The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 8th March, 2018 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 Fellows**		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 8 February 2018	Enclosure 1	J Ord	To Approve	9.00
	4.2 Action Sheet 8 February 2018	Enclosure 2	J Ord	To Action	9.05
5.	**Staff Story**		L Abbiss	To Note & Discuss	9.10
6.	**Healthy Eating Presentation**	Enclosure 3	Interserve/ Transformation	To Note & Discuss	9.20
7.	**Chief Executive's Overview Report**	Enclosure 4	D Wake	To Discuss	9.30
8.	**Safe and Caring**				
	8.1 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 5	D Wulff	To note assurances & discuss any actions	9.40
	8.2 Infection Prevention and Control Report	Enclosure 6	E Rees	To note assurances & discuss any actions	9.50
	8.3 Nurse/Midwife Staffing Report	Enclosure 7	S Jordan	To note assurances & discuss any actions	10.00
	8.4 Quality Account and Quality Targets Report	Enclosure 8	S Jordan	To discuss and approve	10.10

	8.5 Learning from Deaths Report	Enclosure 9	J Hobbs	To note assurances & discuss actions	10.20
9.	**Responsive and Effective**				
	9.1 Finance and Performance Committee Exception report	Enclosure 10	R Miner	To note assurances & discuss any actions	10.30
	9.2 Integrated Performance Dashboard	Enclosure 11	K Kelly	To note assurances & discuss any actions	10.40
	9.3 Cost Improvement Programme and Transformation Overview Report	Enclosure 12	N Younes	To note assurances & discuss any actions	10.50
	9.4 Patient experience report	Enclosure 13	S Jordan	To note & discuss	11.00
10.	**Well Led**				
	10.1 Digital Trust Committee Exception Report	Enclosure 14	M Stanton/ A Becke	To note assurances & discuss any actions	11.10
	10.2 Staff Survey	Enclosure 15	A McMenemy	To note & discuss	11.20
	10.3 Freedom to Speak Up Guardians Report	Enclosure 16	G Palethorpe	To note & discuss	11.30
	10.4 Guardian of Safe Working Report	Enclosure 17	B Elahi	To note & discuss	11.40
	10.5 Workforce Committee Exception Report including Workforce Strategy Update Report	Enclosure 18	J Atkins	To note assurances and discuss any actions	11.50
11.	**Any other Business**		J Ord		12.00
12.	**Date of Next Board of Directors Meeting** 9.00am 12th April, 2018 Clinical Education Centre		J Ord		12.00
13.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		12.00

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

Enclosure 1

The Dudley Group NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 8th February, 2018 at 9.00am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Julian Atkins, Non Executive Director
Doug Wulff, Non Executive Director
Jonathan Fellows, Non Executive Director
Diane Wake, Chief Executive
Karen Kelly, Chief Operating Officer
Tom Jackson, Director of Finance
Julian Hobbs, Interim Medical Director

In Attendance:

Helen Forrester, EA
Andrew McMenemy, Director of HR
Mark Stanton, Chief Information Officer
Liz Abbiss, Head of Communications
Glen Palethorpe, Director of Governance/Board Secretary
Natalie Younes, Director of Strategy and Business Development
Mark Hopkin, Associate Non Executive Director
Carol Love Mecrow, Deputy Chief Nurse
Dr Elizabeth Rees, Director of Infection Prevention and Control (Item 18/020.2)

18/013 Note of Apologies and Welcome
9.01am

Apologies were noted from Siobhan Jordan, Chief Nurse and Ann Becke, Non Executive Director. The Chairman welcomed Tom Jackson, Director of Finance to his first board meeting in this role and the Chairman welcomed Carol Love Mecrow to the meeting who was deputising for the Chief Nurse.

18/014 Declarations of Interest
9.02am

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.

18/015 Announcements
9.03am

None to note.

18/016 Minutes of the previous Board meeting held on 11th January, 2018 (Enclosure 1)
9.04am

At page 5 of the minutes a note was added to clarify that the flu target is 70% and the Trust was ahead of target.

With this amendment the minutes were agreed by the Board as a true and correct record of the meetings discussion and could be signed by the Chairman.

18/017 Action Sheet, 11th January, 2018 (Enclosure 2)
9.06am

18/017.1 Monthly Nurse/Midwife Staffing Report

A paper will be presented to the March Board meeting.

Monthly Nurse/Midwife Staffing Report to be presented to the March Board meeting.

18/17.2 EPRR Core Standard Submission Report

The new EPRR Manager had commenced on the 5 February 2018. The Board noted that the Trust is substantially compliant with the national standards. There was some learning regarding flu preparations and approach which will be reflected in next year's winter plan.

The EPRR risk was reviewed at the Finance and Performance Committee who determined that the Trust's current score for this risk was reasonable. There were no further risks to escalate to the Board therefore the outstanding action can be removed from the Board action sheet.

18/17.3 Clinic Slot Utilisation

The Chief Operating Officer is working with FourEyes to analyse the used slots within clinics and Did Not Attend rates and any further improvements. Clinic slot utilisation will be included in the Integrated Performance Report to Board from March.

Clinic slot utilisation to be included in the Integrated Performance Report to Board

from March onwards.

18/018 Patient Story
9.10am

The Head of Communications presented the patient story. It concerned an emergency case. The patient is a recently appointed Governor. This information was not known by the staff who treated her. The patient is also a nurse who works at another healthcare provider. The patient was very complimentary about the care and timeliness of her assessment and treatment both in Emergency Department and then within the Coronary Care Unit (CCU).

The Chief Operating Officer confirmed that there is always an emergency care bed reserved for Resus patients that need monitoring within CCU and this helps facilitates timely assessment for these very ill patients.

Mr Atkins, Non Executive Director, asked that staff be informed of the positive feedback especially given the pressure the Emergency Department has been under with the increased demand over winter from ill patients.

The Chairman and Board noted the positive story and asked that staff receive feedback with the appropriate acknowledgement also going to the patient.

Staff to be informed of the positive feedback from the Patient Story.

18/019 Chief Executive's Overview Report (Enclosure 3)
9.17am

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

- Healthcare Heroes: The team award had been presented to the Acute Medical Unit (AMU) and the individual award went to Sister Nerys Carr. Information on the awards had been shared on social media.

- CQC: There had been two unannounced CQC inspections in December, with the Community inspection followed by the Well Led Review both in January. A number of recommendations were made for immediate improvement and the Trust is providing feedback to the CQC on a weekly basis. A Quality and Operational Improvement Plan has been developed which will be reported to Clinical Quality, Safety and Patient Experience Committee. Deloitte had been engaged to ensure that the Improvement Plan is fit for purpose and provide an independent view of progress and action delivery. The Chief

Executive also updated the Board that the CQC had provided feedback that there were a number of areas inspected where good performance had been demonstrated.

Mr Fellows, Non Executive Director, asked about staff involvement in the Improvement Plan. The Chief Executive replied that the Trust is meeting weekly with the relevant teams to ensure that they are engaged. Each task has a dedicated delivery owner and each service plan has a local service specific owner responsible for maintaining engagement with colleagues and providing feedback on delivery.

The Chairman confirmed that the first meeting of the System Oversight Group is scheduled for 22nd February, 2018. She asked about the new Emergency Care Centre and how the streaming/triage system would work within that environment. The Chief Operating Officer confirmed that Malling Health were already in situ but the new Centre will not be opening until later in February, when it was expected all "snagging" items following construction would be complete. When the Centre opens an appropriately qualified Streaming Nurse will see all patients to stream them to Primary Care or the Emergency Department. This system aligns with national guidance from the Royal College of Emergency Medicine.

The Chief Executive stated that the Trust needs to work on the relationship between the Trust and Malling Health to ensure there is an effective way to share lessons, drive improvements and flag any concerns quickly.

Dr Wulff, Non Executive Director, raised learning from the Bawa-Garba case and asked if this was being considered. The Chief Operating Officer confirmed that a number of actions had been put in place as a result of the case and the CQC visits. The Trust was committed to ensuring that all children are kept safe whilst in our care. The Medical Director added that the case is not wholly around Paediatric care and the Trust was looking at how it treats all patients and there is a significant amount of assurance provided on a daily basis on the safety and effectiveness of our services. The Chief Executive suggested that a paper is presented to the Clinical Quality, Safety, Patient Experience Committee on the case to demonstrate the Trust response.

The Chairman and Board noted the report

Paper on the Bawa-Garba case to be presented to the Clinical Quality, Safety, Patient Experience Committee.

18/020 Safe and Caring

18/020.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
9.30am

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:

- There had been a reduction in performance in respect of VTE assessments and stroke swallowing assessments. It was agreed that this would be discussed during the Performance Report item later on the agenda.

- Paediatrics and Ophthalmology waiting times: The Board noted that Ophthalmology continued to have long waiting times for some follow up appointments. These had been reduced to 6 months but the Trust had still not achieved its trajectory for sustainable delivery. The ophthalmology team were continuing to clinically risk assess all patients waiting.

- The Committee received the progress report following the unannounced inspections and the detailed action improvement plan. The Committee advised he Board that the Trust had responded, as required, to the section 31 notices.

- The Committee had sought detailed analysis in respect of Caesarean Section rates and once completed the Committee will discuss this further.

The Chief Executive stated that the Improvement Plan is driven by the Trust using local analysis and not just CQC identified areas for improvement. Changing the culture is an important factor that will underpin improvements and action. Board, Executive and Divisional development sessions have been incorporated into the Improvement Plan.

Mr Atkins, Non Executive Director, asked about the oversight of the Divisional culture. The Chief Executive confirmed that the Board will receive assurance around how this is being applied within the Divisions.

The Chairman asked if quality improvement strategies for the longer term will be included in the Improvement Plan. The Chief Executive confirmed that it would be and the Trust aspires to have Quality Champions across the organisation. Mr Atkins asked when the plan for this will be available. The Director of Human Resources confirmed that that Plan will be presented to the Workforce Committee, but would also be an essential theme within the overall plan.

The Chairman asked that engagement with particular service areas be discussed further on the Private agenda.

The Medical Director confirmed that there had been a generally positive response across the organisation to the shortcomings and the consequent improvement plan. He further confirmed that AQUA would be assisting the Trust in developing its quality strategy.

The Director of Finance stated that organisationally the Trust should ensure that both quality and finance are in balance within the developing financial plan.

The Chairman asked about the policies approved by the Committee and whether the Standing Operating Procedures had been updated and whether there were any other areas within the organisation where policy changes are required in light of recent developments. The area of risk was compliance with such procedures. The Director of Governance/Board Secretary confirmed that the Standard Operating Procedures had been updated. The Chief Executive confirmed that sources of new guidance will be overseen at the Risk and Assurance Committee and this will ensure that as new guidance is received into the Trust that appropriate reviews of relevant Policies, Guidelines and Operating Procedures are undertaken. The first monthly meeting of this Committee was scheduled for 16th February, 2018.

The Chairman and Board noted the report, assurances received, items to come back to the Committee and cultural issues discussed.

Cultural change plans reflected within the Quality Improvement Plan to be presented to the Workforce Committee.

18/020.2 Infection Prevention and Control Update (Enclosure 5)
9.47am

The Director of Infection Prevention and Control presented the Infection Prevention and Control Report, given as Enclosure 5. The Board noted the following key issues:

With regard to the Trust's compliance criteria in relation to the Hygiene Code the Board noted that a revised Cleaning Policy had been introduced and arrangements made to ensure there is a more robust HPV fogging programme in place across the Trust.

Performance against the Antimicrobial CQUIN has slipped from its planned trajectory. This was due to a national change within the denominator data changing the Trust reported performance but without any change being made to the target.

In relation to mandatory training the Chief Executive stated that there cannot be any delays and the Director of Infection Prevention and Control needs to drive actions within the respective areas to ensure compliance with the revised time scales for undertaking training annually.

The Chief Operating Officer asked that the EPRR lead be involved in the Trust's review of its isolation facility provision. The Director of Infection Prevention and Control confirmed she would contact the newly appointed lead to get them involved in this work.

The Board noted that the C.Diff trajectory was to have no more than 29 cases apportioned to the Trust and this should be achievable.

MRSA has a zero case tolerance and the Trust continues to have had no cases since September 2015.

Mr Miner, Non Executive Director, asked about the C.Diff target. The Board noted that there were 14 cases where a lapse in care had been identified and 5 cases under review. With a potential maximum of 19 cases the Trust was well inside the target of 29.

Mr Fellows, Non Executive Director, raised the failure against internal screening target. The Director of Infection Prevention and Control confirmed that an action plan is being produced and will be monitored through the Infection Prevention and Control Forum. The data gathered is based on the coded activity. There is an issue to resolve as some elective procedures do not require screening but are within the numbers counted in the data used to calculate this indicator. The Trust is looking at removing these procedure codes to provide a more accurate data set but this is proving to be a very time consuming piece of work. The position will be reviewed at the end of the year to see if the internal target needs to be changed if relevant procedures cannot be removed.

The Chairman confirmed that the Board looks forward to receiving the analysis undertaken and the change this would bring to the Trust's reported performance.

The Chairman asked about mandatory training and identified lapses in care associated with staff failing to be trained. The Director of Infection Prevention and Control confirmed that the CCG will not use mandatory training as a lapse in care between now and the end of the year as we have agreed a change to our training frequency. The Chairman reiterated the importance of ensuring all staff are trained and that the The Director of Infection Prevention and Control had the Board's support to drive this through.

The Chairman and Board noted the report.

The Director of Infection Prevention and Control to ensure that all staff undertake mandatory training within the new time cycles.

18/020.3 Monthly Nurse/Midwife Staffing Report (Enclosure 6)
10.03am

The Deputy Chief Nurse presented the monthly Nurse/Midwife Staffing Report given as Enclosure 6.

The Board noted the following key issues:

- The Trust was achieving safe staffing levels with the support of Agency and Bank staff.
- The Trust was nearly at a 100% fill rate but this was with a significant reliance on temporary staffing. Opening additional capacity had added to the greater reliance on Agency staff.
- Neonatal Unit staffing was under review as the staff complement was queried by a peer review team that visited the Trust in January.

- The detailed staffing review was ongoing and had taken longer than anticipated and was now expected to be completed in March. Successful monthly recruitment exercises were continuing.

Mr Miner, Non Executive Director, asked about the last page on safer staffing numbers and asked for clarification around the first column. The Deputy Chief Nurse confirmed that this was planned hours by ward. The Trust was scoping a piece of work with internal audit to look at the data to ensure its validity and consistency of the numbers reported..

The Chairman asked about the reduction in the number of beds and how this might impact positively on the Trust's reliance on agency staff. The Chairman asked that these numbers be confirmed by the Chief Nurse when she returns from annual leave.

The Chairman asked if there were any specific safety risks due to the level of staffing in certain areas and whether the closure of some provision should be considered. The Chief Executive confirmed that there is a process for service areas to follow to close beds and confirmed that she could provide appropriate assurance to the Board on this.

Mr Fellows, Non Executive Director, expressed concern that no comparative regional or national data had been produced since late summer / early autumn and the Trust should raise this with regulator colleagues as being unacceptable.

Mr Atkins, Non Executive Director, stated that fill rates are based on historic establishments and it is important to receive the awaited staffing review report so that the Board can take assurance around changes approved to staffing levels.

The Chairman and Board noted the report

The Chief Nurse to clarify the data around the reduction in beds and the impact on Agency numbers on her return from annual leave.

The Trust to raise concern over the lack of comparative regional or national data with which to benchmark performance against.

18/020.4 Smoke Free Update Report
10.10am

The Director of Human Resources presented the Smoke Free Update Report given as Enclosure 7. The Board noted the following key highlights:

There had been a discussion at the September 2017 Board but there had been no determination made on the exact way forward although generally the discussion had indicated support for a smoke free hospital environment.

The report provided detail around the options available to the Trust to take this forward to implementation.

The Chairman asked about vaping as there had been some media attention to this recently, she stated that vaping policies would need to be reflected in the Trust's decision and implementation. The Director of Human Resources confirmed that this detail will be picked up after the Board had made a decision about the way forward.

Mr Miner, Non Executive Director, asked if the removal of smoking shelters will mean that there will be no smoking at all on site. The Director of Human Resources confirmed that this would be the case.

The Director of Human Resources stated that the Trust does not sufficiently "police" the current policy.

The Chief Operating Officer stated that her experience of previous organisations removing shelters had resulted in a mess from cigarette ends on site. The Chief Executive stated that as a healthcare provider we should not provide facilities for people to smoke so should support option 2. We have to embrace the Public Health message and not provide opportunities for people to smoke which in turn would damage their health.

The Board **agreed** to pursue option 2; to implement a smoke free environment across the Trust that also removes smoking shelters on site.

Mr Fellows, Non Executive Director stated that we need to put up notices that there is no smoking allowed anywhere on site.

The Chairman and Board noted the report and **agreed** to progress option 2.

18/021 Responsive and Effective

18/021.1 Finance and Performance Committee Exception Report (Enclosure 8) 10.20am

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

The Board noted the following key issues:

- December performance: Year to date deficit of £5m against the plan of a £2m surplus.
- NHSI had been notified that the control total will not be met and a revised forecast has been submitted.

- CIP: The Trust is £3.4m below target of circa £12 million and this was a large factor in the reported deficit. The failure to curtail temporary staffing spend was the main factor contributing to the shortfall.

- Agency Staffing: Agency spend was higher than planned and this is also key contributory factor for the overall deficit being reported.

- The Trust is focussing on the development of its 2018/19 plan, recognising the allocated control total for the next year would present a significant challenge. The Trust would also need to focus on meeting this years revised forecast outturn.

The Board noted that there was no overall slippage on the IT project, just a re-phasing and this will be picked up within the Digital Trust update report later in the agenda.

The Chairman and Board noted the report.

18/021.2 Integrated Performance Report (Enclosure 9)
10.21am

The Chief Operating Officer presented the Integrated Performance Report given as Enclosure 8.

The Board noted the following key issues, in respect of performance in December:

- Referral To Treatment (RTT) pathways around Ophthalmology and Paediatrics are just below the planned standard. The Trust is however achieving the overall 18 week RTT performance target at an aggregate level.

- The Trust's diagnostic standard, DMO1 is meeting the required performance standard on a regular monthly basis.

- The Emergency Department continues to be extremely challenged with an increase in emergency admissions. The Medical Assessment area is working well but cannot by itself address the issues of such an increase in demand. Performance around ambulance turnaround times has been good but this does require lots of work on a daily basis to achieve. Further work is being done around triage and the ambulance off- loading area. The Emergency Department has secured 4 SHOs who are to work on the Trust's staff bank which is enhancing medical cover across the whole week. The Trust is working with the clinical lead within the Emergency Department on swifter escalation at times of pressure. FourEyes continue to develop plans with Trust staff to enable additional support to be accessed in times of high demand. The Chief Operating Officer confirmed that there is a 'different feel' about the Department and an energy to improve patient experience.

- The Trust continues to provide its elective surgery programme.

Mr Atkins, Non Executive Director, commented that appraisal and mandatory training figures had reduced a little across the Trust. The Director of Human Resources added that the drop was understandable given capacity pressures being experienced.

Dr Wulff, Non Executive Director, asked about mixed sex breaches as the dashboard shows 10 and the narrative says none. The Chief Operating Officer stated that this was probably an error in the report but would clarify.

The Chairman asked about the never event detailed in the report. The Board noted that this was an error and related to the previously reported event in November.

The Chairman and Board noted the report

The Chief Operating Officer to clarify the data on mixed sex breaches.

18/021.3 Cost Improvement Programme and Transformation Overview Report (Enclosure 10)
10.30am

The Director of Strategy and Business Development presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 10.

The Board noted the following key issues:

- The Trust had achieved £6.6m against the plan of £12.5m, it was expected the year end outturn would be circa £8m.

- Undelivered in Surgery CIP is due to contract income growth not being fully realised.

- Use of Bank and Agency staffing remained an issue and the project to reduce this had not fully delivered.

The Chairman and Board noted the report.

18/021.4 Q3 Annual Plan Monitoring Report (Enclosure 11)
10.34am

The Director of Strategy and Business Development presented the Q3 Annual Plan Monitoring Report given as Enclosure 11.

The Deliotte externa Well Led review had commended the Trust for presenting such a report to Board on a quarterly basis.

Mr Miner, Non Executive Director, raised job plans for consultants moving from red to amber and asked what had driven this improvement. The Medical Director confirmed that the Trust had done a lot of work in this area. The Trust's systems provider had met with the Chiefs of Service who had been given targets to deliver job planning within their respective service. The Trust had also provided resource to assist in moving relevant staff onto the electronic system. All this focus had seen movement in the delivery of job planning since the last report.

Mr Fellows, Non Executive Director, stated that the Annual Plan process had been discussed at the Finance and Performance Committee. It was understood there will be a different approach taken next year resulting in fewer goals and actions. This would support better delivery of the key objectives and priorities for the Trust.

The Chief Executive stated that job planning should be included on Divisional Risk Registers. The Director of Governance/Board Secretary will check this inclusion at the next Risk and Assurance Meeting later that month.

The Chairman and Board **noted** the report and positive progress around consultant job planning.

Job Planning to be included on Divisional Risk Registers.

18/022 Well Led

18/022.1 S31 CQC Report (Enclosure 12)
10.40am

The Director of Governance/Board Secretary presented the Section 31 CQC Report given as Enclosure 12. The Board noted the following key issues:

A separate risk had been added onto the Risk Register and Board Assurance Framework. A further Section 31 notice has been received in relation to triage and governance arrangements with our urgent care partner and weekly reporting of performance is taking place. This would provide enhanced assurance of improvement. A Section 29 improvement notice had been issued

the previous day and requires a response by May but the Trust had already included all actions within the developed Quality Improvement plan. Action against these notices will be reported to the System Oversight Group, Clinical Quality, Safety, Patient Experience Committee and then in turn to the Board.

The Chief Executive confirmed that Board members have all been copied in to all responses to the CQC.

The Chairman and Board **noted** the report.

18/022.2 Digital Trust Programme Committee Summary Report (Enclosure 13)
10.45am

The Chief Information Officer presented the Digital Trust Committee Exception Report, given as Enclosure 13.

The Board noted the following key highlights:

- The Trust has realigned the Digital Strategy in line with the Trust's Quality Improvement Plan.

- Work is being undertaken around Triage and Paediatric Safeguarding, to support actions agreed following the service inspection of the Emergency Department.

- Roll out delivery timescales for EPR remain the same but the Trust has re-phased some of the deliverables. E-obs for nursing staff on wards remains in the first wave to go live in line with the Trust's overall Improvement Plan.

The Chairman asked about a previous concern raised around capacity of the team to accommodate all re phasing and deliverables. The Chief Information Officer confirmed that the re-phased plan has provided mitigation against the capacity risk.

The Chairman and Board **noted** the report.

18/022.3 Audit Committee Exception Report (Enclosure 14)
10.49am

Mr Miner, Audit Committee Chair presented the Audit Committee Exception Report given as Enclosure 14.

The Board noted the following key highlights:

- Once a year the Audit Committee meets in private with the Trust's auditors. This was undertaken at the January meeting and there were no concerns raised to be escalated to the Board.

- Reports from the auditors were positive and management had dealt with 47 out of 60 recommendations outstanding which was a significantly improved position to that reported earlier in the year. The Audit Committee had asked though that specific overdue actions on certain audit reports were concluded swiftly.

- The auditors will look at the data quality underpinning the reported nursing and midwifery ratios as discussed at a previous board meeting.

The Chief Executive confirmed that the auditors attended the Executive Team meeting that week and it had been a positive meeting it enable a more aligned plan of activity to be prepared for the Internal Auditors across 2018/19.

The Chairman and Board **noted** the report.

18/023 Any Other Business
10:52am
There were no other items of business to report and the meeting was closed.

18/024 Date of Next Meeting
10.52am

The next Board meeting will be held on Thursday, 8th March, 2018, 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 8 February 2018

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/107.4 18/005.4 18/017.1	Monthly Nurse/Midwife Staffing Report	Outcome of Nurse Staffing Review to be presented to the January Board.	SJ	8/3/18	To March Board – On Agenda
17/117	Patient Story	Follow up to the patient story to be presented to the Board.	LA	When care/ treatment completed	
17/131.5	Freedom to Speak Up Guardians Report	The Trust to consider its position in relation to having Speak Up Ambassadors/Champions.	DW	March 18	On Agenda
17/131.6	Learning from Deaths Report	Report to include more detail on impact of patient outcomes of any identified learning.	JH	8/2/18	To March Board – On Agenda
17/132.5	Complaints Report	Action plan of how the Trust would achieve a 28 day response rate to be incorporated into the next quarterly Complaints Report.	SJ	8/3/18	On Agenda
18/006	Staff Story	Patient and staff videos to be combined and made available on the Hub. Board members to be interviewed for their perspective on the 6 Cs.	LA LA	8/3/18 12/4/18	To be completed by March Board. To be completed by April Board.

18/018	Patient Story	Theatre scheduling to be discussed at the February Clinical Quality, Safety, Patient Experience Committee. Staff to be informed of the positive feedback from the Patient Story.	KK LA	20/2/18 8/3/18	
18/17.3	Clinic Slot Utilisation	Clinic slot utilisation to be included in the Integrated Performance Report to Board from March onwards.	KK	8/3/18	
18/019	Chief Executive's Overview Report	Paper on the Bawa-Garba case to be presented to the Clinical Quality, Safety, Patient Experience Committee.	JH	20/2/18	Done, paper taken to 20 February Committee meeting.
18/020	Clinical Quality, Safety, Patient Experience Committee	Cultural change plans reflected within the Quality Improvement Plan to be presented to the Workforce Committee.	SJ	27/2/18	
18/020.2	Chief Nurse Report – Infection Prevention and Control	The Director of Infection Prevention and Control to ensure that all staff undertake mandatory training within the new time cycles.	ER		
18/020.3	Monthly Nurse/Midwife Staffing Report	The Chief Nurse to clarify the data around the reduction in beds and the impact on Agency numbers on her return from annual leave. The Trust to raise concern over the lack of comparative regional or national data with which to benchmark performance against.	SJ SJ	8/3/18 8/3/18	
18/021.2	Integrated Performance Report	The Chief Operating Officer to clarify the data on mixed sex breaches.	KK	8/3/18	
18/021.4	Q3 Annual Plan Monitoring Report	Job Planning to be included on Divisional Risk Registers.	GP	8/3/18	Raised at R&A divisions asked to put directorate risks onto datix

Enclosure 3

Health and Wellbeing CQUIN

The Dudley Group Foundation Trust

The Dudley Group
NHS Foundation Trust

Aims/Objectives

The purpose of the presentation is to provide an overview of the Health and Wellbeing CQUIN (17/18) at a public board meeting.

This will include:

- Details of the CQUIN focussing primarily on ‘Healthy food for staff, visitors and patients’ section
- The role of DGFT relating to the CQUIN
- Current CQUIN work conducted till date
- Q&A session

CARE RESPECT RESPONSIBILITY

The Dudley Group
NHS Foundation Trust

CQUIN Background

- CQUIN stands for commissioning for quality and innovation.
- The system was introduced in 2009 to make a proportion of healthcare providers income ‘conditional’.
- It requires Trusts to demonstrate improvements in quality and innovation in specified areas of patient care.
- The aim of a CQUIN is to implement quality improvement of services and therefore better outcomes for patients.

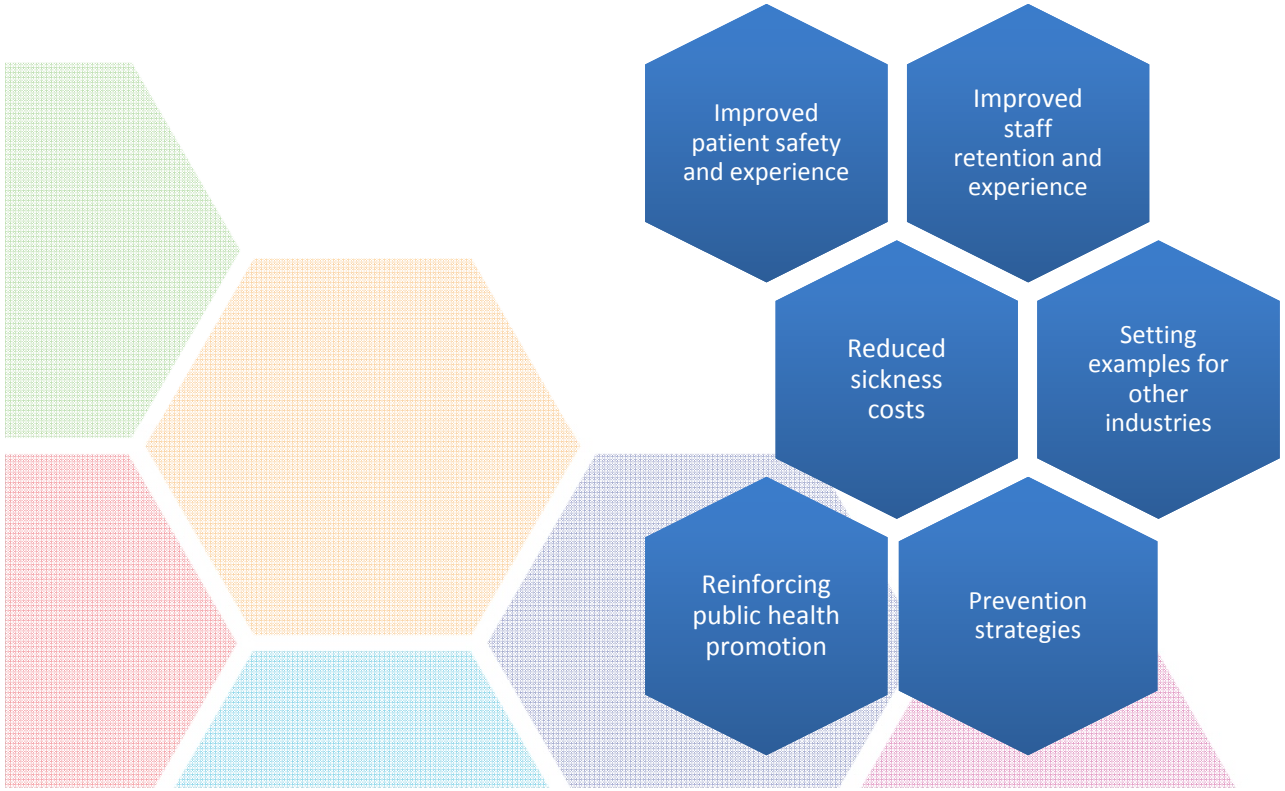
CARE RESPECT RESPONSIBILITY

The Dudley Group NHS Foundation Trust

Overview of the Health and Wellbeing CQUIN (17/18)

- The Health and wellbeing Commissioning for Quality and Innovation (CQUIN) was issued in 2016 by NHS England.

- This CQUIN focusses on improving the health and wellbeing of NHS staff.



CARE RESPECT RESPONSIBILITY

NHS
The Dudley Group
NHS Foundation Trust

Overview of the Health and Wellbeing CQUIN (17/18) continued

- This CQUIN is split into 3 indicators but this presentation will be focussing on the ‘Healthy food for staff, visitors and patients’ initiative.
- This indicator focuses to change the organisational behaviour and culture towards drinks and food sold on NHS premises.
- Aims to make healthier food and drinks more widely available.
- Evidence from Public Health England (2015) found poor staff health and wellbeing cost the NHS £2.4 billion for sickness absence and has also estimated that around 700,000 NHS staff are obese or overweight.

CARE RESPECT RESPONSIBILITY

The Dudley Group NHS Foundation Trust

Overview of the Health and Wellbeing CQUIN (17/18) continued

- Reducing the consumption of foods high in fat, sugar and salt (HFSS) can improve health and wellbeing and lead to a fall in the level of obesity.

CARE RESPECT RESPONSIBILITY

The Dudley Group NHS Foundation Trust

Health and Wellbeing work conducted till date

- Interserve at DGFT has many functions in this organisation including retail catering. Examples of their retail catering functionality include i.e. managing the main restaurant/vending machines, catering for events etc.

- This is key to this CQUIN as they provide food, drinks and snacks on the premises of DGFT including the Education centre and the main restaurant.

- They became involved with the CQUIN in 2016 and play a key role in making sure all food types that are stocked, sold and promoted are CQUIN compliant.

CARE RESPECT RESPONSIBILITY

NHS
The Dudley Group
NHS Foundation Trust

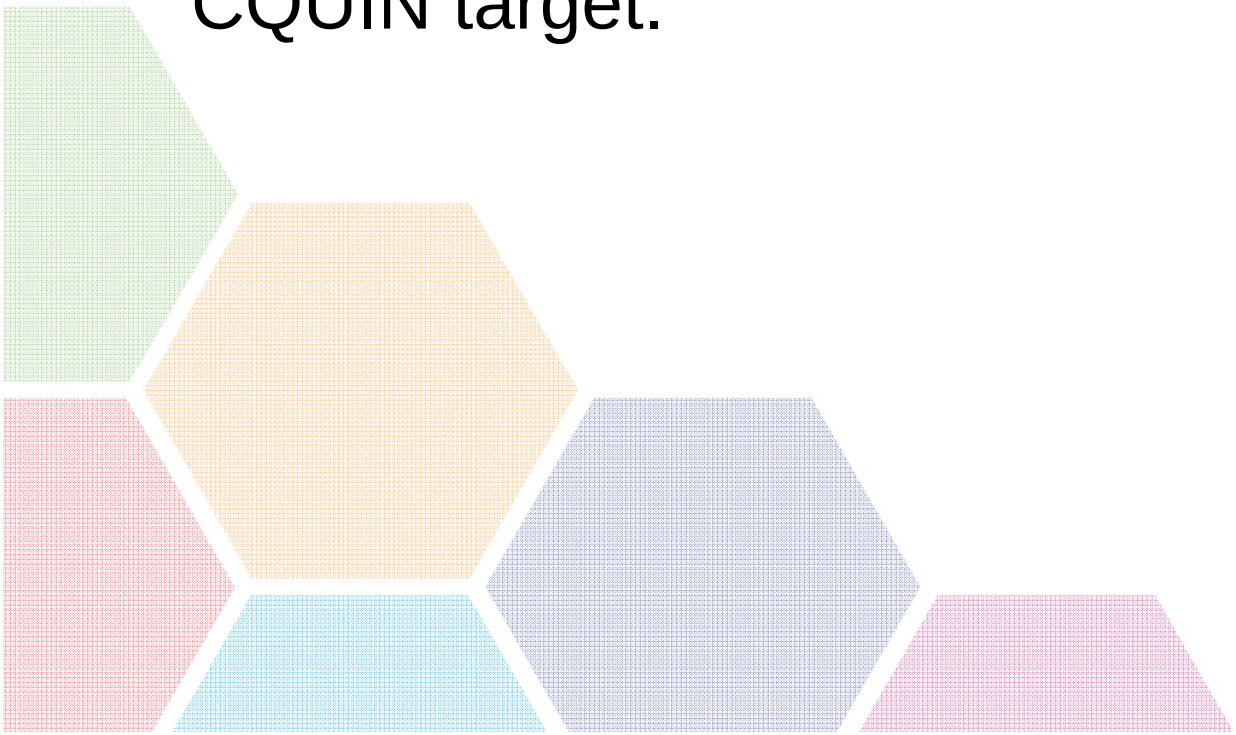
Health and Wellbeing work conducted till date

CARE RESPECT RESPONSIBILITY

NHS
The Dudley Group
NHS Foundation Trust

Summary

- All CQUIN activity required has been conducted to date.
- DGFT is on track of achieving its quarter 4 CQUIN target.



CARE RESPECT RESPONSIBILITY

NHS
The Dudley Group
NHS Foundation Trust

Next steps

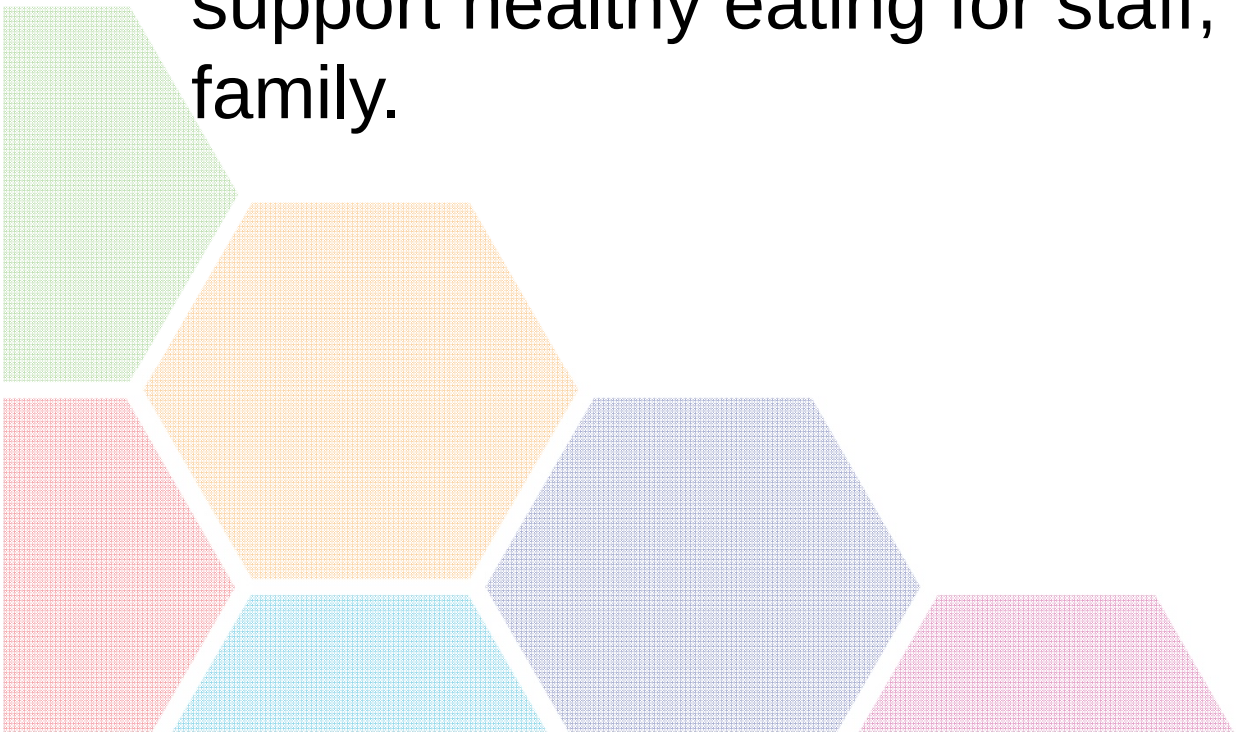
- Introduce a healthier range of drinks such as smoothies. This is due to be launched in the main restaurant at the end of March 2018.
- Increase healthy eating promotions.
- Investigate further healthier food alternatives.

CARE RESPECT RESPONSIBILITY

NHS
The Dudley Group
NHS Foundation Trust

Recommendations

- Note the engagement of DGFT/Interserve with the CQUIN.
- Note the work that has been carried out to support healthy eating for staff, patient and family.



CARE RESPECT RESPONSIBILITY

Enclosure 4

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 8th March 2018

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
- Black Country Pathology
- Flu Update
- Healthcare Heroes
- Emergency Treatment Centre
- Digital Trust Staff Engagement
- Recognition
- Charity Update
- Social Media Activity
- 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 – March 2018

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

6th February	Visit from Healthwatch
7th February	Visit from the Rutherford Cancer Centre
8th February	Board of Directors
	Senior Medical Staff Committee
13th February	Community Team
14th February	Team Brief
15th February	Board of Directors Workshop
	Corbett Hospital Team Brief
19th February	Health Leaders STP Event
21st February	A&E Delivery Board
	MCP Oversight Group
22nd February	Finance and Performance Committee
	Dudley System Oversight and Assurance Group
	Trust/Summit Board to Board
23rd February	Healthcare Heroes Presentation
26th February	Parkinson's Disease Mobile App Launch Presentation
	Healthcare Heroes Presentation
28th February	Partnership Board
	Cardiac Imaging Consultant Interviews
5th March	Black Country STP Urgent and Emergency Care Board
	Non Executive Director Interviews
6th March	Meeting with Worcester Acute

Black Country Pathology

The Black Country Pathology Oversight Group met on 16th February. The full business case has now been to the four Trust Boards and approved without caveat by three Trusts. Further clarification is awaited from Sandwell and West Birmingham who, it is understood, are supportive but had some queries.

Feedback from the very positive visit to the South West London Pathology Service was given to the group. This visit was encouraging both in terms of the benefits of developing BCPS and that the BCPS approach thus far is addressing the important issues. Updates were received from the Clinical Reference Group, the Shadow Management Team and the IT work stream all of which are making progress. A draft People Plan was discussed and an outline timeline on the way forward was agreed by those present. It was agreed that substantive appointments would be made to the Operations Manager and Clinical Director roles.

Flu update

I am thrilled that we have exceeded our target for the number of staff having a flu jab. The target was 70% and we have achieved 75% meaning more staff than ever before have taken the opportunity to protect themselves, their families and their patients from the flu.

Healthcare Heroes

Congratulations to C4 shift lead Claire Higgins and Andrew Boswell, Statutory Training and Retention Lead, Sharon Phillips, Deputy Director of Governance and Anne Welsh, Head of Action Heart.

C4 shift lead Claire Higgins received the individual award for staying behind after long busy shifts to make sure that the husband and young child of an end of life patient were fully supported and for introducing a ward activity box for young children dealing with such a sad situation.

The team award went to three people who don't work together but showed fantastic teamwork to save a man's life in the South Block restaurant.

Statutory Training Lead Andrew Boswell, Deputy Director of Governance, Sharon Phillips and Head of Action Heart Anne Welch were chosen for reacting quickly and used CPR and mouth to mouth to save the life of a gentleman who collapsed while queuing for a drink. They kept calm and worked together truly reflecting our Trust values of care, respect and responsibility

Emergency Treatment Centre open

Our brand new £2.6million Emergency Treatment Centre is now open and means the primary care Urgent Treatment Centre and our Emergency Department are located together at the front of the building. This means all patients arriving on foot for urgent care are seen by a nurse who will stream them to the most appropriate service either urgent care or the emergency department and should report via the new entrance alongside ED.

Digital Trust Staff Engagement

As the countdown gathers pace to the launch of our new electronic patient record system, (EPR) we have lots of training available to staff to get up to speed with the new system and also ensure they know what additional training they will need to attend.

Recognition

Our pharmacy team has received a letter of recognition from the Clinical Research Network (CRN) West Midlands for their exceptional work and contribution to medicine based clinical studies.

Our involvement in recruiting research participants for medication based trials is essential to assess the safety and efficacy of new medicines or existing medicines for different diseases.

Clinical trials undertaken by our pharmacy team involve:

- Initial site feasibility of the clinical trial: looking at whether it will add clinical value and if it's practical to deliver at the Trust.
- Implementation: ensuring the treatment pathway and potential service delivery problems are fully explained and mitigated.
- Maintenance: clinically screening and verifying the prescription for the clinical trial, dispensing, query resolution and patient counselling.

In 2017, the Clinical Research Network West Midlands had a total of 69,747 research participants, with our Pharmacy Department playing an important role in this achievement. In addition, we have also been recognised and thanked for our significant contribution to a number of medicine based studies that patients have taken part in.

The Trust's clinical guidelines initiative has received national recognition for excellence in patient safety at a Royal Society of Medicine Conference.

The clinical guidelines group was set up six months ago and has already made vast improvements to the accessibility and awareness of clinical guidelines across the Trust. The group have been particularly successful at engaging junior doctors in clinical guidelines development.

The Trust's most recent audit was shortlisted for a poster prize at The Royal Society of Medicine Patient Safety Section and received excellent feedback from the judges.

We have also been shortlisted in the Patient Experience Network National Awards (PENNA) in the Staff Engagement/ Improving staff experience category for Improving the experience of patients with a Learning Disability.

Charity Update

The Big Push Wheelchair Campaign

Our Big Push wheelchair campaign has achieved its target of £30,000 for 40 new wheelchairs. I would like to thank all the local businesses and fundraisers who have raised funds helping to achieve this goal and of course to the Dudley News for adopting it as their campaign.

Forget Me Not Ball – Saturday 14 April, Village Hotel, Dudley

The evening in aid of our charity's Dementia Appeal is on Saturday 14th April at the Village Hotel in Dudley. There's plenty of time to book tickets. If tickets are booked before 13th February there's a £5 early bird discount. A £10 deposit secures your ticket (£25 total early bird or £30 after the 13th Feb).

Neon 5k Colour Dash

Go Neon for Neonatal on Sunday 10th June at Himley Hall, Dudley. We are having a phenomenal interest in our Neon Dash which is open to everyone to take part. We will be publishing more information and registration forms in the next few weeks. So if you fancy a colourful walk, run, jog or dance round Himley Park then get your entry in.

Social Media Activity Update

Communications activity
February 2018

Twitter February 2018 (last 28 days)
35 follows
38.7k impressions
127 link clicks
93 retweets
169 likes
23 replies

We have 2,980 followers on Twitter

Highest post in February

The Dudley Group @DudleyGroupNHS
The brand new Emergency Treatment Centre, developed in partnership with Dudley Clinical Commissioning Group is now open!
Here's a sneak peak! ⬇**@DudleyGroupCEO** **@DudleyCCG** pic.twitter.com/27Komee1lq

Facebook February 2018 (last 28 days)
101 page likes
40,256 reach
16,497 engagements
2,791 page views

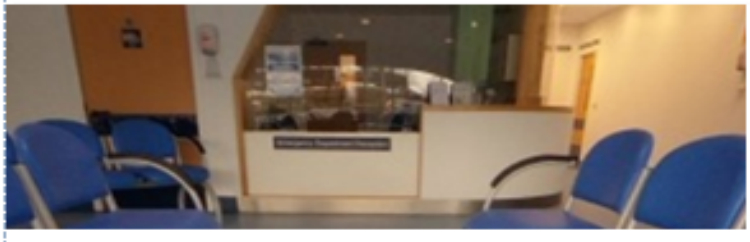
We have 4,261 likes on Facebook

Highest post in February

The brand new Emergency Treatment Centre, developed in partnership with Dudley Clinical Commissioning Group, is now open!

All walk-in patients should report to the nurse streaming desk, who will decide if you need to be seen in the GP-led Urgent Treatment Centre or in the Emergency Department.

Here's a sneak peak!



Please note: we will be able to compare and produce graphs for February and March social media data next month as Facebook only displays statistics over the last 28 days

National NHS News

NHS staff offered first refusal on thousands of new 'affordable homes' on surplus land
Nurses and other NHS staff will be given first refusal on thousands of affordable homes to be built on unused or surplus NHS land across England, the Government has announced. The policy is expected to create around 3,000 homes with the money generated set to be pumped back into health services. The offer to staff will most likely be set out in contracts with property developers who buy these lands.
iNews (31.01.18)

NHS Digital welcomes new guidance as UK firms told to shore up cybersecurity
NHS Digital has welcomed new guidance that will see suppliers of critical services fined if they fail to enforce adequate protection against cyber-attacks. Under new government guidelines targeting Britain's critical industries, financial penalties of up to £17 million will be handed down to healthcare, transport and utility companies that do not implement "the most robust" cybersecurity measures. The NIS Directive will apply to settings within Britain's national healthcare sector, which includes NHS Trusts and Foundation Trusts. ***Digital Health (02.02.18)***

Every single NHS Trust tested has failed cyber security assessments SEVEN months after the WannaCry attack that crippled hospitals
Hundreds of NHS hospitals are unprepared for cyber attacks - with all of the 200 NHS trusts checked for vulnerabilities so far having failed. In a hearing on the WannaCry attack which crippled parts of the health service last year, NHS Digital deputy chief executive Rob Shaw said the results of the assessments do not mean the trusts had failed to take any action to boost cyber security. Mr Shaw said trusts were still failing to meet cyber security standards, admitting some have a "considerable amount" of work to do, although others are "on the journey" to meet requirements. ***The Mirror (06.02.18)***

Thousands of NHS clinical notes go astray in the mail
Procedures intended to ensure that vital medical letters do not go astray are being flouted by some doctors, according to an independent spending watchdog.
The National Audit Office says of the many pieces of mail that are sent in error to doctors, up to 10,000 each month are being forwarded to the troubled outsourcer Capita rather than returned to sender, as they should be. After reviewing a backlog of more than 374,000 pieces of clinical correspondence, NHS England found that 18,829 items of misdirected items raised potential clinical concerns.***Financial Times (02.02.18)***

Hospitals cancelling urgent surgery despite NHS bosses' orders
Hospitals have been cancelling urgent surgery for patients with cancer, heart disease and other life-threatening illnesses, despite NHS bosses' orders not to delay such operations. Hospitals say that the NHS's limited supply of intensive care beds has forced them to prioritise flu patients at risk of dying before surgery over other very sick people, including those with cancer and heart problems. However, since the start of December, acute trusts in England have cancelled up to 91 operations each for patients with cancer, heart problems or an aortic aneurysm – a bulge in one of the body's major vessels that, unless repaired quickly, can burst and kill.
The Guardian (04.02.18)

Liverpool NHS trust 'dysfunctional' and unsafe, report finds
Patients suffered “significant harm” because of multiple serious failings by a “dysfunctional” NHS trust, an independent inquiry has found.
Liverpool Community Health NHS trust (LCH) provided poor, unsafe and ineffective care to patients, including inmates at HMP Liverpool, the scathing report concluded.
An independent panel, commissioned by the regulator NHS Improvement, also found that the trust had “a climate of fear” as a result of the harassment and bullying of staff who raised concerns. The findings of the panel, led by Dr Bill Kirkup, are among the most damning of an NHS trust’s actions since Robert Francis QC’s landmark report into , published five years ago. ***The Guardian (08.02.18)***

More than 100,000 NHS posts unfilled, reveal 'grim' official figures
One in 11 posts across NHS hospital, ambulance and mental health trusts are vacant, according to “grim” official figures which lay bare the health service’s workforce and financial problems for the first time. Quarterly data released by regulator NHS Improvement today, for the year to December, shows the 234 NHS trusts in England “employ 1.1 million whole-time-equivalent staff but that they have 100,000 vacancies”. It shows that a third of the total vacancies are nursing posts.
The Independent (21.02.18)

IVF on the NHS: why more parts of the UK are cutting back on free fertility treatment
The National Institute for Health and Care Excellence (NICE) issued guidelines in 2004 stating women under 40 who have failed to get pregnant after two years of trying should be offered three full cycles of IVF on the NHS. However, the recommendations are not binding and it is up to local NHS providers to decide what to offer – and given just one full cycle of IVF treatment costs around £7,000 many are deciding to restrict IVF treatment, or cut it altogether. A 2017 audit of England’s 208 CCGs by leading charity Fertility Fairness shows only 12 per cent now offer three full cycles – known as “gold standard” areas – a figure which has halved since 2013.***iNews (23.02.18)***

NHS Scotland runs up £26m nurses' overtime bill
NHS boards across Scotland paid out more than £26 million in overtime to nurses and midwives last year, figures have revealed. The overall bill for extra hours worked by nursing and midwifery staff in 2016-17 totalled £26,538,293. That was down from the previous year, when overtime costs amounted to £27.1m but significantly up from the figure of £21.726,537 in 2014-15. Overtime costs varied across the country, ranging from almost £8.8m in NHS Greater Glasgow and Clyde – Scotland’s largest health board – to less than £2000 in NHS Western Isles. The statistics were released to the Scottish Tories under Freedom of Information. ***The National (24.02.18)***

NHS Scotland sees nursing and midwifery vacancies rise
The number of unfilled nursing and midwifery posts in the Scottish NHS has risen since 2011. New analysis of official figures carried out by Scottish Labour shows there were 615.7 vacancies in 2011 compared to 2789.2 at September 2017.
The student intake fell from 3505 in 2010/11 to 2713 in 2012/13, with Labour highlighting First Minister Nicola Sturgeon's decision to cut training places when she was health secretary. ***The National (25.02.18)***

Cost of NHS prescriptions to rise
The cost of NHS prescriptions is due to rise from April. Patients will now have to spend £8.80 on medicine and appliances, a 20p rise from £8.60. Costs for wigs and fabric supports will also rise. A surgical bra will cost £28.85 instead of 28.40 and a spinal or abdominal support will cost £43.60 – up from £42.95. But the cost of pre-payment prescriptions for people with long term health issues will be frozen, at £29.10 for three months and £104 for a year. ***Wilts & Gloucestershire Standard (27.02.18)***

Serious incidents at Lincolnshire NHS trust among highest in country
Lincolnshire Community Health Services NHS Trust (LCHS), which is responsible for out-of-hospital community health services, recorded 233 serious incidents in the year 2016/17, higher than any other health trust in the county. Figures obtained by Blackwater Law via Freedom of Information Requests ranked NHS trusts in England and Wales from the highest to the lowest numbers of recorded incidents. LCHS was eighth highest overall and United Lincolnshire Hospitals Trust (ULHT) was 16th with 152 incidents. LCHS argued that many of the incidents included were "unavoidable" and included over 200 pressure ulcers out of their care. ***Lincolnshire Reporter (27.02.18)***

Public GP satisfaction 'deeply worrying' as figures hit lowest since records began
Public satisfaction with GP services is at its lowest since official records began in 1983, with general NHS satisfaction dropping on last year. Patients labelled staff shortages, government reforms, lack of funding, and long waiting times as the main reasons for rising dissatisfaction. Overall, public satisfaction hit 57% in 2017, indicating a 6pp drop from the year before – while dissatisfaction has risen to the highest level since 2007 (29%). In terms of GP services specifically, figures show that public satisfaction has dropped by 7pp to 65%, the lowest since the survey first began in 1983. ***National Health Executive (28.02.18)***

Public satisfaction with the NHS declines sharply
The latest British Social Attitudes survey, conducted by NatCen, a social research agency, also found dissatisfaction with the NHS at its highest level in a decade.
The proportion of people who said they were "very" or "quite" satisfied with the NHS fell from 63 per cent in 2016 to 57 per cent last year, according to the Nuffield Trust and the King's Fund, two health charities that have analysed the survey. Those who said they were "very" or "quite" dissatisfied increased from 22 per cent in 2016 to 29 per cent in 2017 — the highest level in a decade. The figure has almost doubled in the past three years alone. Satisfaction with family doctors' services fell from 72 per cent in 2016 to 65 per cent last year, the lowest level since the British Social Attitudes survey began in 1983. ***The Financial Times (28.02.18)***

Regional NHS News

Sickness tax: NHS trusts raking in £174MILLION a year from hospital parking fees
Heart of England Trust in the West Midlands heads the table, making £4.89million a year from NHS workers, outpatients and people visiting sick and dying relatives. A full list shows trusts all over the country are raking it in – adding up to a total of £174million. Among the top earners are ones in Leicester, Kent, Leeds and Derby. And nearly two thirds of NHS England trusts raise more than £1million a year from the fees. ***The Mirror (10.02.18)***

NHS 111 impact on A&E in Shropshire remains 'uncertain'
Calls for Shropshire's out-of-hours GP service are expected to be taken by the NHS 111 service from July 3. The current Shropdoc telephone number will no longer be in use from that date. People in Shropshire can already call the 111 number but residents in Wales who are registered with a GP in the county still have to use the Shropdoc number. The 111 number cannot be accessed there. A report, which will be put before members of Shropshire CCG during a meeting today, says that Powys is planning to adopt the Welsh NHS 111 from July 1. ***Shropshire Star (13.02.18)***

Scarlet fever is still sweeping the West Midlands – how to protect your child
There have been more than 60 cases of scarlet fever reported in the West Midlands in the last week alone, as numbers continue to soar. In the week ending February 11, 65 suspected cases of scarlet fever were reported to Public Health England (PHE) in the West Midlands met area. The number of reports is much higher than in the sixth week of the year in the previous four years. There were 26 cases reported in 2017, as well as 34 in 2016, and 18 in 2015. ***Birmingham Live (14.02.18)***

Ambulances' three hour wait outside Worcestershire A&E
West Midlands Ambulance said its Hazardous Area Response Team was sent to assist at Worcestershire Royal Hospital on Friday. According to national guidelines, Worcestershire Acute Hospitals NHS Trust is expected to deal with 95% of patients who attend A and E within four hours, but the BBC understands on Friday it dealt with 47% in four hours and 49% on Saturday. On Friday, it dealt with just 47% in four hours, which rose to 49% on Saturday. ***BBC News (19.02.18)***

Thousands of drunk Brummies are ending up in A&E – and putting the NHS under serious strain
More than 3,000 people ended up in hospitals in the West Midlands last year after hurting themselves while drunk, putting increasing pressure on an already-strained NHS. The latest figures from Public Health England reveal that 3,779 people in our region ended up in A&E after a night of drinking in 2016-17. ***Birmingham Live (20.02.18)***

Nearly 250k heart attacks preventable in West Midlands in last 5 years
NEARLY 250,000 heart attacks could have been prevented in the last five years in the West Midlands, according to the NHS. The NHS Health Check figures also show that around 50,000 strokes could have been averted if caught early enough. Over the last five years, up to 233,570 heart attacks and 46,720 strokes should have been avoided by giving the right follow-up care to people found to be at risk. CVD is a leading cause of disability and death in the UK. It affects around seven million people and is responsible for 26 per cent of all deaths in England – estimated to cost the NHS around £9 billion a year. ***Coventry Observer (20.02.18)***

The West Midlands GP surgeries closing or merging as pressure builds on NHS
Fourteen GP practices in the West Midlands have closed or merged in the last 18 months - with experts blaming 'chronic underfunding' of the NHS. The figures, provided by NHS Digital, come at a time of increasing demand on local health services. Separate data shows the number of patients registered with a GP in the area grew by 31,754 to a total of 2.8m at the end of the year. This increase in numbers combined with a fall in the number of surgeries pushed the average number of patients per surgery up from 6,532 in January 2017 to 6,886 at the end of the year. ***Birmingham Live (22.02.18)***

New Cross misses A&E target again as one-in-four patients wait longer than four hours

Just 73.8 per cent of patients were seen within the national NHS target of four hours during January as the hospital struggled to cope with the winter pressure. Performance was as high as 93.8 per cent last August but dipped to 80 per cent in November, 78 per cent in December and 73.8 per cent last month. The increased pressure has also led to ambulances piling up outside the hospital. The Royal Wolverhampton Trust, which runs New Cross, was fined £45,400 after more than 120 patients were waiting in ambulances for at least half an hour in December. Another 21 were kept waiting for more than an hour. ***Express & Star (28.02.18)***

Enclosure 5

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 8 March 2018

TITLE:	**20 February 2018 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**
	NHS I	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

The Committee requests the Board 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	20 February 2018	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- The Committee reviewed the quality aspects of the Trust's integrated performance report. The Committee noted a number of anomalies in the report and requested that these be addressed and that the level of detail regarding the risks and issues be presented to the Trust in the areas of under-performance.
- The Committee received a report on Infection Prevention and Control which included a forecast of the Trust year end position in respect of the required Hygiene Code compliance statement for 2017/18. The Committee was informed that there remained a significant challenge to secure the move from three yearly staff training to annual training. The Committee asked for a more detailed and specific rectification plan against each of the standards where full assurance could not be given by the Director of Infection Prevention and Control.
- The Committee received a report on action taken as a result of identified Stage 4 Pressure Ulcers. The report included an action plan devised to improve Pressure Area care within the community. The Committee asked that the action plan be reviewed to provide greater clarity and confidence that the actions planned and then taken will prevent grade 4 pressure ulcers from developing both in the community and within the hospital in order for the Trust to meet the Quality Priority of no grade 4 pressure ulcers.
- The Surgery, Women and Children Division provided an update on the actions being taken within ophthalmology to ensure sustainably in the delivery of the service. The Division provided verbal assurance that there are no overdue follow up appointments for urgent or "red" categories of patients but the delays in follow up will not be fully eradicated before the end of March. The Committee were updated on action being taken to better manage leave, be that annual leave, study leave or special leave, to ensure the appropriate rigor is being applied to manage demand. The Division also provided an update on the work being undertaken in respect of pediatric outpatient waiting lists and whist the Division continues to be ahead of its trajectory to clear these, verbal assurance was provided that it continues to address those patients with a booked appointment that are waiting beyond their ideal appointment time.
- The Committee received a report on Safeguarding activity and challenges within

the Trust. The Committee reflected that the verbal update provided more assurance than that in the report itself and asked that future reports were constructed to provide information on improvements made, outcomes of the planned audits of safeguarding activity and the mitigating actions take to manage the corporate risk.

- The Committee was presented with the Maternity Dashboard report which provided information on a wide spread of quality indicators for this service. The Committee was updated on the improved performance across a range of areas since last month's report. The Committee requested that the service activity engage in the development of a comprehensive clinical audit work plan to provide assurance of sustained improvement. The Committee reminded the service that they were keen to receive the report following the review of Caesarian activity and in particular the increase numbers during December.
- 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 reports from the divisions of Medicine & Integrated Care and Surgery with a verbal update from Clinical Support Services. The Committee reflected back to the Divisions and the Chief Operating Officer the lack of detail provided within these reports as to the clinical quality and patient experience risks each division was managing.
- The Committee received a report on the progress against the agreed action plans following the CQC service inspections of Urgent and Emergency Care, Critical Care, Children and Young People, Maternity, Medicine and Community Services. The Committee was updated as to the work to provide assurance over the actions within the improvement plan.
- The Committee received a report on incident management. The report provided assurance on the Serious Incident process being applied and included information on the Trust position in respect of wider incidents. The report documented the continued focus on learning and improvement. The Committee was updated on the actions being taken to close investigations in a timely manner and was informed that in 2 cases no assurance had been provided that the actions had been taken in line with the agreed timescales.
- The Committee was updated on the complaints activity over the month of January 2018. The report provided information on the themes of the complaints and the progress being made on responding to these in a timely manner. Whilst the complaints were being responded to within the timescales agreed with the complainant the Chief Nurse reminded the Committee there was work still to do to secure swifter responses. The Committee asked that the next report provides more details on the changes and learning made across the Trust as a result of complaints and that themes from concerns be triangulated and reported with those from formal complaints.
- 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 water safety, decontamination

and cleaning.

- The Committee received reports from the Health and Safety Group; the Mortality Surveillance Group and the Internal Safeguarding Board. These reports confirmed that the groups were quorate when meeting and were working in accordance with their terms of reference.

Decisions Made/Items Approved

- The Committee supported the closure of 14 Significant Incident Root Cause Analyses (RCA) action plans following assurance from the Corporate Governance Team that, where appropriate, completed actions plans had been evidenced.
- The Committee referred back to the Executive the quality priority targets for a recommendation to be made.
- The Committee ratified three policies based on the recommendation of the Policy Group.

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

A specific rectification plan in respect of the 2017/18 Hygiene Code statement of compliance and that the Infection Prevention and Control Forum report actions taken to find alternate solutions to improve staff annual training compliance rates.

The delivery plan for the electronic VTE system.

The pressure ulcer care action plan be reviewed and reported to provide greater confidence that the actions taken will prevent grade 4 pressure ulcers from developing both in the community and within the hospital in order for the Trust to meet its quality priority of no grade 4 pressure ulcers.

The clinical audit plan including a comprehensive suite of activity within maternity services.

Items referred to the Board for decision or action

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

The Committee also asked the Board to note the feedback provided to a number of the report authors in respect of improving the quality of their reports.

The Committee recommends the Mortality Report to the Board for information.

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Public Board on 8th March 2018

TITLE:	Infection Prevention and Control Forum Report		
AUTHOR:	Dr Elizabeth Rees Director of Infection Prevention and Control	**PRESENTER:**	Dr Elizabeth Rees Director of Infection Prevention and Control

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

- Update of progress with compliance against the Hygiene Code for 2017/18.
- For 2017/18 the Trust has had 28 cases of post 48 hr C. difficile of which 5 cases were identified in January.
- No post 48 hr MRSA bacteraemia cases since September 2015
- For January 2018 there was 1 post 48 hr MSSA bacteraemia identified in the Trust.
- For January 2018 there was 1 post 48 hr E. coli bacteraemia identified in the Trust.
- During January 2018 there were 0 post 48 hr Klebsiella bacteraemia cases.
- During January 2018 there were 0 post 48 hr Pseudomonas bacteraemia cases.
- Update on Flu Data.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Failing to meet minimum standards
	Risk Register: Y		**Risk Score:** No red risks
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe and effective care
	NHSI	**Y**	**Details:** MRSA and C. difficile targets
	Other	**Y**	**Details:** Compliance with Health and Safety at Work Act.

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD: To receive the report and acknowledge the assurances.

The Dudley Group
NHS Foundation Trust

Introduction:

The summary information below demonstrates the data set required to provide assurance of compliance with the Code of Practice (The Health and Social Care Act 2008): Code of Practice on the Control of Infections and Related Guidance, July 2015). Each element has been RAG rated and will be updated monthly to ensure we can show compliance by the end of the financial year 2017/18.

Compliance Criterion	What the registered provider will need to demonstrate	RAG rating
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may post to them.	
Assurance: A risk log of all infection prevention risks identified across the Trust is maintained and updated regularly.		
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Policy in place. Current contract variations being discussed.
Assurance: A Cleaning Policy and associated environmental audits provide assurance that a clean and appropriate environment is maintained. A recent business case has been introduced to ensure a more robust HPV fogging programme.		
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.	Parts C & D of the Antimicrobial CQUIN apply to antimicrobial usage. Part C is met in Q3, part of part D is met in Q3.
Assurance: There is an Antimicrobial Policy in place with appropriate stewardship recommendations. Audits demonstrate compliance with policy. The new lead antimicrobial pharmacist has now taken up post.		
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.	
Assurance: Patient and visitor information is available for a variety of healthcare associated infection issues on the website. Patients identified with infections in hospital are visited and provided with information leaflets including contact information for further support.		

5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	There remains a challenge to achieve the internal MRSA screening target.
Assurance: Patient records are flagged with information about previous healthcare associated infections. Patient admission documentation includes screening questions to identify patients at risk.		
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mandatory IC training has moved to an annual programme for clinical staff. Work is being undertaken to achieve compliance.
Assurance: Staff are provided with mandatory infection control training to ensure they are aware of their responsibilities for the prevention and control of infection.		
7	Provide or secure adequate isolation facilities.	Issues highlighted in critical care areas in relation to limited isolation facilities. Work is ongoing to scope the opportunity for introducing temporary isolation facilities within the areas.
Assurance: There is a policy in place to ensure that patients are isolated appropriately. 25% of the inpatient beds take the form of single ensuite rooms.		
8	Secure adequate access to laboratory support as appropriate.	
Assurance: The Trust has access to a CPA/UKAS accredited Microbiology and Virology laboratory.		

9	Have adherence to policies, designed for the individuals' care and provider organisations that will help to prevent and control infections.	Trustwide scores all green in January 2018.
Assurance: All policies, as recommended in the Hygiene Code, are in place. Audit data confirms compliance with policies and identifies areas for improvement.		
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	
Assurance: There is in house provision of Staff Health and Wellbeing. There are regular reports to the Infection Prevention and Control Forum detailing any issues raised within this system.		

Summary of alert organism surveillance:

Clostridium Difficile – The target for 2017/18 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. The cases that count within this dataset are patients identified after 48 hrs admission with C. difficile in whom a lapse in care has been recognised using the national apportionment tool [1]. For 2017/18 there have been 28 post 48 hr cases to the end of January, of these 15 were associated with a lapse in care, 8 were associated with 'no lapse in care' and 5 are under review. For January 2018 5 post 48 hr cases have been reported.

The process to determine lapses in care is as follows: an RCA is completed for every post 48 hr case, there is a review undertaken internally using the national apportionment form to determine lapses in care. This information is then shared with the CCG who confirm the outcome decision. This results in the ability to describe individual C. difficile cases as 'avoidable/unavoidable'.

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.

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

MSSA bacteraemia (Post 48 hrs) - For January 2018, 1 case of post 48 hr MSSA bacteraemia was reported.

MRSA screening – There is no external compliance target for MRSA screening. The internal target is to achieve 95% compliance with the policy. The percentage of emergency admissions screened for January 2018 is 85%. Data is available locally to the units to enable them to identify patients missing from the dataset.

The percentage of elective admissions screened for January 2018 is 90%. As above data is available locally to all units to enable them to identify patients missing from the dataset.

The Trust has struggled to improve the percentage compliance over the last 6 months to meet the 95% internal target and so there is a plan to establish a task and finish group to address this. This will be discussed at the next IPCF on 28th February 2018.

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. For January 2018, 1 case of post 48 hr E. coli bacteraemia was reported.

Klebsiella* and Pseudomonas* bacteraemias – For January 2018 there were 0 post 48 hr Trust identified Klebsiella bacteraemia cases and 0 post 48 hr Pseudomonas bacteraemia cases.

Infection Control Mandatory Training – The revised mandatory requirement is to update Infection Control training annually for clinical staff. During the implementation phase (i.e., until March 2018) the data will continue to be presented based on the historical 3 yearly cycle. The percentage compliance as at 31.1.18 (target 90%):

Area	Total
Corporate/Management	90%
Medicine and Integrated Care	90%
Surgery	92%
Clinical Support	90%

The clinical areas have been aware of the requirement to move the IC Mandatory training to an annual programme as of December 2017. The training is available through face to face sessions in the CEC (times and dates on the Hub), via on line training and the Infection Control Team will deliver training in the clinical areas by request. The Learning and Development department have provided interim data for the divisions on their current compliance based on an annual target in order to inform them of their position to date. In addition Learning and Development will ensure that staff who appear green on their individual learning record (based on the 3 yearly cycle) but who would not appear green based on the annual requirement will receive an alert to indicate that they will need to undertake this training at the earliest opportunity. The two Associate Chief Nurses have been asked to provide a further update at the Forum in February.

Infection Prevention and Control Forum – It has previously been agreed to increase the frequency of the meetings to 10 per annum and to introduce a cycle of reporting to ensure adequate time for discussion of agenda items. The membership was also reviewed and approved to reflect the revised divisional structures whilst maintaining membership of external agencies including the CCG, Office of Public Health and Public Health England. A number of sub-groups report into the meeting including the Water Safety Group and Antimicrobial Steering Group. The last meeting was held on 24th January 2018; key issues identified were around work required to increase compliance with the MRSA screening policy, the programme to

deliver the Infection Control Mandatory training requirement and a discussion around the seasonal flu activity which included a detailed discussion about the face fit testing programme for staff and the availability of loose fitting respirators for those staff who cannot be face fit tested.

Flu Update:

From 14th December 2017 to 27th February 2018:

Total number of flu tests performed: **548**

- Of those **165 patients** tested positive (Flu A or Flu B)
  - Of those **6** are in patients (as at 27.2.18)
    - Of those **1** are on ITU/MHDU.

The loose fitting respirators have been received in the Trust and are available for use.

GLOSSARY OF TERMS

MSSA

What is Meticillin Sensitive Staphylococcus aureus (MSSA)?
Staphylococcus aureus is a bacterium that is commonly found on human skin and mucosa (lining of mouth, nose etc). The bacterium lives completely harmlessly on the skin and in the nose of about one third of normal healthy people. This is called colonisation or carriage. *Staphylococcus aureus* can cause actual infection and disease, particularly if there is an opportunity for the bacteria to enter the body e.g. via a cut or an abrasion.

What illnesses are caused by Staphylococcus aureus?
Staphylococcus aureus causes abscesses, boils, and it can infect wounds - both accidental wounds such as grazes and deliberate wounds such as those made when inserting an intravenous drip or during surgery. These are called local infections. It may then spread further into the body and cause serious infections such as bacteraemia (blood poisoning). *Staphylococcus aureus* can also cause food poisoning.

MRSA

What is Meticillin Resistant Staphylococcus Aureus (MRSA)?
MRSA stands for meticillin-resistant *Staphylococcus aureus*. They are varieties of *Staphylococcus aureus* that are resistant to meticillin (a type of penicillin) and usually to some of the other antibiotics that are normally used to treat Staphylococcus aureus infections.

Who is at risk of MRSA infection?
MRSA infections usually occur in hospitals and in particular to vulnerable or debilitated patients, such as patients in intensive care units, and on surgical wards. Some nursing homes have experienced problems with MRSA. MRSA does not normally affect hospital staff or family members (unless they are suffering from a severe skin condition or debilitating disease). In general, healthy people are at a low risk of infection with MRSA.

E Coli

What is *Escherichia coli*?

Escherichia coli (commonly referred to as *E. coli*) is a species of bacteria commonly found in the intestines of humans and animals. There are many different types of *E. coli*, and while some live in the intestine quite harmlessly, others may cause a variety of diseases. The bacterium is found in faeces and can survive in the environment.

What types of disease does *E. coli* cause?

The commonest infection caused by *E. coli* is infection of the urinary tract, the organism normally spreading from the gut to the urinary tract. *E. coli* is also the commonest cause of cystitis (infection of the bladder), and in a minority of patients the infection may spread up the urinary tract to the kidneys, causing pyelonephritis.

Otherwise healthy patients in the community may develop cystitis, and patients in hospital who have catheters, or tubes, placed in the urethra and bladder are also at risk. *E. coli* is also present in the bacteria that cause intra-abdominal infections following leakage from the gut into the abdomen, as for example with a ruptured appendix or following traumatic injury to the abdomen.

E. coli bacteria may also cause infections in the intestine. Diarrhoeal infections (intestinal) are caused by a group of *E. coli* known as 'enterovirulent' (harmful to the intestines).

Overspill from the primary infection sites to the bloodstream may cause blood poisoning (*E. coli* bacteraemia). In rare instances, *E. coli* may cause meningitis in very young children.

Klebsiella species

What is Klebsiella?

Klebsiella species includes a number of genre including *Klebsiella oxytoca and Klebsiella pneumoniae*. These organisms are colonisers of the human gastrointestinal tract and are capable of causing a wide variety of clinical syndromes including urinary tract infection, pneumonia and bacteraemia.

What types of disease does *Klebsiella species* cause?

These organisms are rarely associated with diseases in the normal host. They are a cause however of nosocomial and opportunistic infection.

Pseudomonas aeruginosa

What is *Pseudomonas aeruginosa?*

Pseudomonas aeruginosa is sometimes present as part of the normal microbial flora of humans. Hospitalisation may lead to increased rates of carriage, particularly on the skin in patients with serious burns, in the lower respiratory tract of patients undergoing mechanical ventilation, in the gastrointestinal tract of patients undergoing chemotherapy or in any site in persons treated with broad spectrum antimicrobial agents.

What types of disease does *Pseudomonas aeruginosa* cause?

Pseudomonas aeruginosa is an opportunist pathogen causing disease as a result of some alteration or circumvention of normal host defences eg, disruption or circumvention of skin or mucous membrane integrity in the case of intravenous lines, urinary catheters or endotracheal tubes.

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C difficile

What is *Clostridium difficile*?
*Clostridium difficile (*also known as *"C. difficile" or "C. diff")* is a bacterium that can be found in people's intestines (their "digestive tract" or "gut"). However, it does not cause disease by its presence alone; it can be found in healthy people, about 3% of adults and two thirds of babies with no symptoms. It causes disease when the normal bacteria in the gut, with which *C. difficile* competes, are disadvantaged, usually by someone taking antibiotics, allowing the *C. difficile* to grow to unusually high levels. This allows the toxin they produce to reach levels where it attacks the intestine and causes symptoms of disease.

What are the symptoms of *C. difficile* infection?
Clostridium difficile causes diarrhoea (mild to severe) and, unusually, life threatening inflammation of the intestines. Other symptoms can include fever, loss of appetite, nausea and abdominal pain or tenderness.

How do you catch it?
Another person may acquire C.difficile disease by ingesting the bacteria through contact with the contaminated environment or patient. In most healthy people the C.difficile will not be able to multiply in the gut and they will not develop disease. In some more vulnerable people, particularly those whose normal gut bacteria have been disrupted by antibiotic treatment, the C.difficile may be able to multiply in the gut and go on to cause disease.

CPA/UKAS

What is CPA/UKAS?
CPA is Clinical Pathology Accreditation and UKAS is United Kingdom Accreditation Service. These are both organisations responsible for the inspection and accreditation of laboratories providing diagnostic pathology services.

RCA

What is RCA?
RCA is a root cause analysis which is an analytical method by which an investigation into a particular event seeks to identify the underlying cause.

PFI

What is PFI?
PFI is the abbreviation used for Private Finance Initiative and in this context is used to describe Summit Healthcare and Interserve Facilities Management.

CCG

What is CCG?
CCG is the Clinical Commissioning Group and in this context refers to Dudley Clinical Commissioning Group.

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RAG

What is RAG?

RAG is Red, Amber, Green which is a term used to describe the risk rating associated with risks described within the report.

Reference

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

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

Enclosure 7

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 8th March 2018

TITLE:	**Monthly Nurse/Midwife Staffing Position – March 2018 report containing January 2018 data**		
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 historic establishments as agreed by the previous Chief Nurse and the continuing 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 some improvement as the year progresses although a reduction in December has occurred, particularly in the unqualified figures.

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 specialist areas of the Trust e.g. out-patients are in the process of being reviewed.

Following the query on data accuracy that was raised and discussed last month, this has all been rectified for this month and future reports.

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 December.

Monthly Nurse/Midwife Staffing Position

March 2018 Report containing January 2018 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 January 2018 (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.

Table 1 shows there was some improvement as 2017 progressed and the previously noted reduction last month has reversed slightly in January. There is still a need to move staff to support additional capacity. On occasion, the fill rate is over 100%. This tends to occur with C2, the paediatric ward, and NNU (neonatal unit) as the planned hours are derived from the dependency tools used for each shift. Each shift the planned hours are determined by the acuity of the children/neonates actually on the ward/unit. 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. C8). The low fill rate during the days in a) CCU/PCCU reflects the problems in recruiting staff to this particular area and b) in MHDU and EAU reflects the winter pressures and opening the new larger EAU and the four ‘flexi’ bed area in MHDU for capacity reasons. The low fill rates for B3 are due to that ward now starting to use the new planned levels following the recent staffing review.

Table 1. Percentage fill rates January 2017 to the present

	Qualified Day	Unqualified Day	Qualified Night	Unqualified Night
January	94%	96%	94%	99%
February	93%	95%	96%	99%
March	95%	97%	97%	100%
April	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%
October	96%	97%	97%	99%
November	95%	97%	96%	101%
December	95%	93%	95%	96%
January 2018	95%	94%	97%	97%

With regards to the CHPPD, as has been explained in previous monthly reports this is the national indicator that can be used to benchmark the Trust. This is outlined in Table 2.

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

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*	4.7	N/A	N/A	3.8	N/A	N/A	8.5	N/A	N/A
July*	4.5	N/A	N/A	3.9	N/A	N/A	8.4	N/A	N/A
August*	4.6	4.7	4.7	3.9	3.1	3.1	8.4	7.9	7.9
Sept.*	4.5	N/A	N/A	3.7	N/A	N/A	8.2	N/A	N/A
October	4.6	N/A	N/A	3.8	N/A	N/A	8.4	N/A	N/A
November	4.5	4.6	4.7	4.0	3.0	3.1	8.5	7.8	7.8
December	4.8	N/A	N/A	4.1	N/A	N/A	8.9	N/A	N/A
January 2018	4.72	N/A	N/A	3.86	N/A	N/A	8.58	N/A	N/A

N/A = Data not available.

Compared to last month's report, this report contains updated regional and national average figures for November 2017 which have only just been made available this month. Over time, it can be seen that the Trust's CHPPD for qualified staff has been increasing but has generally remained below the regional and national medians. The unqualified CHPPD remains above the comparators. Nursing and Finance Division staff are still in the process of exploring whether these calculations are directly comparable. So far we have been informed that the CHPPD figures in the Model Hospital should not include both adult and children critical care, but we know for instance that that is not the case for our figures e.g. the 8.5 CHPPD in November. We await the response from our latest query on this issue.

Conclusion

This report demonstrates that we are achieving nearly 100% fill rate using the historic establishments and a significant reliance on temporary staff (bank and agency). The reduction in the figures in December have improved slightly but not to previous levels reflecting the need to move staff to support additional capacity. Benchmarking the Trust workforce data using the CHPPD can be informative and will continue on the basis of discovering whether the Trust and regional/national medians are directly comparable.

The staffing review which commenced in May 2017 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 has also considered the outcome of the most recent six monthly Safer Nursing Tool exercise and patient acuity.

Both the main medical and surgical ward area, NNU and Critical Care reviews have been completed and decisions made following discussion and approval at Director level and the Finance and Performance Committee. The NNU staffing review took place in August 2017 and it was noted at the time that that the Trust's overall staffing compliance with the British Association of Perinatal Medicine (BAPM) Service Standards was 28.9% compared to the national average of 57.37%. The review detailed what action would be required to be compliant. The executives agreed to increase staffing incrementally to reach 66% compliance with a further review. The NNU Peer Review took place in January of this year and both nurse and medical staffing was raised as a concern and work is underway within the Division to review the staffing.

Reports have been produced on a number of specialist areas which include Main Out Patients Department (OPD), Renal Unit, Emergency Department, Emergency Assessment Unit and Medical Day Case and will be available for consideration shortly. The review of the Community services is near conclusion.

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

Ward	Day RN Day RM Plan	Day RN Day RM Actual	Day CSW Day MSW Plan	Day CSW Day MSW Actual	Night RN Night RM Plan	Night RN Night RM Actual	Night CSW Night MSW Plan	Night CSW Night MSW Actual	Qual Day	UnQual Day	Qual N	UnQual N	Actual CHPPD Sum 24:00 Occ	Registered	Care staff	Total
Evergreen																
A2	249	224	219	207	155	139	187	179	90%	95%	90%	96%	1,220	3.57	3.80	7.37
A3																
A4																
B1	118	105	72	64	70	71	73	70	89%	89%	101%	96%	563	3.56	2.86	6.42
B2(H)	124	116	248	231	93	88	216	204	93%	93%	95%	94%	888	2.68	5.88	8.56
B2(T)	93	89	128	123	62	64	98	97	96%	96%	102%	99%	692	2.58	3.81	6.39
B3	236	208	184	159	191	179	157	149	88%	86%	94%	95%	1,071	4.23	3.38	7.61
B4	186	169	257	229	155	141	192	188	91%	89%	91%	98%	1,356	2.68	3.69	6.37
B5	186	180	137	133	157	156	109	104	97%	97%	99%	95%	976	4.04	2.91	6.95
B6																
C1	186	164	293	273	155	141	163	157	88%	93%	91%	96%	1,473	2.42	3.50	5.92
C2	179	234	67	66	170	187	37	35	131%	99%	110%	95%	723	6.83	1.45	8.27
C3	189	189	396	381	155	151	387	381	100%	96%	97%	98%	1,578	2.59	5.79	8.38
C4	155	149	63	61	93	93	93	92	96%	97%	100%	99%	659	4.18	2.79	6.97
C5	189	186	254	250	155	146	185	179	98%	98%	94%	97%	1,399	2.78	3.59	6.36
C6	93	88	67	68	62	62	64	65	95%	101%	100%	102%	509	3.45	3.14	6.59
C7	186	156	146	144	124	115	138	133	84%	99%	92%	96%	1,078	2.86	3.01	5.87
C8	205	190	217	246	186	175	217	251	93%	113%	94%	116%	661	6.34	9.02	15.36
CCU_PCCU	217	176	31	30	155	150	-	-	81%	97%	97%		650	5.88	0.55	6.44
Critical Care	389	390	65	60	394	395	-	-	100%	92%	100%		330	27.94	2.00	29.94
EAU	279	242	341	257	279	261	341	308	87%	75%	94%	90%	1,474	4.01	4.60	8.61
Maternity	549	545	217	206	527	520	155	147	99%	95%	99%	95%	543	19.52	7.61	27.13
MHDU	126	104	37	29	125	114	6	5	83%	78%	91%	83%	148	17.32	2.53	19.85
NNU	169	171	-	6	159	157	-	-	101%		99%		383	9.83	0.19	10.02
TOTAL	**4,303**	**4,072**	**3,438**	**3,220**	**3,622**	**3,504**	**2,818**	**2,744**	**95%**	**94%**	**97%**	**97%**	**18,374**	**4.72**	**3.86**	**8.58**

Enclosure 8

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 8th March 2018

TITLE:	**A. Quality Priorities. Targets: Present position in 2017/18 and proposals for 2018/19** **B. Local Indicator for External Audit**		
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:

Quality Priorities. Targets: Present position in 2017/18 and proposals for 2018/19

At its December 2017 meeting the Clinical Quality, Safety and Patient Experience (CQSPE) Committee agreed to continue with the present quality priority topics of:

Patient Experience
Nutrition and Hydration
Pressure Ulcers
Medications
Infection Control

In addition, the committee agreed to add the following two new topics as quality priorities:
Discharge Management
Incident Reporting

Now that we are coming to the end of the financial year and our end of year position with the present targets is becoming clearer, it is time to agree the specific targets for the above topics for 2018/19. The initial draft of the Quality Report 2017/18 is presently being compiled and will need to be sent in March to the relevant outside bodies for comment and so our agreed future targets need to be in that draft.

Following discussion by the Executive Directors and relevant senior staff the enclosed paper covers proposals for the targets to be agreed, although we are still awaiting from NHSi the targets set for infection control. As a number of targets for 2017/18 are unlikely to be met it is proposed that they are rolled over to the future (2018/19) and so to change these at this time would be inappropriate.

Local Indicator for External Audit

Each year a local indicator for external audit (as well as the two mandated indicators) needs to be proposed to the Governors for their agreement. The CQSPE has agreed that incidents of patient falls should be proposed to the Governors.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**Y**	**Details:** Quality Report requirements
	Other	**Y**	**Details:** DoH Quality Account requirements

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

RECOMMENDATIONS FOR THE BOARD: To discuss and agree: a) the quality priority targets for 2018/19 and b) the local indicator that will be proposed to the Governors for their agreement.

THE DUDLEY GROUP NHS FOUNDATION TRUST

A. QUALITY PRIORITIES

TARGETS: PRESENT POSITION AND PROPOSALS FOR 2018/19

1. Introduction

In December 2017 the Clinical Quality, Safety and Patient Experience (CQSPE) Committee agreed to continue with the present quality priority topics of:

- Patient Experience (FFT/Pain Control)
- Pressure Ulcers
- Infection Control
- Nutrition and Hydration
- Medications

In addition, the CQSPE agreed to add the following two new topics as quality priorities:

- Discharge Management
- Incident Reporting

It is now time to agree on next year's targets for each of these topics. Listed below are each of the present five priority topics together with the latest position with this year's targets. Proposed targets for next year are also listed for agreement by the Board.

2. Quality Priorities/Targets for 2017/18, latest position and proposed targets for 2018/19.

Priority 1: Patient experience

TARGET 1: Achieve monthly scores in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average.

Present position 2017/18

We have both the Trust and National scores up to the end of December (that is for nine months –except for the four maternity scores as there has been a national issue with the November scores which have not been published and so there are only seven months data for these). The chart below indicates the number of months out of the nine (or seven) that the Trust has achieved the target:

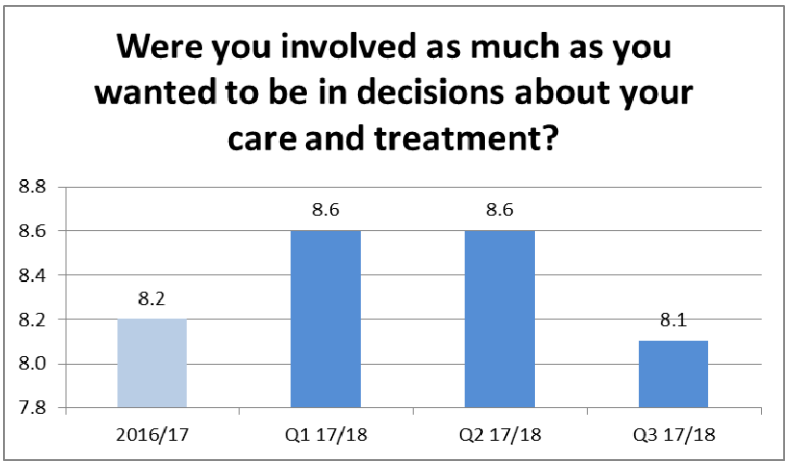
Inpatient	A & E	Antenatal	Birth	Postnatal Ward	Postnatal Community	Community	Outpatients
4	0	6	7	7	6	6	3

The chart demonstrates that with the data we have to date the target was only achieved in two of the seven areas.

Proposed target 2018/19
Based on the above results, it is proposed that the same target as 2017/18 is used in 2018/19.

TARGET 2: Improve the overall year score from 2016/17 to 2017/18 for the following question used in our local real-time survey: Were you involved as much as you wanted to be in decisions about your care?

Present Position 2017/18



The results of the local survey question 'Were you involved as much as you wanted to be in decisions about your care?' the score at the end of each quarter this year is shown below compared to the 2016/17 full year score of 8.2. This priority is likely to be achieved for the whole year although a dip in the third quarter has occurred.
(Weighted scores are calculated using the percentages in the frequency tables using partial credit methodology – this follows how the results of the National Patient Surveys are presented).

Proposed Target 2018/19

This is such an important question and as the Trust had a low result for this question in the National Survey of 2016 (6.79 – national comparative figures: Highest Trust having 9.54 and the Lowest 5.89) and due to the dip in quarter three it is proposed that this target is retained.

TARGET 3: Ensure that in 95% or more cases, a patient's pain score is recorded at least every four hours (unless otherwise indicated in the exception box).

Present Position 2017/18
Ensure that in 95% or more cases, a patient's pain score is recorded at least every four hours (unless otherwise indicated in the exception box)

Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD
Score (%)	94	95	97	87	90	87	93	93	97	93	93

(Key for this and similar charts: Individual months from April to January are listed and A-J = The accumulative score for the 10 months. Green = A period when the target was achieved, Amber = A period when the target was not achieved)

It is clear this target is unlikely to be met for the full year based on the April to January score of 93%. This question was introduced due to the Trust's low score on this topic in the National Survey. In 2015 the Trust's score was 8.2 (out of 10) and in 2016 it reduced to 7.69 (in that year the national picture across all Trusts was: Highest score of 9.87 and Lowest of 6.98). At present, the 2017 scores available are only preliminary (they still need to be moderated by the CQC) and the Trust score is 7.9

Proposed Target 2018/19
We have not achieved this target in 2017/18 and due to the latest available results from the National patient survey, it is proposed that it is retained for 2018/19.

Proposed New Target 2018/19

The FFT target above (TARGET 1) relates to the percentage scores of the patients who do respond to the survey. It is also important for the Trust to encourage as many patients as possible to respond and so it is proposed that a target relating to the numbers taking part in the survey is also included with the following words:

TARGET 4: Achieve monthly response rates in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average.

Priority 2: Pressure ulcers	
Hospital	**Community**
a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year. b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2017/18 reduces from the number in 2016/17.	a) Ensure that there are no avoidable stage 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable stage 3 pressure ulcers acquired on the district nurse caseload in 2017/18 reduces from the number in 2016/17.

Present Position 2017/18

Hospital – Avoidable Pressure Ulcers

Period	2016/17	2017/18
No. of Stage 3	29	5
No. of Stage 4	1	2
Total	30	7

Community - Avoidable Pressure Ulcers

Period	2016/17	2017/18
No. of Stage 3	15	18
No. of Stage 4	0	5
Total	15	23

Please note that the figures for 2017/18 may change dependent on the outcomes of the remaining RCA investigations which are awaiting review as to whether they are avoidable or unavoidable.

As the note under the charts indicates, the Trust is still awaiting confirmation on the outcomes of a number of root cause analyses. It is therefore difficult to fully understand

the true position with regards to the stage 3 target in the hospital. The data does clearly indicate however we will not achieve the targets for stage 4 avoidable ulcers both in the hospital and community and stage 3 in the community.

Proposed Targets 2018/19
It is proposed that the present targets are retained with the following words:

a) Ensure that there are no avoidable stage 4 acquired pressure ulcers throughout the year: i) in the hospital and ii) on the district nurse caseload .

b) Ensure that the number of avoidable stage 3 acquired pressure ulcers in 2018/19 reduces from the number in 2017/18: i) in the hospital and ii) on the district nurse caseload.

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

Present Position 2017/18

C. difficile: For 2017/18 there have been 23 cases of Clostridium difficile that have been identified as Trust apportioned in accordance with the Public Health England definition. Of these 14 cases had been identified as having lapses in care and 4 cases identified with no lapses in care. The remaining 5 cases remain under review. The target is therefore being achieved so far this year.

MRSA: There have been no Trust assigned MRSA bacteraemia in this period (in fact, there have not been any Trust assigned cases since September 2015).

Proposed Targets 2018/19

The targets for these indicators are mandated by NHSI. The Trust is presently unaware of its targets for 2018/19 although the zero tolerance to MRSA will be retained. It is proposed that the mandated targets from NHSI become the Trust quality targets once these are known.

Priority 4: Nutrition and Hydration

a) HOSPITAL: 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

Present position 2017/18

Date	Quarter 1	Quarter 2	Quarter 3	Wards: January	
				95% and above	13
Score (%)	95	95	94	94 to 81%	2
				80% and less	4

It can be seen that for the first part of the Nutrition Audit target it was achieved in the first two quarters but not the third. The year to date figure so far is 95%. The second part of the target which relates to all individual ward scores in Quarter 4 will not be met as in January 13 of the 19 areas having scores 95% or above so it will be difficult for the 6 areas not achieving this score in January to get to 95% or above for the whole quarter.

Proposed Target 2018/19

Due to the non-achievement of this target it is proposed that it is retained for 2018/19.

b) HOSPITAL: At least 95% of acute patients will receive a nutritional assessment using the nationally recognised MUST (Malnutrition Universal Screening Tool).

Present Position 2017/18

Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD
Score (%)	85	98	92	92	90	93	93	96	92	94	92

The MUST target was only met for two of the months up to January and so will not be acheived for the whole year.

Proposed Target 2018/19

Again, due to the non-achievement of this target it is proposed that it is retained for 2018/19. It is also proposed that the wording is amended to:

At least 95% of acute patients will receive a nutritional assessment within 24 hours* of admission using the nationally recognised MUST (Malnutrition Universal Screening Tool). (* The timescale will be audited once the IT system can support this)

c) COMMUNITY: At least 95% of patients will receive a nutritional assessment on initial contact with the community health nursing team using the nationally recognised MUST (Malnutrition Universal Screening Tool).

Present Position 2017/18

Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD
Score (%)	94	98	98	96	98	96	88	96	95	95	95

The table above indicates that the target is likely to be achieved this year.

Proposed Target 2018/19

Due to the importance of this topic and it pertains to the community, it is proposed that it is retained for 2018/19.

Priority 5: Medications

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.

Present Position 2017/18

Medications Signed and Dated

Date	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	YTD
Score (%)	92	96	94	90	91	94	93	91	96	95	93

It can be seen that this target will not be met.

Proposed Target 2018/19

On the basis of the unmet target and the importance of effective medication administration, it is proposed that this target is retained for 2018/19.

Proposed new target

In addition, it is important to reduce and where possible, eliminate the risk and consequences of exposing a patient who is known to have an adverse reaction or allergy or sensitivity to a product that may be used in their care. This further target is therefore proposed:

All patients who have a known potential to have an adverse reaction or have an allergy or sensitivity to a product/medication are clearly identified by having a red identification band in place.

3. Proposed targets for 2018/19 for the two new priority topics.

Priority 6: Discharge Management

We consider safe and effective discharge to be of central importance in the pathway of care for our patients. We recognise that being discharged from hospital, which patients often feel is a place of safety, can be an anxious time. We also recognise that, once the decision has been made that discharge home can take place, it is an important element of a patient's experience that this takes place quickly and efficiently. Discharge planning needs to commence on the day of admission.

Proposed targets are:

a) All patients will have a recorded Expected Discharge Date (EDD) within 48 hours of admission determined by assuming ideal recovery and assuming no unnecessary waiting.

b) Early discharge. All medical and surgical wards will discharge the following number of patients before midday: In Q1, at least one patient. In Q2 at least two patients, which will be maintained in Q3 and Q4.

c) Delays in discharge. The total number of days that patients due for discharge are delayed will reduce by the following compared to the same quarter in 2017/18: Q1 by 5%, Q2 by 10%, which will be maintained in Q3 and Q4.
(Targets a) and b) will commence when the IT system has capability to support)

Priority 7: Incident Reporting

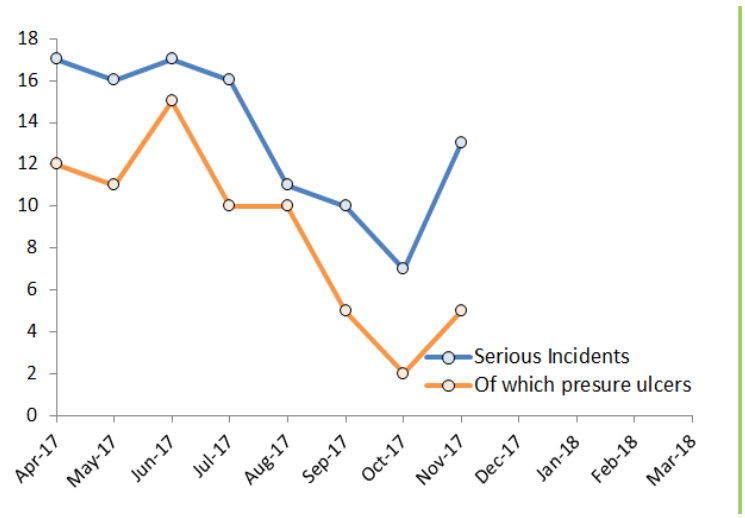
The safety of our patients is paramount. It is widely recognised that organisations with a positive culture have a high incident reporting rate with a reducing number of Serious Incidents, the latter resulting from learning and changing practice. Possible targets on this topic include increasing the incidents being reported and reducing the Serious Incidents and level of harm.

With regards to the overall reporting rate, comparative figures are published every six months from the NRLS (National Reporting and Learning System). At the time of writing this report, the latest comparative figures available are for the period of October 2016 to March 2017 which 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. It is acknowledged that there is room for further improvement. The following target is therefore proposed:

a) The Trust's reporting rate will increase every quarter, culminating in a 5% increase for the whole year and its comparative position on the reporting rate of incidents will improve every six months.

For Serious Incidents the numbers have been reducing during 2017/18. The following graph shows the numbers:

Serious Incidents



By the very nature of healthcare and human factors it is unlikely that these numbers would fall to zero and so a realistic and not over ambitious target on this topic needs to be agreed. As pressure ulcer targets are already included in Section 2 above, it is proposed that the target here covers the non-pressure ulcer Serious Incidents. With regards to the number of these, for the first eight months of 2017/18 there were 39 compared to 63 in 2016/17 and so the numbers are already reducing and so the following target is proposed:

b) In 2018/19, for the full year reduce the number of Serious Incidents (non-pressure ulcers) by 5% compared to the numbers in 2017/18.

B. Local Indicator for External Audit

Each year a local indicator for external audit (as well as two nationally mandated indicators) needs to be proposed to the Governors for their agreement. In the last three years, FFT (Friends and Family Test), Clostridium Difficile and Nutrition NCIs (Nursing Care Indicators) were chosen. This year the CQSPE have agreed to suggest that the important issue of falls incidents is proposed to the Governors for their agreement.

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 8th March 2018

TITLE:	**Report on Learning from Deaths**		
AUTHOR:	**J Hobbs** **Medical Director**	**PRESENTER**	**J Hobbs** **Medical Director**
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		

CORPORATE OBJECTIVE:
S02: Safe and Caring Service
S03: Drive service improvements, innovation and transformation

SUMMARY OF KEY ISSUES:

Currently the Trust has reported < 1% cases of avoidable mortality. The Prism 2 study suggests 3-4% of Trust Mortality is avoidable using the threshold of 50%. In the last quarter the Trust has taken the following actions in relation to improve reporting. Firstly the number of reviews now complete is 92% which compares well nationally. The second is to shorten the time to first review to 30%. Thirdly to improve consistency of challenge secondary reviewers are to undergo SJR training. LeDeR reviewers now attend the DMG group and all deaths are subject to a level 2 review internally.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Safe, Effective, Caring, Responsive, Well-led**
	NHSI	**Y/N**	**Details:**
	Other	**Y**	**Details:** **National Quality Board – National Guidance on Learning from Deaths (March 2017)**

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

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD
Detail further assurance required.

Mortality report

Purpose of the paper

To provide the information and assurance necessary to the board that mortality rates at Dudley hospital are within the acceptable range and that the hospital has implemented the recommendations contained in the learning from death document.

Data set

	Parameter	*Period*	*Numbers*
Mortality	Crude mortality	Jan 2016 to Dec 2017	1707 – 2.81% *
	SHMI	Oct 2016 to Sep 2017	0.98
	HSMR	Nov 2016 to Oct 2017	102.6
Condition specific alerts	Secondary malignancies	See below	N/A
Rule 28 notices	Care of pressure area	Q2	1
National audits	National Hip fracture Intensive Care Lung Cancer National Vascular Registry	2017 2015/2016 2016 2016	See below
Highest 6 condition groups	Sepsis Cerebrovascular disease Secondary malignancy COPD GI haemorrhage Non-Hodgkin's Lymphoma	See below	N/A
MPR level 1	Completion	Sep 2017 – Dec 2017[!]	400/577 (70%)
Thematic trends		N/A	N/A

NOTE: *Deaths as % of all inpatient admissions (excl. Well babies, Obstetrics, Midwifery)
[!] Date range = date of death of patient, not audit or review.

SHIMI is a measure of overall care and includes consideration of deaths within 30 days of discharge from hospital. There is some adjustment for comorbidities and risk stratification. Whilst coding may be a confounder, interpretation of SHMI should focus on trends and condition specific mortality alerts to provide assurance as to the effectiveness and safety of the service.

HSMR is calculated on inpatient deaths only. The provision of regional services and palliative and hospice care can significantly influence this measure.

Given the limitations of any one measure outcomes should be assessed on an appreciation of all measures.

Currently all mortality indices are within the expected range.

Condition specific Alerts from HED: **(Last 2 months)**

Alert	CCS Diagnostic Group	Expected Death	Observed Death	Number of Discharges	Score
CUSUM	42-Secondary malignancies	1.51	3	45	3.65
HSMR	42-Secondary malignancies	25.87	46	677	177.84

- HSMR Alert Period **September 2016-August 2017**
- SHMI Alert Period **August 2016-July 2017**
- CUSUM Alert Month **August 2017**

Six Highest condition groups. (Source HED)

Diagnostic Group (CCS)	No. of discharges	Expected	Observed	HSMR	Crude mortality rate	Obs. - Exp.
Septicemia (except in labor)	823	146.46	188	128.36	22.84%	42
Acute cerebrovascular disease	674	108.63	126	115.99	18.69%	17
Secondary malignancies	648	26.97	43	159.44	6.64%	16
Chronic obstructive pulmonary disease and bronchiectasis	1305	56.07	66	117.71	5.06%	10
Gastrointestinal hemorrhage	775	27	35	129.61	4.52%	8
Non-Hodgkin`s lymphoma	190	8.06	15	186.07	7.89%	7

Septicaemia: More detailed review of individual notes in progress, however, it is notable on reviewing information behind these figures that:

- Of 215 cases with a primary diagnosis of sepsis, the certified cause of death was NOT sepsis in more than 50%
- The number of deaths in hospital was equal to the number of “expected” deaths.

Secondary malignancies: More detailed review of individual notes underway.

Rule 28 notices.

Issue about availability of treatment materials. Actions complete.

National Audits:

Subject	Report time	DGFT	National	Within expected
National hip 30 day mortality	2017	7.3%*	6.7%	Y
Intensive care all mortality index	15/16	1.03	1.0	Y
Intensive care lower risk mortality index	15/16	0.81	1.0	Y
National Vascular Registry in hospital mortality	2016	0.4%	1.5%	Y
National Vascular Registry 30 day mortality	2016	2.3%	2.1%	Y

- National hip 30 day mortality: This figure represents a notable improvement following learning/actions implemented as described in previous report.

Within Learning from Deaths is a template dashboard to guide Trusts to report quarterly information, it is important to note that the NMCRR programme SJR methodology does not allow the calculation of whether a death has a greater than 50% probability of being avoidable.]

Deaths where there may have been a problem in care that may have affected outcome (Q3):

This information taken from Datix (adverse incident) reports; future reports will describe further learning and actions where appropriate. From 1/1/2018 the MTS has been linked to Datix:

Location	Category	Investigation complete?	Conclusion
Surgery	Unexpected	Yes	No failure of care
Emergency Department	Unexpected	No	Awaited
Obs/Paeds	Neonatal	Yes	No failure of care
Obs/paeds	Neonatal	Yes	No failure of care
Emergency Department	Unexpected	No	Awaited
MAU	Possibly Delayed treatment	No	Awaited
Surgery	Posssibly Delayed treatment	No	Awaited
Emergency Department	Possibly Delayed treatment	No	Awaited
Emergency Department	Possibly Delayed treatment	No	Referred to coroner

Learning from Departmental Audits (level1) and Panel (level 2):

Themes	Action	Time
End of life (DNAR)*	Escalate to resus team to include in training	Immediate
End of life (inappropriate admission)	Develop links with CCG to mitigate against inappropriate admission	End June 2018
End of Life: general considerations about the appropriate level of treatment	The Medical Director, Chief Nurse, and Directors have agreed a whole hospital commissioned programme to implement the Gold Standards Framework (for Hospitals) which is due to commence in April 2018.	This is a 2 year programme which involves 6 workshops 4 in the first year and 2 in the second year.
Failure to escalate concerns	Induction for junior doctors	Immediately via chiefs of service
Inter-speciality communications	Clarify responsibilities	Immediately via chiefs of service
Location of patient	Coordinate bed managing and clinician views	End April 2018

Theme	Event	Trust response	Audit
Risk	**Neurosurgical**	**Introduction of**	**Electronic**

stratification & escalation	**pathways**	**NORSE pathway**	**audit** **Report to CQPSE**
Escalation	**Septicaemia**	**E alerting** **Training** **Daily & weekly audit**	**Weekly A&E audit** **Join AQ**
Investigation	**Acute surgical abdomen**	**Emlap pathway** **Additional SPR on call**	**Initial audit complete** **Further audit to encompass all acute patients referred.**
Treatment	**VTE**	**Pt safety alert** **Electronic VTE to be implemented**	**RSM audit**

Development of reporting: (MSG is the Mortality Surveillance Group)

Perinatal:

The MBRRACE figures are historical. Note: 2015 figures published in 2017. Crude and adjusted perinatal mortality figures are below West Mids average for 2017 (Detailed report submitted to MSG)

Learning is detailed in each case of stillbirth in the departmental report and as a matter of course is discussed at the departmental perinatal audit meeting.

Paediatrics

The Clinical Service Lead has attended the MSG.

All neonatal deaths are reviewed in the network and learning points are documented. The MSG has requested that feedback is presented to the MSG going forward and significant thematic learning can be incorporated into this report.

All paediatric deaths are tracked on the MTS, but are subject to external review. Feedback from external review will in future be reported to MSG so that we can report learning where appropriate.

Emergency Department

Historically, because patients who die in ED are not admitted to hospital, they have not been included in the Trust's mortality indices nor considered in Board reports except when the death has been reported on Datix.

Nevertheless, the ED has always carried out reviews of deaths occurring in the department. They have a review process guided by the College of Emergency Medicine and will, going forward, report to the MSG so that themes and learning can be presented here.

Learning Disabilities

The LD liaison nurse has presented to the MSG. She is now trained in the LeDeR process. Trained reviewers may be asked to review cases from other Trusts.

Learning: The first set of reviews of DGNHSFT patients suggests that

- DNAR process needs reinforcing (see above themes)
- Clinical staff need further education/support around initiating planning meetings and decisions around involvement of next-of-kin and/or IMCA

Action: LD nurse will initially plan training ad hoc and will report back to MSG. MSG may need to recommend escalation.

Summary

Currently the Trust has reported < 1% cases of avoidable mortality. The Prism 2 study suggests 3-4% of Trust Mortality is avoidable using the threshold of 50%.

In the last quarter the trust has taken the following actions in relation to improve reporting. Firstly the number of reviews now complete is 92% which compares well nationally. The second is to shorten the time to first review to 30%. Thirdly to improve consistency of challenge secondary reviewers are to undergo SJR training.

LeDeR reviewers now attend the DMG group and all deaths are subject to a level 2 review internally.

Mortality Performance By Specialty Created on 07/02/2018 15:48:22.

Deaths between 01/04/2017 and 31/10/2017

Specialty	Deaths	Audited	%
Cardiology	45	40	89
Diabetes	12	12	100
Endocrinology	13	12	92
Gastroenterology	83	72	87
General Medicine	129	118	91
General Surgery	56	50	89
Geriatric Medicine	128	122	95
Haematology (Clinical)	5	3	60
Intermediate Care	19	8	50
Medical Assessment	90	86	96
Paediatrics	1	1	100
Renal	43	41	95
Respiratory	158	133	84
Stroke Medicine	36	22	61
Stroke Rehabilitation	20	16	80
T&O Rehabilitation	22	22	100
Trauma & Orthopaedics	20	20	100
Urology	8	7	88
Vascular Surgery	30	26	87

Appendix 1

Learning from Deaths Dashboard

The Dudley Group NHS Foundation Trust: Learning from Deaths Dashboard - December 2017-18

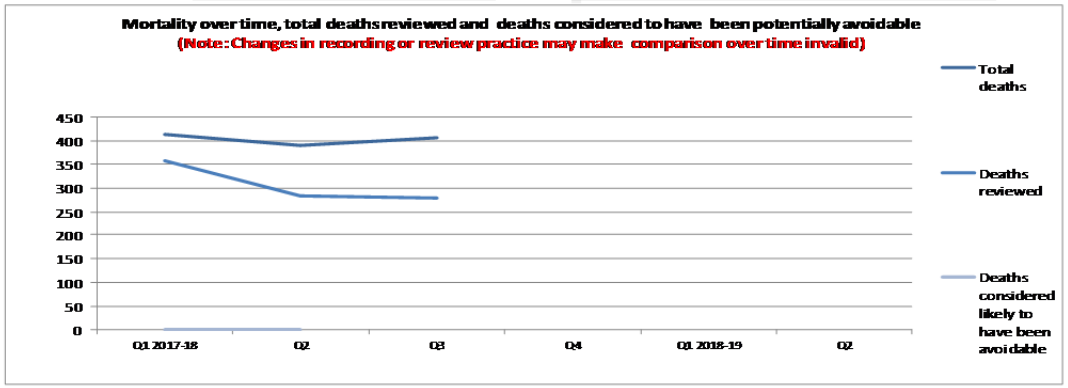
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
149	124	53	90	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
407	390	279	284	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1210	0	920	0	2	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



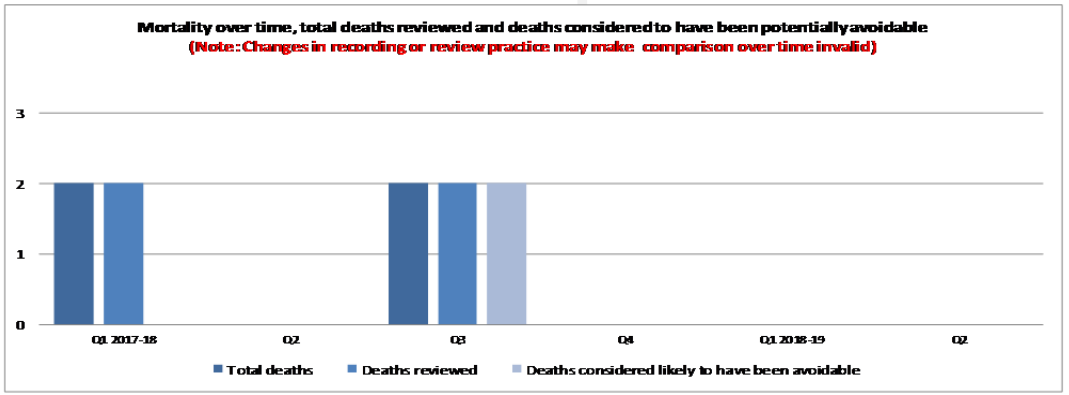
Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	53	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	0	0.0%	This Quarter (QTD	279	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	0.2%	This Year (YTD)	2	0.2%	This Year (YTD)	4	0.4%	This Year (YTD)	912	99.1%

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	1	0	1	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
2	0	2	0	2	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	0	4	0	2	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Enclosure 10

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 8 March 2018

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Chris Walker Deputy Director of Finance	**PRESENTER**	R Miner Non-Executive Director

CLINICAL STRATEGIC AIMS: Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way

CORPORATE OBJECTIVE: S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

Summary reports from the Finance and Performance Committee meeting held on 22 February 2018.

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	**22 February 2018**	**Richard Miner**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- The financial position as at 31st January 2018 was discussed in detail. The January financial performance had deteriorated by £900k in relation to the forecast position reported to the Committee in January. This was in the main due to continued agency expenditure linked to additional capacity opened during January within the hospital. Although the reported forecast financial position of the Trust remains at an £8.6m deficit there is now a risk to the achievement of this position due to the January trading position. The introduction of further and more immediate cost controls and increased financial governance was discussed.
- The balance sheet, cash and capital position at 31st January 2018 was discussed in detail. This included increased risk to the liquidity position due to the January trading position. Payments on account have been requested from local CCG's to mitigate this risk.
- The transformation and CIP position was debated. The full year programme delivery is now forecast to be £8.0m which is below plan and a deterioration from the previous months forecast.
- Current performance on ED was discussed including the requirements for the remainder of the financial year. All other key targets were reviewed and assurance provided on achievement.
- A nursing and midwifery workforce report was discussed. This reviewed safer staffing, agency usage and recruitment.
- Medical agency expenditure and the reduction in expenditure due to substantive recruitment and agency caps were discussed.
- Performance of the PFI contract in January was reviewed which included the Theatre Ultra Clean Canopy contract non-compliance.

Decisions Made / Items Approved

- None

Actions to come back to Committee

- Detailed 2018-19 plan including cash and capital to be presented to the special F&P Committee on 5th March 2018.
- Business plan for the 'Terafirma' IT service provider to be presented to the March F&P Committee.

Performance Issues to be referred into Executive Performance Management Process

- Introduction and management of further and more immediate cost controls and increased financial governance.

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

- Financial and liquidity risks to be reviewed and scores increased.

Items referred to the Board for decision or action

- Chairman's action on the approval of the contract for the purchase of IT devices.

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 8th March 2018

TITLE:	Integrated Performance Report for Month 10 (January) 2018		
AUTHOR:	Andy Troth Head of Informatics	**PRESENTER:**	Karen Kelly 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

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.

The Dudley Group
NHS Foundation Trust

Integrated Performance Report - Board




January 2018

Created by: Informatics.
Title of report: Integrated Performance Report

Executive Lead:	**CQSPE**	**Chief Nurse, Siobhan Jordan**
	Performance	**Chief Operating Officer, Karen Kelly**
	Finance	**Director of Finance, Tom Jackson**
	Workforce	**Director of HR, Andrew McMenemy**

The Dudley Group NHS Foundation Trust

Quality Dashboard

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Complaints	-	80	100	112	116	172	132	144	105	58	51	-	-	1,070
Compliments	-	659	399	315	324	384	492	579	525	862	851	-	-	5,390
Friends & Family – Community – Footfall	1.20%	1.10%	0.90%	2.10%	3.30%	3.20%	1.90%	4.90%	5.20%	4.30%	3.30%	-	-	3%
Friends & Family – Community – Recommended %	95.80%	94%	96%	97.40%	98%	98.20%	97.10%	95.10%	95.90%	95.70%	96.30%	-	-	96.40%
Friends & Family – ED – Footfall	7.90%	15.40%	13.70%	17.10%	15.30%	16%	19.60%	28.50%	24.70%	17%	21.20%	-	-	18.80%
Friends & Family – ED – Recommended %	85.10%	75%	76.10%	78.70%	77.40%	72.50%	75.90%	83.60%	80.30%	77.40%	74.40%	-	-	77.70%
Friends & Family – Inpatients – Footfall	17.80%	28.70%	30.80%	32.80%	34.20%	32.30%	27.80%	33.90%	33.90%	30.90%	30.10%	-	-	31.60%
Friends & Family – Inpatients – Not Recommended %	-	0.60%	1.10%	0.70%	0.90%	1.40%	1.50%	2%	1.50%	2.60%	1.80%	-	-	1.40%
Friends & Family – Inpatients – Recommended %	96.60%	96.40%	95.60%	96.50%	96.40%	96.30%	95.90%	95.10%	95.30%	95.10%	94.10%	-	-	95.70%
Friends & Family – Maternity – Footfall	30.10%	30.90%	48.90%	40.40%	48.60%	56.30%	39.60%	34.80%	45.10%	23.60%	38.40%	-	-	41%
Friends & Family – Maternity – Not Recommended %	-	0.50%	0.70%	0.50%	0.80%	1%	0.80%	0.60%	0.70%	0%	0.20%	-	-	0.60%
Friends & Family – Maternity – Recommended %	98.30%	98.80%	97.80%	98.20%	98.60%	97.60%	97.80%	98.60%	95%	98.40%	97.20%	-	-	97.70%
Friends & Family – Outpatients – Footfall	1.60%	1.50%	1.90%	2.30%	2.60%	4.80%	2.90%	10.90%	5.90%	3.50%	5.90%	-	-	4.20%
Friends & Family – Outpatients – Recommended %	92.60%	95.30%	95.20%	91.60%	95.30%	93.40%	92.30%	90.80%	89.80%	92.80%	91.70%	-	-	92%
HCAI – Post 48 hour MRSA	0	0	0	0	0	0	0	0	0	0	0	-	-	0
HCAI CDIFF – Due To Lapses In Care	13	2	1	1	4	1	5	0	1	0	0	-	-	15
HCAI CDIFF – Not Due To Lapses In Care	20	0	0	1	0	0	1	1	4	0	0	-	-	7
HCAI CDIFF – Total Number Of Cases	33	2	1	2	4	1	6	1	5	1	5	-	-	28
HCAI CDIFF – Under Review	0	0	0	0	0	0	0	0	0	1	5	-	-	6
Incidents - Appointments, Discharge & Transfers	724	58	71	65	90	93	90	95	78	82	99	-	-	821
Incidents - Blood Transfusions	128	4	13	6	8	4	5	10	11	5	5	-	-	71
Incidents - Clinical Care (Assessment/Monitoring)	898	80	98	86	99	108	114	112	160	129	125	-	-	1,111
Incidents - Diagnosis & Tests	350	33	31	24	35	39	37	32	31	30	32	-	-	324
Incidents - Equipment	228	32	23	29	23	33	15	21	15	23	25	-	-	239
Incidents - Facilities (Security, Estates, Transport, Fire etc.)	401	38	45	65	52	61	37	42	29	39	24	-	-	432
Incidents - Falls, Injuries or Accidents	1,629	133	132	109	130	101	98	130	139	103	133	-	-	1,208
Incidents - Health & Safety	301	17	24	38	27	34	28	26	27	17	39	-	-	277

The Dudley Group NHS Foundation Trust

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Incidents - Infection Control	63	6	5	6	8	9	3	14	12	11	7	-	-	81
Incidents - Medication	4,441	293	334	324	312	226	287	499	608	341	372	-	-	3,596
Incidents - Obstetrics	935	89	73	87	127	102	85	80	78	68	79	-	-	868
Incidents - Pressure Ulcer	2,573	239	253	225	241	315	280	316	302	277	366	-	-	2,814
Incidents - Records, Communication & Information	562	47	52	40	123	64	68	79	68	65	87	-	-	693
Incidents - Safeguarding	638	51	60	63	63	49	78	80	79	76	89	-	-	688
Incidents - Theatres	195	13	11	15	27	18	12	17	10	22	20	-	-	165
Incidents - Venous Thrombo Embolism (VTE)	137	14	17	4	21	11	5	6	11	5	7	-	-	101
Incidents - Violence, Aggression & Self Harm	660	51	91	81	76	62	49	68	73	34	53	-	-	638
Incidents - Workforce	401	30	22	41	58	69	63	54	84	66	47	-	-	534
Maternity : Early Booking KPI: % of women who see midwife/maternity healthcare professional	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%
Maternity : Increase in breast feeding initiation rates by 2% per year	55.89%	57.45%	60.42%	60.99%	56.98%	53.47%	47.82%	58.39%	61.31%	55.08%	58.43%	-	-	56.97%
Maternity : Smoking In Pregnancy : Reduce to a prevalence of 12.1% across the year	14.75%	17.75%	14.57%	13.66%	12.91%	17.44%	13.69%	14.75%	19.78%	15.80%	17.59%	-	-	15.79%
Mixed Sex Sleeping Accommodation Breaches	62	5	3	0	0	2	6	4	0	10	5	-	-	35
Never Events	1	0	0	1	0	0	0	0	1	0	0	-	-	2
NQA - Matrons Audit	89%	89%	92%	92%	92%	92%	92%	93%	95%	93%	-	-	-	92%
NQA - Nutrition Audit	96%	96%	95%	93%	95%	96%	95%	95%	93%	95%	92%	-	-	95%
NQA - Paediatric Nutrition Audit	98%	98%	100%	100%	91%	92%	97%	98%	98%	98%	100%	-	-	97%
NQA - Safety Thermometer	90	2	11	-	3	-	-	-	-	-	-	-	-	16
NQA - Skin Bundle	96%	93%	97%	94%	96%	95%	96%	93%	95%	96%	94%	-	-	95%
NQA - Think Glucose - EAU/SAU	-	83%	47%	82%	89%	65%	66%	80%	93%	100%	100%	-	-	74%
NQA - Think Glucose - General Wards	88%	92%	91%	89%	93%	94%	98%	97%	96%	98%	99%	-	-	94%
Nursing Care Indicators - Community Childrens	99%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	-	-	99%
Nursing Care Indicators - Community Neonatal	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%
Nursing Care Indicators - Critical Care	98%	98%	100%	98%	100%	100%	98%	98%	100%	99%	98%	-	-	99%
Nursing Care Indicators - District Nurses	94%	91%	98%	94%	96%	97%	94%	91%	93%	92%	95%	-	-	94%
Nursing Care Indicators - EAU	93%	88%	86%	98%	92%	94%	88%	97%	97%	97%	63%	-	-	90%
Nursing Care Indicators - ED	88%	91%	86%	93%	72%	92%	92%	92%	91%	86%	83%	-	-	87%
Nursing Care Indicators - Evergreen	90%	98%	91%	83%	97%	89%	85%	82%	-	-	-	-	-	89%

The Dudley Group NHS Foundation Trust

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Nursing Care Indicators - General Wards	93%	93%	95%	96%	95%	94%	95%	95%	96%	97%	95%	-	-	95%
Nursing Care Indicators - Maternity	92%	100%	94%	97%	95%	95%	95%	95%	97%	94%	97%	-	-	96%
Nursing Care Indicators - Neo Natal	98%	98%	99%	99%	99%	99%	99%	99%	98%	99%	98%	-	-	99%
Nursing Care Indicators - Paediatric	98%	94%	100%	97%	84%	95%	95%	97%	96%	97%	95%	-	-	95%
Nursing Care Indicators - Renal	95%	98%	99%	97%	98%	99%	92%	96%	93%	96%	98%	-	-	97%
PALS Concerns	-	177	235	234	232	-	189	218	209	197	187	-	-	1,878
Saving Lives - 01a CVC Insertion	98%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	-	-	99%
Saving Lives - 01b CVC Ongoing Care	99%	98%	98%	98%	93%	100%	94%	100%	100%	100%	100%	-	-	98%
Saving Lives - 02a Peripheral Lines Insertion	97%	97%	96%	99%	99%	99%	99%	97%	98%	98%	98%	-	-	98%
Saving Lives - 02b Peripheral Lines Ongoing Care	96%	98%	99%	97%	99%	98%	98%	98%	99%	98%	98%	-	-	98%
Saving Lives - 03a Renal Dialysis Insertion	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%
Saving Lives - 03b Renal Dialysis Ongoing Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%
Saving Lives - 04a Surgical Site Pre Op	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%
Saving Lives - 04b Surgical Site Intraoperative	100%	100%	100%	100%	100%	100%	100%	100%	90%	53%	96%	-	-	95%
Saving Lives - 04c Surgical Site Post Op	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%
Saving Lives - 05 Reducing Ventilation associated pneumonia	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	-	100%
Saving Lives - 06a Urinary Catheter Insertion	99%	100%	100%	100%	100%	98%	100%	98%	100%	100%	100%	-	-	99%
Saving Lives - 06b Urinary Catheter Ongoing Care	99%	99%	100%	98%	99%	98%	100%	100%	100%	99%	98%	-	-	99%
Saving Lives - 07 C.difficile	87%	100%	100%	-	75%	100%	88%	75%	75%	75%	100%	-	-	88%
Saving Lives - 08a Clinical equipment Decontamination Infected	99%	100%	100%	100%	99%	99%	99%	98%	100%	99%	99%	-	-	99%
Saving Lives - 08b Clinical equipment Decontamination Non Infected	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%	100%	-	-	99%
Saving Lives - 11 Enteral Feeding (New)	98%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	-	-	99%
Serious Incidents - Action Plan overdue	206	4	5	5	9	4	11	10	8	-	-	-	-	56
Serious Incidents - Clinical Care (Assessment/Monitoring)	20	1	2	-	1	-	1	2	3	1	1	-	-	12
Serious Incidents - Diagnosis & Tests	10	1	1	-	-	-	-	-	-	-	1	-	-	3
Serious Incidents - Facilities (Security, Estates, Transport, ICT, etc.)	-	-	-	-	-	-	-	1	-	-	-	-	-	1
Serious Incidents - Falls, Injuries or Accidents	32	3	-	2	3	-	2	2	3	2	2	-	-	19

The Dudley Group NHS Foundation Trust

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Serious Incidents - Infection Control	6	1	-	-	-	-	-	2	2	-	-	-	-	5
Serious Incidents - Medication	1	-	-	-	-	-	-	-	1	-	-	-	-	1
Serious Incidents - Obstetrics	5	-	1	-	-	1	-	-	-	-	-	-	-	2
Serious Incidents - Pressure Ulcer	150	6	13	9	10	13	7	-	5	6	13	-	-	82
Serious Incidents - Records, Communication & Information	6	-	-	-	-	-	-	-	-	-	1	-	-	1
Serious Incidents - Theatres	3	-	-	-	1	-	-	-	-	-	-	-	-	1
Stroke Admissions : Swallowing Screen	77.02%	72.72%	76.27%	82.22%	82.69%	88.09%	90.24%	89.18%	71.79%	80%	81.81%	-	-	81.29%
Stroke Admissions to Thrombolysis Time	51.24%	100%	55.55%	0%	63.63%	77.77%	71.42%	71.42%	75%	42.85%	62.50%	-	-	64.17%
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)	87.56%	94.23%	96.49%	93.33%	96.22%	92.72%	90.69%	100%	80%	81.08%	92.45%	-	-	92.17%
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation	79.31%	100%	85.71%	100%	81.81%	100%	100%	100%	90%	100%	100%	-	-	96.03%
Time to Surgery - Elective admissions operated on within two days for all procedures	92.81%	91.36%	82.83%	87.81%	92.65%	89.70%	70.68%	93.44%	94.65%	57.44%	83.69%	-	-	85.08%
Time to Surgery : Emergency Procedures (Appendectomy)	94.29%	100%	96.96%	95.45%	97.43%	97.05%	100%	96%	93.33%	90.90%	100%	-	-	97.22%
Time to Surgery : Emergency Procedures (Femur Replacement)	94.92%	94.44%	84.61%	80%	100%	95.23%	94.11%	89.47%	100%	100%	100%	-	-	93.82%
Time to Surgery : Emergency Procedures (Reduction of fracture of bone)	92.80%	94.23%	95.65%	88.09%	95.34%	86%	86.48%	95.34%	94.11%	89.28%	100%	-	-	92.23%
Time to Surgery : Emergency Procedures (Upper GI Diagnostic endoscopic)	64.98%	58.33%	70.58%	73.68%	70.37%	63.15%	92.85%	62.50%	57.14%	46.15%	77.27%	-	-	66.06%
VTE Assessment Indicator (CQN01)	94.75%	92.24%	91.97%	93.50%	94.08%	94.74%	94.37%	95.05%	93.97%	92.12%	92.25%	-	-	93.44%

The Dudley Group NHS Foundation Trust

Executive Summary by Exception

Key Messages

1 Performance Matters — Committee: F&P

A&E 4 hour wait

The combined Trust and UCC performance was below target in month at 81.71%. Whilst, the Trust only (Type 1) performance was 70.21%.

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

	Attendances	Breaches	Performance
A&E Dept. Type 1	8745	2605	70.21%
UCC Type 3	6055	102	98.328%

Cancer Waits

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

Cancer – 62 Day from Urgent GP Referral to Treatment performed on target for the month at 87% (Provisional)

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

No. of Patients treated on or over 104 days (DGFT)	2
No. of Patients treated on or over 104 days (Tertiary Centre)	2
No. of Patients treated on or over 104 days (Combined)	4

2WW

The target was achieved once again in month. During this period a total of 959 patients attended a 2ww appointment with 43 patients attending their appointments outside of the 2 week standard, achieving a performance 96.1% against the 93% target.

Referral To Treatment (RTT)

The performance of the key target RTT Incomplete Waiting Time indicator remained strong, with performance of 93.53% in month against a target of 92%, a slight decrease in performance from 93.85% in the previous month. Urology did not meet the target in month at 90.91%, down from 91.81% in previous month. Ophthalmology is at 79.21%, down from 81.78% in the previous month. Plastic Surgery has returned to achieveing target at 92.83%. There were no 52-week Non-admitted Waiting Time breaches in month.

Diagnostic waits

The diagnostic wait target was achieved in month with a performance of 99.26%. The number of patients waiting over 6 weeks was 37.

Of the 37, MRI accounted for 30 (7 other).

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

2 Financial Performance Matters — **Committee: F&P**

The position on the Trust's liquidity ratio was 0.3 days against a planned position of 12.6 days at Month 10. Liquidity continues to deteriorate against plan as a result of the movement from plan on I&E, the receipt of no STF in the 2nd half of the year and the impact on cash.

Executive Summary by Exception cont.

Key Messages

CQSPE

HCAI

Total No. of C. Diff cases identified after 48hrs for the month was 5. (28ytd.)

	December	YTD
Total No. of cases due to lapses in care	N/A	15
Total No. of cases NOT due to lapses in care	N/A	7
No. of cases currently under review (ytd)	6	N/A
Total No. of cases ytd.	N/A	28

There were 0 post 48 hour MRSA cases reported in month.

Never Events

There werre zero never events in month.

Mixed Sex Sleeping Accommodation Breaches (MSA)

There were 5 breaches reported in month.

VTE Assessment On Admission: Indicator

The indicator did not achieve the target in month with provisional performance at 92.26% against a target of 95%. This is a slight increase on the previous month's performance of 92.13%.

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

4 Workforce — Committee: F&P

Appraisals:

The month has seen the position worsen slightly in the percentage of appraisals undertaken, from 86.9% to 84.4%. No Divisions are red. Clinical Support, Corporate/Management, Surgery and Medicine and Integrated Care are all amber at 84.2%, 85.04%, 84.39% and 84.22% respectively (>80% <90%). All down from last month.

Mandatory Training:

Mandatory Training has improved from 86.64% to 87.15% in month. The Director of HR is working with respective Divisions based on the feedback from a series of forums that were held to identify issues within the mandatory training system. No divisions are red and Corporate Management are green with 91.19%. Within the Clinical Support Division, Division Management and Imaging are red at 69.7% and 78.91% respectively, both up from last month. Within Medicine and Integrated Care, Urgent Care is red at 72.36% up from last month; and within Surgery no directorates are red.
The Chief Executive has signalled that for the year of 2017/18 that the Trust's targets need to be met.

Sickness:

Sickness rate overall has increased from 5.07% in the previous month to 5.70% in month. All Divisions are red with Medicine & Integrated Care 5.69%, Surgery Division5.79%, Corporate Management 5.91% and Clinical Support 5.2%. Within the Medicine & Integrated Care Division, Integrated Care and Nursing Medicine Directorates are red with 5.13% and 7.83% respectively. Within the Surgery Division; Nursing Surgery, OPD and Health Records, Surgery Division Management, Theatres & Critical Care Directorates and Trauma & Orthopaedics are red with 6.81%, 5.41%, 9.26%, 6.93% and 4.07% respectively.

The Dudley Group NHS Foundation Trust

Patients will experience safe care - "At a glance"

Executive Lead: Siobhan Jordan

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Jan-18	Actual YTD	Trend	Month Status
Friends & Family Test - Footfall						
Friends & Family Test - ED	14.5%	21.3%	22.1%	19.0%	↑	
Friends & Family Test - Inpatients	26.0%	35.1%	30.1%	31.7%	↓	
Friends & Family Test - Maternity	21.7%	34.4%	38.5%	41.1%	↑	
Friends & Family Test - Outpatients	4.7%	14.5%	5.9%	4.3%	↑	
Friends & Family Test - Community	3.5%	9.1%	3.4%	3.1%	↓	
Friends & Family Test - Recommended						
Friends & Family Test - ED	89.9%	93.4%	74.4%	77.8%	↓	
Friends & Family Test - Inpatients	96.3%	97.4%	94.1%	95.7%	↓	
Friends & Family Test - Maternity	96.0%	98.1%	97.2%	97.4%	↓	
Friends & Family Test - Outpatients	94.6%	97.2%	91.8%	92.1%	↓	
Friends & Family Test - Community	96.4%	97.7%	96.1%	96.4%	↑	
Complaints						
Total no. of complaints		N/A	52	334	↑	
Complaints closed within target	90%	90%	100.0%	96.4%	↔	
Complaints re-opened			0	2	↔	
PALs Numbers			235	0	↑	
Ombudsman						
Dementia (1 month in arrears)						
Find/Assess		90%	88.0%	96.4%	↓	
Investigate		90%	100.0%	100.0%	↔	
Refer		90%	97.6%	96.1%	↑	
Falls						
No. of Falls		0	85	806	↑	
Falls per 1000 bed days		6.63	4.49	0.08	↑	
No. of Multiple Falls		N/A	5	81	↑	
Falls resulting in moderate harm or above			1	14		
Falls resulting in moderate harm or above per 1000 bed days		0.19	0.05	0.08	↓	
Pressure Ulcers (Grades 3 & 4)						
Hospital Avoidable		0	5	18	↑	
Hospital Non-avoidable		0	3	11	↑	
Community Avoidable		0	2	39	↑	
Community Non-avoidable		0	9	68	↓	
Mixed Sex Accommodation Breaches						
Single Sex Breaches		0	5	35	↓	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Jan-18	Actual YTD	Trend	Month Status
Mortality (Quality Strategy Goal 3)						
HSMR Rolling 12 months (**Latest data Oct 17**)	110	105	103	N/A		
SHMI Rolling 12 months (**Latest data Sept 17**)	1.10	1.05	0.98	N/A		
HSMR Year to date (**Latest data Oct 17**)			107	N/A		
Infections						
Cumulative C-Diff due to lapses in care		15	15	N/A		
MRSA Bacteraemia		0	0	0	↔	
MSSA Bacteraemia		0	1	6	↑	
E. Coli - Total hospital		0	0	24	↔	
Stroke Admissions - PROVISIONAL						
Stroke Admissions: Swallowing Screen		75%	81.8%	80.2%	↑	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	92.5%	94.7%	↑	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	100.0%	93.5%	↑	
VTE - PROVISIONAL						
VTE On Admission		95%	92.6%	93.5%	↑	
Incidents						
Total Incidents			1274	4486	↓	
Recorded Medication Incidents			372	3596	↑	
Never Events			0	2	↔	
Serious Incidents			18	134	↑	
of which, pressure ulcers			13	89	↑	
Incident Grading by Degree of Harm						
Death			2	8	↑	
Severe			2	17	↔	
Moderate			8	83	↔	
Low			277	2109	↑	
No Harm			1158	11770	↑	
Percentage of incidents causing harm		28%	20.0%	15.9%	↑	
NQA Think Glucose						
NQA Think Glucose - AMU/SAU	85%	95%	100%	72%	↔	
NQA Think Glucose - General Wards	85%	95%	99%	93%	↑	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Jan-18	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)					
All Cancer 2 week waits	93%	96.2%	94.9%	↑	
2 week wait - Breast Symptomatic	93%	96.7%	97.6%	↑	
31 day diagnostic to 1st treatment	96%	98.4%	98.7%	↓	
31 day subsequent treatment - Surgery	94%	95.5%	98.7%	↓	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	↔	
62 day urgent GP referral to treatment	85%	87.9%	86.1%	↑	
62 day screening programme	90%	93.8%	97.7%	↓	
62 day consultant upgrades	85%	89.9%	93.1%	↓	
Referral to Treatment					
RTT Incomplete Pathways - % still waiting	92%	93.5%	94.6%	↑	
RTT Admitted - % treatment within 18 weeks	90%	87.0%	88.4%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	94.1%	92.9%	↑	
Wait from referral to 1st OPD	26	32	290	↑	
Wait from Add to Waiting List to Removal	39	48	419	↑	
ASI List		1325	0	↓	
% Missing Outcomes RTT		0.0%	0.1%	↓	
% Missing Outcomes Non-RTT		7.0%	4.6%	↓	
DM01					
No. of diagnostic tests waiting over 6 weeks	0	37	1575	↑	
% of diagnostic tests waiting less than 6 weeks	99%	99.3%	97.6%	↓	
ED - TRUST					
Patients treated < 4 hours Type 1 (Trust ED)	95%	70.4%	80.1%	↑	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	81.8%	87.6%	↑	
Emergency Department Attendances	N/A	8741	87214	↑	
12 Hours Trolley Waits	0	4	0	↑	
Ambulance to ED Handover Time - TRUST					
30-59 minute breaches		691	3872	↓	
60+ minute breaches		109	622	↓	
Cancelled Operations - TRUST					
% Cancelled Operations	1.0%	2.0%	1.4%	↑	
Cancelled operations - breaches of 28 day rule	0	6	14	↑	
Urgent operations - cancelled twice	0	0	0	↔	

Performance - Key Performance Indicators cont.

	Target	Jan-18	Actual YTD	Trend	Month Status
GP Discharge Letters					
GP Discharge Letters	90%	80.1%	78.6%	↑	
Theatre Utilisation - TRUST					
Theatre Utilisation - Day Case (RHH & Corbett)		73.6%	76.2%	↓	
Theatre Utilisation - Main		87.3%	86.1%	↑	
Theatre Utilisation - Trauma		89.9%	91.7%	↓	
GP Referrals (1 month in arrears)					
GP Written Referrals - made		6971	61003	↓	
GP Written Referrals - seen		6452	51556	↓	
Other Referrals - Made		2158	23909	↓	
Throughput					
Patients Discharged with a LoS >= 7 Days		7%	7%		
Patients Discharged with a LoS >= 14 Days		3%	3%		
7 Day Readmissions		4%	3%		
30 Day Readmissions - PbR		8%	7%		
Bed Occupancy - %		90%	90%		
Bed Occupancy - % Medicine & IC		94%	94%		
Bed Occupancy - % Surgery, W&C		87%	87%		
Bed Occupancy - Paediatric %		59%	58%		
Bed Occupancy - Orthopaedic Elective %		75%	77%		
Bed Occupancy - Trauma and Hip # %		96%	94%		
Number of Patient Moves between 8pm and 8am		104	958		
Discharged by Midday		14%	15%		
DNA Rates					
New outpatient appointment DNA rate	8%	10.9%	9.7%	↓	
Follow-up outpatient appointment DNA rate	8%	9.6%	8.3%	↓	
Total outpatient appointment DNA rate	8%	10.0%	9.7%	↓	
Average Length of stay (Quality Strategy Goal 3)					
Average Length of Stay - Elective	0.0	3.5	3.2	↑	
Average Length of Stay - Non-Elective	3.4	5.7	5.3	↓	

Financial Performance - "At a glance"

Executive Lead: Tom Jackson

The Dudley Group NHS Foundation Trust

Performance - Financial Overview

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	581	468	-19.4%	-113	5,547	4,904	-11.6%	-643
Day Cases	4,186	4,171	-0.4%	-15	39,959	41,042	2.7%	1,083
Non-elective inpatients	5,238	3,826	-27.0%	-1,412	51,698	47,255	-8.6%	-4,443
Outpatients	39,903	41,851	4.9%	1,948	374,890	367,860	-1.9%	-7,030
A&E	8,610	8,741	1.5%	131	85,235	87,214	2.3%	1,979
Total activity	**58,518**	**59,057**	**0.9%**	**539**	**557,329**	**548,275**	**-1.6%**	**-9,054**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	137	147	6.8%	9	1,100	937	-14.8%	-163
Pay	838	-277	-133.0%	-1,115	5,653	2,413	-57.3%	-3,240
Non-Pay	331	423	27.6%	91	2,907	3,411	17.3%	504
Total CIP	**1,307**	**293**	**-77.6%**	**-1,014**	**9,660**	**6,761**	**-30.0%**	**-2,899**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	29,134	27,363	-6.1%	-1,770	274,533	269,708	-1.8%	-4,825
Other Clinical	128	130	1.5%	2	1,282	1,114	-13.1%	-168
STF Funding	1,000	0	-100.0%	-1,000	6,573	2,487	-62.2%	-4,086
Other	1,848	1,777	-3.8%	-70	18,441	18,882	2.4%	441
Total income	**32,110**	**29,271**	**-8.8%**	**-2,839**	**300,829**	**292,191**	**-2.9%**	**-8,638**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-17,281	-18,736	8.4%	-1,455	-172,084	-177,388	3.1%	-5,303
Drugs	-2,879	-3,082	7.0%	-203	-27,397	-27,868	1.7%	-471
Non-Pay	-8,087	-7,567	-6.4%	520	-72,771	-73,007	0.3%	-236
Total Costs	**-28,247**	**-29,384**	**4.0%**	**-1,138**	**-272,252**	**-278,263**	**2.2%**	**-6,011**

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	**3,859**	**-97**	**-102.5%**	**-3,956**	**28,532**	**14133**	**-50.5%**	**-14,400**
Depreciation	-765	-778	1.7%	-13	-7,778	-7648	-1.7%	130
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,120	-1,129	0.8%	-9	-11,201	-11005	-1.8%	196
SURPLUS/(DEFICIT)	**1,974**	**-2,003**	**-201.5%**	**-3,977**	**9,553**	**-4520**	**-147.3%**	**-14,073**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	1,119	2,283	104.0%	1,164	13,228	13048	-1.4%	-180
Inventory					2,869	3132	9.2%	263
Receivables & Prepayments					21,188	21681	2.3%	493
Payables					-19,877	-24928	25.4%	-5,051
Accruals					-2,826	-2399	-15.1%	427
Deferred Income					-4,611	-3438	-25.4%	1,173
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					17,335	9,733	-43.9%	-7,602
Loan Funding							n/a	0
KPIs								
EBITDA %	12.00%	-0.30%	-12.3%		9.50%	4.80%	-4.6%	
Deficit %	6.10%	-6.20%	-12%		3.20%	-1.50%	-4.7%	
Receivable Days					0.0	0.0	n/a	
Payable (excluding accruals) Days					0.0	0.0	n/a	
Payable (including accruals) Days					0.0	0.0	n/a	
Use of Resource metric					1	3		

The Dudley Group NHS Foundation Trust

Workforce - "At a glance"

Executive Lead: Andrew McMenemy

People	Target 17/18	Target YTD	Jan-18	Actual YTD	Trend	Month Status
Workforce						
Sickness Absence Rate	3.75%	3.75%	5.70%	4.33%	↓	
Staff Turnover (1 month in arrears)	0%	0%	9.6%	9.2%	↓	
Mandatory Training	90.0%	90.0%	87.1%	85.7%	↓	
Appraisal Rates - Total	90.0%	90.0%	84.4%	84.7%	↓	

Enclosure 12

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board on 8th March 2018

TITLE:	Transformation and Cost Improvement Programme (CIP) Summary Report		
AUTHOR:	Lisa Peaty, Deputy Director: Strategy & Business Development	**PRESENTER**	Natalie Younes, Director: Strategy & Business Development

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 58 schemes currently on the work programme which contribute to the £12.5m identified. 3% of the CIP has currently been identified as non recurrent savings.

Based on the Month 10 position (January 2018), the Trust has achieved *c.* £6.7m against the year to date (YTD) plan of £9.6m giving a variance of -£2.9m. However, the full year effect variance forecast by to under-deliver by £4.7m (i.e. delivery of £8.0m).

Exception reports have been developed for underperforming CIP schemes which outline the mitigating actions in place to address underperformance.

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 TRUST BOARD: *(Please tick or enter Y/N below)*

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE TRUST BOARD
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

TRUST BOARD

Summary Report: Month Ten (January 2018)

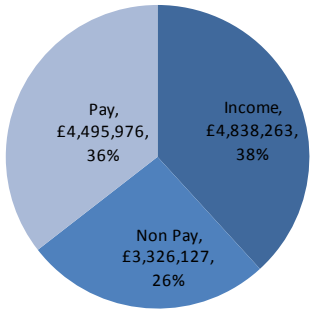
Date of Trust Board: 8th March, 2018

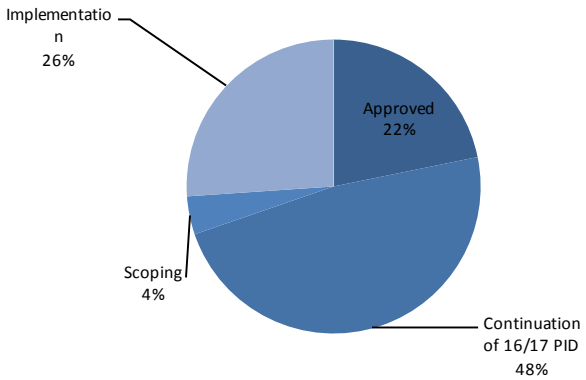
Executive Summary – 2017/18

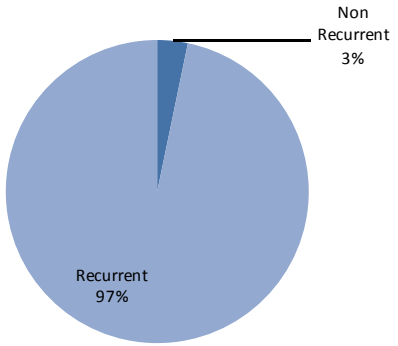
The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18. To support this, there are 57 schemes on the work programme which contribute to the £12.5m identified, and 3% of of the CIP has currently been identified as non recurrent savings.

A summary of CIP performance as at Month 10 is provided below (with supporting detail overleaf):

CIP Project Plans	Full Year (FY)			YTD Performance Against Identified Plans			Y/E Forecast of Identified Plans	
	FY Target	FY Identified	Variance Against FY Target	YTD Pan	YTD Actual	YTD Variance	FYE Forecast	FYE Variance
Total	£12,500,000	£12,630,351	£ 130,351	£ 9,636,780	£ 6,761,221	-£ 2,875,560	£ 7,962,768	-£ 4,667,583







Based on the Month 10 position, the Trust has identified schemes totalling £12.6m against a Full Year (FY) target of £12.5m.

As at Month 10 the Trust is forecasting to deliver £8m.

Executive Summary – 2017/18

	YTD	FYE			Submitted Plan
Planned	£9,636,780			Identified	£12,630,351
Actual	£6,761,221			Target	£12,500,000
Forecast		£7,962,768			
Variance	-£2,875,560	-£4,667,583			£130,351

Programme (Click for details)	YTD Plan	YTD Actual	YTD Variance	FYE Plan	FYE Forecast	FYE Variance
Surgery Women and Children's	£2,693,853	£1,481,436	-£1,212,417	£3,232,624	£2,085,336	-£1,147,288
Medicine and Integrated Care	£1,172,187	£1,237,894	£65,707	£1,457,627	£1,469,437	£11,810
Clinical support Services	£819,164	£1,037,955	£218,791	£998,746	£1,311,361	£312,615
Corporate Directorates	£1,650,702	£1,785,911	£135,209	£2,020,149	£2,149,121	£128,973
Cross Workstream	£3,300,873	£1,218,024	-£2,082,849	£4,921,205	£947,513	-£3,973,692
View all Projects	£9,636,780	£6,761,221	-£2,875,560	£12,630,351	£7,962,768	-£4,667,583

2017/18 Forecast Non Recurrent	£410,039
% of Total CIP Forecast as Non Recurrent	3%

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 8 March 2018

TITLE:	**Patient Experience Report – Quarter 3, 2017/18**		
AUTHOR:	Jill Faulkner Head of Patient Experience	**PRESENTER**	Siobhan Jordan Chief Nurse
CORPORATE OBJECTIVE: SO1: Deliver a great patient experience			

SUMMARY OF KEY ISSUES:

The Trusts number one priority is to deliver a great patient experience; this is the first comprehensive report to be presented to the Board. This report details:

- Patient Experience including Friends & Family Test
- Patient Complaints and Learning
- Compliments
- Patient Advice & Liaison Service (PALS)

This report covers the period October to December 2017 referred to as Quarter 3 (Q3). The aim of this report is to detail the multiple forms of patient feedback received and to evidence actions being taken to continually focus and improve the patient and their families' experience.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, effective and caring
	NHSI		**Details:** Supports effective governance
	Other	**Y**	The Local Authority Social Services and National Health Service (England) Complaints Regulations 2009

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

To note the content of the Q3 Patient Experience report.

Patient Experience Report

1. Introduction

The Trust's number one priority is to deliver a great patient experience; this is the first comprehensive report to be presented to the board. This report details:

- Patient Experience including Friends & Family Test (FFT)
- Patient Complaints
- Compliments
- Patient Advice & Liaison Service (PALS)

This report covers the period October to December 2017 referred to as Quarter 3 (Q3). The aim of this report is to detail the multiple forms of patient feedback received and to evidence actions being taken to continually focus and improve the patient and their families' experience.

There are multiple forums in place to improve Patient Experience across the Trust as follows:

The **Patient Experience Improvement Group (PEIG)** is held on a fortnightly basis. This meeting is well attended, with representation from across the Trust, to include members from Guest, Corbett and the Community.

Action plans from the all national surveys are presented and monitored. The Trusts national Adult Inpatient Survey has been a standing item at every meeting to ensure accountability and that all actions have been delivered. The Trust was rated 139 out of 149 in the 2016 survey which has focussed this group on improvement.

Actions from this survey are now almost complete and a monitoring and audit system is in place to ensure that actions are continually carried out.

There is oversight of the following action plans linked to surveys and feedback received as follows:

- Dementia
- Community Services
- Cancer Patient Experience Survey (national)
- Children & Young People Survey (national)
- Emergency Department Survey (national
- Adult Inpatients Survey (national)
- End of Life/Voices
- PLACE (national)
- Maternity Survey (national)

The PEIG reports into the **Patient Experience Group (PEG)** which is held on a quarterly basis. This meeting has representation from the Clinical Commissioning Group, Healthwatch, our PFI partners and staff from across the Trust. The PEG oversees all the work that has been undertaken during the previous quarter.

An action from the various surveys and patient feedback has been to establish **patient focus groups**. Work has commenced and to date the following user groups have met: The Bereavement User Group, Shout up Parents (Lifting Spirits), Maternity User Group and Dementia User Group. The maternity department have engaged in the Whose Shoes event which is a facilitation tool to help empower both staff and service users to make positive changes. The Head of Patient Experience has been instrumental in establishing user engagement.

Within Q3 we successfully implemented:

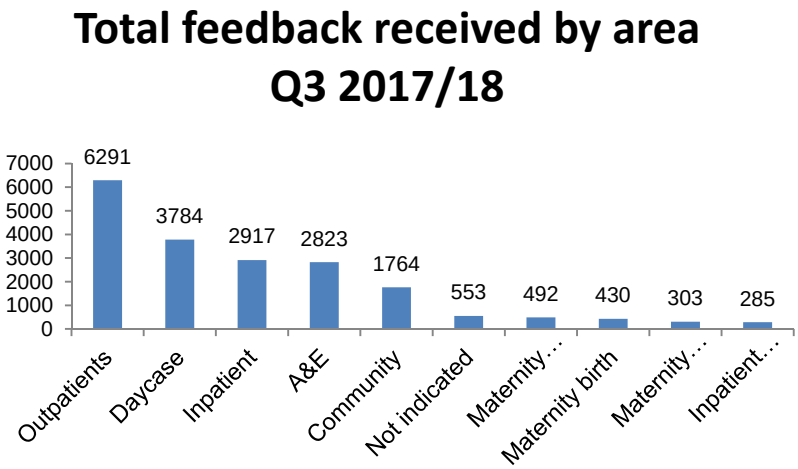
- Fruit & vegetable stall which benefits both patients and staff.
- Refreshments and water fountains available in waiting areas and the Emergency Department.
- Increased the number of parking passes for patients undergoing chemotherapy and parents of neonatal patients.
- Funding has been secured for televisions in the Children's ward.
- Introduced Patient Experience training on to the Trust induction.
- Expanded the SMS platform for FFT survey.
- Introduced Feedback Friday.
- Support the wider trust to deliver patient experience actions.

The Head of Patient Experience further utilised the opportunity through Dragons Pen to improve patients experience and the outcomes will be reported in Q4.

In January 2018 the first **Complaints Review and Learning Group** took place to focus on Trust wide thematic review and learning. The Chief Nurse chairs this group.

Patient Stories
The Board receives a patient's account bi monthly. The aim of this activity is to demonstrate where we deliver high quality care as well as where we can improve.

Patient feedback
The Trust received 19,642 pieces of feedback during Q3 in comparison to 14,778 received in the previous quarter. This included responses to the Friends and Family Test (FFT) utilising a variety of mediums such as paper, SMS, App and the web. Additionally we collate feedback through real time Surveys, NHS Choices, complaints, compliments and PALS.



2. Friends and Family Test (FFT)

FFT gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely likely to extremely unlikely; they are to recommend the service to their friends and family if they needed similar care or treatment. The FFT is intended as a service improvement tool, measuring performance continually and enabling increased responsiveness to near and real time feedback. It is also a mechanism to encourage and motivate staff and reinforce good practice. It is used to benchmark services both

internally and externally. Achieving a percentage recommended FFT score equal to or better than the national average is one of the Trusts Quality Priorities and is relevant when a significant number of patients are asked.

Improving FFT response rates across all areas remains a focus with improvements seen following the expansion of the SMS FFT survey solution to all areas. The Patient Experience team continues to work with all areas to support initiatives to improve the response rate.

The FFT percentage recommended scores for Q3 are as follows:

% FFT Scores	Oct 17	Nov 17	Dec 17	% FFT Scores	Oct 17	Nov 17	Dec 17
Inpatient	**95.1%**	**95.3%**	**95.1%**	**Maternity Postnatal Ward**	**97.7%**	**96.3%**	**97.8%**
National	96%	96%	96%	National	94%	n/a*	94%
A and E	**83.6%**	**80.3%**	**77.4%**	**Maternity Postnatal Community**	**100%**	**100%**	**100%**
National	87%	87%	85%	National	98%	n/a*	98%
Maternity Antenatal	**99.3%**	**89.1%**	**97.3%**	**Community**	**95.1%**	**95.9%**	**95.7%**
National	96%	n/a*	97%	National	95%	96%	96%
Maternity Birth	**98.5%**	**96.9%**	**98.9%**	**Outpatients**	**90.8%**	**89.8%**	**92.8%**
National	96%	n/a*	97%	National	94%	94%	94%

Response rates for the rolling twelve month period to January 2018 are detailed on the tables below:

Community Services Response rates

	2017											2018
Ward	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
Community Nursing Services	0.4%	0.8%	1.1%	0.8%	5.1%	10.7%	6.1%	3.7%	11.3%	10.8%	9.6%	7.4%
Rehabilitation & Therapy Services	2.1%	1.7%	1.5%	1.3%	1.4%	0.6%	2.7%	1.7%	3.4%	4.2%	2.8%	2.7%
Specialist Services	0.1%	0%	0.1%	0%	0.1%	0.3%	0.6%	0.3%	0.4%	1.2%	0.7%	0%
Overall	**1.2%**	**1.2%**	**1.1%**	**0.9%**	**2.1%**	**3.3%**	**3.2%**	**1.9%**	**4.9%**	**5.2%**	**4.3%**	**3.3%**

ED services Response Rates

	2017											2018
Ward	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
Acute Medical Unit											75%	69.9%
Emergency Ambulatory Care												
Emergency Assessment Unit	47.1%	52.7%	53.3%	36.1%	68.9%	55.4%	60.1%	63.5%	72.9%	86.2%		
Emergency Department	12%	15.3%	11.6%	11%	12.3%	11.3%	12%	15.9%	24.7%	20.6%	13.5%	16.9%
Overall	**15.4%**	**18.6%**	**15.4%**	**13.7%**	**17.1%**	**15.3%**	**16%**	**19.6%**	**28.5%**	**24.7%**	**17%**	**21.2%**

Maternity services Response Rates

	2017											2018
Ward	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
Antenatal	36.3%	32.9%	25.1%	62.6%	45.1%	76%	100%	96.1%	64.1%	56.6%	16.4%	47.8%
Birth	29%	37.2%	32.8%	50.5%	50.1%	47.5%	53.2%	27.8%	35.7%	53.9%	28.4%	39.2%
Postnatal Community	22.9%	19.4%	28.8%	33%	18.1%	17.1%	36.3%	21.6%	7%	7.1%	14.5%	27.8%
Postnatal Ward	29.2%	37.2%	32.8%	50.7%	50.1%	47.3%	52.4%	27%	35.1%	53.2%	28.5%	38.3%
Overall	**29.5%**	**32.7%**	**30.9%**	**48.9%**	**40.4%**	**48.6%**	**56.3%**	**39.6%**	**34.8%**	**45.1%**	**23.6%**	**38.4%**

Outpatient services Response Rates

	2017											2018
Ward	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**
Outpatients	1.9%	1.7%	1.5%	1.9%	2.3%	2.6%	4.8%	2.9%	10.9%	5.9%	3.5%	5.9%
Overall	**1.9%**	**1.7%**	**1.5%**	**1.9%**	**2.3%**	**2.6%**	**4.8%**	**2.9%**	**10.9%**	**5.9%**	**3.5%**	**5.9%**

Inpatients services Response Rates

Ward	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
A1												
A2	1.9%	1.2%	4.9%	11%	0.2%	15.3%	7.7%	1.5%	17.8%	4.2%	1.9%	2.2%
A3	10.3%	21.8%	38%	0%								
A4												
B1	19.3%	38.4%	38.2%	41.4%	47.4%	34.6%	51.1%	55.6%	73.5%	61.3%	50.3%	45.6%
B2 Hip	22.4%	16.2%	18.5%	26.9%	29.4%	36.3%	23.8%	22.8%	32%	19.1%	32.8%	38.4%
B2 Trauma	25.7%	35.7%	54%	58.3%	91.1%	100%	100%	74.4%	100%	100%	100%	100%
B3	14.1%	10%	12.1%	24.1%	15.2%	21.9%	21.3%	18.5%	29.4%	36.3%	27.8%	30.5%
B4	8.5%	8.5%	6.1%	30.8%	46.6%	37.5%	21.5%	35.4%	50.2%	39.7%	37.2%	50.7%
B5	17.2%	9.1%	18.1%	61.3%	55.1%	70.6%	19.4%	29.3%	52.7%	56.9%	54.1%	48.2%
B6	0%	0%	0%	5%					48.4%	3.2%	33.3%	5.3%
C1	5.8%	26.7%	27.9%	33.6%	20%	31.2%	8.9%	22.8%	61.5%	38.7%	19.8%	21.9%
C2	12.9%	16%	17.7%	12.4%	14.6%	20.9%	30.5%	11.9%	16.3%	19.1%	26.1%	14.6%
C3	42.3%	23.6%	19%	13.4%	45%	40.2%	62.8%	58%	53.3%	40.7%	13.8%	46%
C4	0%	9.3%	19.1%	18.1%	49.1%	59.1%	40%	38.4%	38.8%	48%	60%	49%
C5	8.4%	6.8%	12.8%	47.9%	37.6%	48.7%	23.6%	50.3%	50.5%	54.7%	45.1%	40.8%
C6	7.1%	7.6%	10.8%	15%	18.4%	30.6%	32.8%	21.6%	32.9%	33.9%	25.5%	38.8%
C7	14%	22%	18.4%	38.3%	59.2%	31.7%	38.7%	27.3%	36.2%	27.3%	29.8%	34.4%
C8	4.8%	14.2%	9.7%	26.2%	13.9%	16.4%	40.9%	28.2%	21%	29.8%	13.4%	6.1%
CCU & PCCU	15.5%	19.4%	16%	24.5%	21.5%	27.2%	23.4%	6.2%	30.8%	26.9%	18.9%	17%
Day Case	21.3%	21.3%	38%	32.5%	34.9%	33.2%	34.6%	29.6%	32%	32.3%	30.2%	30.2%
Evergreen	66.6%	38.8%	69%	59.8%	49.4%	61.4%	41%	15.6%	4.3%			
ITU	0%		0%		50%		100%	100%	100%	100%	0%	33.3%
MHDU	16.6%	20%	100%	62.5%	61.5%	50%	40%	16.6%	46.1%	42.8%	72.7%	100%
Neonatal	22.8%	14.8%	8.3%	15.9%	32.5%	61.1%	31.4%	31.5%	6.1%	100%	65%	54.9%
SHDU	100%	0%	60%	0%	100%			100%	100%	100%	0%	33.3%
Overall	**18.1%**	**18.3%**	**28.7%**	**30.8%**	**32.8%**	**34.2%**	**32.3%**	**27.8%**	**33.9%**	**33.9%**	**30.9%**	**30.1%**

3. NHS Choices

In Q3, 62 people uploaded feedback electronically to NHS Choices or Care Opinion, an increase of 10 comments on the previous quarter. Of those 62 comments, 58% were positive and 42% were negative.

4. Complaints

The Trust received 101 complaints during Q3 compared to 115 in Q2 and 81 in Q1. This is a decrease of 12% compared to the previous quarter and a 25% increase from Q1.

Two key metrics within the complaints service is that:

- All complaints will be acknowledged within 3 working days, this is a national standard.
- Complaints will receive a reply from the Trust within 40 working days

As at 31 December 2017 there were 166 open complaints, 4 complaints hosted by Dudley Clinical Commissioning Group (CCG) and 1 complaint hosted by The Royal Wolverhampton NHS Trust.

The Trust had 280,141 clinical patient contacts in Q3 which equates to 0.0360% of patients/family's making a complaint.

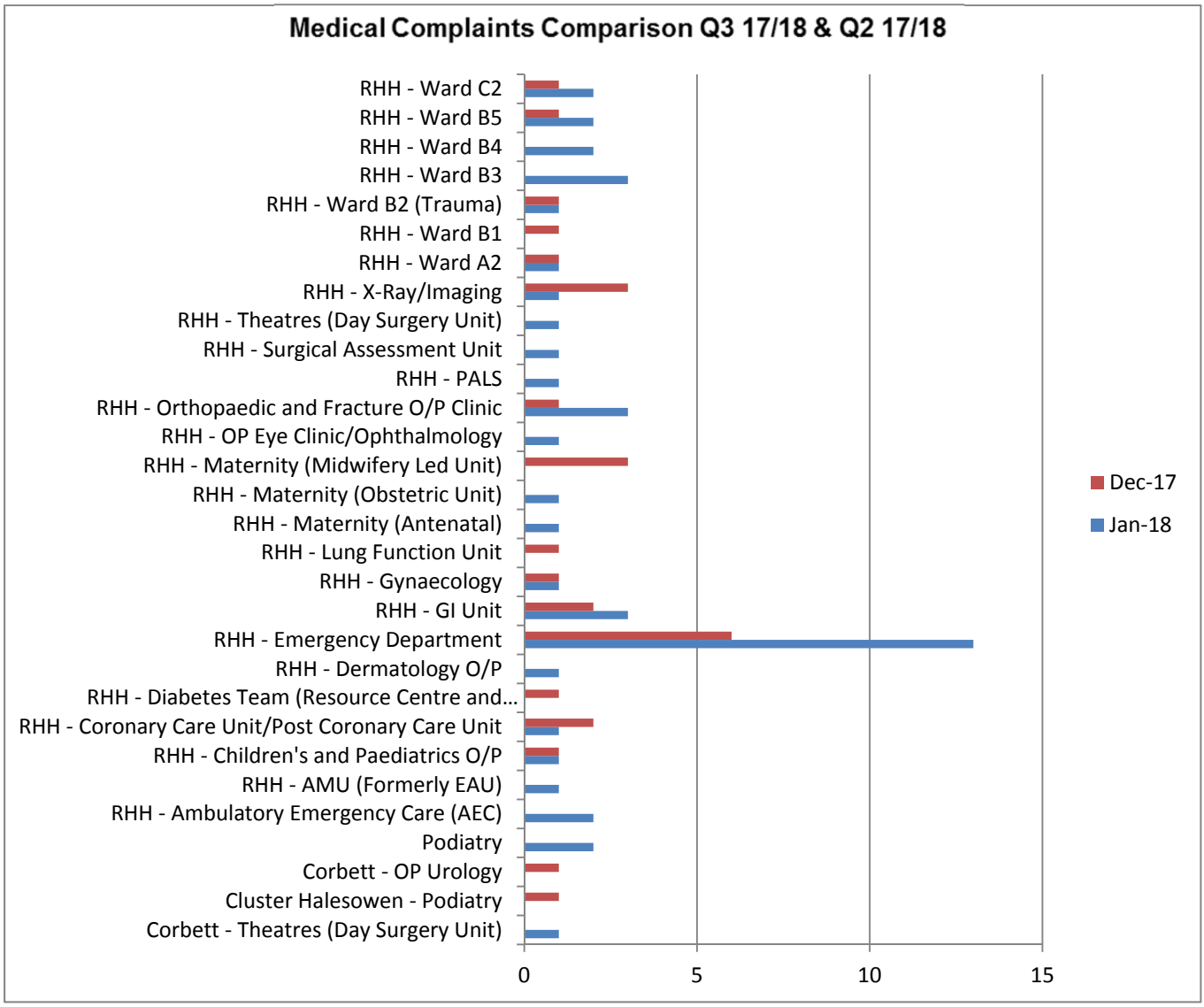
The divisional performance during Q3 is as follows:

- Surgery Division 39 complaints
- Medicine & Integrated Care Division 53 complaints
- Clinical Support Division 8 complaints
- Other 1 complaint

The ‘other’ complaint related to a patient being dissatisfied with the parking facilities available for those who are attending Action Heart.

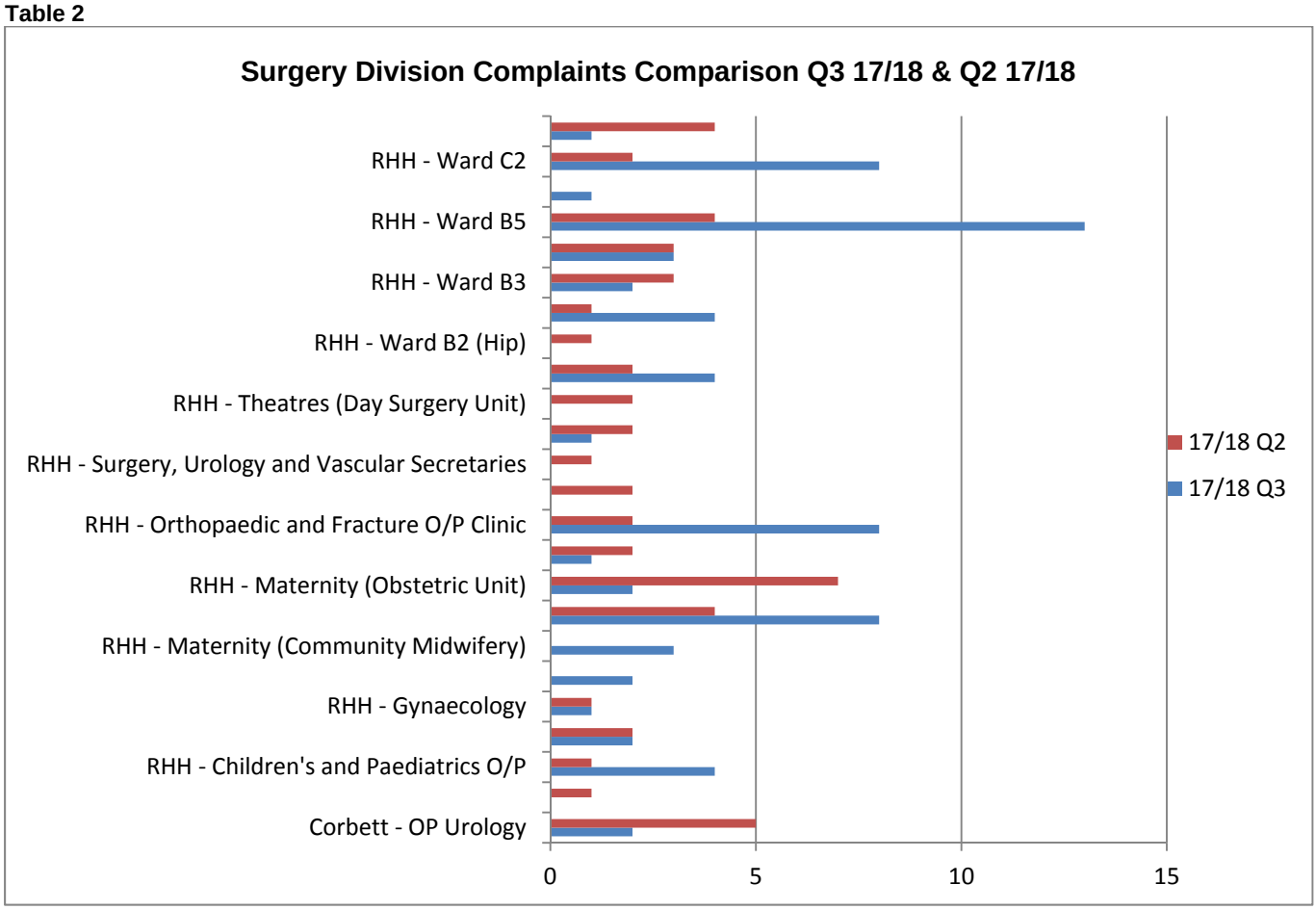
The following graphs illustrate complaints received within the division and which specific area of the Trust. They also demonstrate a comparison between Q2 and Q3.

Table 1



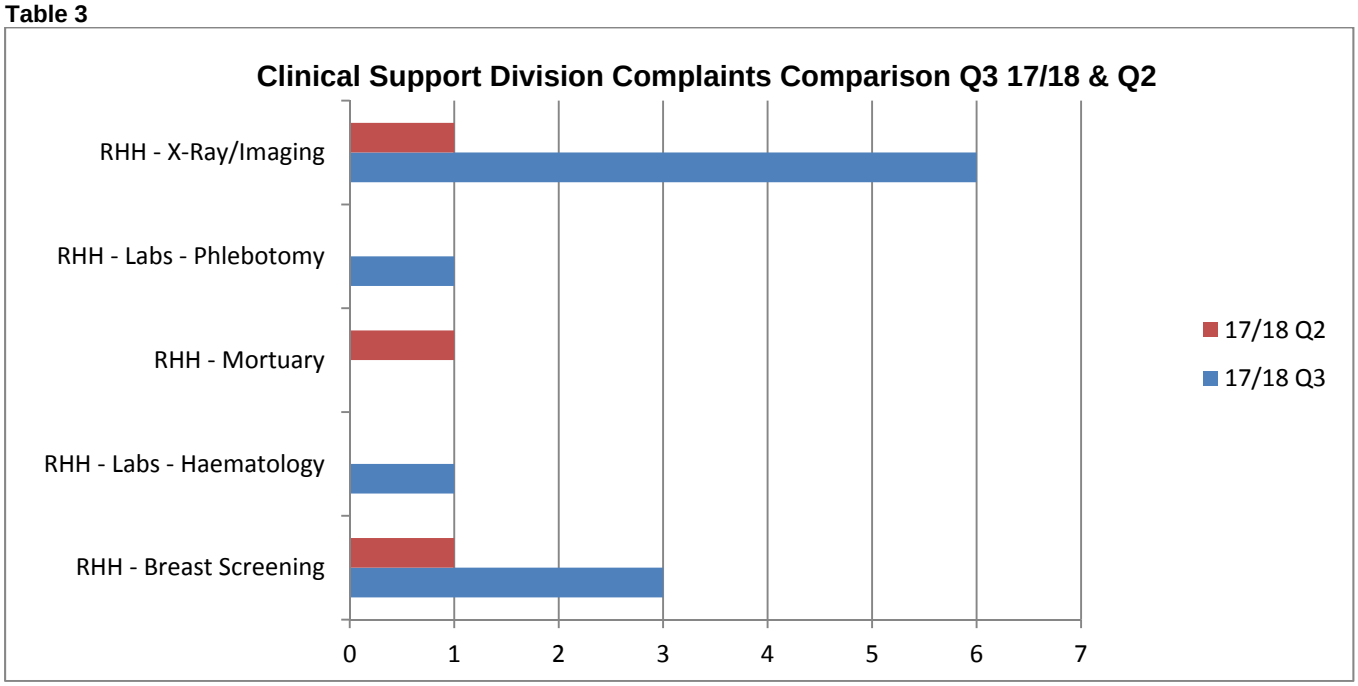
The Emergency Department has seen a significant rise in complaints. Wards C5 and C7 have also seen an increase in complaints received. The Head of Patient Experience has discussed these increases with the leaders within the Divisions of each area.

Table 2



There has been an increase in complaints received regarding Ward B5 and Ward C2. Maternity and orthopaedic and fracture clinic have also seen an increase. The Head of Patient Experience has discussed these increases with the leaders within the Divisions of each area.

Table 3



Meetings have taken place to address the rise in complaints related to radiology and actions have commenced as the majority of complaints are specifically related to staff attitude.

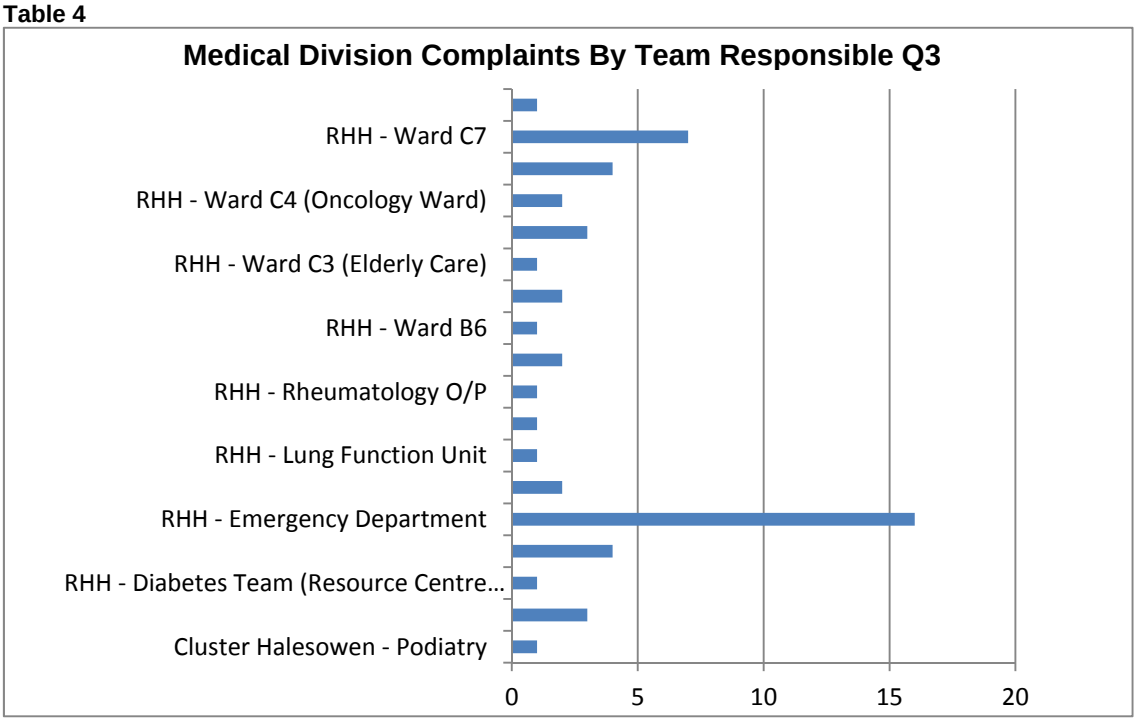
There has been one complaint received regarding community services relating to podiatry at Halesowen. To ensure concerns are raised within the community setting the community booklet is being updated with robust details of how to make a complaint or raise concerns. The Chief Nurse is concerned by the lack of complaints in the Community and welcomes increased FFT data to support this reality.

Medicine & Integrated Care Division

During Q3, a total of 53 complaints were received by the Medical & Integrated Care Division which indicates a decrease of 15% from Q2, 2017/18 (61) and 60% increase (32) for the same period last year (Q3, 2016/17). The Emergency Department has seen the most complaints during Q3 followed by ward C7 (Gastroenterology).

Table 4 details complaints received by service:

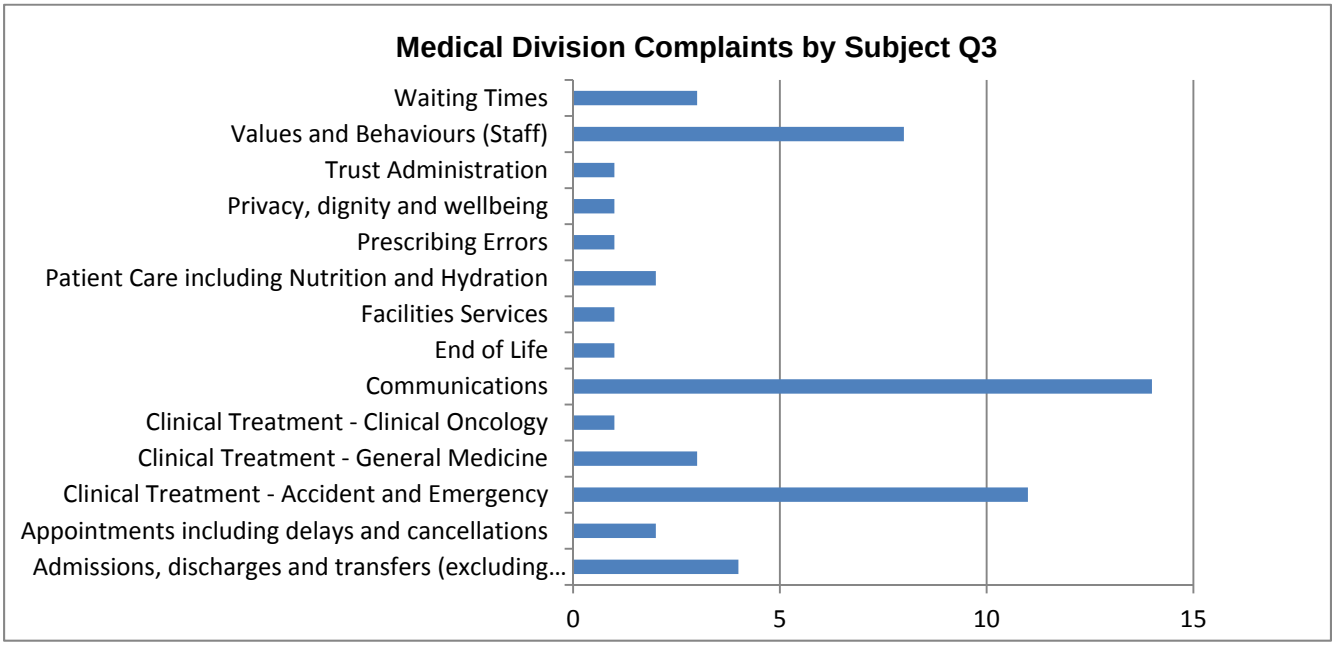
Table 4



Please note that table 1 and table 4 will differ in terms of the number of complaints received as opposed to number of complaints received by team responsible as all subjects within a complaint are captured and logged separately. For example, one letter of complaint may cover a range of subjects linked to multiple divisions, areas and teams responsible.

Table 5 details complaints received by subject.

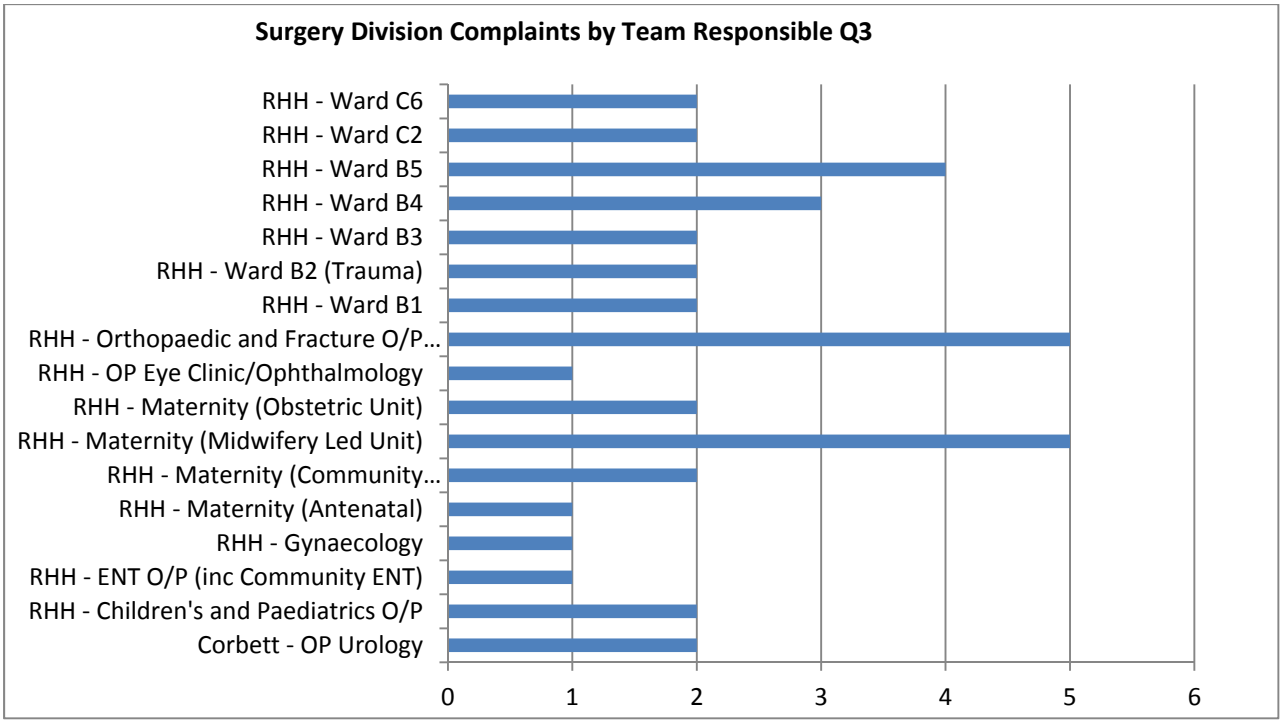
Table 5



Surgery Division

During Q3, a total of 39 complaints were received by the Surgical Division which indicates a 20% decrease from Q2, 2017/18 (49) and 44% increase (22) for the same period the previous year (Q3, 2016/17). Further analysis has identified that maternity (Midwifery-led Unit), orthopaedics and fracture clinic outpatients, ward B5, general surgery (female) and ward C2 (children's ward) have seen a significant increase in complaints.

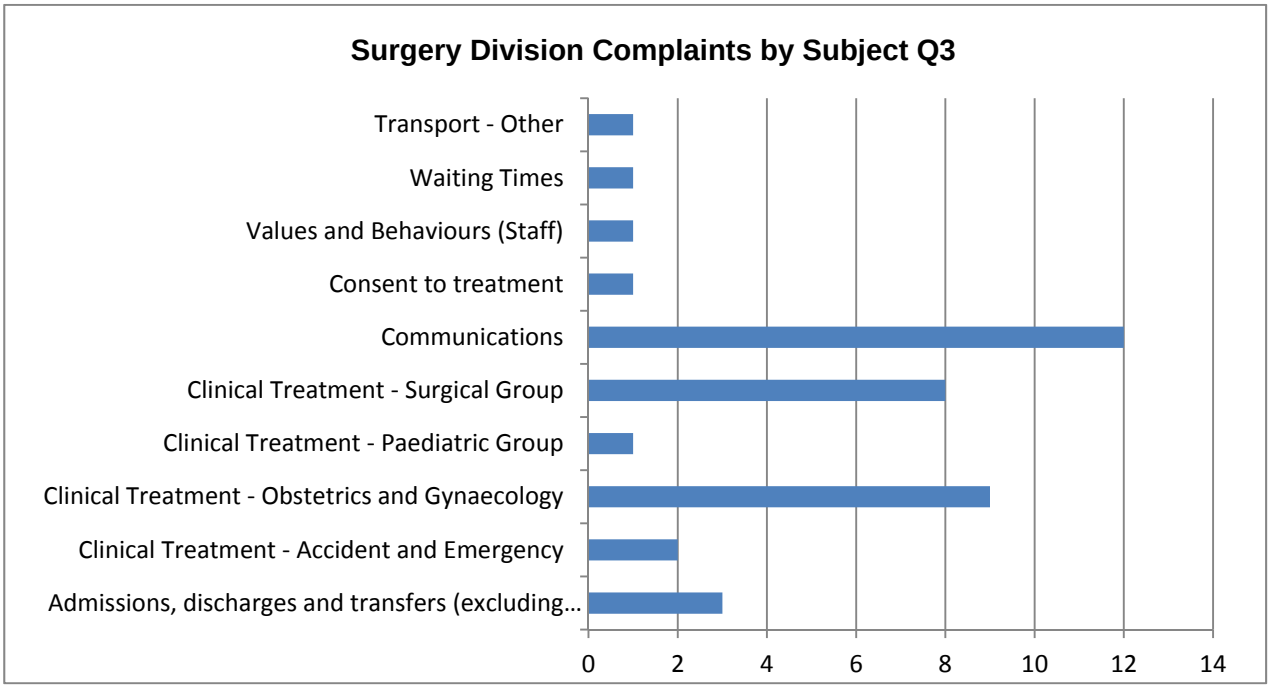
Table 6



Please note that table 2 and table 6 will differ in terms of the number of complaints received as all subjects within a complaint are captured and logged separately.

Table 7 details complaints received by subject.

Table 7



Clinical Support Division

During Q3, a total of 8 complaints were received by the Clinical Support Division which indicates a 167% increase from Q2.

There has been an increase in complaints received about the Imaging Department. Complaints received were in relation to delay in treatment, delay in obtaining a death certificate, staff attitude and patient assistance with clinical and catheter care. Communication with patients and family's has been raised including staff appearing to be disinterested and not providing basic care. In addition, patients felt that staff were rude and unprofessional during treatment conversations.

Table 8 details complaints received by service:

Table 8

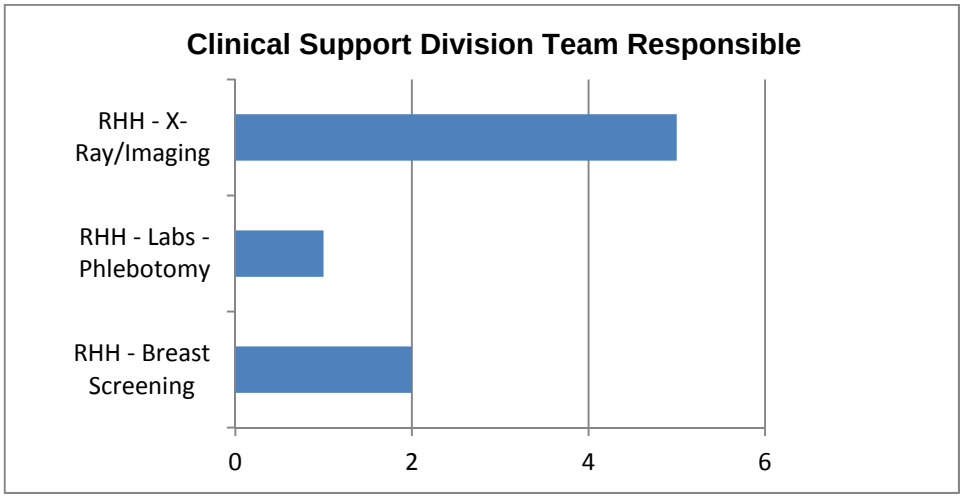
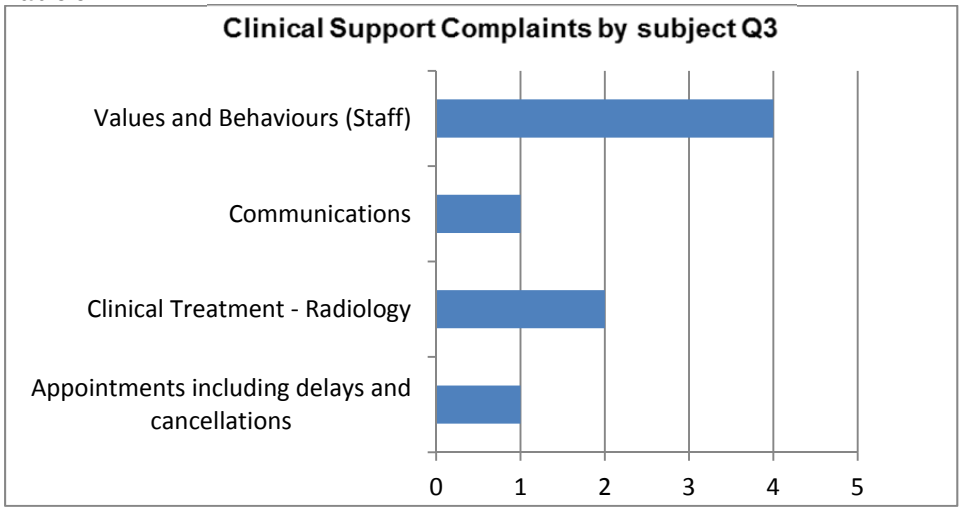


Table 9 details complaints received by subject.

Table 9



Complaint Themes

The top 5 themes across the 3 divisions are as follows:

Quarter 3, 2017/18
Values and Behaviours (Staff)
Communications
Clinical Treatment – Accident and Emergency
Admissions/discharges & transfers
Clinical Treatment - Obstetrics and Gynaecology

Reopened Complaints

During Q3 the Trust received correspondence from 6 complainants; who were dissatisfied with their original complaint response from the Trust.

This included clinical and chronological discrepancies within the initial response letter. The complaints were initially closed in Q1 and Q2. Out of the 6 reopened complaints, 2 have been closed.

These related to:

- Surgery Division 4
- Medicine & Integrated Care Division 2

Complaint responses

The Trust has been unable to achieve the locally agreed response time of 40 working days due to the high number of complaints and capacity issues as well as some complex complaints. Moving forward the Trust Board would like to see complaints responded to within 28 days however this cannot be achieved until the backlog of complaints have been addressed.

Trusts are encouraged to set the number of working days which they believe is reasonable to reply sufficiently to users who have reason to complain. However there is an expectation that the Trust will comply with locally agreed timeframe in 90% of all cases.

Within the reported quarter the Trust replied to 84 complaints in total. Of the 84 responses only 11 (13%) were closed within 40 working days.

All complaints that were not responded to within the 40 working days had correspondence from the Trust requesting and asking for their agreement to an extended timeframe, this is in line with 'The Local Authority Social Services and NHS Complaints (England) Regulations 2009.

Two Local Resolution Meetings (LRM) took place in Q3 which impacted on the 40 working day timescale being extended to accommodate such a meeting.

Complaint Outcomes

Of the 84 formal complaints responded to in Q3 the outcomes of these were as follows:

- 4 upheld
- 35 partially upheld
- 45 not upheld

To date the outcome of complaints received within the Trust has been determined by the local investigator. The Chief Nurse has requested an audit into this practise and has asked that outcomes are determined by the Head of Patient Experience from March 2018.

Member of Parliament

There were no Member of Parliament (MP) cases received during Q3.

Local Government Ombudsman

The Trust received no applications from the Local Government Ombudsman (LGO) during Q3.

The LGO investigates complaints relating to councils, all adult social care providers (including care homes and home care agencies) and some other organisations providing local public services.

Parliamentary Health Service Ombudsman

The Trust received no applications from the Parliamentary Health Service Ombudsman (PHSO) during Q3 and none have been resolved during this quarter.

Complaints Satisfaction Surveys

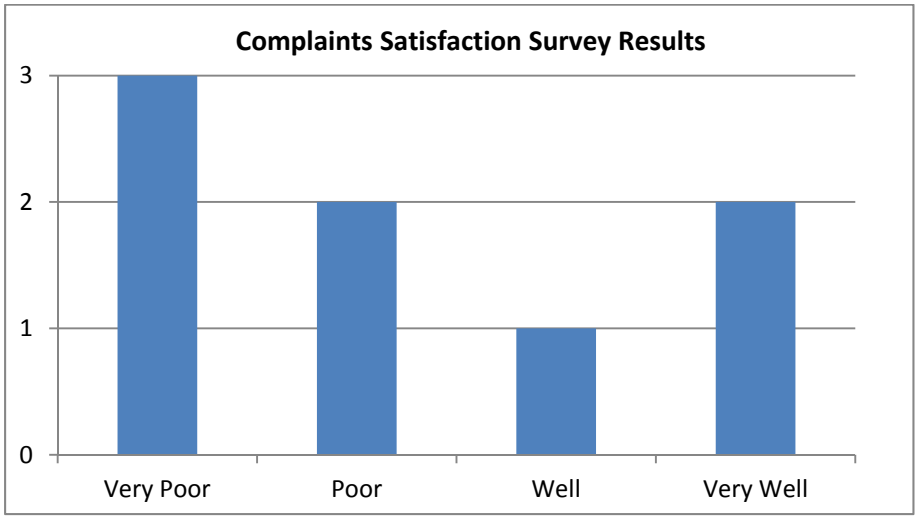
It is mandated that all trusts participate in the complaints satisfaction survey and is part of the NHS Complaints Legislation (2009). All complainants have the opportunity to complete a complaint satisfaction survey.

During Q3, 27 complaint satisfaction surveys were sent out and of those sent the Trust has received 8 completed surveys back. It has been agreed locally that surveys are sent out 6 weeks after closure to allow time for the complainant to consider the response.

The survey is intended to be about the process and management of the complaint and not about the outcome. However, often complainants that are unhappy with the outcome of their complaint base their survey response on their dissatisfaction. All survey responses are anonymous.

Table 10 illustrates the feedback received from the complaints satisfaction survey received in Q3.

Table 10



5. Compliments

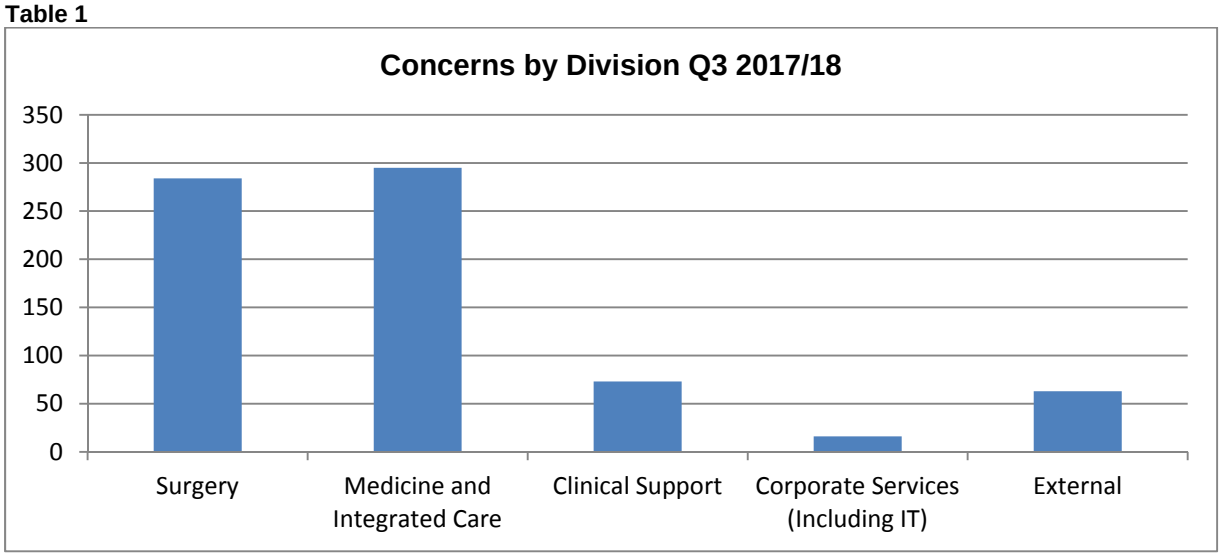
The Trust continues to receive a high number of compliments equating to around 0.4% of patient activity. All compliments received by the Chief Executive and the Chief Nurse are acknowledged personally and shared with the staff involved. A total of 1,966 compliments were received in Q3 which indicates a 64% increase from Q2 (1200), 2017/18.

6. Patient Advice Liaison Service

Patient Advice Liaison Service (PALS) received 731 new concerns in Q3, which is a 3% increase compared to Q2.

Table 1 details the breakdown by division during Q3:

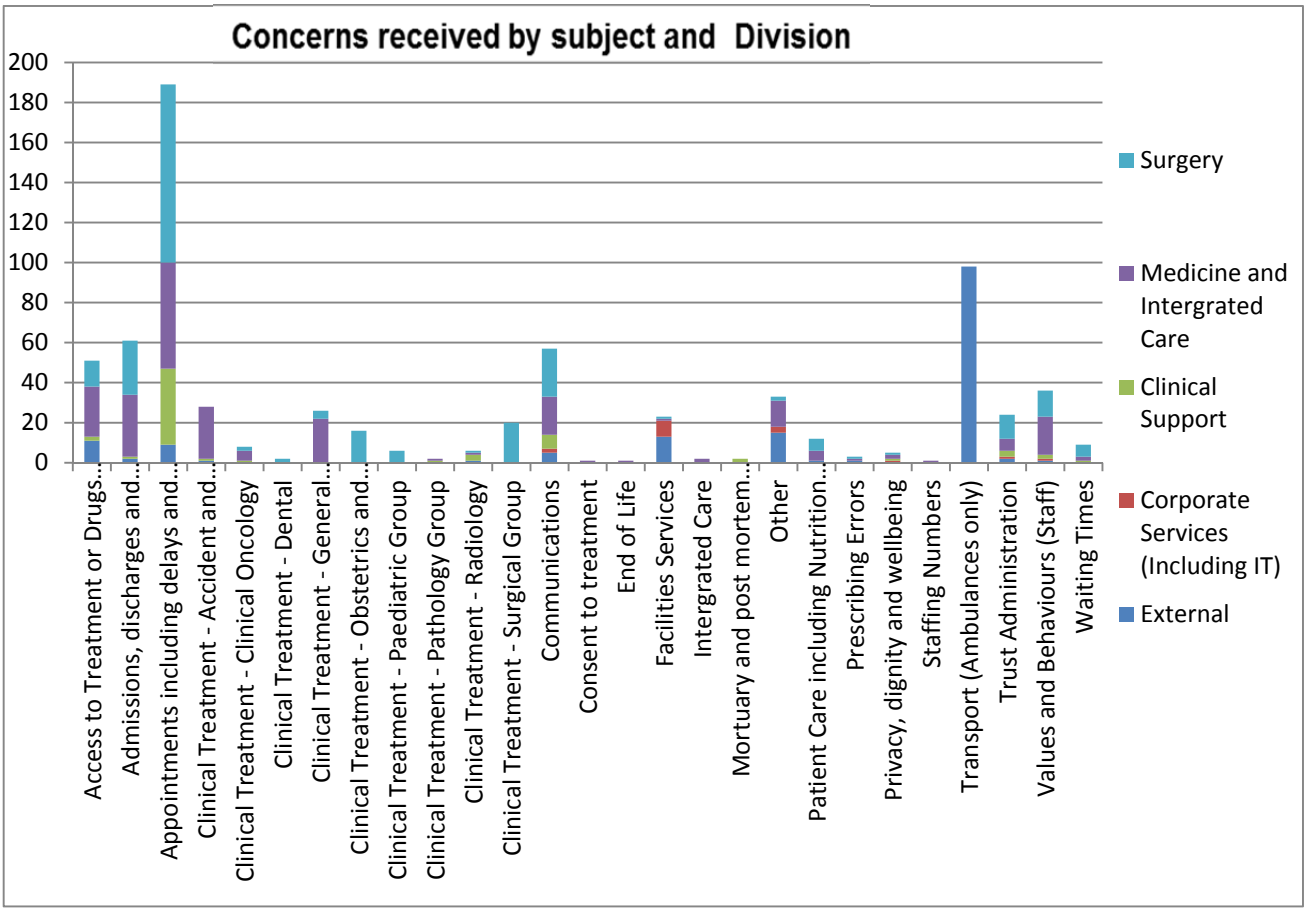
Table 1



Please note that the below tables shows a greater number of categories than PALS concerns received as some have multiple categories assigned to an individual concern.

The most commonly raised concerns relate to delayed appointments and communication.

Table 2



The PALS team consists of 3 Band 4's staff members. We receive an average of 60 new concerns each week. These are escalated as appropriate (internally/externally) with the aim to seek resolution within 24 hours. The Head of Patient Experience is in the process of locating PALS to Russells Hall Hospital main reception with a view to increasing accessibility and visibility of the service.

Conclusion

This report has provided an over view of activity related to Patient Experience including Friends & Family Test, Patient Complaints and Learning, Compliments, Patient Advice & Liaison Service (PALS).

The Chief Nurse supported by the Head of Patient Experience is committed to the development of staff and continuous improvement. The Patient Experience Strategy is in DRAFT and will be reported on in the next quarter.

It is intended that the Trust will provide both improved patient experience opportunities and complaints training once complaints are achieving both key metrics of 3 days acknowledgement and 40 days correspondence for at least 90% of complaints as well as notable improvement in key areas of concern.

Enclosure 15

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 8th March 2017

TITLE:	**Staff Survey Findings 2017**		
AUTHOR:	**Rachel Andrew, Head of Learning and OD**	**PRESENTER**	**Andrew McMenemy, Director of Workforce**

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

The report attached outlines the key headline results from the National Staff Survey 2017.The staff survey provides an opportunity to review staff views in relation to their wellbeing and experience at work. Therefore this report provides a summary of the key areas that have improved and the areas where scores have deteriorated. Attached to this report is also the national staff survey summary report that will be published online from 6th March 2018.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	X	**X**	

RECOMMENDATIONS FOR THE BOARD

1. Board is requested to review the outcomes of the survey and to agree the approach to actions for 2017.

Staff Survey 2017 – Key Findings, Engagement Plan and Actions

Background

The Staff Survey is undertaken between September and December each year. The content is devised nationally with the opportunity for the addition of 3 local questions unique to the Trust.
The overarching purpose of the staff survey is to inform local improvements in staff experience and well being and the questions are divided into key themes to enable a review of outcomes against:

- Appraisals and Support for Development
- Equality and Diversity
- Errors and Incidents
- Health and wellbeing
- Working patterns
- Job Satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying.

The responses give an overall summary on staff engagement but also provide the opportunity to look at individual areas for improvement against each question.

In 2017, 4712 staff were eligible to complete a survey. The process was online only and staff received their individual survey link via email. Picker were selected to undertake the survey on behalf of the Trust, to coordinate responses and supply reports following the survey.

A number of activities were undertaken to improve response rates including:

- Follow up emails from Picker to non-respondents (6 in total)
- Posters throughout the sites
- Hub promotion
- Promotion at Team Brief and Division Management
- Updated response rate league tables shared with Divisions weekly
- Drop-ins on main corridors
- Visits to wards/work areas to promote uptake

The Trust receives two types of result report:

- An overall report from NHS England on the national comparison and against historical results.
- An overall report from Picker and a number of detailed reports broken down into Localities. These results provide a historical comparison and a comparison with 20 peers in Acute and Community Provider Trusts.

2017 Results

A total of 1702 returned a completed survey giving a return rate of 36.1%.
The average response rate for Combined Acute and Community Trusts was 43%.
A visual summary is enclosed as Appendix 1 and the National Summary report is attached at Appendix 2 which provides details of responses against all key findings.

There are a number of key findings illustrated which provide a summary of performance on staff engagement scores and which flag the areas we have improved or show a positive score compared to peers – and those where we have deteriorated or show a negative score compared to peer.

These are:

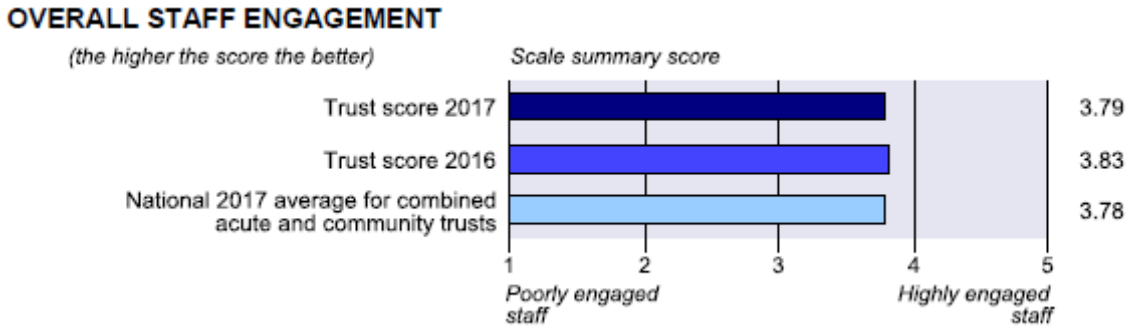
- Overall staff engagement scores
- Areas we perform well (highest rank compared to peers)
- Areas we perform less well (lowest ranking compared to peers)
- Key findings where staff experience has improved since 2016
- Key findings where staff experience has deteriorated since 2016.

Staff Engagement

This uses the scores from 5 questions and combines the response of those who agree and strongly agree compared to the number of staff who responded to the question.

		Your trust in 2017	Average for similar Trusts	Your trust in 2016
Q21a	Care of patients / service users is my organisation's top priority	75%	75%	75%
Q21b	My organisation acts on concerns raised by patients / service users	76%	73%	76%
Q21c	I would recommend my organisation as a place to work	60%	59%	63%
Q21d	If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	70%	69%	72%
KF1	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, Q21c-d)	3.74	3.75	3.77

This shows how we compare with other combined trusts on an overall indicator. Possible scores range from 1-5 with 1 indicating staff are poorly engaged (with their work, their team and their trust) and 5 indicating high levels of engagement.



This indicates that although the score has decreased slightly overall since last year, it remains average when compared with trusts of a similar type. The overall score is made up from questions that make up key findings 1, 4 and 7. These key findings relate to the staff perceived ability to contribute to improvements at work, their willingness to recommend the trust as a place to work or receive treatment and the extent to which they feel motivated and engaged with their work. Overall, since 2016 there have been no changes to performance in staff recommendation and in staff ability to contribute towards improvements. These remain average in performance. There has also been no significant change in relation to staff motivation at work (69%) and this is above (better than) average when compared to all acute and community trusts.

Top and Bottom ranking Scores

The results provide a comparison between the areas where the trust compares most favourably with other trusts; and those areas where we compare least favourably.

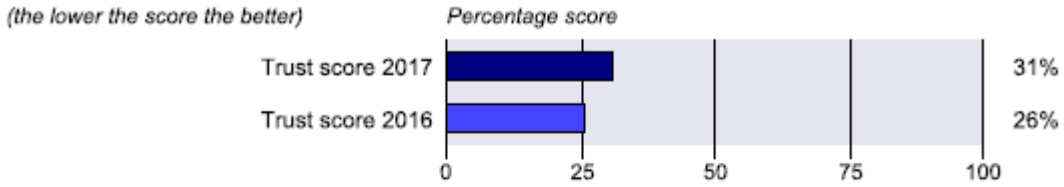
Top 5 ranking scores		Bottom 5 ranking scores	
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (lower score better)	Trust 21%	KF16 Percentage of staff working extra hours (lower score better)	Trust 75%
	National 24%		National 71%
KF31 Staff confidence and security in reporting unsafe clinical practices (higher score better)	Trust 3.74	KF22 Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months (lower score better)	Trust 16%
	National 3.67		National 14%
KF11 Percentage of staff appraised in last 12 months (higher score better)	Trust 90%	KF18 Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves(lower score better)	Trust 55%
	National 86%		National 53%
KF23 Percentage of staff experiencing physical violence from staff in last 12 months (lower score better)	Trust 1%	KF2 Staff satisfaction with the quality of work and care they are able to deliver (higher score better)	Trust 3.83
	National 2%		National 3.90
KF12 Quality of appraisals (higher score better)	Trust 3.19	KF17 Percentage of staff feeling unwell due to work related stress in the last 12 months (lower score better)	Trust 41%
	National 3.11		National 38%

Comparisons Over Time

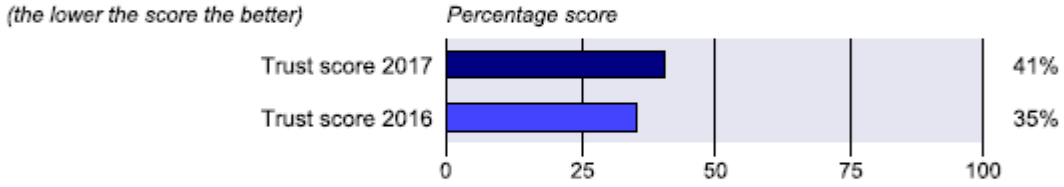
Since 2016, there is one key finding which has improved is KF11: the percentage of staff appraised in the last 12 months moving from 88% to 90%.

There are 5 key findings that have deteriorated since 2016. This includes one key finding (KF17) which is also a key finding in our bottom ranked scores when compared with others.

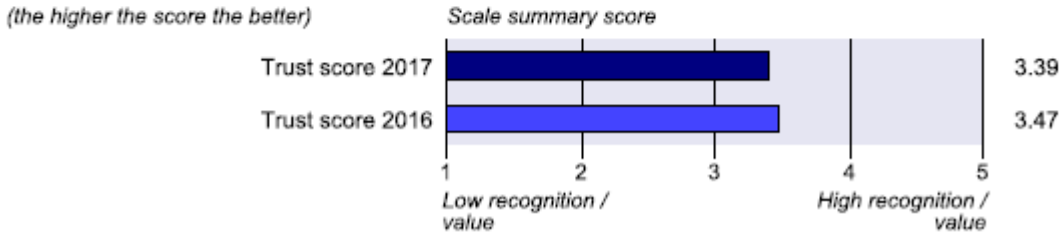
! KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month



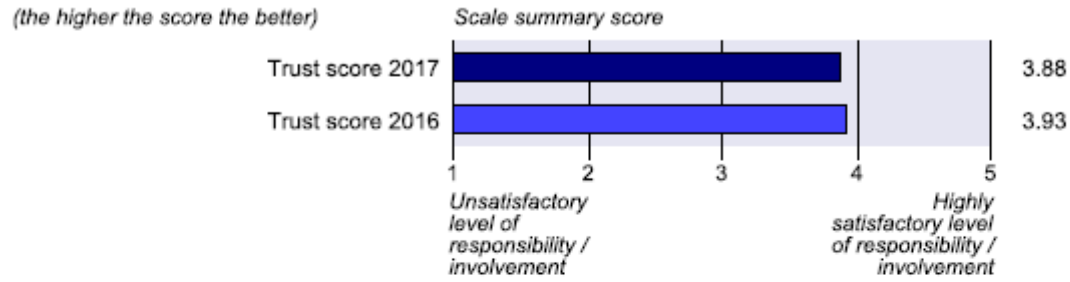
! KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months



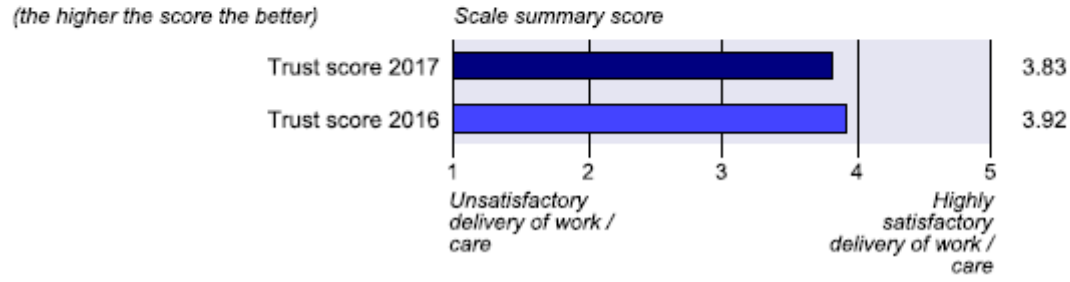
! KF5. Recognition and value of staff by managers and the organisation



! KF8. Staff satisfaction with level of responsibility and involvement



! KF2. Staff satisfaction with the quality of work and care they are able to deliver



Health and Wellbeing CQUIN

In addition, there are three questions within the staff survey that are used as a measure of performance for the national Health and Wellbeing CQUIN. Those scores required a 5% increase from 2015.

Results from the 2017 survey show a significant increase in staff reporting work related stress. There has been a positive increase in the organisation's action on health and wellbeing and some decrease in MSK reporting. This is below the target set in the CQUIN which was a 5% increase in 2 out of 3 questions. There is still the opportunity to receive a partial payment for the increase in positive response to question 9a.

Responses for all 3 questions are below:

	Question	2015	2016	2017	+/- from 2015	Nat Score
Q9a	Organisation definitely takes positive action on health and wellbeing	**26%**	**29%**	**30%**	**+4%**	**32%**
Q9b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	**74%**	**76%**	**75%**	**+1%**	**75%**
Q9c	Not felt unwell due to work related stress in last 12 months	**68%**	**64%**	**59%**	**-9%**	**63%**

Survey Findings and Areas for Focus

The outcomes above indicate five key areas for improvement:

- Staff recognition;
- Staff satisfaction with level of responsibility and involvement;
- Staff satisfaction with quality of work;
- Staff feeling unwell as a result of work-related stress;
- Staff experiencing physical violence from patients or relatives.

KF28 indicates an increased percentage of staff witnessing errors and potential harm, however, this is linked to an increase in KF34 which is the confidence in reporting clinical incidents and errors.

Approach to Engagement and Action Plans

A summary of results is being prepared to be shared with staff to provide headline results overall – and then a planned approach to ensuring all localities look at their individual findings and areas for improvement. This will give them the opportunity to reflect and identify areas for local action. A series of engagement sessions with staff are planned in order to listen to their views and hear from them on what actions they think are required to address the areas identified in the survey. This will support the overall actions in place and connect to recruitment and retention initiatives, health and wellbeing plans and engagement activities.

In previous years, staff survey action plans have had a short-term focus and on attempting to resolve some of the issues within the year prior to the next staff survey taking place. Although this has seen some success in terms of delivering visible outcomes, some issues require longer-term planning and only focusing on the actions that are directly connected to the key findings may result in wider impact not being assessed. As a result, the planned approach for 2017 is different.

For 2017, the focus will be to identify a more strategic approach to organisation-wide improvements for staff and wellbeing and then to use the survey responses (alongside other measures throughout the year) as a benchmark. This gives the opportunity to focus on the bigger issues and in making improvements in areas already identified as important to staff – recognition, engagement, communication and staffing infrastructure. For example, in relation to staff sickness and stress related sickness (both reporting higher incidences in the 2017 survey), Powell et al (2014) state:

- better staff experiences (particularly re: wellbeing, job design, and the organisation generally) are linked to lower absenteeism & greater patient satisfaction
- staff (particularly nurse) experience is a causal driver of absenteeism
- staff experience linked to turnover and patient mortality

This connects with the recent presentation at the Trust from Michael West and his 5 pillars of work around organisational success. The 5 pillars he promotes are:

1. An inspirational vision of high quality care
2. Clear aligned goals at every level with helpful feedback
3. Good people management and employee engagement
4. Continuous learning and quality improvement
5. Enthusiastic team-working, cooperation and integration

West, Baker, Dawson, Dixon Woods, et al. (2013) "Quality and safety in the NHS." *Lancaster, University of Lancaster.*

The work from this year's staff survey is therefore to connect each of those pillars to existing streams of ongoing activity, are connected to work on patient safety and experience and then to ensure that work is embedded across the trust.

This would be through the following actions:

1. A clear and well communicated trust vision with objectives that are focussed on delivering high quality care and they are endorsed by all.

2. Ensuring staff have clear objectives that are SMART, linked to the organisation vision and there is support in place to achieve them.

3. Managers and Leaders have the time and skills to support and develop their staff. Recognising effort and outcome is part of everyday work behaviour. Health and wellbeing activity is part of this pillar.

4. Quality and safety is the bedrock of our work and all are committed to implementing this. Everyone understands why this is important. All staff are given the opportunity to learn from experience with a focus on learning from excellence.

5. Values and behaviour are important and standards are clear for all staff. This means that positive behaviour is celebrated and role modelled and teams are committed to working together – across the organisation towards the agreed goals.

Next Steps

The engagement process with staff regarding the results will commence immediately. This will provide an action plan focusing on the areas for improvement. The feedback will also influence the priorities associated to the Workforce Strategy and Workforce Business Plan for 2018/19.

It is therefore expected that the main actions will be presented to the Workforce Committee in April 2018 that focuses on the areas of improvement and also to support better outcomes for the 2018 survey.

Staff Survey Summary 2017

Trust wide results

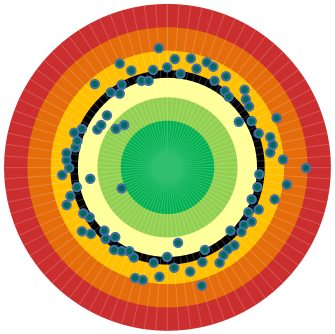
Response Rates

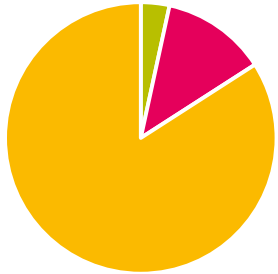
4712	1702	36.1%	43%
Overall invited	Participants	Trust Response rate	National Average response rate

Internal benchmarking comparisons with Trust average and corporate areas		Trust	Clinical Support	Corporate /Management	Medicine & Integrated Care	Surgical Division
Overall staff engagement score		3.79	3.64	3.87	3.80	3.76
I would recommend my organisation as a place to work.	Advocacy	3.57	3.38	3.69	3.55	3.55
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	Advocacy	3.78	3.71	3.92	3.72	3.79
Care of patients / service users is my organisation's top priority.	Advocacy	3.89	3.78	4.12	3.81	3.83
I am able to make suggestions to improve the work of my team / department.	Involvement	3.82	3.67	3.85	3.88	3.79
There are frequent opportunities for me to show initiative in my role.	Involvement	3.78	3.58	3.80	3.84	3.75
I am able to make improvements happen in my area of work.	Involvement	3.45	3.22	3.51	3.48	3.44
I look forward to going to work.	Motivation	3.56	3.39	3.62	3.61	3.51
I am enthusiastic about my job.	Motivation	4.04	3.95	4.07	4.07	3.99
Time passes quickly when I am working.	Motivation	4.21	4.07	4.26	4.24	4.17

Results at a glance

Your historical changes to all questions





Have you improved from 2016?

A total of 88 questions were used in both the 2016 and 2017 surveys. Compared to the 2016 survey, your organisation is:

- Significantly BETTER on 3 question(s)
- Significantly WORSE on 11 question(s)
- The scores show no significant difference on 74 question(s)

Top four positive areas

- ✓ Not experienced **physical violence, harassment, bullying or abuse** from staff
- ✓ Staff **confidence** and security **in reporting** unsafe practice
- ✓ Have had an **appraisal** in the last 12 months
- ✓ **Quality of appraisals** has improved in the last 12 months

Bottom four areas for action

- × Don't work **additional unpaid hours** over and above contracted hours
- × Not experienced **physical violence, harassment, bullying or abuse** from staff
- × **Patient/service user feedback** collected within department
- × Feel my **role makes a difference** to patients/service users

2017 National NHS staff survey

Brief summary of results from The Dudley Group NHS Foundation Trust

Table of Contents

1. Introduction to this report

This report presents the findings of the 2017 national NHS staff survey conducted in The Dudley Group NHS Foundation Trust.

In section 2 of this report, we present an overall indicator of staff engagement. Full details of how this indicator was created can be found in the document ***Making sense of your staff survey data***, which can be downloaded from www.nhsstaffsurveys.com.

In sections 3 and 4 of this report, the findings of the questionnaire have been summarised and presented in the form of 32 Key Findings.

These sections of the report have been structured thematically so that Key Findings are grouped appropriately. There are nine themes within this report:

- Appraisals & support for development
- Equality & diversity
- Errors & incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care & experience
- Violence, harassment & bullying

Please note, two Key Findings have had their calculation changed and there have been minor changes to the benchmarking groups for social enterprises since last year. For more detail on these changes, please see the ***Making sense of your staff survey data*** document.

As in previous years, there are two types of Key Finding:

- percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions

- scale summary scores, calculated by converting staff responses to particular questions into scores. For each of these scale summary scores, the minimum score is always 1 and the maximum score is 5

A longer and more detailed report of the 2017 survey results for The Dudley Group NHS Foundation Trust can be downloaded from: www.nhsstaffsurveys.com. This report provides detailed breakdowns of the Key Finding scores by directorate, occupational groups and demographic groups, and details of each question included in the core questionnaire.

Your Organisation

The scores presented below are un-weighted question level scores for questions Q21a, Q21b, Q21c and Q21d and the un-weighted score for Key Finding 1. The percentages for Q21a – Q21d are created by combining the responses for those who “Agree” and “Strongly Agree” compared to the total number of staff that responded to the question.

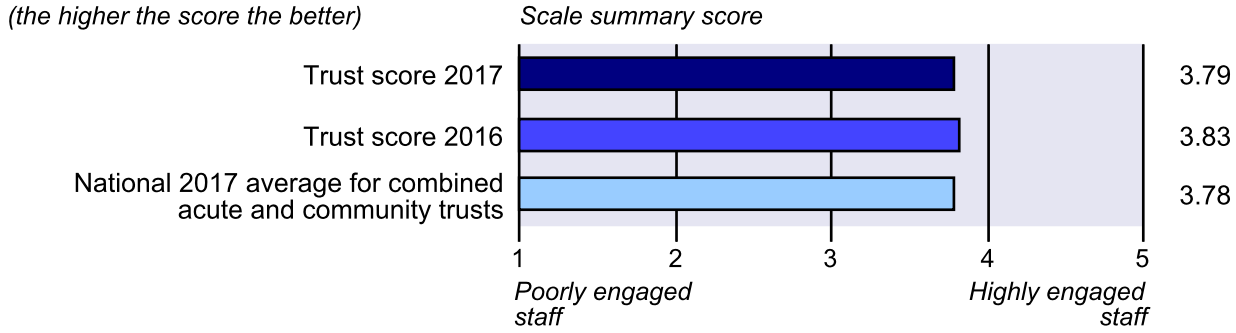
Q21a, Q21c and Q21d feed into Key Finding 1 “Staff recommendation of the organisation as a place to work or receive treatment”.

		Your Trust in 2017	Average (median) for combined acute and community trusts	Your Trust in 2016
Q21a	"Care of patients / service users is my organisation's top priority"	75%	75%	75%
Q21b	"My organisation acts on concerns raised by patients / service users"	76%	73%	76%
Q21c	"I would recommend my organisation as a place to work"	60%	59%	63%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	70%	69%	72%
KF1.	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21c-d)	3.74	3.75	3.77

2. Overall indicator of staff engagement for The Dudley Group NHS Foundation Trust

The figure below shows how The Dudley Group NHS Foundation Trust compares with other combined acute and community trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The trust's score of 3.79 was average when compared with trusts of a similar type.

OVERALL STAFF ENGAGEMENT



This overall indicator of staff engagement has been calculated using the questions that make up Key Findings 1, 4 and 7. These Key Findings relate to the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work (Key Finding 7); their willingness to recommend the trust as a place to work or receive treatment (Key Finding 1); and the extent to which they feel motivated and engaged with their work (Key Finding 4).

The table below shows how The Dudley Group NHS Foundation Trust compares with other combined acute and community trusts on each of the sub-dimensions of staff engagement, and whether there has been a significant change since the 2016 survey.

	Change since 2016 survey	Ranking, compared with all combined acute and community trusts
OVERALL STAFF ENGAGEMENT	• No change	• Average
KF1. Staff recommendation of the trust as a place to work or receive treatment *(the extent to which staff think care of patients/service users is the trust's top priority, would recommend their trust to others as a place to work, and would be happy with the standard of care provided by the trust if a friend or relative needed treatment.)*	• No change	• Average
KF4. Staff motivation at work *(the extent to which they look forward to going to work, and are enthusiastic about and absorbed in their jobs.)*	• No change	✓ Above (better than) average
KF7. Staff ability to contribute towards improvements at work *(the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work.)*	• No change	• Average

Full details of how the overall indicator of staff engagement was created can be found in the document ***Making sense of your staff survey data***.

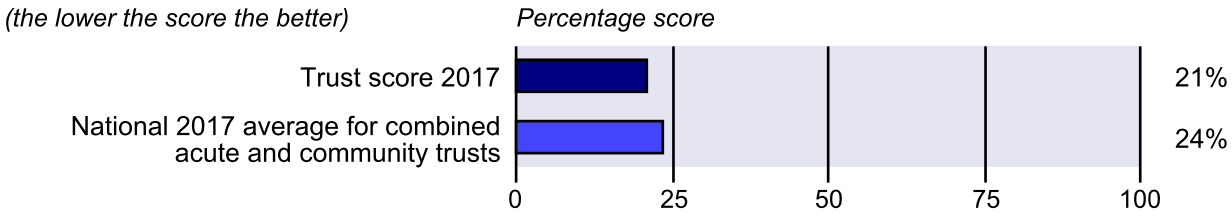
3. Summary of 2017 Key Findings for The Dudley Group NHS Foundation Trust

3.1 Top and Bottom Ranking Scores

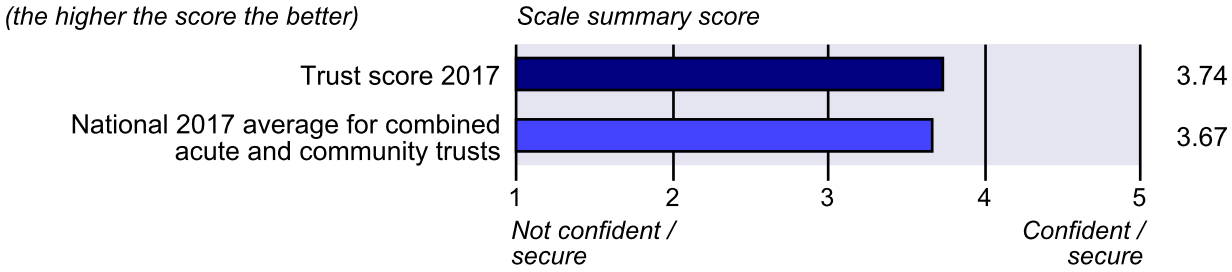
This page highlights the five Key Findings for which The Dudley Group NHS Foundation Trust compares most favourably with other combined acute and community trusts in England.

TOP FIVE RANKING SCORES

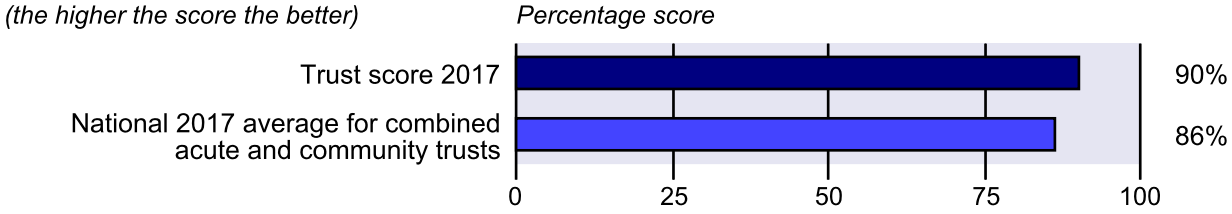
✓KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months



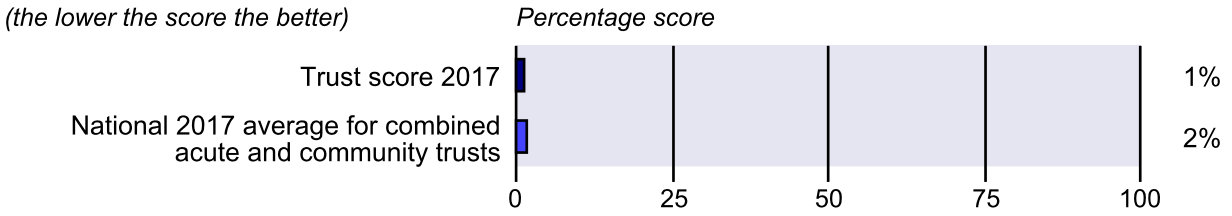
✓KF31. Staff confidence and security in reporting unsafe clinical practice



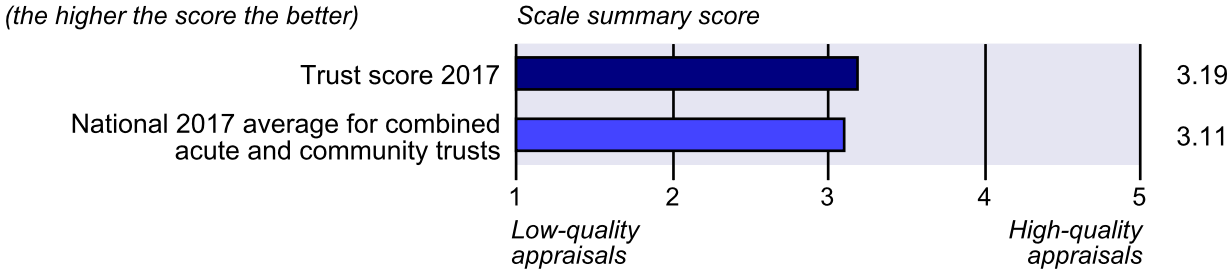
✓KF11. Percentage of staff appraised in last 12 months



✓KF23. Percentage of staff experiencing physical violence from staff in last 12 months



✓KF12. Quality of appraisals



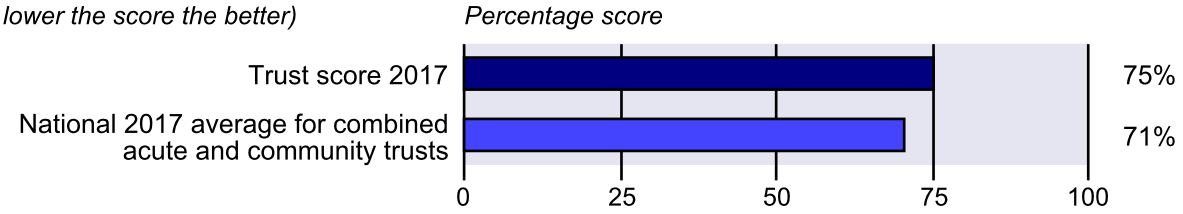
For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 43 (the bottom ranking score). The Dudley Group NHS Foundation Trust's five highest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 1. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings for which The Dudley Group NHS Foundation Trust compares least favourably with other combined acute and community trusts in England. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

BOTTOM FIVE RANKING SCORES

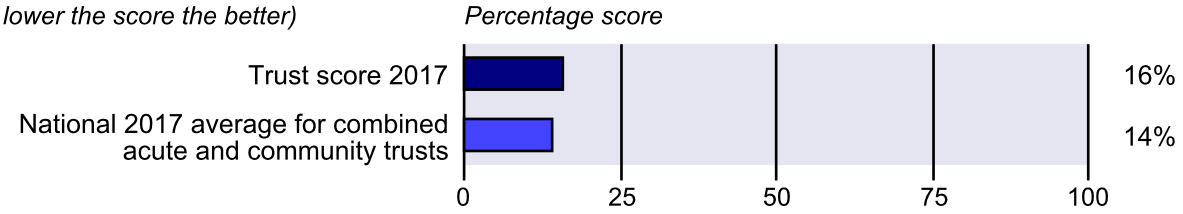
! KF16. Percentage of staff working extra hours

(the lower the score the better)



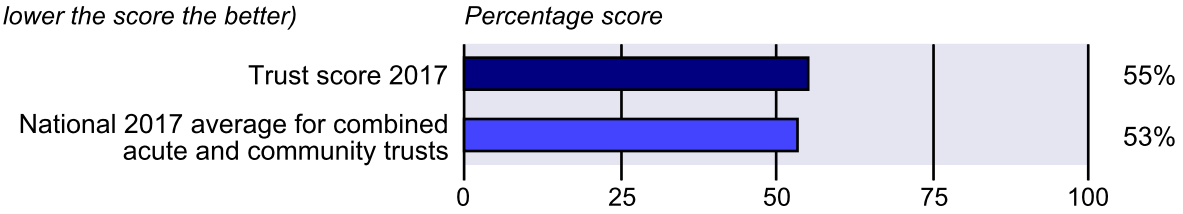
! KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



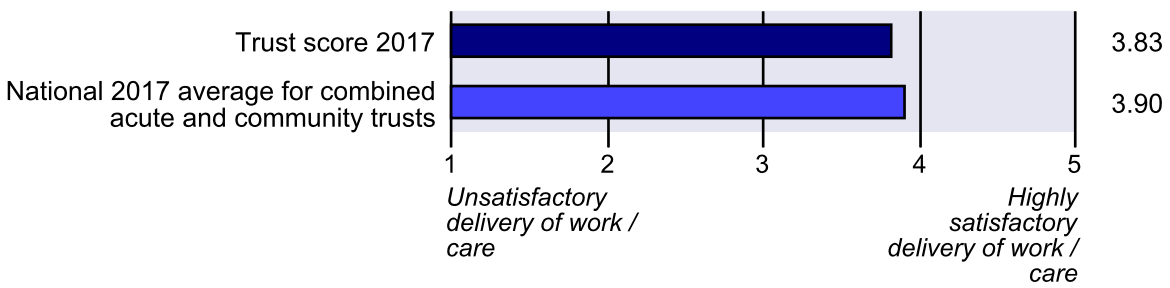
! KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

(the lower the score the better)



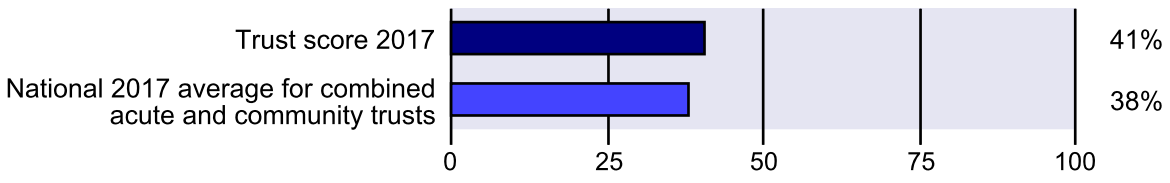
! KF2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



! KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



For each of the 32 Key Findings, the combined acute and community trusts in England were placed in order from 1 (the top ranking score) to 43 (the bottom ranking score). The Dudley Group NHS Foundation Trust's five lowest ranking scores are presented here, i.e. those for which the trust's Key Finding score is ranked closest to 43. Further details about this can be found in the document ***Making sense of your staff survey data***.

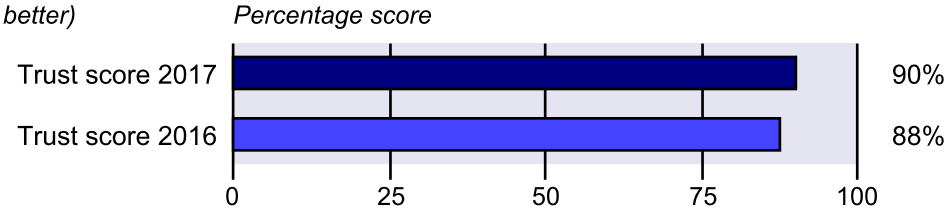
3.2 Largest Local Changes since the 2016 Survey

This page highlights the Key Finding that has improved at The Dudley Group NHS Foundation Trust since the 2016 survey.

WHERE STAFF EXPERIENCE HAS IMPROVED

✓KF11. Percentage of staff appraised in last 12 months

(the higher the score the better)



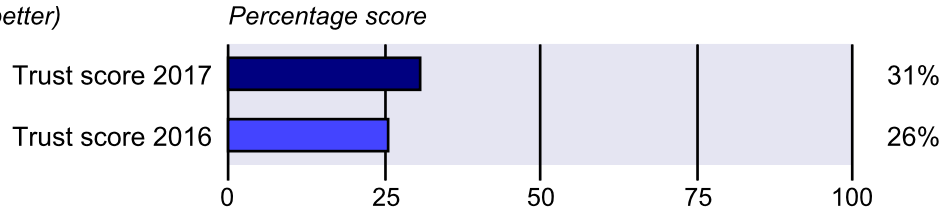
Because the Key Findings vary considerably in terms of subject matter and format (e.g. some are percentage scores, others are scale scores), a straightforward comparison of score changes is not the appropriate way to establish which Key Findings have improved the most. Rather, the extent of 2016-2017 change for each Key Finding has been measured in relation to the national variation for that Key Finding. Further details about this can be found in the document ***Making sense of your staff survey data***.

This page highlights the five Key Findings where staff experiences have deteriorated since the 2016 survey. It is suggested that these areas might be seen as a starting point for local action to improve as an employer.

WHERE STAFF EXPERIENCE HAS DETERIORATED

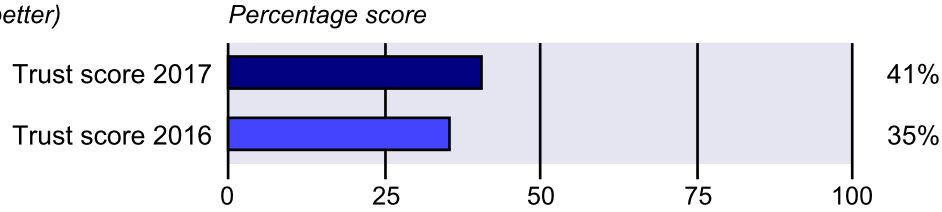
! KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



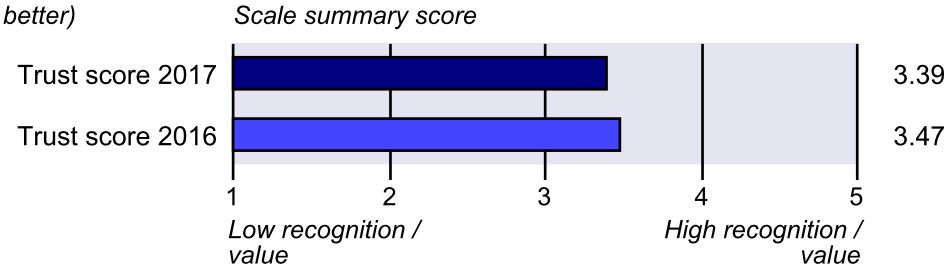
! KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months

(the lower the score the better)



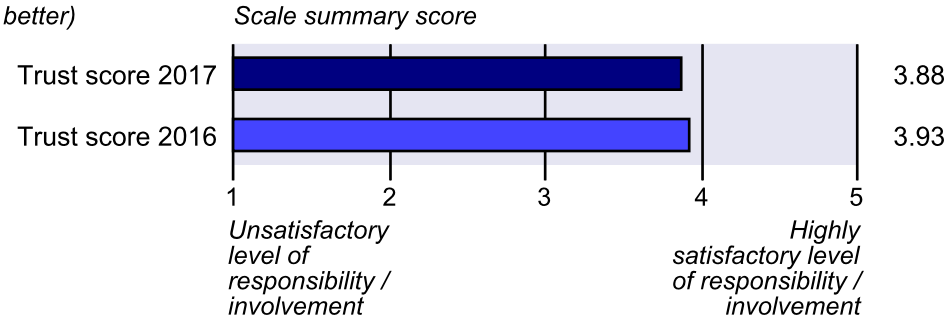
! KF5. Recognition and value of staff by managers and the organisation

(the higher the score the better)



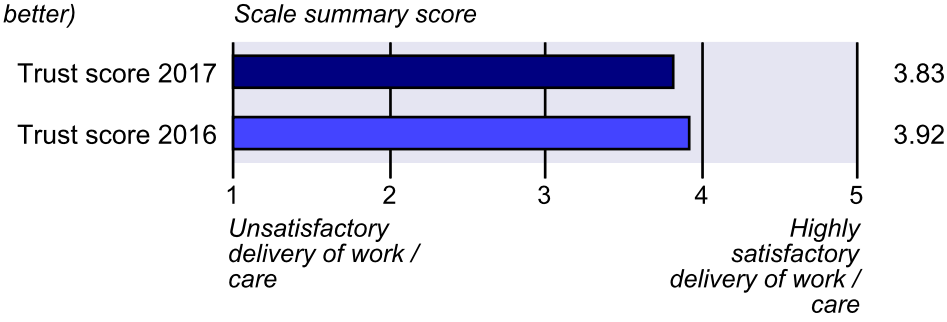
! KF8. Staff satisfaction with level of responsibility and involvement

(the higher the score the better)



! KF2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



3.3. Summary of all Key Findings for The Dudley Group NHS Foundation Trust

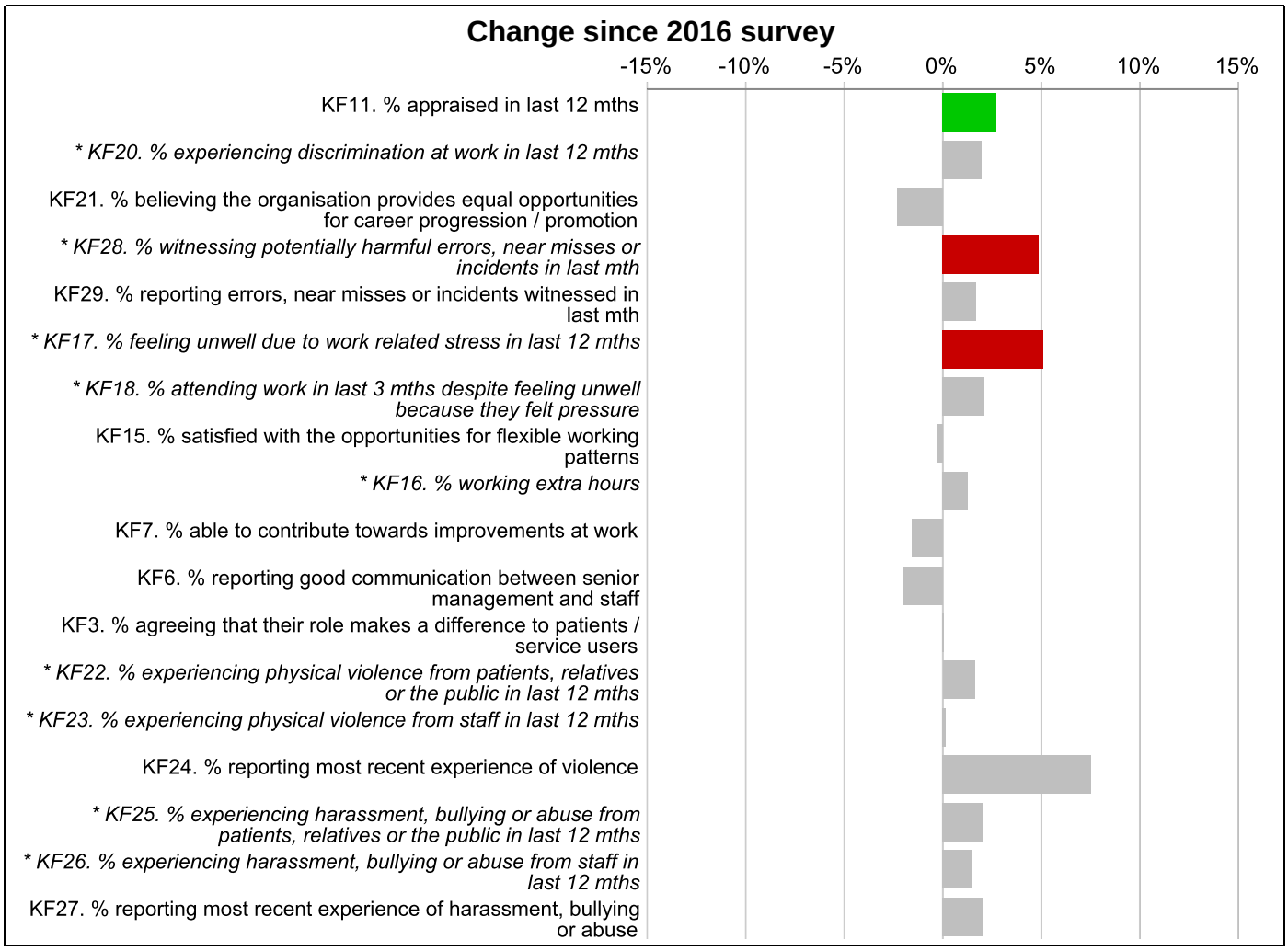
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



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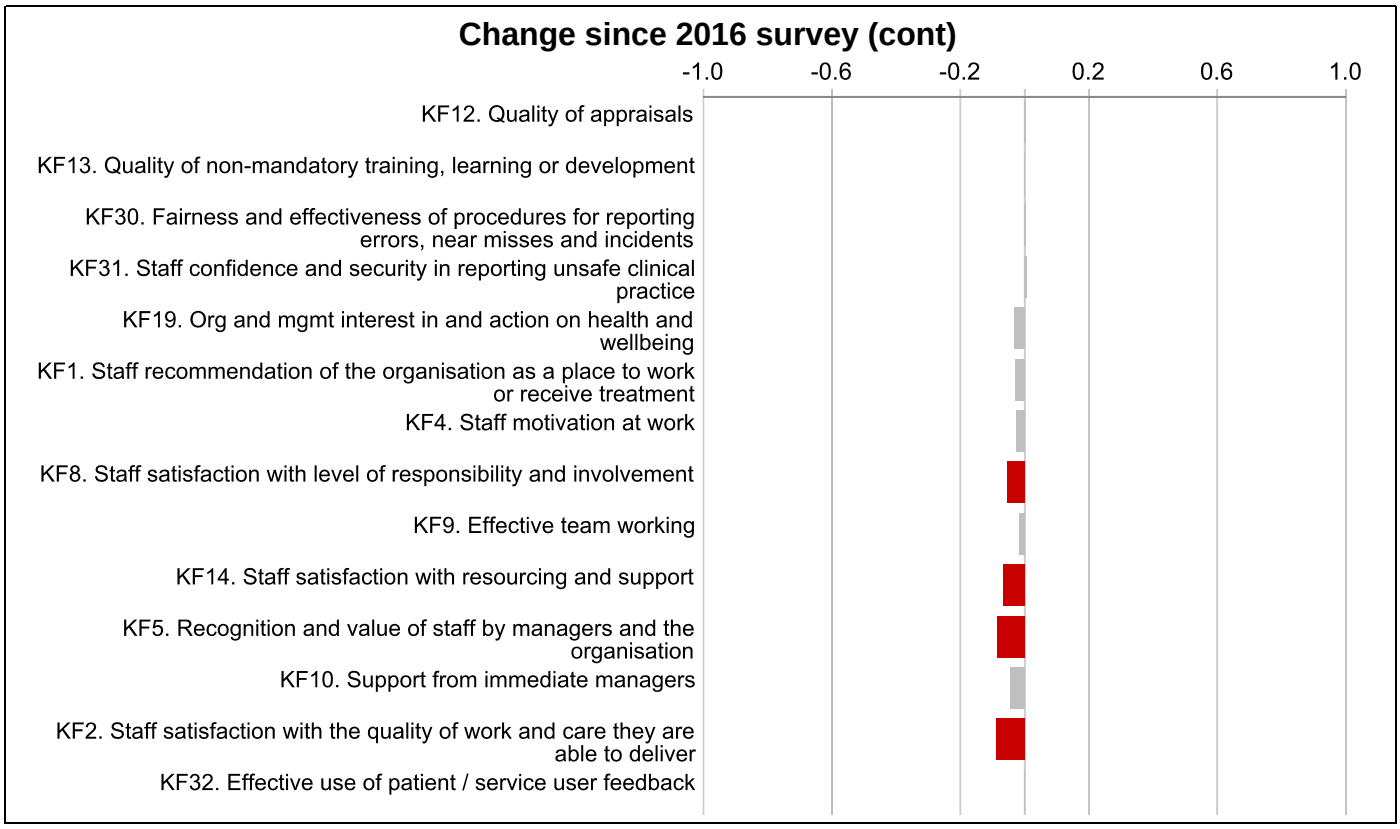


3.3. Summary of all Key Findings for The Dudley Group NHS Foundation Trust

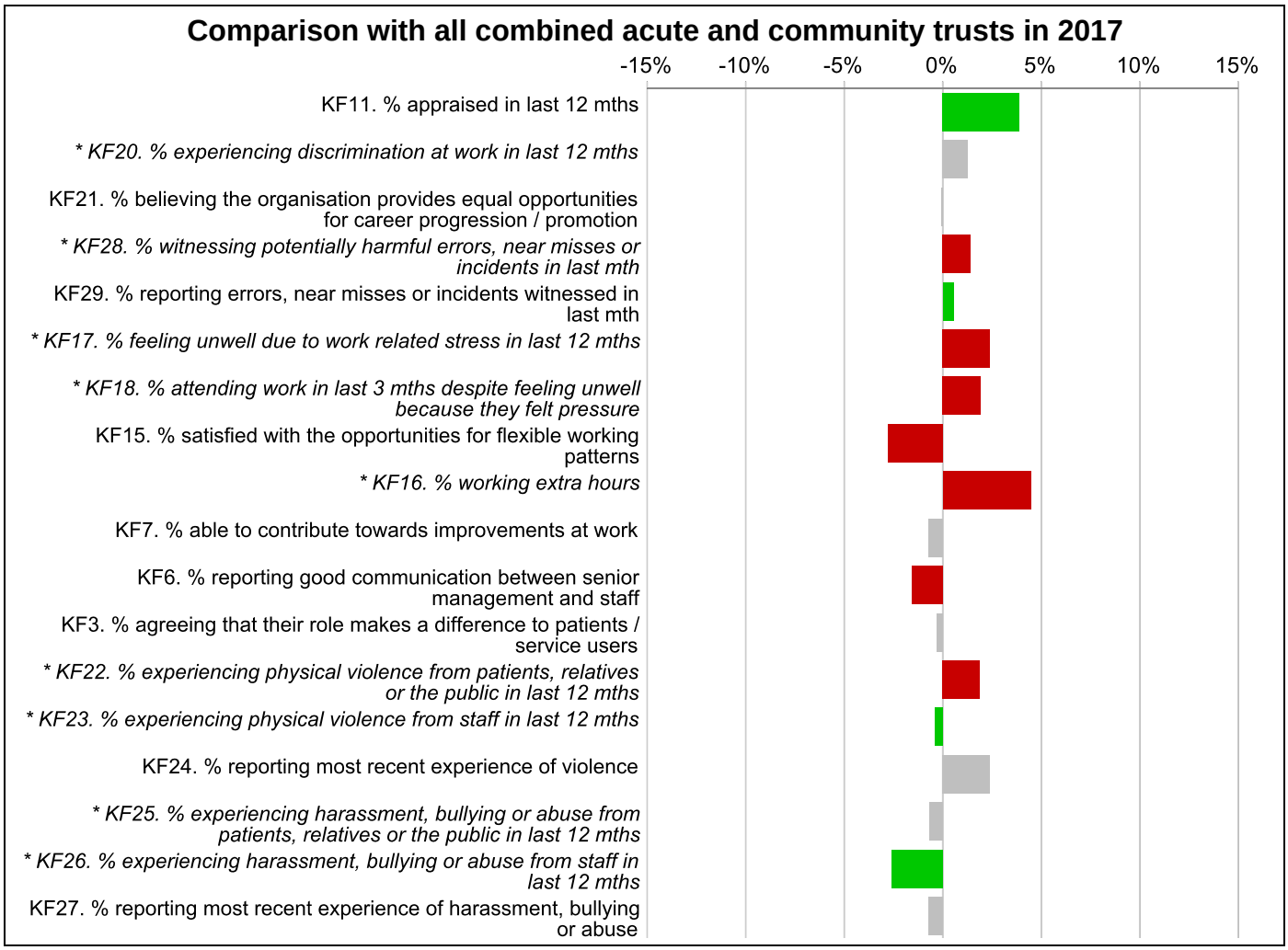
KEY

Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



3.3. Summary of all Key Findings for The Dudley Group NHS Foundation Trust

KEY

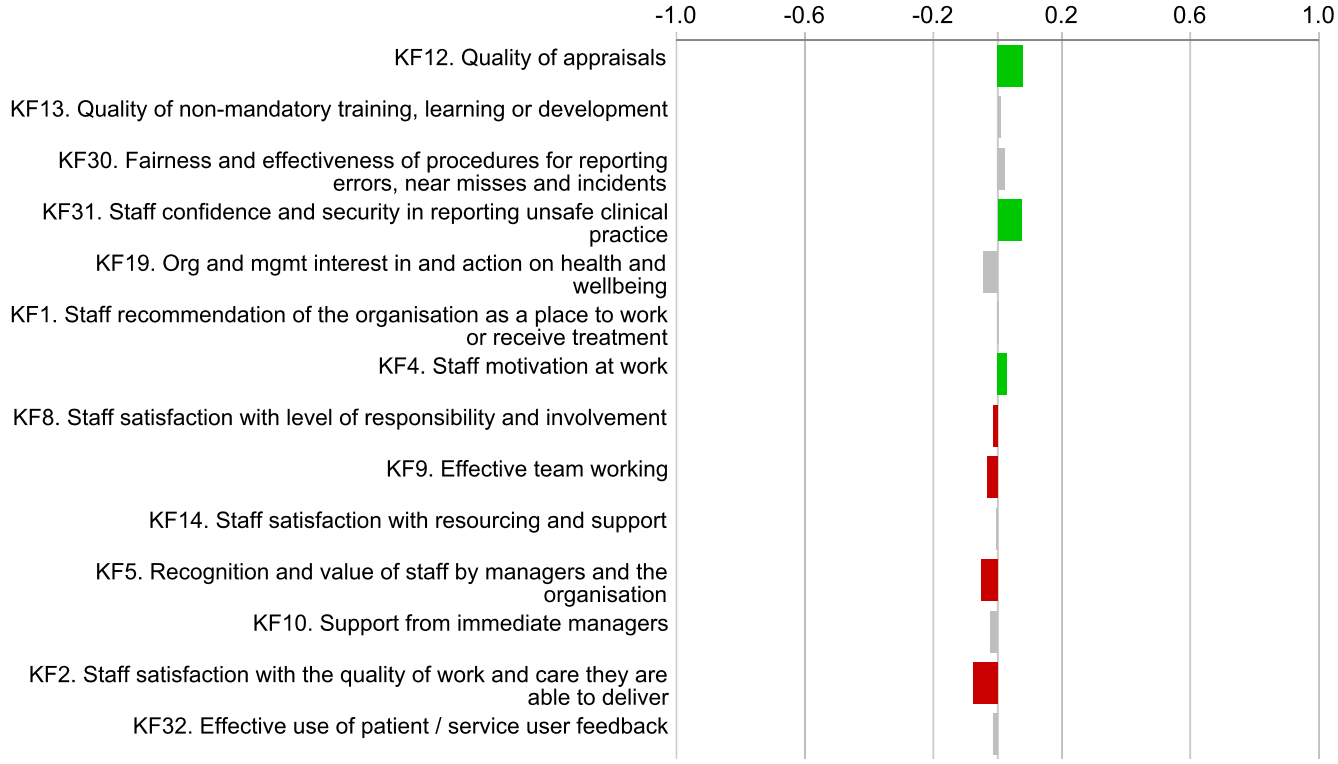
Green = Positive finding, e.g. better than average.

Red = Negative finding, i.e. worse than average.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

Comparison with all combined acute and community trusts in 2017 (cont)



3.4. Summary of all Key Findings for The Dudley Group NHS Foundation Trust

KEY

✓ Green = Positive finding, e.g. better than average, better than 2016.

! Red = Negative finding, e.g. worse than average, worse than 2016.

'Change since 2016 survey' indicates whether there has been a statistically significant change in the Key Finding since the 2016 survey.

-- No comparison to the 2016 data is possible.

* For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.

	Change since 2016 survey	Ranking, compared with all combined acute and community trusts in 2017
Appraisals & support for development		
KF11. % appraised in last 12 mths	✓ Increase (better than 16)	✓ Above (better than) average
KF12. Quality of appraisals	• No change	✓ Above (better than) average
KF13. Quality of non-mandatory training, learning or development	• No change	• Average
Equality & diversity		
* *KF20. % experiencing discrimination at work in last 12 mths*	• No change	• Average
KF21. % believing the organisation provides equal opportunities for career progression / promotion	• No change	• Average
Errors & incidents		
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	! Increase (worse than 16)	! Above (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	• No change	✓ Above (better than) average
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	• No change	• Average
KF31. Staff confidence and security in reporting unsafe clinical practice	• No change	✓ Above (better than) average
Health and wellbeing		
* *KF17. % feeling unwell due to work related stress in last 12 mths*	! Increase (worse than 16)	! Above (worse than) average
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	• No change	! Above (worse than) average
KF19. Org and mgmt interest in and action on health and wellbeing	• No change	• Average
Working patterns		
KF15. % satisfied with the opportunities for flexible working patterns	• No change	! Below (worse than) average
* *KF16. % working extra hours*	• No change	! Above (worse than) average

3.4. Summary of all Key Findings for The Dudley Group NHS Foundation Trust (cont)

	Change since 2016 survey	Ranking, compared with all combined acute and community trusts in 2017
Job satisfaction		
KF1. Staff recommendation of the organisation as a place to work or receive treatment	• No change	• Average
KF4. Staff motivation at work	• No change	✓ Above (better than) average
KF7. % able to contribute towards improvements at work	• No change	• Average
KF8. Staff satisfaction with level of responsibility and involvement	! Decrease (worse than 16)	! Below (worse than) average
KF9. Effective team working	• No change	! Below (worse than) average
KF14. Staff satisfaction with resourcing and support	! Decrease (worse than 16)	• Average
Managers		
KF5. Recognition and value of staff by managers and the organisation	! Decrease (worse than 16)	! Below (worse than) average
KF6. % reporting good communication between senior management and staff	• No change	! Below (worse than) average
KF10. Support from immediate managers	• No change	• Average
Patient care & experience		
KF2. Staff satisfaction with the quality of work and care they are able to deliver	! Decrease (worse than 16)	! Below (worse than) average
KF3. % agreeing that their role makes a difference to patients / service users	• No change	• Average
KF32. Effective use of patient / service user feedback	• No change	• Average
Violence, harassment & bullying		
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	• No change	! Above (worse than) average
* *KF23. % experiencing physical violence from staff in last 12 mths*	• No change	✓ Below (better than) average
KF24. % reporting most recent experience of violence	• No change	• Average
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	• No change	• Average
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	• No change	✓ Below (better than) average
KF27. % reporting most recent experience of harassment, bullying or abuse	• No change	• Average

4. Key Findings for The Dudley Group NHS Foundation Trust

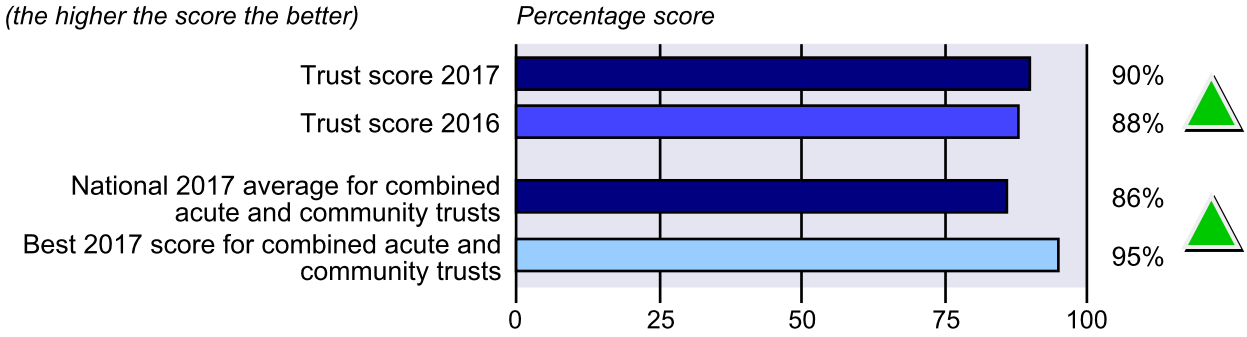
The Dudley Group NHS Foundation Trust had 1702 staff take part in this survey. This is a response rate of 36%[1] which is below average for combined acute and community trusts in England (43%), and compares with a response rate of 44% in this trust in the 2016 survey.

This section presents each of the 32 Key Findings, using data from the trust's 2017 survey, and compares these to other combined acute and community trusts in England and to the trust's performance in the 2016 survey. The findings are arranged under nine themes: appraisals and support for development, equality and diversity, errors and incidents, health and wellbeing, working patterns, job satisfaction, managers, patient care and experience , and violence, harassment and bullying.

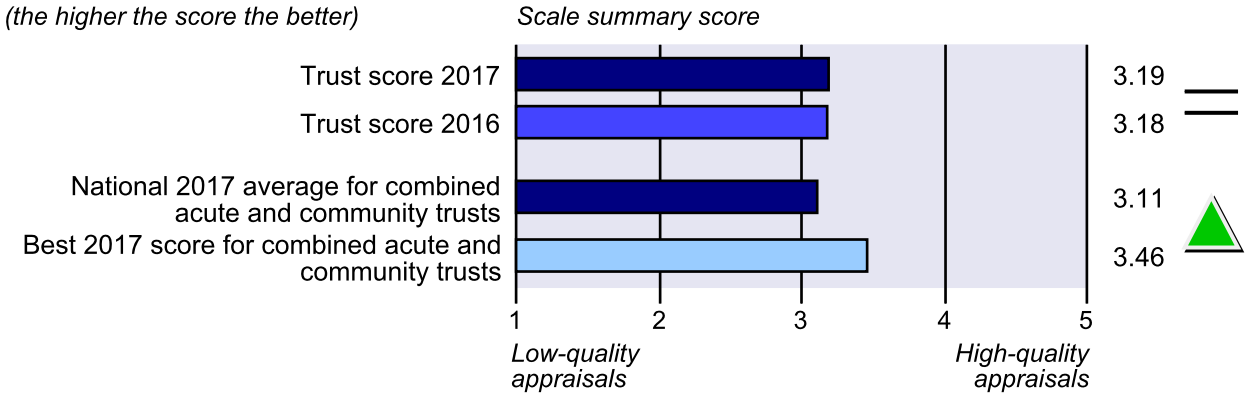
Positive findings are indicated with a green arrow (e.g. where the trust is better than average, or where the score has improved since 2016). Negative findings are highlighted with a red arrow (e.g. where the trust's score is worse than average, or where the score is not as good as 2016). An equals sign indicates that there has been no change.

Appraisals & support for development

KEY FINDING 11. Percentage of staff appraised in last 12 months



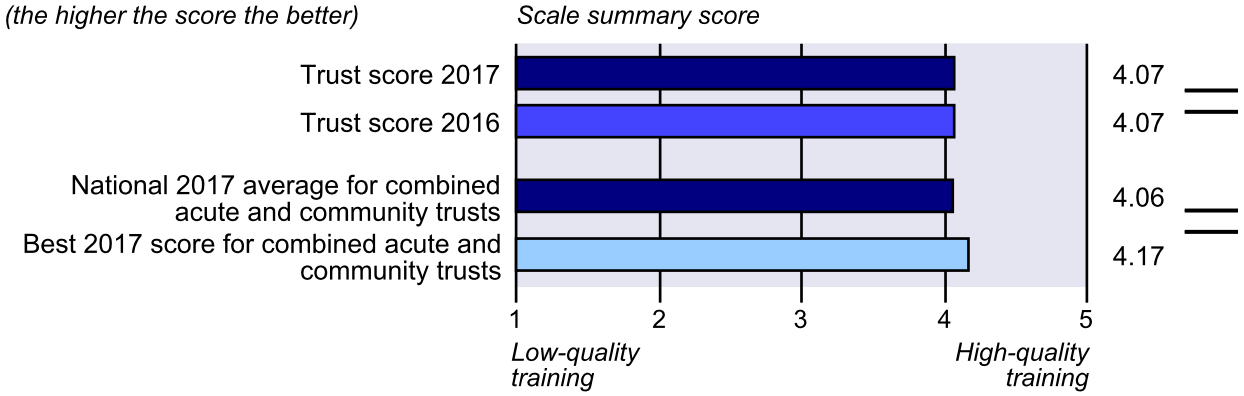
KEY FINDING 12. Quality of appraisals



[1]Questionnaires were sent to all 4712 staff eligible to receive the survey. This includes only staff employed directly by the trust (i.e. excluding staff working for external contractors). It excludes bank staff unless they are also employed directly elsewhere in the trust. When calculating the response rate, questionnaires could only be counted if they were received with their ID number intact, by the closing date.

KEY FINDING 13. Quality of non-mandatory training, learning or development

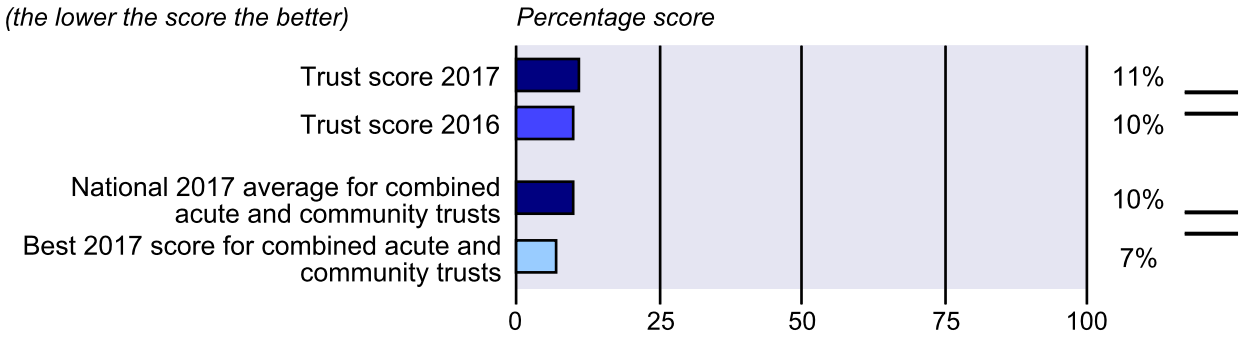
(the higher the score the better)



Equality & diversity

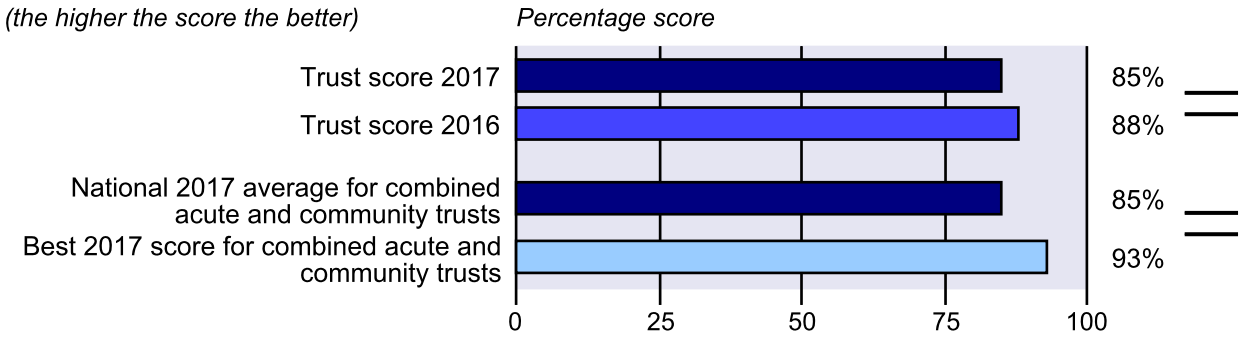
KEY FINDING 20. Percentage of staff experiencing discrimination at work in the last 12 months

(the lower the score the better)



KEY FINDING 21. Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion

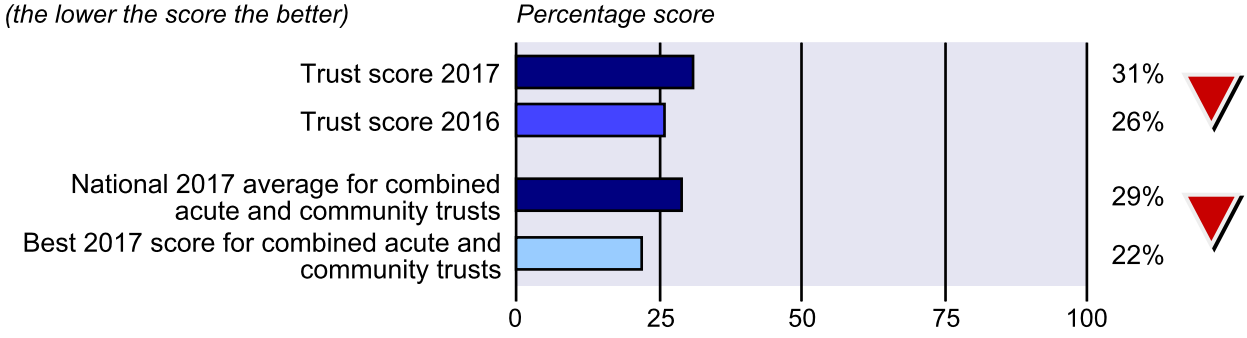
(the higher the score the better)



Errors & incidents

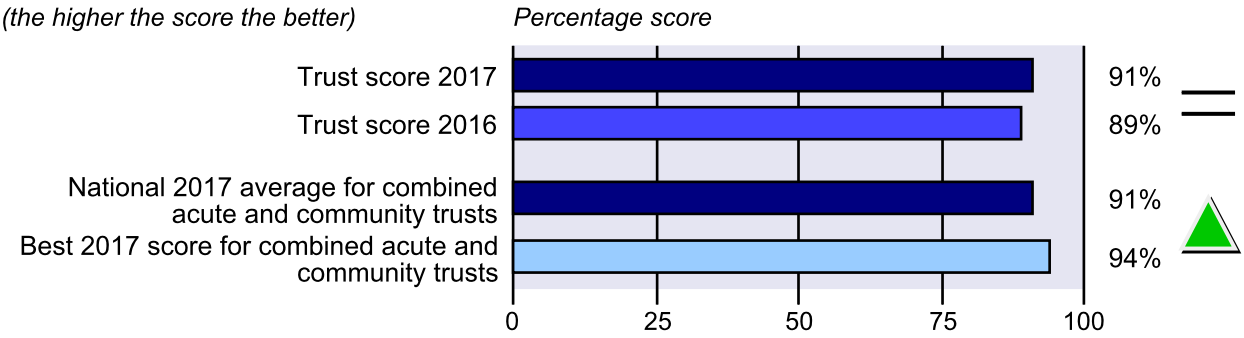
KEY FINDING 28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month

(the lower the score the better)



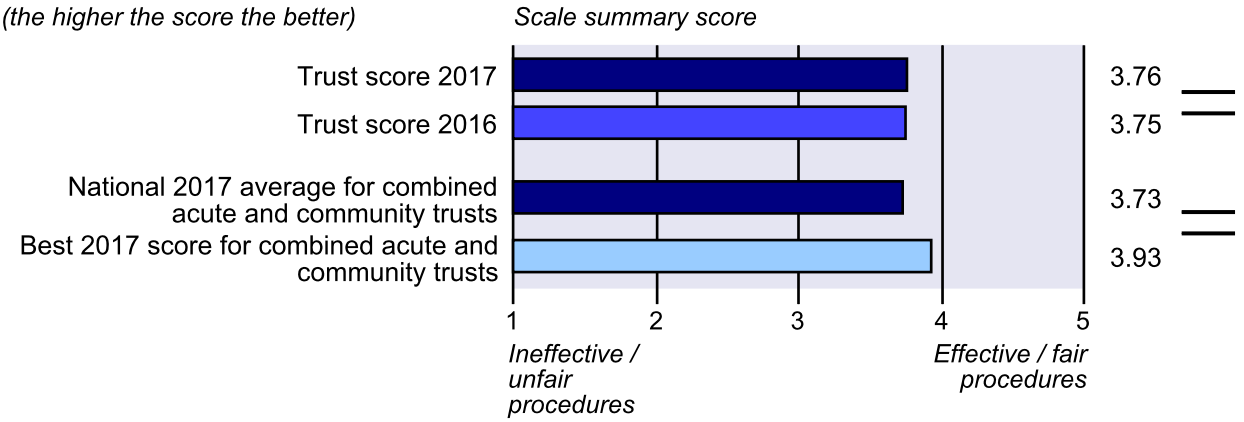
KEY FINDING 29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month

(the higher the score the better)



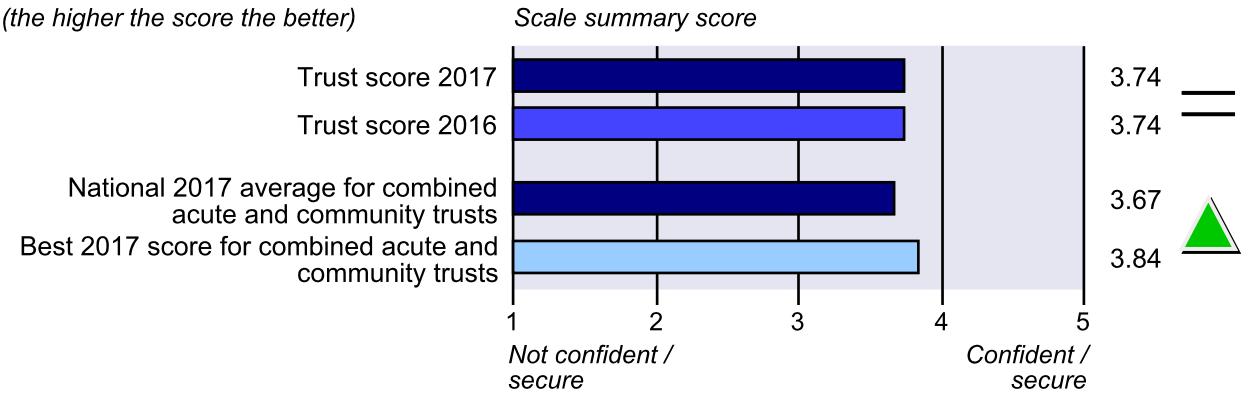
KEY FINDING 30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents

(the higher the score the better)



KEY FINDING 31. Staff confidence and security in reporting unsafe clinical practice

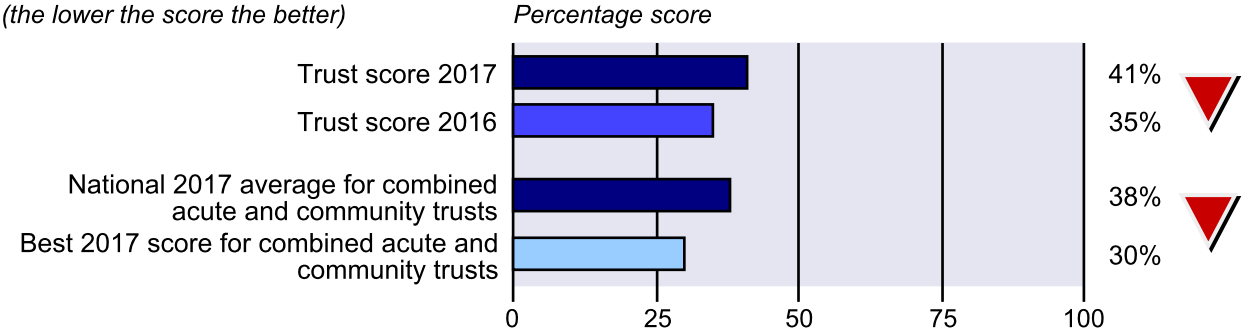
(the higher the score the better)



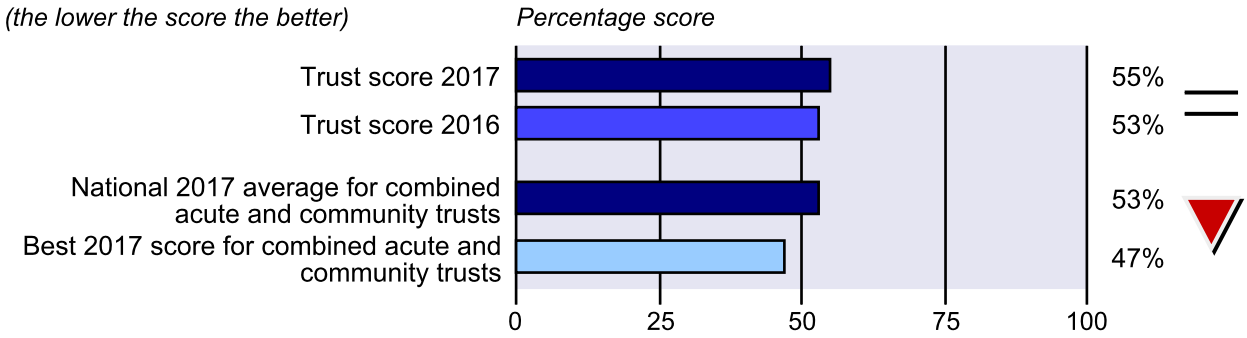
Health and wellbeing

KEY FINDING 17. Percentage of staff feeling unwell due to work related stress in the last 12 months

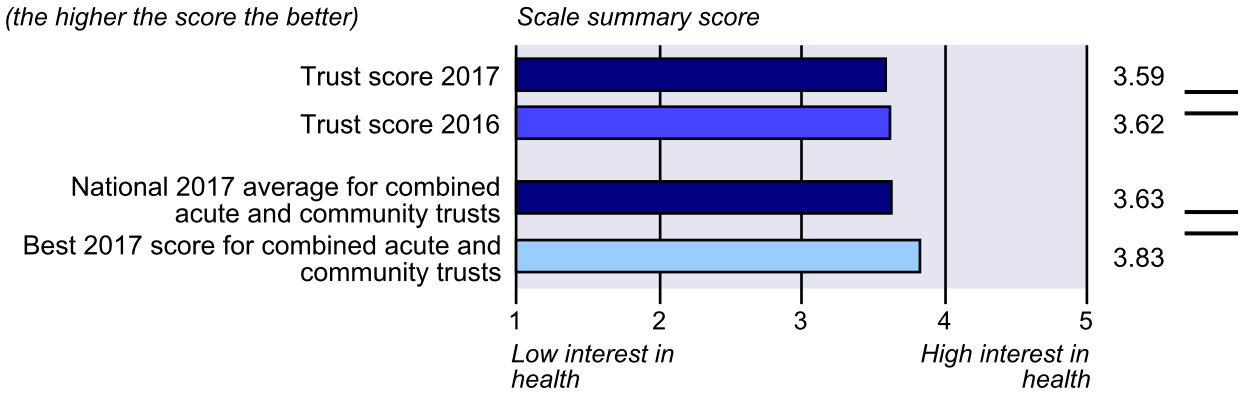
(the lower the score the better)



KEY FINDING 18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

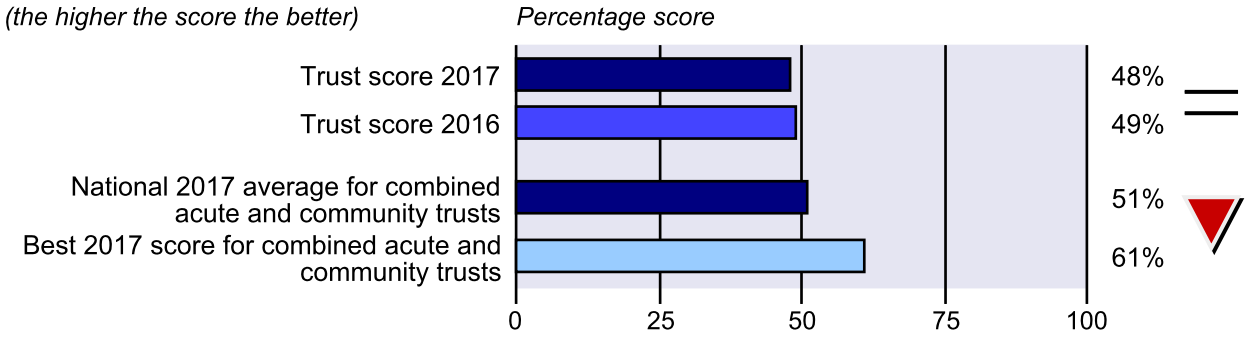


KEY FINDING 19. Organisation and management interest in and action on health and wellbeing

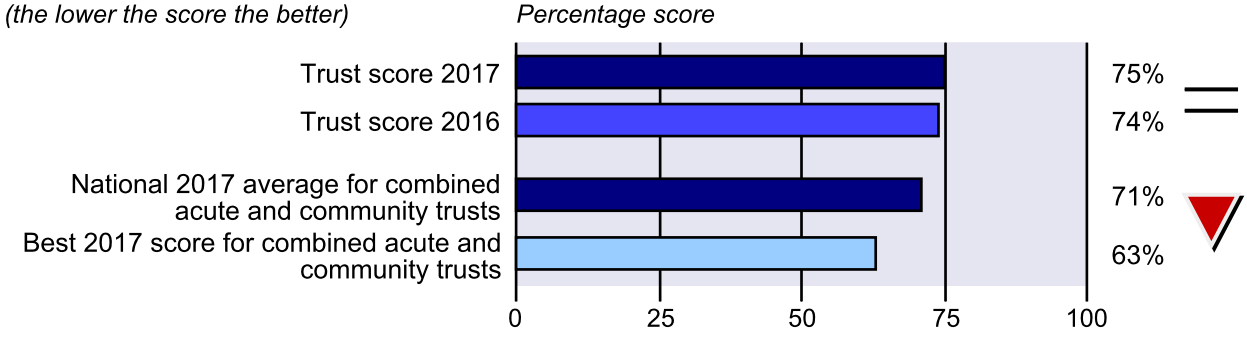


Working patterns

KEY FINDING 15. Percentage of staff satisfied with the opportunities for flexible working patterns

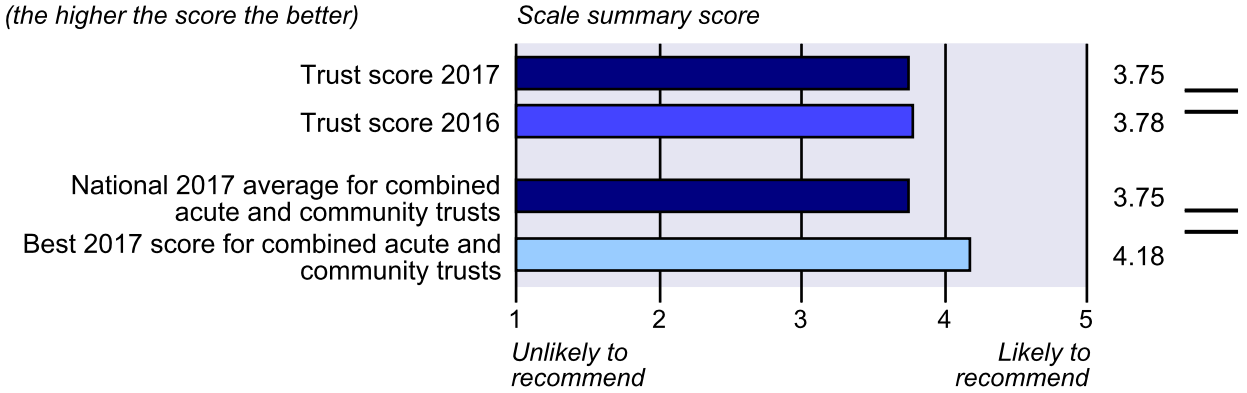


KEY FINDING 16. Percentage of staff working extra hours

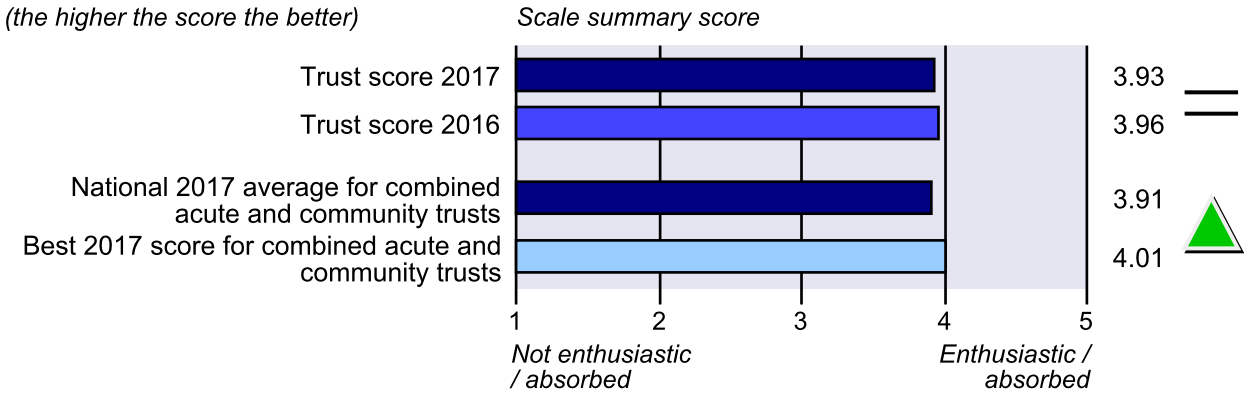


Job satisfaction

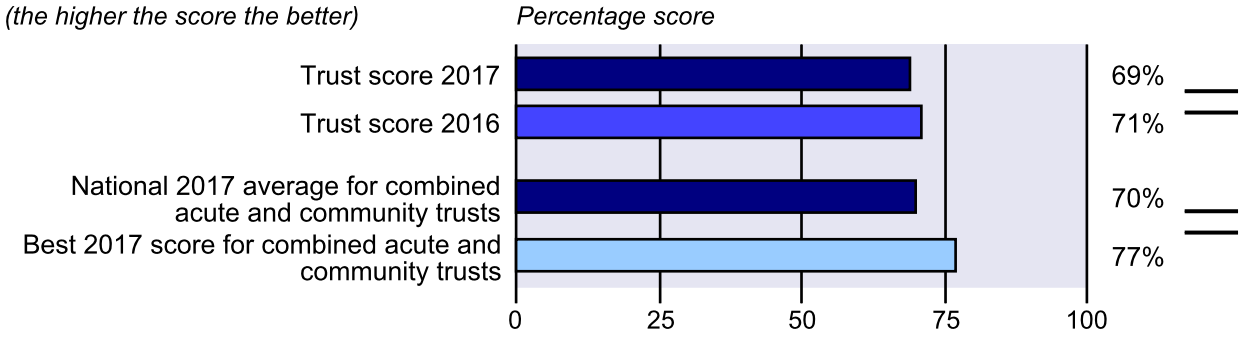
KEY FINDING 1. Staff recommendation of the organisation as a place to work or receive treatment



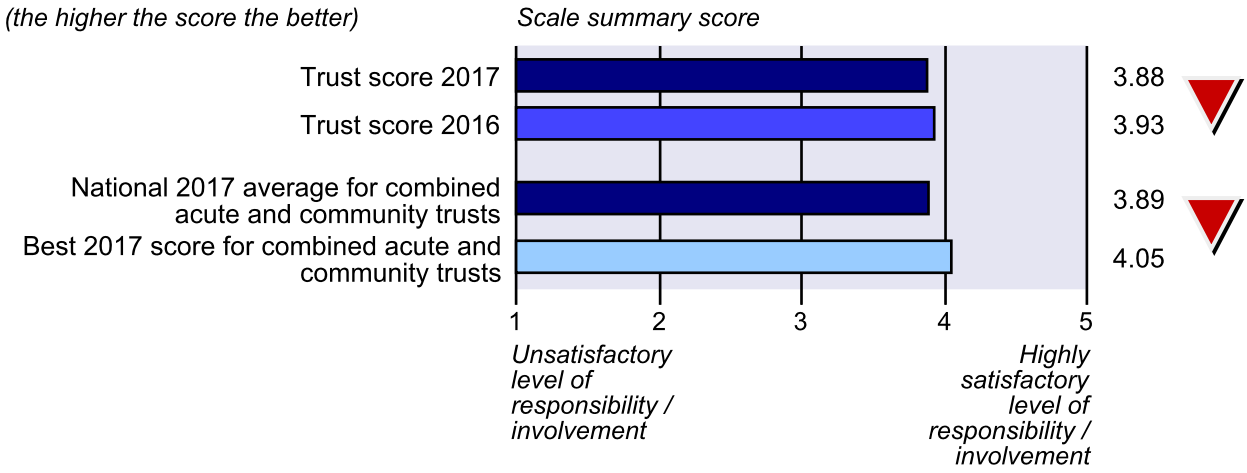
KEY FINDING 4. Staff motivation at work



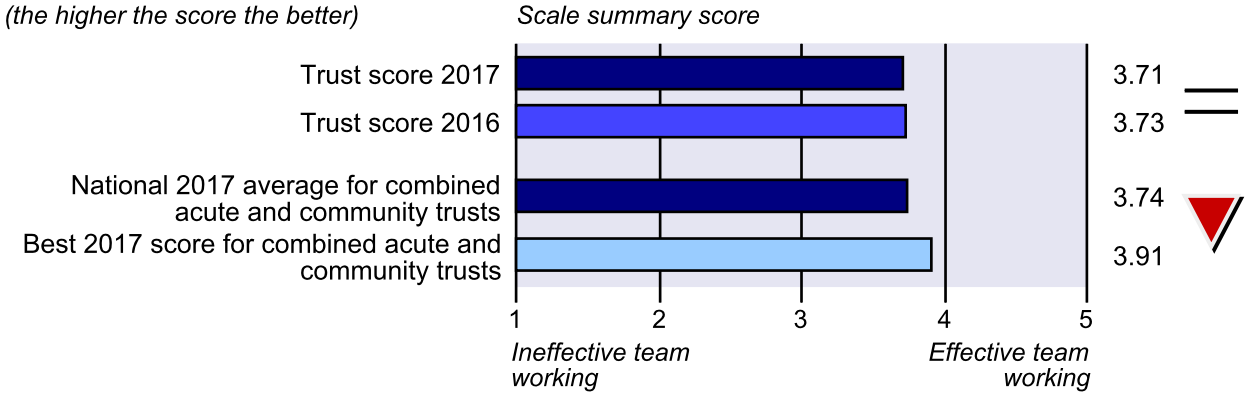
KEY FINDING 7. Percentage of staff able to contribute towards improvements at work



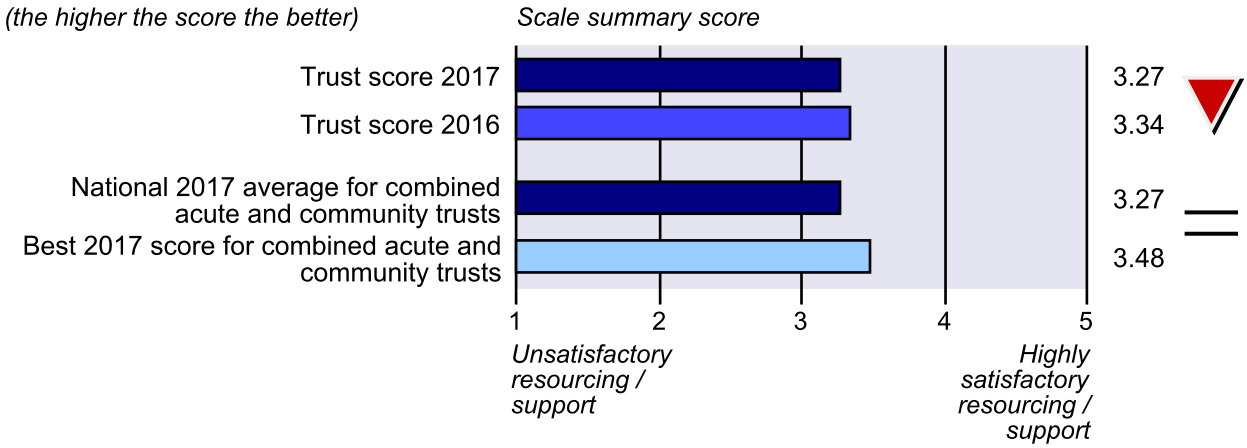
KEY FINDING 8. Staff satisfaction with level of responsibility and involvement



KEY FINDING 9. Effective team working

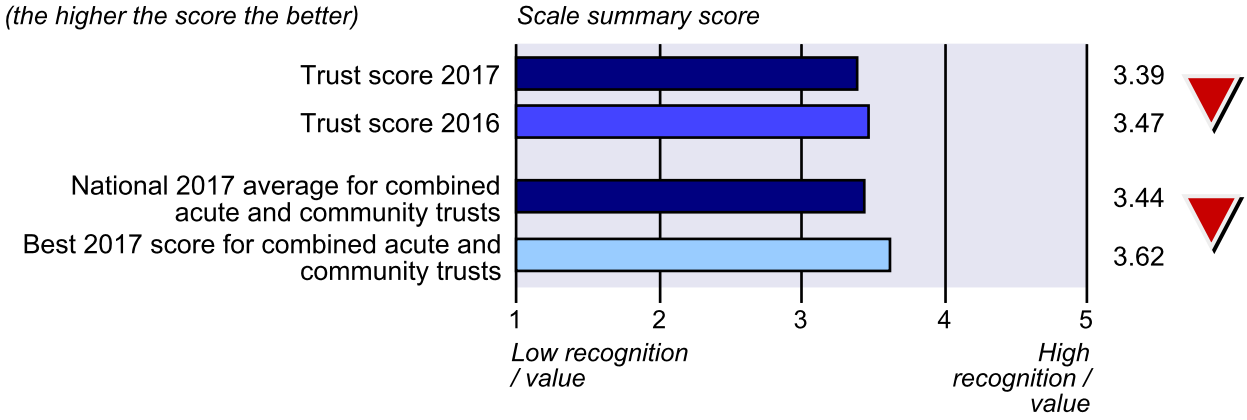


KEY FINDING 14. Staff satisfaction with resourcing and support

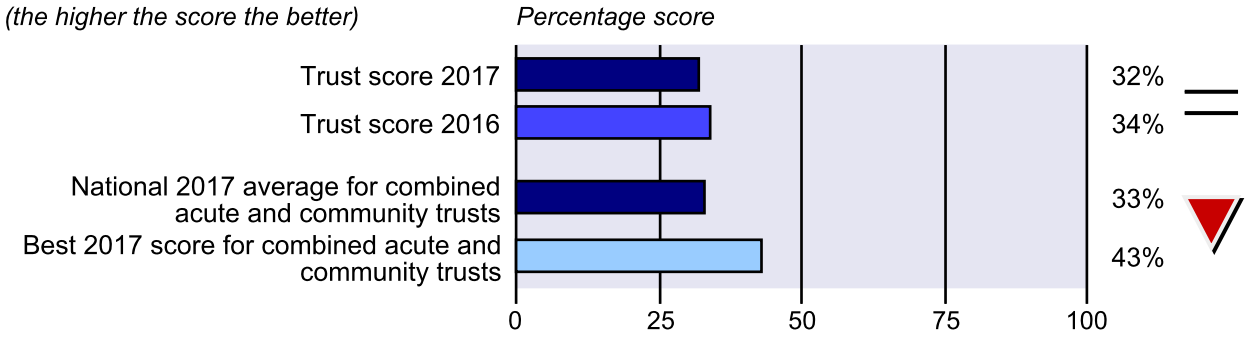


Managers

KEY FINDING 5. Recognition and value of staff by managers and the organisation

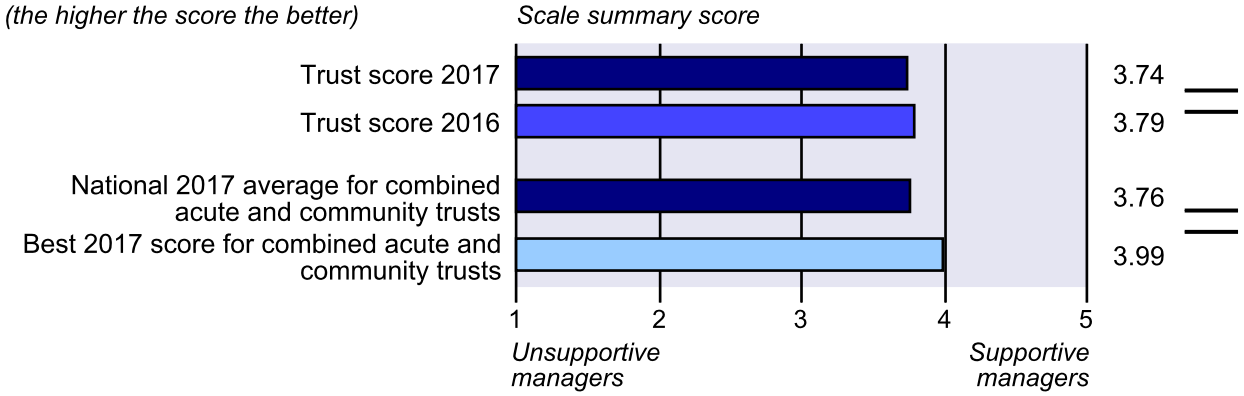


KEY FINDING 6. Percentage of staff reporting good communication between senior management and staff



KEY FINDING 10. Support from immediate managers

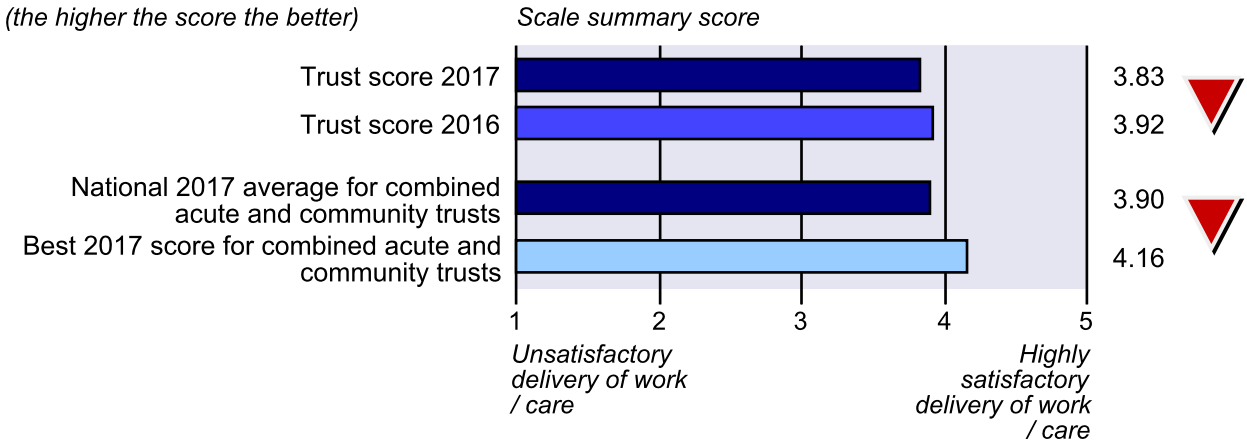
(the higher the score the better)



Patient care & experience

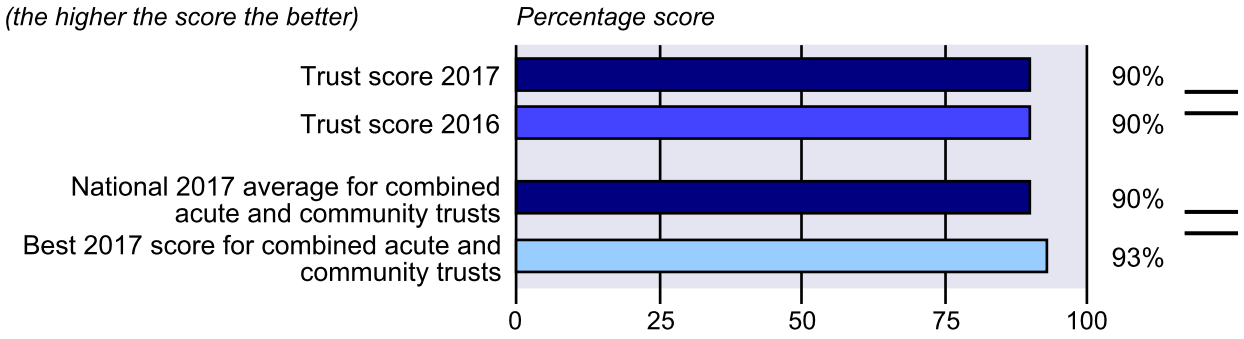
KEY FINDING 2. Staff satisfaction with the quality of work and care they are able to deliver

(the higher the score the better)



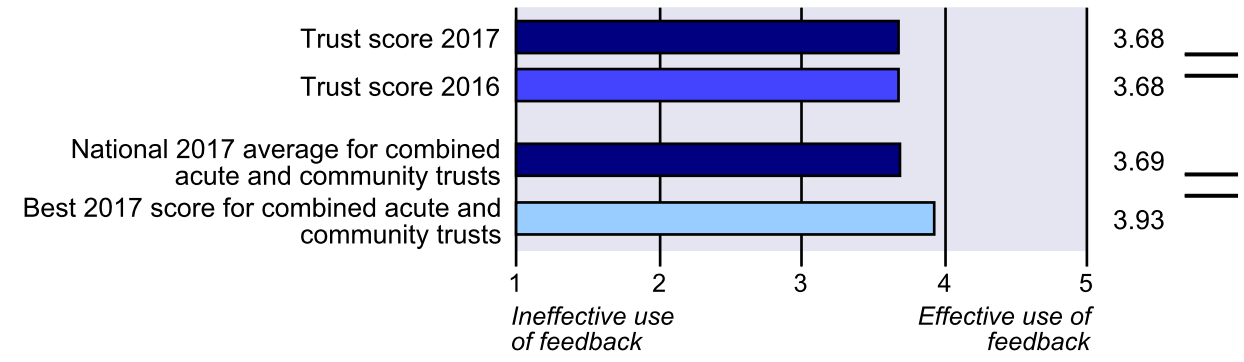
KEY FINDING 3. Percentage of staff agreeing that their role makes a difference to patients / service users

(the higher the score the better)



KEY FINDING 32. Effective use of patient / service user feedback

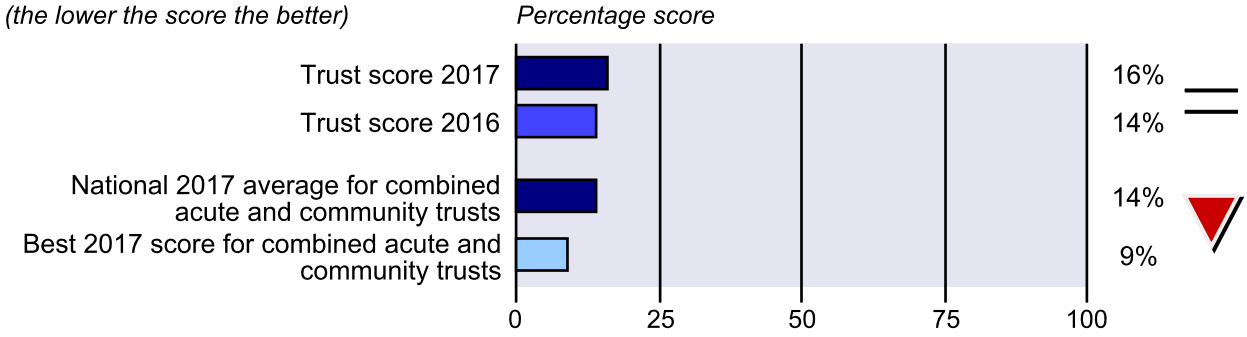
(the higher the score the better)



Violence, harassment & bullying

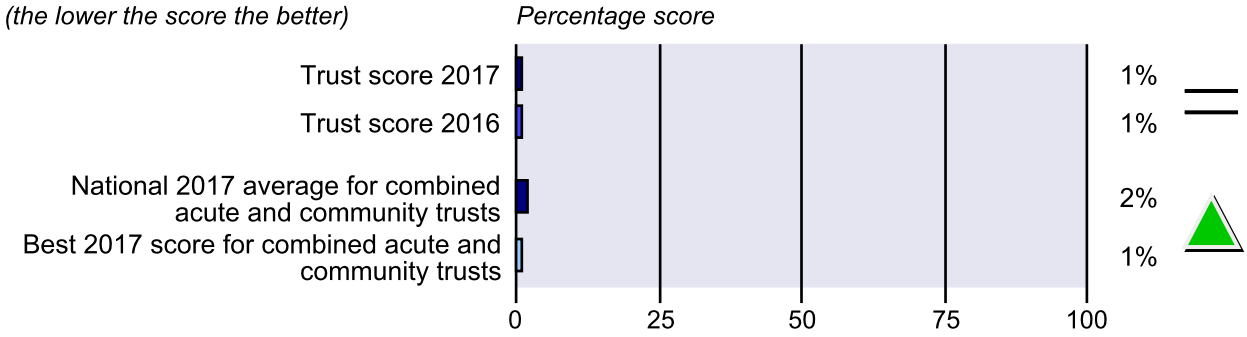
KEY FINDING 22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months

(the lower the score the better)



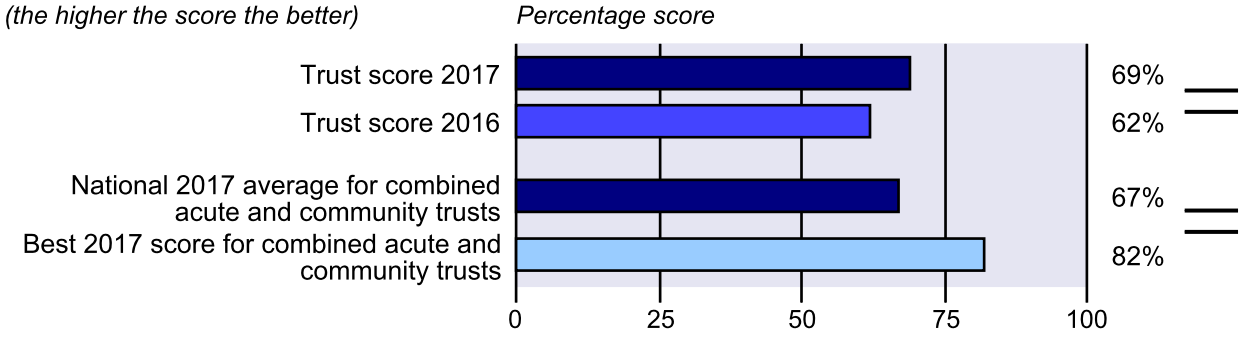
KEY FINDING 23. Percentage of staff experiencing physical violence from staff in last 12 months

(the lower the score the better)



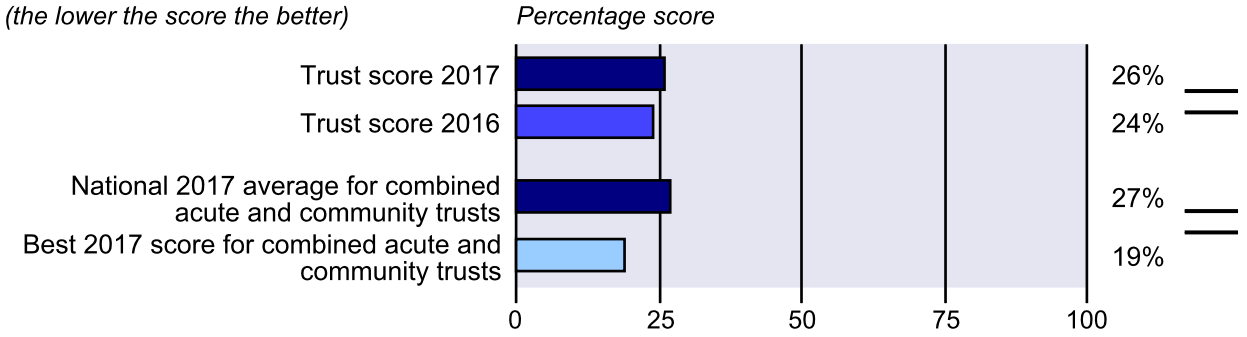
KEY FINDING 24. Percentage of staff / colleagues reporting most recent experience of violence

(the higher the score the better)



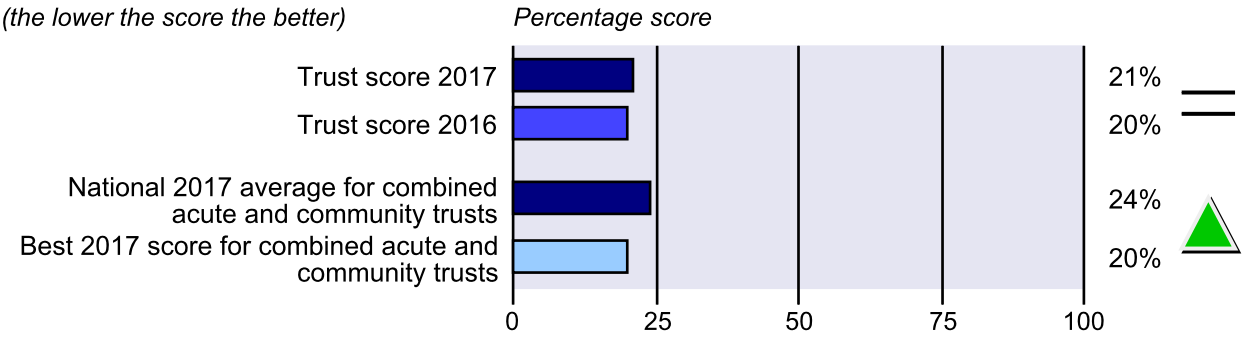
KEY FINDING 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months

(the lower the score the better)



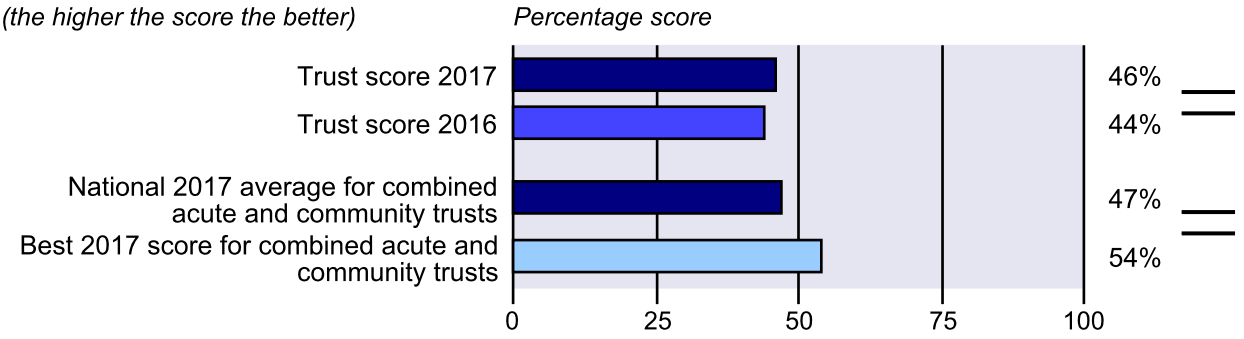
KEY FINDING 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

(the lower the score the better)



KEY FINDING 27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse

(the higher the score the better)



Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 8th March 2018

TITLE:	**Speak Up (FTSU) Guardian Update**		
AUTHOR:	Derek Eaves, Professional Lead for Quality/FTSU Guardian Carol Love-Mecrow Deputy Chief Nurse/FTSU Guardian	**PRESENTER**	Carol Love-Mecrow Deputy Chief Nurse/FTSU Guardian

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:

This paper gives an update on:

- Numbers and types of recent concerns raised and an outline of outcomes from some of the concerns raised.
- Numbers of concerns raised at the Trust compared with other Trusts.
- National/Regional Guardian activity
- Recent actions and future plans

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well Led
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To receive and note the latest developments with Freedom to Speak Up Guardian issues.

THE DUDLEY GROUP NHS FOUNDATION TRUST
Freedom to Speak Up (FTSU) Guardian March 2018 update

Numbers of concerns raised at the Trust

The table below indicates the numbers and types of concerns raised with the Guardians each full quarter this financial year and from January 1st to date (March 1st). This latest period is in effect only two months so it is difficult to comment on any immediate quarterly trend over and above the previous increasing numbers each period. As previously noted, the National Guardian Office (NGO) has discussed the difficulties in categorising types of concerns being raised and those below are locally based. The majority of concerns being raised are regarding behaviour unrelated to patient care. We have divided the national category on this topic into two: a) perceived bullying and harassment and b) perceived unfair behaviour, the latter including concerns raised about unfair recruitment, unfair rotas and concerns about redeployment of staff. All of these two types of concerns have been concerns regarding line and senior managers.

2017/18	Number	Anonymously	Patient Safety	Behaviour: Bullying/ Harassment	Behaviour: Unfair	Other
Apr-Jun	2	0	0	2	0	0
Jul-Sep	14	3	4	8	2	0
Oct-Dec	17	0	3	8	6	0
Jan-Mar*	7	2	1	1	4	1

** To 1st March only*

The table below breaks down the types of staff who are raising the concerns and it can be seen that these come from a cross section of staff with more contact being made by medical staff.

2017/18	Number	Nursing	Midwife	Medical	AHP	Clinical Scientist	Administration/ Ancillary	Unknown
Apr-Jun	2	0	0	0	0	0	0	0
Jul-Sep	14	7	2	0	1	0	3	1
Oct-Dec	17	7	0	1	0	1	8^	0
Jan- Mar*	7	3	1	2	0	0	0	1

^1 of these was a PFI staff member ** To 1st March only*

Actions/Outcomes

The concerns being raised vary considerably in complexity and as a consequence the time and resources required to come to a conclusion do differ markedly. Some issues can be resolved quickly by the Guardian, sometimes with the assistance of the Chief Executive, in liaison with local management while others are handed over, with the agreement of the person raising the concern, to such departments as Human Resources and Complaints.

The following are some latest examples of actions/outcomes as a result of concerns raised on the following topics:

- Recruitment process: a mistake in an advertisement for an internal post resulting in tighter future management processes
- Referrals between clinical teams: meeting arranged between lead consultants of the two areas involved and agreement made on improvements to referral communication
- Nervecentre processes: involved the Director of Medical Education in progressing this and a project agreed on clarifying the issues.

- Unfair rostering: person undertaking the rostering changed and plan to move to auto-rostering in place
- Unfair behaviour: mediation meeting held with an agreed outcome to all parties.
- Working arrangements: An alternative offered to member of staff but this was rejected and so issue handed back to the Human Resources Department.

Numbers of concerns raised at the Trust compared with other Trusts.

With regards to the Q3 figures there were 17 concerns raised at the Trust. At the end of January the National Guardian Office (NGO) released the final data of the submissions from Trusts for Q3. The headlines were:

- 1,919 cases were raised to Freedom to Speak Up Guardians / ambassadors / champions.
- 598 of these cases included an element of patient safety / quality of care.
- 899 included elements of bullying and harassment.
- 103 related to incidents where the person speaking up may have suffered some form of detriment.
- 336 anonymous cases were received.
- 22 trusts did not receive any cases through their Freedom to Speak Up Guardian.
- 214 of the 232 NHS trusts listed in our directory sent returns.
- 92 percent of Trusts submitted data
- Highest Trust had 75 cases (Local Trusts: 13, 18, No data returned x2)

National/Regional Guardian activity

On the 6th March the two Guardians will be attending the National Guardian Office National Conference. Carol Love-Mecrow has been asked to take part in a panel discussion.

Recent actions and future plans

Ad hoc meetings with the Chief Executive continue. The Speak Up Guardian Webpage on the Hub has been expanded to include information on the Guardian of Safe Working and in particular how medical staff report exceptions. The two Guardians met with PFI managers to explain the concept and details of the role so that they could cascade this information to their staff. The Guardians have also attended the latest Junior Doctor Forum.

Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on the 8th March 2018

TITLE:	**Guardian of safe working report**		
AUTHOR:	**Mr Babar Elahi – Guardian of safe Working Hours**	**PRESENTER**	**Mr Babar Elahi – Guardian of safe Working Hours**

CORPORATE OBJECTIVES:

SO2: **Safe and Caring Services**
SO4: **Be the place people choose to work**
SO5: **Make the best use of what we have**

The report covers the following elements:

- Guardian's quarterly report with ongoing challenges
- Progress to date

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: Implementation of revised JD contract may adversely impact on rotas**
	Risk Register: Y COR102		**Risk Score: 16**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links to safe, caring and well led domains**
	Monitor	**N**	**Details:**
	Other	**Y**	**Details: national requirement for effective guardian role**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the actions taken by the Trust and its appointed guardian of safe working.

The Dudley Group NHS
NHS Foundation Trust

Board of Directors

Guardian of Safe Working Report
March 2018

Purpose

To give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

This paper provides a summary of the following areas related to JDT and the 2016 TCS:

- Challenges
- Exception reports
- Vacancies (data provided by Medical Work Force Department)

Background and Links to Previous Papers

The role of Guardian of Safe Working Hours (GSW) is to:

- Ensure the confidence of doctors that their concerns will be addressed
- Require improvements in working hours and work schedules for JDTs
- Provide Boards with assurance that junior medical staff are safe and able to work, identifying risks and advising Board on the required response
- Ensure the fair distribution of any financial penalty income, to the benefit of JDTs.

This is the 5th GSW report and covers the period of 1st November 2017 to 20th Feb 2018. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

Challenges

Engagement

Engagement with the junior doctor workforce continues to improve. The Guardian is following his strategy to engage junior doctors, which involves.

- Holding regular Guardian Junior doctor forum.
- Introduction to Guardian and his role by attending Junior Doctor Induction Day
- Attending junior doctor forum arranged by Postgraduate Clinical Tutor
- Attending junior doctors' operational forum
- Creating a dedicated Guardian email in the trust
- Creating a webpage on the Trust HUB which carries information on Guardian role as well as

how to make exception reports.

- Regular communication to junior doctors through emails
- Using Trust HUB to advertise important information to junior doctors

As mentioned in the last GSW board report, there continues to be improvement in the engagement by the Educational Supervisors (ES) and Clinical Supervisors (CS) towards exception reports.

Trust Exception Reporting Policy

As mentioned in the last report, trust exception reporting policy is still awaiting its approval from JLNC.

Software System

As mentioned in the previous guardian reports, the Allocate software has some issues. Guardian has been invited to attend a conference arranged by Software provider, scheduled for October 2018. This will give an opportunity to Guardian to raise the concerns all the users are experiencing.

Medical Registrars Rota Gaps

Medical Registrar raised concerns about the current staffing levels and the gaps in Medical Registrar rota at the Guardian Junior Doctors Forum. The current rota has four full-time equivalent registrar gaps. This issue was thoroughly discussed in the Guardian Junior doctor forum with the Medical Director, who has assured the junior doctors that this will be addressed as a matter of urgency. Medical Registrars will be updated on the outcome very soon.

Regional Guardian of Safe Working Meeting

The Guardian in his capacity as the Chair for Guardians of West Midlands arranged a meeting of all guardians with the support of Health Education England on 8th Feb 2018 at Walsall Hospital. Guardian can assure the board that we are performing better than neighbouring trust in terms of engagement with junior doctors and in dealing with exception reports.

Junior Doctors Forum

The Guardian junior doctor forum was held on 28th of Feb 2018. This time it was a joint forum by the trust Guardian and Clinical Tutor. The engagement by Medical Director was encouraging and highly appreciated by the junior doctors. Forum was a great success with excellent junior doctor engagement. Doctors from across all specialities and grades were present. Trust senior management addressed all their concerns.

Exception Reports by Department – From 1st November 2017 to 20th February 2018 total

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
None	5	5	0	ED -1 Gen Medicine – 2 Surgery - 2

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	1	1	1	0
ST3	1	1		

Response Time

Within 48 hours	Within 7 days	Longer than 7 days	Still open
2	3		0

Exception Reports and Fines.

We have received 5 exception reports by 5 doctors

- There were no immediate Safety Concerns reported.
- 1 exception report has been completed with no further action agreed by the supervisor and the junior doctor.
- 3 have resulted in compensation: overtime payment.
- 1 has been agreed as compensation: time off in lieu.

High level data

Number of doctors/dentists in training (total): 192 (this number includes current vacancies and MTI posts and is from the most up to date ESR report)

Number of doctors/dentists in training on 2016 TCS (total): 192

Numbers of doctors/dentists in training on the new contract at February 2018: 192

Gaps as at February

Speciality / Grade	**FY1**	**FY2**	**ST 1-2**	**GPVTS**	**ST 3-8**	**Trust SHO**	**Trust Middle Grade**	**Total**	**Notes**
Cardiology					2			2	**Pakistani MTI- Currently in progress**
Diabetes			1					1	
Elderly Care			1	3	2	4	1	11	
EAU			1					1	
Gastro	1							1	

ED						3		3	**2 MTI's currently in progress- Calcutta**
General Surgery	1						4	6	
Vascular Surgery	1							1	
Haematology					1			1	
T & O			1					1	
Obs & Gynae								0	
Paeds								0	
Pathology								0	
Plastics								0	
Respiratory				1				1	**Pakistani MTI- Currently in progress**
Stroke					1			1	**Pakistani MTI- Currently in progress**
Urology	1							1	
Total	**4**	**0**	**4**	**4**	**7**	**7**	**6**	**30**	

Next Steps

1. To encourage wider junior doctor engagement by the Guardian.
2. To use the Trust HUB to promote the role of Guardian in the Trust.

1. Conclusion

Guardian can give assurance to the Trust Board that Junior Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

2. Recommendation

The Dudley Group NHS
NHS Foundation Trust

The Board are asked to read and note this first report from the Guardian of Safe Working

Author	**Babar Elahi** **Guardian of Safe Working**
Executive Lead	**Chief Executive**
Date	**28th Feb 2018**

Enclosure 18

The Dudley Grou
NHS Foundation Trust

Paper for submission to the Board on 8th March 2018

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

CORPORATE OBJECTIVES

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

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

SUMMARY OF KEY ISSUES:

The attached provides a summary of the assurances received at this meeting, the decisions taken and the tracking of actions for subsequent meetings of this Committee.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
Y	Y		Y

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	27th February 2018	Doug Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

No declarations registered.

Assurances received

Matters Arising

1. The Committee received confirmation of the Trust's commitment to proceeding with a smoke free environment following the paper supported at the February 2018 Trust Board. The Committee acknowledged its role in overseeing the project plan with implementation expected in November 2018.

Workforce Governance

2. The standard report highlighting risks associated with the workforce was presented. It was acknowledged that the descriptions associated to the new risks added need further development to ensure they highlighted the risk as well as the associated consequence. The Committee was also keen to ensure that there was effective coordination with workforce related risks alongside mitigations agreed at other committees. It was therefore agreed to have further time at the next Committee dedicated to workforce risks to allow a greater level of analysis and assurance.

3. The Committee received a policy update with confirmation on policies being developed but at this time no policies were reported as being out of date.

4. The practical arrangements for transferring to the new appraisal window were developed further and presented to the Committee. It was agreed that further communication as well as the collation of appraisal dates prior to April 2018 would help assist in ensuring a smooth transfer as well as the continuation of high levels of compliance. The Committee were advised that we are waiting for final publication of Trust objectives in order that this can inform managers of strategic direction and support clearer local objective setting. It is expected that this will be published and provided to the L&D for wider circulation prior to the new appraisal window. Finally, the Committee requested that consideration was given to the quality of the appraisal meetings and outcomes. The Committee were advised that this would be taken forward within the appraisal training programme alongside the outcomes from the work on training needs analysis.

5. The Committee received a Medical Revalidation Report from Mr. Paul Stonelake, Responsible Officer for the Trust. There were concerns raised regarding our performance alongside appraisal for medical staff. This initiated a discussion as to how this may be better managed internally in the Trust.

Workforce Education

6. The Committee was disappointed to understand that the Trust was not in a good position to fulfil its target for achieving the apprenticeship levy in 2017/18. The issues raised were:

- National delays in developing apprenticeship programmes;
- Lack of awareness at the Trust to engage with the apprenticeship programme.

The Committee has therefore asked that the next meeting receives an action plan of how the Trust will achieve greater levels of interest in order to meet our plan for 2018/19.

The previous Committee had approved the revision of terms and conditions associated to apprentices that allowed them to be aligned to other local NHS Trusts. However, it was disappointing that this has yet to be implemented and assurance was provided that implementation would take place from 1st April 2018.

7. The Committee received an update on the implementation of the new Band 6-8 Development programme that is currently being shared across the Trust for consultation. It is expected that the first cohort will take place from April 2018.

8. The Committee received the first iteration of the Training Needs Analysis work that links directly with the appraisal process. The outcome of the appraisal window will give the Committee better insight of our development priorities with a report to be received following the conclusion of the new appraisal window.

9. The Committee received an update on the Trust's involvement with the Local Workforce Action Board (LWAB). The discussion was limited, however, the Committee were assured that the Trust are well represented in all work streams in order to ensure we receive access to relevant external funding associated to staff development.

Workforce Performance

10. The Workforce Key Performance Indicators were presented to the Committee with an emphasis on sickness absence and turnover. Therefore further detail was provided on both areas. In terms of absence management the Committee were advised of changes to the current policy that provides greater controls to support the management of absence. This is supported by the new training programmes to support managers manage absence more effectively. The Committee were advised that the programmes were introduced in January 2018 with a positive response from managers. In terms of turnover the Committee were provided with some analysis on exit interviews. However, the number of exit interviews conducted were small and gave no real indication of patterns. Therefore the Committee have asked that the focus groups associated to the Staff Survey

feedback are used as an opportunity to take feedback from those in post as well as an additional question(s) alongside Staff FFT.

11. The CQUIN areas associated to workforce are currently green in terms of progress. In particular the Committee recognised the work undertaken to achieve 75% flu vaccination rate as at the date of the committee meeting alongside the target of 70%.

Workforce Strategy

12. The Committee received the Workforce Business Plan that gave assurance that agreed objectives are on track at this time. The Business Plan is attached to this paper to provide the Board of progress. The Committee is expecting to receive a revised Workforce Business Plan at the next meeting indicating priorities for 2018/19.

Workforce Change

13. The Committee were provided confirmation that the MTI recruitment process has now been initiated alongside our colleagues in Pakistan. It was reported that practical difficulties have been encountered with the process and that the first candidates have commenced in February 2018. The Director of HR and Medical Director will receive weekly updates on progress with this recruitment.

Decisions Made / Items Approved

1. To review the workforce related risks for broader discussion at the next meeting.

2. To receive action plan to support improved performance associated to the Apprenticeship Levy.

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

1. The Committee require further feedback regarding:
   - Update on Leadership Programme;
   - Workforce Related Risks;
   - Apprenticeship Action Plan;
   - Workforce Business Plan;
   - Outcome of training needs analysis.

Items referred to the Board for decision or action

The Committee on this occasion does require any decision from the Board.