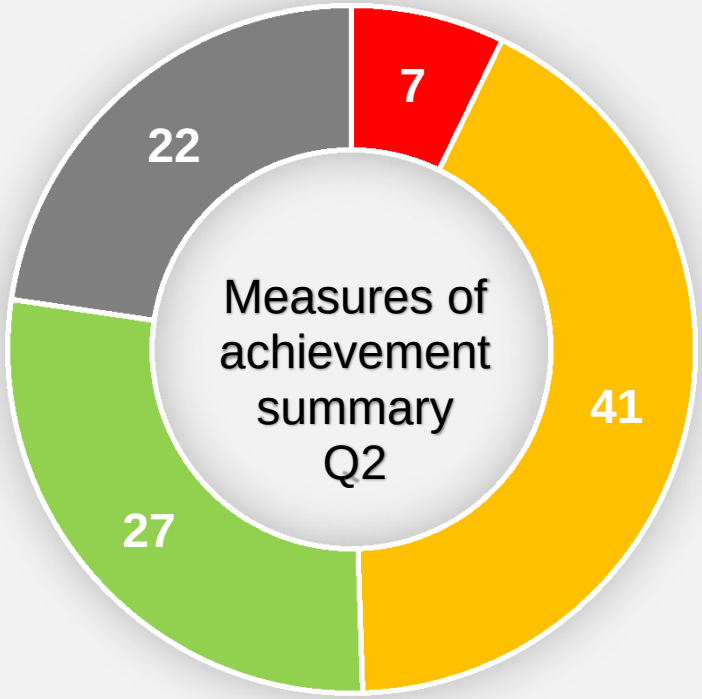
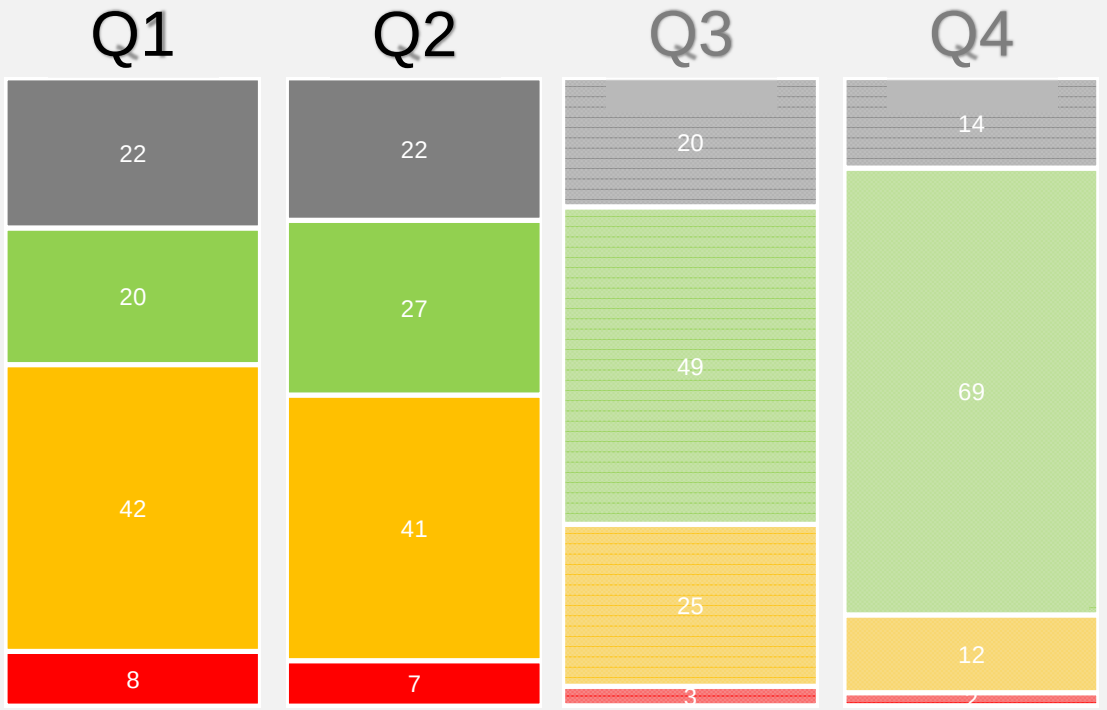
Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1 & Q2 RAG Q3 & Q4 RAG Forecast	Risks to Delivery & Mitigating Actions
bid in conjunction with BCHCare Foundation Trust ✓ Support and engage staff in the change process ✓ Develop and implement revised care pathways					to milestones in a timely way with a project manager in place to coordinate and ensure pace ii) understanding the detail of the impact on the business of the Trust iii) development of a set of business cases by partners which are due to be completed by the end of Quarter 4.
	✓ *Revised care pathways scoped*				
	✓ *Bid successful*				**Progress update and risks to delivery**: Regular discussions weekly with GP collaborative have taken place throughout the PQQ and will continue through bidding process,
	✓ *Communications plan in place for staff*				
➢ **Develop the Trust's market share in the Wyre Forest** ✓ Identify and exploit opportunities for increasing the Trust's market share in the Wyre Forest.	✓ *Establish clinics at Bewdley Medical Centre*	March 2018	Director of Strategy & Business Planning		**Progress update and risks to delivery**: Wyre Forest CCG do not wish to expand the number of clinics and will review this as part of contract negotiations for 2018/19. **Mitigating actions**: DGFT will participate fully in contract negotiations.
	✓ *Expand clinics located at Hume Street*				**Progress update and risks to delivery**: Wyre Forest CCG do not wish to expand the number of clinics and will review this as part of contract negotiations for 2018/19. **Mitigating actions**: DGFT will participate fully in contract negotiations.

OPERATIONAL PLAN PERFORMANCE

The Dudley Group NHS Foundation Trust

Appendix 2 Q2 2017/18





1 Deliver a great patient experience

2 Deliver safe and caring services

3 Drive service improvement, innovation & transformation

4 Be the place people choose to work

5 Make the best use of what we have

6 Deliver a viable future