The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 12th April, 2018 at 8.30am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	8.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	8.30
3.	**Announcements**		J Ord	To Note	8.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 8 March 2018	Enclosure 1	J Ord	To Approve	8.30
	4.2 Action Sheet 8 March 2018	Enclosure 2	J Ord	To Action	8.35
5.	**Staff Story**		L Abbiss	To Note & Discuss	8.40
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	8.50
7.	**Safe and Caring**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report - Presentation on Service Improvement Plan	Enclosure 4	D Wulff	To note assurances & discuss any actions	9.00
	7.2 Infection Prevention and Control Report	Enclosure 5	E Rees	To note assurances & discuss any actions	9.20
	7.3 Nurse/Midwife Staffing Report	Enclosure 6	S Jordan	To note assurances & discuss any actions	9.30
	7.4 Nurse Revalidation Report	Enclosure 7	S Jordan	To note assurances	9.40
8.	**Responsive and Effective** 8.1 Finance and Performance Committee Exception report	Enclosure 8	J Fellows	To note assurances & discuss any actions	9.45

	8.2 Integrated Performance Dashboard	Enclosure 9	K Kelly	To note assurances & discuss any actions	9.55
	8.3 Cost Improvement Programme and Transformation Overview Report	Enclosure 10	N Younes	To note assurances & discuss any actions	10.05
	8.4 Annual Plan	Enclosure 11	N Younes	To note & discuss	10.15
	8.5 Audit Committee Exception Report and Internal Audit Plan	Enclosure 12	R Miner	To note assurances & discuss actions	10.25
9.	**Well Led**				
	9.1 Digital Trust Committee Exception Report	Enclosure 13	M Stanton/ A Becke	To note assurances & discuss any actions	10.35
	9.2 Board Assurance Framework Report	Enclosure 14	G Palethorpe	To note & discuss	10.45
	9.3 Charitable Funds Committee Exception Report	Enclosure 15	J Atkins	To note assurances & discuss	10.55
	9.4 Fit and Proper Persons Requirement Report	Enclosure 16	A McMenemy	To note assurances	11.05
10.	**Any other Business**		J Ord		11.10
11.	**Date of Next Board of Directors Meeting** 9.00am 3rd May, 2018 Clinical Education Centre		J Ord		11.10
12.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		11.10

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

Enclosure 1

The Dudley Group NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 8th March, 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
Julian Hobbs, Interim Medical Director
Diane Wake, Chief Executive
Karen Kelly, Chief Operating Officer (Item P18/034.2)
Tom Jackson, Director of Finance
Siobhan Jordan, Chief Nurse
Ann Becke, Non Executive 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
Dr Jo Bowen, Consultant in Palliative Care (Item 18/030)
Natalie Hill, Lead Nurse B5 (Item 18/030)
Katrina Jones, Catering Manager Interserve FM (Item 18/031)
Gulnar Vasta, Service Improvement Team (Item 18/031)
Dr Babar Elahi, Guardian of Safe Working (Item 18/035.4)

18/025 Note of Apologies and Welcome
9.02am

Apologies were noted from Jonathan Fellows, Non Executive Director and Dr Mark Hopkin, Associate Non Executive Director.

18/026 Declarations of Interest
9.04am

There were no declarations of interest.

18/027 Announcements
9.04am

No announcements to note.

18/028 Minutes of the previous Board meeting held on 8th February, 2018 (Enclosure 1)
9.05am

Page 3, 2nd paragraph, should read "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 facilitate timely assessment for these very ill patients."

Page 5, 4th paragraph, should read "The Director of Human Resources confirmed that the Plan will be presented to the Workforce Committee, but would also be an essential theme within the overall plan."

Page 6, 3rd paragraph, should read "Cultural change reflected within the Quality Improvement Plan to be presented to the Workforce Committee."

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

18/029 Action Sheet, 8th February, 2018 (Enclosure 2)
9.10am

18/029.1 Monthly Nurse/Midwife Staffing Report

The Chief Executive had written to the Board confirming that the Trust will staff up to the current establishment and review the position in high pressure areas. Therefore this item was agreed as actioned and closed.

18/029.2 Staff Story

Patient and staff videos on 6 C's will be combined and made available on the Hub by the end of March. The Board members perspective on the 6 C's will be presented to the May Board meeting. This will be carried forward.

18/029.3 Patient Story

The Chief Executive confirmed that Theatre scheduling had improved dramatically and the Trust will look to move to a centralised function for scheduling. Dr Wulff, Non Executive Director, requested that an update is still presented to the Clinical Quality, Safety, Patient Experience Committee on these planned improvements.

The Board noted that feedback from the patient story had been provided. So this item can be closed.

18/029.4 Clinic Slot Utilisation

Work is progressing on improved reporting on the use of available clinic slots, Once this work is complete then the tracking of slot utilisation will be placed within the Integrated Performance Report. Therefore this specific action can be closed and monitored through the developed Integrated Performance Report.

18/029.5 Clinical Quality, Safety, Patient Experience Committee

The Quality Improvement Plan will be presented to this meeting as part of the report from the Committee to Board. As this will become a regular item from CQSPE to the Board then this specific action was agreed to be closed

18/029.6 Chief Nurse Report – Infection Prevention and Control

The Chief Executive had met with the Infection Control team and had committed ongoing support to release staff to allow them to undertake mandatory training on an annual cycle. This item will be tracked through the Infection Prevention and Control report so this item was agreed to be closed.

18/029.7 Monthly Nurse/Midwife Staffing Report

The reduction in beds will be discussed in the Private Board meeting.

The Chief Nurse confirmed that the Trust had checked the position with other organisations who confirmed that they had access to the same date range for this data. The Board noted that the Trust uses the latest data that is available for comparative purposes. This item was therefore closed.

18/029.8 Integrated Performance Report

The position on mixed sex data was included in the Integrated Performance Report.

Patient and staff videos to be combined and made available on the Hub by the end of March. Board members perspective on the 6Cs to be presented to the Board in May.

Update on Theatre scheduling to be presented to the Clinical Quality, Safety, Patient Experience Committee.

Quality Improvement Plan to be presented as part of the Clinical Quality, Safety, Patient Experience Committee report on a monthly basis.

18/030 Patient Story
9.24am

Dr Jo Bowen, Palliative Care Consultant and Natalie Hill, Lead Nurse on Ward B5, joined the meeting. The Head of Communications presented the patient story. The story was given by the daughter of a patient that passed away at the Trust in December 2016. The story whilst containing a number of positive messages did draw to the Board's attention the poor attitude and behaviour from one member of the nursing team on Ward B5 and the positive response by the Palliative Care Team in ensuring actions were taken with the nurse in question.

The Lead Nurse confirmed that the individual's practice was not acceptable and the individual was still receiving continuous training and teaching. A more positive patient care culture had been embraced by staff under Nurse Hill's leadership.

The Chairman welcomed the confirmation that ongoing supervision is being provided to the staff member to ensure behavioural change continues.

Dr Bowen confirmed that there are a number of ongoing actions around Palliative Care taking place within the Trust, all with the aim of improving patient experiences towards the end of their life.

The Head of Communications stated that the story showed the impact that just one person's poor attitude can have on the overall experience of the patient and in this case their family.

Dr Wulff, Non Executive Director, commented that it was positive to note the changes made within that ward since the story.

The Chief Nurse confirmed that End of Life Care training is becoming mandatory for staff. The Board noted that the video will be shown to all Lead Nurses and Matrons to reinforce the message that just one poor interaction can have a significant impact on the patient and families perception of the Trust.

Mr Atkins, Non Executive Director, added that it is better if the Trust encourages staff colleagues to identify poor attitude rather than such concerns coming from patients.

The Chairman confirmed that during her visits to wards she noted that Palliative Care was highlighted on ward notice boards.

The Chairman and Board noted the story.

18/031 Healthy Eating Presentation (Enclosure 3)
9.48am

Gulnar Vasta, Service Improvement Team and Katrina Jones, Catering, Interserve FM, presented on the actions being taken by the Trust and its partners regarding the Healthy Eating and the Health and Wellbeing CQUIN. Their presentation covered:

- Overview of the Health and Wellbeing CQUIN
- CQUIN background
- Health and Wellbeing work conducted to date
- Summary
- Next Steps being taken by Interserve

Mrs Becke, Non Executive Director, asked whether chips were still to be offered to patients. The Board noted that oven chips were still available if patients requested them.

Mr Miner, Non Executive Director, asked how feedback from patients on menus and food quality was collected. Katrina confirmed that feedback surveys are undertaken and verbal feedback is also considered. Gulnar confirmed that questions are also included in the staff survey.

The Director of Human Resources asked about engagement with WH Smith regarding their food and snack offer. It was confirmed that they are engaged with healthy eating initiatives and are compliant with the CQUIN requirements.

Mr Atkins, Non Executive Director, asked how we keep up to date with latest recommendations from various health bodies and reports. It was confirmed that all guidance is considered and less than 20% of food and drink offerings in the Trust are above healthy alternative standards.

The Chairman and Board noted the contents of the presentation and the positive work undertaken.

18/032 Chief Executive's Overview Report (Enclosure 4)
10.03am

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

- CQC Report: The report was expected at any time. A Quality Improvement Plan is in place and will be developed further on receipt of the report.

- Black Country Pathology: The Business Case had been approved and was being taken forward. A Clinical Director and Project Manager were being appointed substantively.

- Healthcare Hero Awards: C4 shift lead Claire Higgins had received the individual award for staying behind after long busy shifts to make sure that a husband and young child of an end of life patient were fully supported and introducing a ward activity box for young children dealing with such a sad situation. The team award went to Andrew Boswell, Statutory Training Lead, Sharon Phillips, Deputy Director of Governance and Anne Welch, Head of Action Heart, who were chosen for reacting quickly and using CPR and mouth to mouth to save the life of a gentleman who had collapsed while queuing for a drink.

- Emergency Treatment Centre: The Centre had now opened. There were some concerns around the size of the ambulance triage area and this had now been utilised as the minor injuries area within ED. Ambulance triage had been relocated back to its original site.

The Chairman and Board noted the report

18/033 Safe and Caring

18/033.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 5)
10.07am

Dr Wulff, Committee Chair, presented the Clinical Quality, Safety and Patient Experience Committee Exception Report, given as Enclosure 5.

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

- Information on the Quality Improvement Report had been addressed in the report later on the Board agenda.

- The issue relating to Infection Prevention and Control improvement will be picked up within enclosure 6 on the Board agenda.

- The Committee received assurance around the ongoing work in Surgery and Women and Children's around Paediatrics and Ophthalmology waiting lists, in particular relating to annual and study leave.

- Items to come back to the Committee included the delivery plan for the electronic VTE system, pressure ulcer care action plan and clinical audit plan.

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

18/033.3 Monthly Nurse/Midwife Staffing Report (Enclosure 7)
10.11am

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

The Board noted the following key issues:

- The Trust was achieving safe staffing levels, due to the additional numbers of agency and bank staff.

- The Trust is committed to recruitment and retention of its substantive staff.

The Chairman asked for clarification around the review of community services staffing. The Board noted that the Community review had been completed and recommendations would be taken forward through Finance and Performance Committee.

The Chairman and Board noted the report and the work going in to recruitment and retention.

18/033.4 Quality Account and Quality Targets Report (Enclosure 8)
10.13am

The Chief Nurse presented the Quality Account and Quality Targets Report given as Enclosure 8.

The contents of the report had been discussed at a number of meetings. The Trust had retained a number of the original quality priorities and added two new ones.

The Chief Executive confirmed that she was delighted to see Discharge Management included as a priority.

Mrs Becke, Non Executive Director, raised Nutrition and Hydration and asked if assessments were undertaken but not being recorded on the system. The Chief Nurse confirmed that achievement is at 95% and actions had been put in place to ensure that assessments are undertaken and recorded accurately and in a timely manner.

The Chairman raised the pressure ulcer target for avoidable stage 3 ulcers. She stated that she would like to see a percentage reduction defined within the target and it would be useful to see the month and date of reporting of all figures so that the Board received consistent information in papers presented.

The Chairman and Board noted the report and approved the proposed targets and the amendment to the percentage reduction on pressure ulcers.

The Quality Priority Targets were approved subject to the addition of a percentage reduction to be defined within reduction of grade 3 pressure ulcers quality metric.

18/033.5 Quality Improvement Plan
11.05am

The Director of Governance/Board Secretary, updated the Board on the Quality Improvement Plan. The Trust had established exception reporting to Clinical Quality, Safety Patient Experience Committee and was meeting with areas that were falling behind on the delivery of their actions within the initially determined delivery dates. It was a challenge for ED to move forward on actions due to capacity pressures within the Department.

The Board noted that Plans are included on the Directors shared drive allowing Directors to review and support teams with the delivery of the required actions.

The Board was shown how the dashboards work and the governance process around these.

The Chairman and Board noted the report and thanked the Director of Governance for the overview.

18/033.5 Learning from Deaths Report (Enclosure 9)
10.25am

The Medical Director presented the Learning from Deaths Report given as Enclosure 9. The Board noted the following key highlights:

The format of the report had improved from previous reports to Board, a number of actions were being taken forward and Datix incidents were now included within the mortality tracker system.

The report was now demonstrating more learning and the main themes from the mortality reviews were detailed in the report.

VTE data shows that the Trust is not meeting the target but past Internal Audit reviews had identified that issues were with the recording of data. There are plans to introduce an electronic system to support better reporting.

The Trust's SHMI of 100 suggests that mortality rate is within acceptable parameters. The Medical Director had looked in detail at Sepsis reporting. The Trust's SHMI within this area meant it was an outlier and work was being undertaken to understand the reasons for this.

Mr Miner, Non Executive Director, stated that currently all mortality indices were within the expected range and he asked for assurance that there was nothing for the Board to be concerned about. The Medical Director confirmed that the Trust had appointed a Clinical Patient Safety and Culture Lead and they will work with Aqua (Quality Strategy organisation) on mortality to be able to provide improved assurance on this.

The Chief Executive stated that the management of Sepsis is an area of concern especially within AMU and ED pathways. The Chairman endorsed this and was encouraged to see the focus in this area.

The Chief Executive confirmed that we need to make the triangulation of information clearer to provide improved assurance to the Board.

The Medical Director confirmed that the NHSI mortality dashboard will be incorporated into the next report.

The Chief Nurse confirmed that staff, in addition to appropriate training, are being given reminder cards on how to identify deteriorating patients.

The Chairman and Board noted the report and the further improvements to the report as detailed.

NHSI Mortality Dashboard to be included in the next Learning from Deaths report to Board.

18/034 Responsive and Effective

18/034.1 Finance and Performance Committee Exception Report (Enclosure 10) 11.14am

Mr Miner, Non Executive Director, presented the Finance and Performance Committee Exception Report, given as Enclosure 10.

The Board noted the following key issues in respect of performance for January 2018:

- The focus of the last meeting had been on the Trust's financial performance. There continued to be high agency spend and financial performance had deteriorated. The Trust needed to step up cost control with immediate effect and the Executives had set out the controls required.

- .CIP position: The Trust was only realising £8m which was below target. The reduced figures had links to increased use of agency spend.

- Medical agency expenditure was improving, but controls were still needed.

- There had been an Extraordinary Finance and Performance Committee meeting held on 5th March to look at the budget for 2018/19.

Mrs Becke, Non Executive Director, commented that CIP delivered had decreased again and asked what was the reason for this. The Chief Executive confirmed that this was mainly down to agency spend. The Trust had placed a ban on the use of high cost agency staff. There is further work to be done around different models of care and how this will positively impact on staffing requirements.

Mr Atkins, Non Executive Director stated that at February's Board the CIP was down to £9.2m but now it was down to £8m just one month later.

Mrs Becke asked for assurance that the Trust was utilising its own staff wherever it can to reduce reliance on Agency. The Chief Executive confirmed that it was.

The Director of Human Resources confirmed that the Trust utilises its own staff first, then those from the Bank, and agency as a last resort.

The Chief Nurse confirmed that senior nursing staff had been asked to put in additional bank shifts and Community staff were also doing shifts to share the pressure across the organisation.

The Chairman asked for a paper to be presented to Workforce Committee then to Board to show actions being taken in respect of the utilisation and retention of staff. Mr Miner, Non Executive Director, confirmed that internal audit are doing work in this area and the outcome of this will be important to identify areas where control can be strengthened .

The Director of Finance confirmed that controls are in place and the Trust needs to maintain focus on this for the remaining weeks of this year and use the learning from this for strict control next year.

The Chairman asked about current year financial outturn. The Director of Finance stated that the position is very challenging.

The Chairman updated the Board that in between the last meeting and this she had taken Chairman's action to sign an order for £750k as part of the wider already approved and funded EPR project. This had also been endorsed at the Finance and Performance Committee.

The Board approved the action.

The Chairman and Board noted the report.

Paper to be presented to the Workforce Committee and then Board showing the actions being taken in respect of the utilisation and retention of staff.

18/034.2 Integrated Performance Report (Enclosure 11)
10.41am

The Chief Operating Officer presented the Integrated Performance Report given as Enclosure 11.

The Board noted the following key issues in respect of the performance in January with a current update.

- ED: The Trust will not achieve the 95% target for year end. Currently the Trust was achieving a combined performance of 79% with the Urgent Care Centre. There had been unprecedented demand from ambulance service arrivals and that Monday and Tuesday of this week had been the busiest days ever at the Trust. The Board noted that Dudley is one of highest recipients of ambulances in the West Midlands and was taking over 140 ambulances per day, which were arriving in batches of 10 to 12 at times during the day. Minors was running well at the front door and the relationship with the Urgent Care Centre is good. HALOs were under pressure and the Trust was currently very pressured after an extremely busy night. Immediate actions were being taken including sourcing medical doctors to provide in reach work into ED, lead nurses are directing medical teams and Social Care services are being based in the Department all to support patient flow. All patients are being reviewed by the Chief Operating Officer and lead nurse so patients do not wait unnecessarily for discharge. Issues impacting on this are dealt with swiftly. The Chairman and Board noted and understood the demand pressures. The Chief Executive confirmed that the majority of patients arriving need medical intervention and the Trust was looking at the acute medical model of care in operation to see if that can be improved to support flow. The Medical Director stated that the Trust needs to redesign the acute medical pathway to drive through required improvements. An independent service review from the Royal College of Emergency Medicine had been scheduled and the Trust will work through any of their recommendations for improvement.

- RTT: The Trust was achieving this target. The Trust was looking at slot re-utilisation to further improve out-patient services area and would look at improvements against the current baseline, the outcome of this will be included in the next report.

Mrs Becke, Non Executive Director, asked for assurance that the Trust was focussing on patients waiting for a bed. The Chief Operating Officer confirmed that there were no 12 hour breaches.

Dr Wulff, Non Executive Director, asked if anyone from General Practice was involved and looking at patient flows. The Chief Executive stated that we need to develop a single point of access in the Community to try and keep patients at home. The A&E Delivery Board and Partnership Board also look at ED attendances and actions being taken.

The Director of Finance, confirmed that the scope of the MCP does include an outcome measure for a reduction in emergency admissions.

The Chief Operating Officer confirmed that help provided from staff colleagues was recognised and appreciated by the ED staff.

The Chairman and Board noted the report.

Slot re-utilisation to be included in the next Integrated Performance Report to Board.

18/034.3 Cost Improvement Programme and Transformation Overview Report (Enclosure 12)
11.27am

The Director of Strategy and Business Development presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 12.

The Board noted the following key issues:

- The main areas of the report had already been covered in the Finance and Performance Committee report.

- The Trust was re-looking at Carter Model Hospital opportunities and working closely with Finance and the Divisions to get the best start for next year

The Chairman and Board noted the report.

18/034.4 Patient Experience Report (Enclosure 13)
11.28am

The Chief Nurse presented the Patient Experience Report given as Enclosure 13.

The Board noted the good governance and oversight in place around patient experience.

There had been 84 complaints but only 11 of these had been responded to within 40 days.

The Chairman asked for more information on complaints response timeframes and background on complaints in a table format.

The Chief Nurse confirmed that this had been requested by the Clinical Quality, Safety, Patient Experience Committee (CQSPE) for similar and this would be available for the next CQSPE meeting report.

The Chairman and Board noted the report and triangulation which was positive to see.

More background on complaints and the response timeframes to be included in the next report to the CQSPE and Board.

18/035 Well Lead

18/035.1 Digital Trust Committee Report (Enclosure 14)
11.31am

The Chief Information Officer confirmed that there was no report as the February Committee meeting had been cancelled.

The Chief Information Officer confirmed that the project was currently to plan and an update will be provided to the next Board meeting. Go live was still planned for 23rd April, 2018.

18/035.2 Staff Survey Report (Enclosure 15)
11.48am

The Director of Human Resources presented the Staff Survey Report, given as Enclosure 15.

The Board noted the following key highlights:

- The full report was available online or can be shared by email with the Board.
- The report gave a summary of the national results which were embargoed until the 6th March which was why this was a to follow paper for this meeting.
- The Trust had received initial findings from the Picker survey team a few weeks ago and had at that stage commenced on an action plan.
- The overall response rate was disappointing, but understandable given the other demands on staff time, and the Trust needs to replicate the energy that was put into the flu campaign around the delivery of actions in order to track improvement into the next survey.
- The engagement score had decreased, albeit the Trust performs a little better than the national comparator for engagement.

- Page 4 provided the top and bottom ranking scores.

- There were some positive scores, including a high rate of useful appraisals being undertaken.

- Low scores were for staff feeling unwell as a result of work. The Trust needs to consider its workforce priorities in light of this feedback going forward.

- There were a number of areas of improvement identified and going forward the Trust is planning for greater connectivity between the new appraisal process and the Trust's key goals. The Board noted that there were also opportunities through its Development Programme to provide opportunities for staff to be supported in their development.

- An action plan will be presented to the Workforce Committee and Board on improvement priorities.

Mrs Becke, Non Executive Director, commented that clinical support as a division had more red areas than others. The Chief Executive confirmed that it was likely the feedback has been influenced by the major changes taking place in Pathology, which were not seen as favourable by some staff

The Chairman acknowledged that the senior team had done a lot of work on staff recognition projects supporting improved staff experiences.

The Chairman said she welcomed the results being triangulated with feedback which will be obtained from focus groups.

Mr Miner, Non Executive Director, stated that results were not far away from National averages. The Trust needs to look at the performance of outstanding Trusts to enable us to determine the actions that may have the greatest impact. The Chief Executive confirmed that Leeds Teaching Hospitals have published how they have improved year on year and it would be good to link in with them.

The Chief Nurse confirmed that staff value the Healthcare Heroes awards but they should not just be about clinicians and we need to ensure that other staff groups are included in the recognition scheme. The Chief Executive added that the Trust keeps working to encourage staff to make nominations.

Mr Atkins, Non Executive Director, commented on the low response rate to the survey generally and that we need to recognise that this can skew the results.

Mrs Becke, Non Executive Director asked if the well being CQUIN was nationally set. The Director of Human Resources confirmed that it was and it was actually a two year CQUIN.

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

Staff Survey action plan to be presented to the Workforce Committee and Board.

18/035.3 Freedom to Speak Up Guardians Report (Enclosure 16)
12.02am

The Director of Governance/Board Secretary presented the Freedom to Speak Up Guardians Report given as Enclosure 16.

The Board noted the following key highlights:

- Page 3 gives the Board assurance that the Trust makes and submits a number of concerns to the centre.
- There had been 17 concerns raised and the Trust was middle ranking in numbers reported compared to others.
- The Guardians have regular engagement with Human Resources for support and advice.
- The Trust had attended the National Guardians conference and one of our Guardians had taken part in a panel discussion.
- The Guardians continue to have regular meetings with the Chief Executive.

The Chairman asked about whether Freedom to Speak Up Champions should be used in the organisation. The Board noted that it was felt that they were not required at this time given the good level of engagement occurring.

The Chairman asked that themes should be still recorded on the Hub from anonymous complaints. The Board were informed this process remains in place.

Chairman and Board noted the positive report.

18/035.4 Guardian of Safe Working Report (Enclosure 17)
11.34am

The Guardian of Safe Working presented his Report given as Enclosure 17.

The Board noted the following key highlights:

- The report covers the period 1st November 2017 to February 2018.

- The report reflects the positive position of the Trust.
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- Engagement with all juniors has been challenging but there is an intranet page to support juniors with soft working information and meetings.

- All senior trainees are now on the new contract.

- There is a nationally organised meeting arranged with Allocate (IT provider) for October where the Guardian will raise the improvements wanted with the software supplier.

- Medical Registrar rota had 4 full time equivalent gaps and this was raised at the February Junior Doctors Forum.

- The Regional Guardians meeting was facilitated by Health Education England and intelligence from that meeting was that the Trust was the best performing in the Region for response times to junior doctor concerns.

- There are no current case exceptions dealt with in excess of 7 days.

- 192 trainees were currently on the new contract. This shows a reduction in trainee numbers from the 199 in the last report, due to rotation or other factors.

- There were 30 rota gaps, but the Guardian stated that all rotas were compliant with staffing support from temporary staff.

The Director of Human Resources asked about the Junior Doctors Mess. The Guardian was encouraging trainees to discuss requirements but concerns had not been raised with him. The Board noted that the build for the new Mess was taking place.

The Medical Director confirmed that engagement at the Junior Doctors Forum was good and additional meetings were being held to encourage proactive resolution of issues.

The Chairman asked about the gaps in the Elderly Care rota and if this posed any significant issue. The Director of Human Resources confirmed that plans are in place to fill the gaps.

The Chairman and Board noted the detailed report and thanked the Guardian for his work locally and nationally.

18/035.5 Workforce Committee Exception Report (Enclosure 18)
12.07am

Dr Wulff presented the Workforce Committee Exception Report given as Enclosure 18 for information.

The Director of Human Resources confirmed that the Appendix was missing from the report and would be circulated to the Board by email.

The Chairman and Board noted the report.

18/033.2 Infection Prevention and Control Update (Enclosure 6)
12.08am

The Chief Executive presented the Infection Prevention and Control Report, given as Enclosure 6. The Board noted the following key issues:

There had been 15 lapses of care to date against the target of 29 cases. There were 5 cases in January still to be reported on.

The revised annual training programme commences in the new financial year and compliance with this will be reported within the reports from April. There was an action plan for infection prevention standards. The Chief Executive had met with the team and a number of the indicators on the plan were green (complete).

The Infection Prevention and Control Committee had approved the new Cleaning Policy. The Board noted that there had been lapses in cleaning by PFI partners and the Chief Executive had escalated these to the Deputy Director of Finance to progress with the PFI partners.

Mr Atkins, Non Executive Director, asked about the position on training. The Chief Executive confirmed that the Trust is moving to one year monitoring from April and is doing everything possible to get all appropriate staff trained. The Chairman asked for numbers to be included in the next report.

The Chairman and Board noted the report.

Numbers of staff trained on infection prevention and control against the annual target to be included in the next report to Board.

18/036 Any Other Business
12:12noon

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

18/037 Date of Next Meeting
12:12noon

The next Board meeting will be held on Thursday, 12th April, 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 March 2018

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/117	Patient Story	Follow up to the patient story to be presented to the Board.	LA	When care/ treatment completed	
18/029.8	Action Sheet	Patient and staff videos to be combined and made available on the Hub by the end of March. Board members perspective of the 6Cs to be presented to the Board in May. Update on Theatre scheduling to be presented to the Clinical Quality, Safety, Patient Experience Committee. Quality Improvement Plan to be presented as part of the Clinical Quality, Safety, Patient Experience Committee report on a monthly basis.	LA LA KK SJ	31/3/18 3/5/18 27/3/18 27/3/18	Done Deferred to April Committee meeting. Done
18/034.4	Patient Experience Report	More background on complaints and the response timeframes to be included in the next report to the CQSPE Committee and Board.	SJ	27/3/18 & 7/6/18	Done
18/033.4	Quality Account and Quality Targets Report	The Quality Priority Targets were approved subject to the addition of a percentage reduction to be defined within reduction of grade 3 pressure ulcers quality metric.	SJ	12/4/18	Done
18/034,2	Integrated Performance Report	Slot re-utilisation to be included in the next Integrated Performance Report to Board.	KK	12/4/18	Done

18/033.2	Infection Prevention and Control Update	Numbers of staff trained on infection prevention and control against the annual target to be included in the next report to Board.	ER	12/4/18	Figures available 10/4/18 – verbal update to Board.
18/034.1	Finance and Performance Committee Exception Report	Paper to be presented to the Workforce Committee and then Board showing the actions being taken in respect of the utilisation and retention of staff.	SJ	24/4/18	
18/035.2	Staff Survey Report	Staff Survey action plan to be presented to the Workforce Committee and Board.	AM	24/4/18 & 3/5/18	
18/033.5	Learning from Deaths Report	NHSI Mortality Dashboard to be included in the next Learning from Deaths report to Board.	JH	7/6/18	

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 12th April 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
- NHSI Lean Programme
- My Letters Launched
- Healthcare Heroes
- Capacity Champions
- Digital Trust Staff Engagement
- Charity Update
- Social Media Activity Update
- National NHS News
- Regional NHS News

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		Y	**Y**

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

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – April 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

8th March	Board of Directors
9th March	Black Country Pathology Board
12th March	Community Team Brief
13th March	Community Team Brief
15th March	CQC Never Event Advisory Group
20th March	Strategic Objectives Roadshow
21st March	A&E Delivery Board
22nd March	Dudley MCP Staff Briefing
23rd March	Strategic Objectives Roadshow
	NHSI Quarterly Review Meeting
28th March	Partnership Board
29th March	Dudley System Oversight Meeting
3rd April	Black Country STP Urgent and Emergency Care Board
4th April	Easter Bunny Boat Race
	MCP GP Meeting
9th April	Team Brief
10th April	Community Team Brief

NHSI Lean Programme

We are delighted to have been selected to take part in the NHSI Lean Programme in association with the Virginia Mason Trust. The three-year lean programme will support the Trust to deliver a lean management system which recognises both the context and needs of the organisation.This programme will teach and develop staff skills throughout the organisation to ensure we are effective and efficient and embed a culture of continuous quality improvement.

My Letters Launched

We have introduced a new system to send patient letters by email. The service called 'My Letters' enables patients to choose to receive their appointment letters by email rather than post. Patients can register online and we will just need their mobile number on our record system to enable this. This initiative supports the Trust's accessible information agenda.

We hope that these exciting developments will give patients better control over their appointments and help us to reduce Do Not Attend rates further. This will complement our existing two way text message reminder service which is also helping to reduce the amount of appointments that are missing.

Healthcare Heroes

Congratulations to Emergency Theatre Team 4 who are this month's team Healthcare Hero winners!

Emergency Theatre Team 4 received the team award for pulling together and helping each other to manage two almost simultaneous emergency patients with large volume blood loss during immense pressures. Well done all!

Julie Cartwright received the individual award for the exceptional support and guidance she offers her team, allowing them to work efficiently and effectively whilst creating a very positive working environment.

Julies work approach means we can provide a lot more diverse, unique and very high-quality services for our patients' and her different way of thinking has seen a reduction in our physiotherapy patient waiting times. Well done all!

Capacity Champions

I am also pleased to announce we have launched a recognition award for the areas that are doing the most to ensure safe, effective discharge of patients. The first two fantastic wards, B4 and C5 were thrilled to received there award which recognises those wards are doing all they can to help keep patients moving through the hospital and back to their place of residence.

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. The eObs training commenced on Monday 26th March for staff to learn how to use that module of the new Electronic Patient Record.

Charity Update

Bunny Boat Race Update

A great morning was had by all the teams who took part in the Easter Bunny Boat Race. It's not too late to 'give your money to the bunny' donate via https://www.justgiving.com/fundraising/easterbunnyboatrace

As at 4th April we had raised over £700 for our end of life patients to improve their environments with sky lights in the ceiling. Thank you to everyone who rowed their boats and to all the people who generously donated.

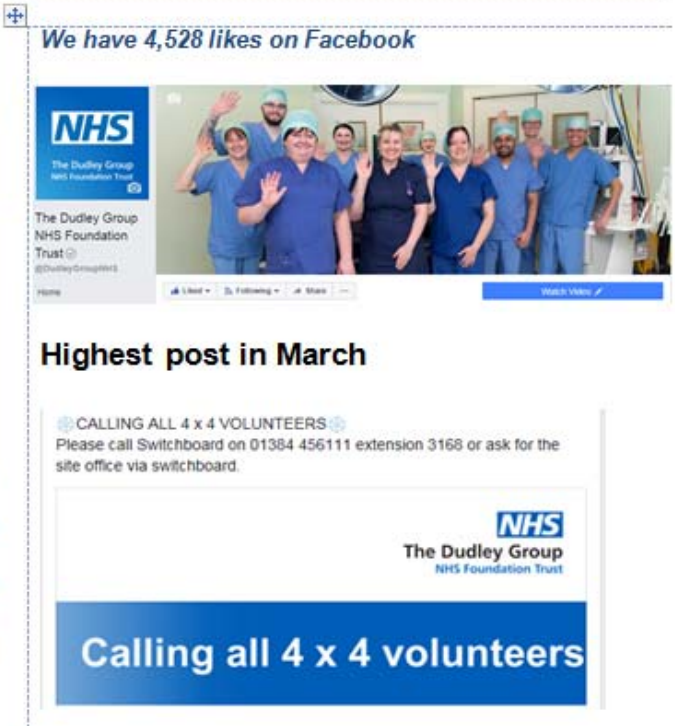
Neon 5k Colour Dash

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

Twitter March 2018 (last 28 days)
64 follows
82.3k impressions
133 link clicks
253 retweets
397 likes
34 replies

Facebook March 2018 (last 28 days)
367 page likes
193,888 reach
61,551 engagements
6,787 page views



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 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 12 April 2018

TITLE:	**27 March 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			**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 Committee requests the Board to endorse its decision not to change the Terms of Reference for 2018/19.

The Dudley Group NHS Foundation Trust

The Committee requests the Board to note that it has requested the Medicine Division to improved attendance at the Committee supported by improved reporting from their Divisional Governance and Performance meetings.

The Committee requests the Board to endorse the referral to the Audit Committee to consider that the planned internal audit work on data quality consider a sample of the quality measures reported to 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	27 March 2018	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- The Committee received an update report from the Medical Director in respect of VTE, conforming that the Trust is NICE complaint but that the current system is cumbersome. The Committee was informed that the introduction of the digital trust programme will improve both the process itself and the underlying quality of data as it will not be reliant on manual data transfer and entry. The Committee were updated that the Surgical Division had taken action to improve their performance but that Medicine needed to provide information on their trajectory for improvement especially within AMU.
- The Committee received a report on the improvements being made within the Trust in respect of the NORSE Pathway (for neurosurgical emergencies). These planned improvements link to the digital trust roll out and the launch of a regional PACS, both of which will improve connectivity between the Trust and the major trauma centre in Birmingham. A NORSE Patient Safety Group is to be established to oversee the delivery of these planned developments and will report back to the Committee via the Clinical Effectiveness Group.
- The Committee received a report from the Risk and Assurance Group which provided information on the receipt and debate of information covering NPSA alerts, coroners cases including actions taken as a result of regulation 28 rulings, serious incidents including their progress and tracking of improvements. The Group made three recommendations to the Committee, the first being that the Committee delegate the detailed review of alerts to this group thus freeing up time of the Committee to consider matters by exception, that the Committee increase its oversight of VTE performance (recognising that the Committee had itself identified as an area it wanted more assurance on, see point previously) and that the Committee increase its oversight of NEWS performance and outcomes of actions being taken as a result of the increased auditing within ED.
- The Committee reviewed the quality aspects of the Trust Integrated Performance Report. The Committee noted a number of anomalies had been addressed by Information in this report but there still remained some data reporting issues to be resolved including the need to incorporate the correct performance target for falls being a number per 1000 bed days. The Committee was pleased to see the

addition of information in respect of Dementia which confirmed the quality of that service. The Medical Director updated the Committee on the recent positive independent service visit in respect of the vascular service. This report once formally received would be brought to the Committee.

- The Committee received a report on Infection Prevention and Control which included a forecast of the Trust year end position in respect of the 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 that more detail be placed in the Board report as to the trajectory for compliance with the annual target and an update on the Hygiene Code compliance statement
- The Committee received a report on actions 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 report also included a separate action plan in respect of actions from a Coroners regulation 28 ruling in respect of a case with a grade 4 pressure ulcer which had been considered by the Risk and Assurance Group earlier that month. The Committee continued to seek a greater understanding of the changes being made to ensure that the quality priority of *no avoidable grade 4 pressure ulcers* occurring either in the community or the hospital for next year.
- 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 continued to be no overdue follow up appointments for urgent or "red" categories of patients. The Division provided a revised trajectory to eradicate delayed follow up by July 2018 The Division also provided an update on the work being undertaken in respect of paediatric outpatient waiting lists and whist the Division is this month slightly behind its trajectory the service remains on track to have eliminated these waits by the end of May 2018. The Committee requested that the Division continue to provide an update on these areas.
- The Committee received an update from the Medical Director on the work being undertaken in respect of the deteriorating patient. This report contained an action plan in respect of the delivery of a deteriorating patient strategy for the Trust. The Committee was reminded of the e-observations that will be available with the digital trust roll out and as well as the improvement in real time data t for oversight of these patients. The Committee was also informed that there is a planned external review of the Trust's processes for management the deteriorating patient planned for May 2018 and the outcome of this with any associated recommendations will be reported back to the Committee.
- The Committee was presented with the Maternity Dashboard report and updated on the improved performance across a range of areas since last month's report. The Committee was given a verbal update on the progress being made with the review of Caesarian activity during December and the Clinical Service Lead confirmed that the report will be presented to the next Committee meeting in April.
- 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, Surgery and Clinical Support Services. The Committee asked that the Director of Governance meet with the Medicine & Integrated Care Division support them in improving the detail within the report for the next meeting.
- 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 plans showed progress made across each of the services. The Committee received feedback from the Emergency Department and endorsed the actions being taken by the Executive in respect of enhanced oversight of this action 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 Trust had seen a decrease in reported incidents in the month of February and given the Trust's quality priority will be undertaking further communications encouraging staff to report all incidents and not just those of a serious nature. The report documented the continued focus being placed 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 1 case no assurance had been provided that the actions had been taken in line within the agreed timescales. This case has been referred to the division. The Committee was informed that on one occasion the initial duty of candour conversations were not held with the families within the ten day requirement, it had been held on the 11th day.
- The Committee received a patient experience report for the month of February. The report provided an update on compliments, friends and family feedback, concerns and complaints activity. The Committee was updated on the number of open complaints and the actions required of the respective Divisions to better manage these.
- 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 was updated on the actions taken in respect of the theatre canopies to ensure they were complaint following the recent inspection.
- The Committee received a report from the Internal Safeguarding Board and a wider report on Safeguarding developments, activities and challenges across the Trust. The Head of Safeguarding took the Committee through the developed improvement plan and the associated timescales for delivery of the identified actions.
- The Committee received a report on the Trust's development of quality KPIs and quality dashboards. The Committee considered that there was a need for the Trust internal auditor review of data quality to cover the processes underpinning a sample of these key quality metrics. The Committee agreed that the Committee Chair should speak to the Audit Committee chair about this.

- The Committee reviewed it effectiveness and as part of that reviewed its Terms of Reference and set key objectives for the forthcoming year. These objectives were to focus on quality priorities, quality initiative delivery, enhancing the oversight of quality impact assessments, improving the quality of reporting from the divisions and to continue to undertake deep dive reviews of key BAF risks for which the Committee has oversight. The Committee members, supported by the Trust Chair, felt it would be useful for the Committee to have a separate session on how it could focus its agenda and challenge of the papers represented to make the meeting more effective and reduce the non-essential discussion.
- The Committee considered the corporate risk relating to accessible information and the assurance provided supporting the current score. The Committee recognised that whilst enhancements had been made across the year there remained IT limitations until the EPR project is delivered.
- The Committee received reports from the Quality and Safety Group, Patient Experience Group, Infection Prevention and Control Forum and Medicines Management Group. 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 agreed to the delegation of the detailed review of NPSA alerts to the Risk and Assurance Group.
- The Committee ratified one policy based on the recommendation of the Policy Group.
- The Chair to organise with the Director of Governance a separate Committee meeting to review the Committee's agenda and the focus of member challenge of the papers represented to make the meeting more effective and reduce the non-essential discussion.
- The Committee agreed to make no changes to its Terms of Reference.

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

The Committee requested that the Medicine Division provide an update for the next meeting in respect of actions taken and any further planned to ensure consistent delivery of the VTE performance target.

The final report from the independent service visit of the vascular service once received.

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 progress being made in respect of ophthalmology and paediatric outpatient waits.

Once the external review of the processes for managing the deteriorating patient has been undertaken, planned for May 2018, the report's findings to be presented to the Committee.

The outcome of review of all cesarean section cases in December to be reported to the April Committee.

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 requests the Board to endorse its decision not to change the Terms of Reference for 2018/19.

The Committee requests the Board to note that it has requested the Medicine Division to improved attendance at the Committee supported by improved reporting from their Divisional Governance and Performance meetings.

The Committee requests the Board to endorse the referral to the Audit Committee to consider that the planned internal audit work on data quality consider a sample of the quality measures reported to the Committee..

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board on 12th April 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:

- Improved compliance against the Hygiene Code for 2017/18 (final update to be provided to the May Trust Board following year end with an expectation of full compliance).
- Mandatory Infection Control training - during the current 3 month implementation phase (January – March 2018) the Trust is green for February. The numbers for March will be gathered on the 10th April and verbal update including a trajectory against the annual requirement will be provided at Board.
- Update on NHSi action plan – a further visit by Dr Adams was conducted on 20th March 2018. Improvements were noted in the general ward areas, however, concerns were raised against specific issues on the NNU. The action plan has been updated to reflect these.
- For 2017/18 there have been 28 post 48 hr case with 0 cases in February. Of these 17 were associated with a lapse in care, 11 were associated with 'no lapse in care'. The Trust remains within trajectory of 29 cases associated with a lapse in care.
- No post 48 hr MRSA bacteraemia cases since September 2015

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.

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 with a view to being complete by end March 2018.
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 being met in Q4, part of part D is met in Q4.
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.	Task and Finish Group established to deliver MRSA screening by July 2018. Current compliance at 90%.
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 is moving to an annual programme for clinical staff. Compliant at 90% for clinical staff based on current criteria at year end as agreed with NHSi. A

		phased approach to reach 90% compliance with annual training by March 2019 will be established from April 2018.
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.	Funding has been secured for a Pod for ITU; business case is being created.
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 February, of these 17 were associated with a lapse in care, 11 were associated with 'no lapse in care'. For February 2018 0 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 February 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 February 2018 is 89.1%. Data is available locally to the units to enable them to identify patients missing from the dataset.

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

The Task and Finish Group has been established and good progress has been made towards accurately recording MRSA screening compliance which we believe will bring us closer to target.

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 February 2018, 2 cases of post 48 hr E. coli bacteraemia were reported.

Klebsiella* and Pseudomonas* bacteraemias – For February 2018 there was 1 post 48 hr Trust identified Klebsiella bacteraemia case 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 (ie, until March 2018) the data will continue to be presented based on the historical 3 yearly cycle. The percentage compliance as at 28.2.18 (target 90%):

Area	Total
Corporate/Management	91%
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 have sent an email to all 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, to advise them to undertake this training at the earliest opportunity. The data for March is gathered on the 10th April. Medicine and Surgery are working to provide a plan to ensure delivery of the annual training programme. A verbal update will be provided at Board.

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 22nd March 2018; key issues identified were around those highlighted by the recent NHSi visit on 20th March (see below), an update on the Task and Finish Group's work towards compliance with the MRSA Screening Policy, the programme to deliver the Infection Control Mandatory training requirement and discussion regarding the continued deterioration in the PFI partner's cleaning audit scores. There were assurances from the Estates Department that, through the contract monitoring pathway, an action plan was being implemented by Interserve to improve these scores. The Estates Team were asked to include, in further reports, details of compliance with the immediate rectification of cleaning issues highlighted during audits, to provide assurance that in the majority of cases, any failings identified during audits are rectified within an hour.

NHSi visit – 20th March 2018

Dr Debra Adams returned for a further visit following her initial visit on 8th November 2017. Dr Adams had been provided with the action plan (appendix 1) below prior to her arrival and was satisfied with the progress of the actions and also with the presentation of the actions against the hygiene code. Following feedback on the action plan Dr Adams visited a number of ward areas, these were: C1, B6 and Neonatal Unit. Dr Adams commented that there were many positive observations where she could see that issues had been addressed eg, cleaners' trolleys were clean, urinary catheter documentation was in order, hand gel was available at ward entrances and each bed space and crash trolleys were clean. However, a number of issues, already being addressed within the current action plan were highlighted, particularly, pull cords (work is in progress with planned completion for end of April 2018) and assurances around macerator seal maintenance. In addition some new issues were identified, particularly around concerns on the Neonatal Unit, resulting in the Trust still being red RAG rated for Infection Control.

The Neonatal Unit (NNU) – key issues highlighted were around location and maintenance of blood gas machine, the processes in place for washing and drying baby clothes on the NNU, the cleaning of incubators in the room which also houses the washing machine and dryer (all incubators inspected, however, were clean and labelled appropriately) and concerns about the security of breast milk held within the breast feeding room. The particular concerns were that neither the room, fridge or freezer were lockable and that the bottles storing the breast milk did not have tamper proof seals on them. Also, confirmation around toy cleaning was required. These elements have been added to the action plan attached.

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.

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.

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.

Appendix 1

ACTION PLAN FOLLOWING NHSi VISIT – 8TH NOVEMBER 2017

The Dudley Group NHS Foundation Trust

Manager/Lead	Dr Elizabeth Rees, Director of Infection Prevention and Control	**Executive Lead**	Ms Siobhan Jordan, Chief Nurse
Associated Staff	Miss A Murray, Matron, Infection Prevention and Control	**Action Plan updated on**	21st March 2018 (post NHSi review visit on 20th March 2018)

RAG status	Not started	Underway	Complete

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
Criterion 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 pose to them.							
1	Criterion 1	Annual report should be 3 clicks away on the external website to allow public viewing.	Link Annual Report to the Infection Control Page on the Trust's public facing website.	Dr E Rees		Immediate	
2	Criterion 1	Required to make an assurance statement in relation to the Hygiene Code.	a) To include a statement within next year's annual report (in addition to verbal assurance being given to Trust Board).	Dr Rees	There is on going tracking against the Hygiene Code reported to CQSPE in order that a statement can be delivered within next year's annual report.	June 2018	
			b) To include the compliance statement within the Trust's next IC Board paper.	Dr E Rees	Compliance statement included in December's Trust Board paper.	December 2017	
3	Criterion 1	The annual programme does not have quarterly review dates.	Add quarterly review dates to the Annual Work Programme.	Miss A Murray		Immediate	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
4 **Added 20.3.18**	Criterion 1 and 2	Cleaning Scores are presented with RAG ratings in order to facilitate observance of non-compliance.	To provide cleaning scores with RAG ratings.	Mr A Rigby (for Estates Report)	20.3.18 – Dr Adams identified 2 dusty fans and tape on ANTT trays on C1 and dirty medical equipment on NNU; to ask for assurance on above at next IPCF on 22.3.18.	January 2018 Update required 22.3.18	
34	Criterion 1	To place respirators on Trust's Risk Register until they are serviced and usable and to order Grab bags (loose fitting respirators) today.	Mrs Watkiss agreed to update the Trust's Risk Register and Mrs Bree will ensure the Grab bags are ordered.	Mrs Watkiss and Mrs Bree	Grab bag available in Trust; respirators have been returned and risk register has been updated.	March 2018	
35 **Added 1.3.18**	Criterion 1	To ensure respirators are maintained going forward.	Mr Rigby will ask Mr Shaw to add respirators to medical devices library to ensure maintenance going forward.	Mr Rigby	Mr Shaw has confirmed that he has responsibility for maintenance going forward since addition to medical devices library.	March 2018	
5	Criterion 1	IPC Forum should be a committee to ensure a strong enough presence to provide the Trust with assurance against the Hygiene Code.	a) Amend terms of reference and reporting structures.	Dr E Rees	Review complete – Forum will be renamed 'Group'.	April 2018	
			b) To create an IC Risk Register. c) To include IC Risk Register on the IPCForum agenda and to review by exception.	Dr E Rees	Risk Register has been created and will be reported at the Forum, by exception, quarterly.	February 2018	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
6	Criterion 1	Medical representation at the IPCForum to facilitate clinical engagement on IC matters.	Identify medical champions for IPC Forum.	Dr J Hobbs	Dr Hobbs has asked Dr Rees to approach divisions again.	June 2018	
7	Criterion 1 and 2	The Neonatal Unit *Enterobacter cloacae* SI from May 2017 to be signed off.	To sign off SI action plan and move risk assessment regarding sinks to the Trust IC Risk Register.	Dr E Rees	Complete – revised action plan accepted by the division.	December 2017	
8	Criterion 1	Clostridium difficile 30 day all cause mortality data.	To be presented 6 monthly at the IPCForum.	Mr B Jones/CCG	C. diff 30 day mortality data reported at IPCF. Mr Jones suggested that going forwards this data is provided to the HCAI meeting.	March 2018	
9	Criterion 1	Provide assurance to IPCForum of compliance with Isolation Policy.	To present 6 monthly audit data of compliance with the policy to the IPCForum.	Miss A Murray	Complete	January 2018	
10	Criterion 1	NEDs to be trained to challenge the Trust Board.	To provide IC training for NEDs.	Dr E Rees	Training given to NEDs on 7th December.	December 2017	
11	Criterion 1	Evidence of information contained in reports to be apparent within the IPCForum minutes.	To embed all reports into the ICPForum minutes.	Mrs L White	Complete	January 2018	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
12	Criterion 1, 5 and 6	Annual Infection Prevention Training to ensure knowledge is embedded into action.	Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19.	Dr E Rees and Miss A Murray	Completed on 18th January for Matrons.	January 2018	
					L& D are still showing data as 3 yearly. All areas are working towards achieving compliance with the annual training requirement.	April 2018	
13	Criterion 1	Analytical support to be considered to provide expertise to existing IPC team.	To develop and JD, advert and PS in order to advertise this post.	Miss A Murray	JD and PS developed – awaiting banding. Complete.	January 2018	
14	Criterion 1	To advertise for a substantive Consultant Microbiologist	To advertise post using existing College approved JD and PS.	Dr E Rees	Currently being advertised on NHS Jobs.	December 2017	
15	Criterion 1 and 5	Catheter Care Bundles reflect national guidance but senior nursing staff seemed unaware of all available tools.	As part of the current health economy work around urinary tract infection, protocols around the management of catheters will be reviewed for each participating organisation; DGFT will review its own.	Miss A Murray and Mr B Jones	Working across healthcare economy catheter passport has been created; it will go to ACE panel for approval in March. Report back to IPCF at April meeting. Mr Jones suggested that after approval by ACE this item is included in the HCAI agenda.	April 2018	
Action No.	**Code of Practice compliance**	**Recommendations**	**Actions Required**	**By Whom**	**Progress to date**	**Agreed completion date**	**Status (RAG)**

	criterions*						
16	Criterion 1	Insufficient assurance that quality IPC rounds report findings.	Train Trust Governors to act as 'secret shoppers' to provide more assurance.	Miss A Murray and Mr Walker	Trust Governors have been trained to enable them to undertake the 'secret shopper' role.	March 2018	
26	Criterion 1	Compliance with audit trail of sharps boxes.	Remind ward staff not to lock boxes without completing location labels and remind porters not to collect boxes unless safely locked and location details completed.	Mrs Pain and Mr Walker	Staff reminded at Matrons' meeting and Portering staff have received toolbox talks. Random checks have shown full compliance.	February 2018	
Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.							
17	Criterion 2	a) IPCT to be involved in all planning activities, refurbishment and change of use programmes throughout the Trust. b) No evidence of outstanding Estates risks.	a) To create a policy ensuring IPCT involvement in all such Trust activities.	Mr A Rigby and Miss A Murray	Policy – IC in the Built Environment has been created and will be circulated to Forum members for comments at March meeting.	March 2018	
			b) To include in the IPCF Facilities Report as outstanding RAG rated Estates risks.	Mr A Rigby	Report now RAG rated.	January 2018	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
18	Criterion 2	Aspergillus risk assessments to be documented as being undertaken.	a) To create a policy ensuring aspergillus risk assessment is undertaken.	Mr A Rigby and Interserve/Summit	Policy completed, to be circulated with minutes for April meeting.	March 2018	
			b) To audit policy.	Mr A Rigby	Aspergillus to be included in checklist when works are being carried out. Audits to be reported in Estates Report to IPCF.	June 2018	
24 **Added 13.2.18**	Criterion 2	Assurance to IPCF of how cleaners' trolleys and rooms are cleaned.	Provide Interserve's action plan to IPCF to understand how cleaners' trolleys and rooms are cleaned.	Mrs Porter	Method statement provided by Interserve to the Trust	28th February 2018	
25 **Added 13.2.18**	Criterion 2	Assurance to IPCF that cleaning reagents (ie, bleach tablets) are stored safely (ie, locked in reagent cupboard).	Ensure cleaning reagents are suitably locked in appropriate storage cupboards.	Mrs Pain	Mrs Pain will ask for reagent storage check to added to Medicine's Management audit.	March 2018	
27 **Added 13.2.18 20.3.18**	Criterion 2	To ensure pull cords are wipeable.	To provide programme for replacement of corded pull cords with easy to clean plastic cords. 20.3.18 – Pull cords on C1 and B6 identified as dirty during Dr Adams' visit. Programme of replacement has only completed first floor to date.	Mrs Dyke	Programme for all cords to be replaced by May 2018. Update at June meeting.	June 2018	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
28 **Added 13.2.18**	Criterion 2	Assurance that mattresses are clean prior to use.	To add 'check date of clean' to checklist to ensure mattresses are clean prior to use and include in regular Matron audits.	Miss Murray	IPCT will provide A4 poster for wards (to be added to Medical Devices policy) on how to clean a mattress and insert a green 'I am clean' sticker.	March 2018	
29 **Added 13.2.18 20.3.18**	Criterion 2	To ensure macerators are maintained appropriate and seals are kept clean.	To check maintenance records of macerators and remind staff to clean seals. 20.3.18 – Dr Adams' visit identified ongoing issues with macerator seals on C1. To confirm as already agreed the verifications.	Mr Rigby and Mrs Pain	Interserve are maintaining the macerators as per manufacturer's instructions and staff have been reminded about cleaning the seals. Mr Rigby has received some assurance around the monthly, quarterly and annual maintenance but is awaiting further.	June 2018	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
33 **Added 13.2.18**	Criterion 2	To replace material curtains with disposable curtains in UCC and ED.	Mrs Porter agreed to provide the IPCF with the number of curtain changes in these areas in order for the Trust to understand the cost of such a change.	Mrs Porter	UCC has disposable curtains (non trust premises). Frequency of curtain change has been agreed during the revision of the Cleaning Policy.	June 2018	
19	Criterion 2	a) Revised Cleaning Policy approaching sign off. Interserve must share implementation plan with DGFT. b) Assurance must be given to Trust that training of Interserve staff reflects needs of policy. c) Lack of confidence regarding the cleanliness of domestic trolleys.	a) Request implementation plan from Interserve for next IPCF meeting. b) To review Interserve staff's toolbox talks reflect Cleaning Policy needs. c) Interserve to share cleaning policy for domestic equipment with the Trust.	Mr A Rigby Miss A Murray Mr A Rigby	Complete	January 2018 January 2018 January 2018	
4	Criterion 1 and 2	Cleaning Scores are presented to IPCF with RAG ratings in order to facilitate observance of non-compliance.	To provide cleaning scores with RAG ratings.	Mr A Rigby (for Estates Report)	Complete	January 2018	
Action No.	**Code of Practice compliance criterions***	**Recommendations**	**Actions Required**	**By Whom**	**Progress to date**	**Agreed completion date**	**Status (RAG)**

7	Criterion 1 and 2	The Neonatal Unit *Enterobacter cloacae* SI from May 2017 to be signed off.	To sign off SI action plan and move risk assessment regarding sinks to the Trust IC Risk Register.	Dr E Rees	Complete. Risk assessment has been signed off by division.	December 2017	
36 **Added 20.3.18**	Criterion 2	All mattresses not in use to be stored appropriately and correctly labelled with 'I am green' sticker or labelled as 'condemned'.	To review the Trust's Mattress Policy and ensure it's fit for purpose and to evidence by audit.	Mrs J Pain/Mrs J Bree and Mrs K Anderson		June 2018	
37 **Added 20.3.18**	Criterion 2	There were excessive amounts of baby clothes in the clinical area to launder. It is required that the laundry procedures ensures appropriate thermal disinfection.	To review the provision of baby clothes and laundering on Neonatal unit and to agree a process to deliver the recommendation.	Mrs K Anderson	There is an expectation that laundering of clothing will not take place on the NNU. Alternative solutions are being investigated.	June 2018	
38 **Added 20.3.18**	Criterion 2	To confirm the decontamination arrangements for baby incubators.	To review the SOP for incubator decontamination to ensure it is fit for purpose and to evidence by audit.	Infection Prevention and Control Team and Mrs K Anderson		June 2018	
Action No.	**Code of Practice compliance criterions***	**Recommendations**	**Actions Required**	**By Whom**	**Progress to date**	**Agreed completion date**	**Status (RAG)**

Criterion 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.							
12	Criterion 1, 5 and 6	Annual Infection Prevention Training to ensure knowledge is embedded into action.	Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19.	Dr E Rees and Miss A Murray	Completed on 18th January for Matrons.	January 2018	
					See above.	April 2018	
15	Criterion 1 and 5	Catheter Care Bundles reflect national guidance but senior nursing staff seemed unaware of all available tools.	As part of the current health economy work around urinary tract infection, protocols around the management of catheters will be reviewed for each participating organisation; DGFT will review its own.	Miss A Murray and Mr B Jones	Working across healthcare economy catheter passport has been created; it will go to ACE panel for approval in March. Report back to IPCF at April meeting.	April 2018	
23	Criterion 5	Compliance with MRSA screening target.	Provide action plans to explain how the Trust target (90%) will be achieved.	Miss Murray/Mrs Pain/Mrs Bree	A Task and Finish group has been established and held its first meeting. Further work is required. Update given at April IPCF.	April 2018	
Action No.	**Code of Practice compliance criterions***	**Recommendations**	**Actions Required**	**By Whom**	**Progress to date**	**Agreed completion date**	**Status (RAG)**
Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of prevention and controlling infection.							

20	Criterion 6	Staff to comply with Trust policy on uniform and workwear and theatre staff to comply with theatre operational policy regarding theatre attire	Uniform and workwear policy to be circulated to medical staff.	Dr E Rees and Miss A Murray	SOP has been agreed by Forum at February's meeting; will now be implemented.	February 2018	
30 **Added 13.2.18**	Criterion 6	To ensure consistency and uniformity with PPE regarding colour of aprons in the Trust.	To ensure Procurement understand that colours of aprons cannot be changed without consultation as colours often denote purpose.	Infection Prevention Team	Aprons are purchased via national framework. Issue nationally with thinner aprons being supplied. In order to obtain better quality aprons staff ordered 'blue' aprons (which did not conflict with any colour coding in the Trust). The supply issue with the white aprons is now being resolved and we will return to the preferred quality.	28th February 2018	
31 **Added 13.2.18**	Criterion 6	To ensure consistency of PPE regarding glove usage.	IC Team to include a reminder staff during mandatory training that gloves are only to be used if the procedure requires it and never in public areas.	All during mandatory training		28th February 2018	
Action No.	**Code of Practice compliance criterions***	**Recommendations**	**Actions Required**	**By Whom**	**Progress to date**	**Agreed completion date**	**Status (RAG)**
32 **Added**	Criterion 6	Assurance to IPCF that junior medical staff undertake appropriate	To enquire with Post Graduate centre regarding training.	Dr Rees	Clinical skills have developed a self	April 2018	

13.2.18		skills training during their time at DGFT (junior doctor witnessed carrying syringe of blood by hand).			declaration tool to confirm that non-training grades have had appropriate training including IC elements required.		
12	Criterion 1, 5 and 6	Annual Infection Prevention Training to ensure knowledge is embedded into action.	Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19.	Dr E Rees and Miss A Murray	a) Training delivered by Dr Adams on 18th January.	December 2017	
					b) See above.	April 2018	
Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.							
21	Criterion 9	MRSA Screening Policy has 'meticillin' spelled with an 'h' ie, 'methicillin'.	Amend policy.	Dr E Rees		Immediate	
22	Criterion 9	The Management of Patients and Staff with Diarrhoea policy to reflect national guidance relating to stool type.	Review policy to ensure compliance.	Dr E Rees		Immediate	
39 **Added 20.3.18**	Patient Safety Issue	To confirm the security arrangements around the storage of breast milk to ensure expressed breast milk cannot be tampered with/contaminated.	To review the arrangements for safe storage of expressed breast milk.	Mrs K Anderson		April 2018	
40 **Added 20.3.18**	Patient Safety Issue	To confirm the temperature and 'use by' dates applied to stored expressed breast milk to ensure that it is safe to use.	To review SOP for monitoring temperatures in the fridge and freezers used for milk storage.	Mrs K Anderson/Mrs J Pain	All milk was held within date during the audit held on 21.3.18. temperature monitoring was in place.	April 2018	
Action No.	**Code of Practice compliance criterions***	**Recommendations**	**Actions Required**	**By Whom**	**Progress to date**	**Agreed completion date**	**Status (RAG)**

41 **Added 20.3.18**	Criterion 2	To establish a cleaning schedule for toys on the NNU and to ensure that there are no soft toys.	To remove soft toys and to review toy cleaning SOP.	Mrs K Anderson/Mrs J Pain	The soft toys present have been removed. All toys have been decontaminated according to the agreed policy and all toys have been HPV fogged.	April 2018	

*These criteria form the Hygiene Code taken from The Health and Social Care Act 2008 – Code of Practice on the prevention and control of infections and related guidance; July 2015.

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 12th April 2018

TITLE:	**Monthly Nurse/Midwife Staffing Position – April 2018 report containing February 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. This is against the historic establishments as agreed by the previous Chief Nurse. There is a 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. There has been some increase in the fill rates 2017 progressed although a reduction has occurred from November/December onwards into the new year.

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 as have some of the specialist areas. The new templates for the medical and surgical wards took effect from April 8th with clear rules on the use of temporary staff. The community and the remaining other specialist areas of the Trust are in the process of being reviewed.

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 February.

Monthly Nurse/Midwife Staffing Position

April 2018 Report containing February 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 February 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 is slightly less than 100% but this has been achieved by using the historic establishments with 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 although the overall fill rates of both qualified and unqualified staff have reduced from November/December 2017 onwards. This is a result of opening extra capacity and the need to move staff to support these areas. 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 exceeds 100%. This occurs when it is recognised that there will be a reduction in qualified staff (e.g. C1, C3 and C8). The low fill rate during the days in a) Coronary Care Unit/Post Coronary Care Unit 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 already using the new planned levels following the recent staffing review and the need to increase staffing levels as a priority.

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%
February 2018	93%	94%	96%	96%

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
Jan 17	4.30	4.7	4.7	3.50	2.9	2.9	7.8	7.7	7.6
Feb 17	4.34	N/A	N/A	3.63	N/A	N/A	7.97	N/A	N/A
March 17	4.44	N/A	N/A	3.74	N/A	N/A	8.18	N/A	N/A
April 17	4.55	4.8	4.8	3.73	3.1	3.1	8.28	7.8	7.9
May 17	4.4	4.9	4.8	3.8	3.1	3.1	8.2	7.9	7.9
June 17	4.7	N/A	N/A	3.8	N/A	N/A	8.5	N/A	N/A
July 17	4.5	N/A	N/A	3.9	N/A	N/A	8.4	N/A	N/A
Aug 17	4.6	4.7	4.7	3.9	3.1	3.1	8.4	7.9	7.9
Sept. 17	4.5	N/A	N/A	3.7	N/A	N/A	8.2	N/A	N/A
Oct 17	4.6	N/A	N/A	3.8	N/A	N/A	8.4	N/A	N/A
Nov 17	4.5	4.6	4.7	4.0	3.0	3.1	8.5	7.8	7.8
Dec 17	4.8	N/A	N/A	4.1	N/A	N/A	8.9	N/A	N/A
Jan 18	4.72	4.5	4.6	3.86	3.0	3.0	8.58	7.5	7.6
Feb 18	4.52	N/A	N/A	3.76	N/A	N/A	8.28	N/A	N/A

N/A = Data not available.

This report contains updated regional and national average figures for January 2018 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.

Following communication from the NHSi Model Hospital staff and discussions with our peers, there remains variation in the data source across the region with some Trusts not including critical care areas and so it is clear that direct comparisons therefore cannot be made at this time. We will continue to report and liaise with experts on the validity of this data.

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 from November/December reflect 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 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 further 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, a number of which are with Directors for consideration. They will be presented to the Finance and Performance Committee in April and May. The review of the Community services is near conclusion.

Safer Staffing Summary **Feb** Days in Month 28

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	224	211	199	187	140	137	168	160	94%	94%	98%	95%	1,149	3.63	3.62	7.26
A3																
A4																
B1	96	84	63	56	61	60	60	57	87%	89%	98%	95%	436	3.76	3.05	6.81
B2(H)	112	101	224	215	84	84	196	187	90%	96%	100%	95%	793	2.79	6.08	8.87
B2(T)	84	79	115	113	56	56	86	86	94%	98%	100%	100%	610	2.59	3.91	6.51
B3	240	174	172	143	193	172	143	141	72%	83%	89%	99%	946	4.29	3.52	7.81
B4	168	154	205	184	140	127	151	146	92%	90%	91%	97%	1,256	2.62	3.15	5.78
B5	168	161	111	111	144	143	86	82	96%	100%	99%	95%	930	3.84	2.49	6.33
B6																
C1	168	147	270	270	140	125	164	166	88%	100%	89%	101%	1,316	2.42	3.97	6.40
C2	177	207	58	53	172	184	35	32	117%	91%	107%	91%	752	6.10	1.22	7.32
C3	196	168	363	367	168	141	341	351	86%	101%	84%	103%	1,416	2.62	6.08	8.70
C4	140	125	58	57	84	84	84	76	89%	98%	100%	90%	605	3.94	2.64	6.58
C5	168	167	227	218	140	131	172	172	99%	96%	94%	100%	1,315	2.59	3.55	6.14
C6	84	73	56	53	56	56	56	55	87%	95%	100%	98%	452	3.42	2.87	6.29
C7	168	156	148	134	113	108	147	129	93%	90%	95%	88%	983	3.13	3.14	6.27
C8	184	176	248	248	168	162	256	256	96%	100%	96%	100%	1,170	3.39	5.17	8.56
CCU_PCCU	196	160	28	38	140	131	-	6	82%	136%	94%		572	5.97	0.89	6.85
Critical Care	314	316	56	46	309	309	-	-	101%	82%	100%		193	38.04	2.50	40.54
EAU	252	219	308	250	252	248	308	262	87%	81%	98%	85%	1,372	4.08	4.39	8.47
Maternity	496	501	196	178	476	462	140	138	101%	91%	97%	99%	433	21.48	8.55	30.03
MHDU	112	92	40	37	111	107	9	9	82%	93%	96%	100%	217	10.79	2.54	13.34
NNU	168	157	-	-	169	160	-	-	93%		95%		359	10.14	0.00	10.14
TOTAL	**3,914**	**3,625**	**3,145**	**2,956**	**3,315**	**3,187**	**2,602**	**2,511**	**93%**	**94%**	**96%**	**96%**	**17,275**	**4.52**	**3.76**	**8.28**

Enclosure 7

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 12th April 2018

TITLE:	**Nursing/Midwifery Revalidation**		
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:

Nursing/Midwifery Revalidation was introduced in April 2016. The system at the Trust has been running smoothly since then. All staff have provided the relevant evidence with a small number having their exceptional circumstances (e.g. long term sickness) agreed by the Nursing and Midwifery Council which means they only have to undertake the process after a further three years.

The revalidation system we have in place is linked to the Electronic Staff Record (ESR). Every month the database is updated for starters and leavers through the ESR link. All managers are told of all of their staff revalidation dates. All managers are informed in advance on a monthly basis by email of their staff who are due to revalidate in two months time so that they can remind those staff about the need to have their evidence confirmed and arrange the confirmation of evidence (all staff are allocated a confirmer, which is usually their line manager). Once the confirmer has confirmed the evidence they email an internal address with the date that this is done and the Trust database is updated (a reminder system is in place when managers do not respond). The staff member applies to the NMC to re-register and revalidate and through the link to the ESR the registration of the staff member is confirmed to the Trust.

The Trust has been proactive in ensuring all registered staff are aware of their responsibilities in respect to revalidation and has publicised this issue extensively. There is a section on the Trust intranet given over to this topic.

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: The Board is asked to note the latest position with Nursing/Midwifery Revalidation.

Enclosure 8

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 12 April 2018

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Tom Jackson Director of Finance	**PRESENTER**	J Fellows 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 29 March 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	**29 March 2018**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- The February 2018 financial position was discussed in detail. February financial performance identified an in month deficit of £2.478m which was £1.398m worse than plan. Cumulatively, the position was a deficit of £9.626m which is £11.599m worse than plan. Underperforming income plans, overspends on pay budgets and under delivery of CIP plans continue to drive the financial position.
- The delivery of the reported year end position of £8.6m deficit was debated and options considered.
- The balance sheet, cash and capital position as at 28th February was discussed with particular emphasis on liquidity, the downside cashflow forecast and actions required to address any implications arising from any future deteriorating cash position.
- Building on the financial planning document presented to the Committee on 5th March a detailed financial budget package for 2018/19 was presented and discussed incorporating the delivery of an accepted control total of £4.526m. The challenging 2018/19 CIP target was discussed at length. Assurance was sought from the formalisation and resourcing of the Financial Improvement Plan. Additionally, a presentation was received from FourEyes highlighting areas of productivity opportunity and progress to date in theatres and outpatients.
- Key performance targets were reviewed with emphasis on the A and E target delivery. The implementation of the proposed new medical model to address flow issues was discussed.
- An update on Nursing and Midwifery was received focussing on safer staffing levels and agency controls with a detailed discussion on recruitment and retention options and challenges.
- Medical agency spend was discussed and whilst spend is higher than plan, assurance was provided that spend in these areas is either appropriate or an action plan is in place to bring spend in line with expected levels.
- Performance of the PFI Contract in February was reviewed. An update was provided and assurance received regarding resolution to Theatres Ultra Clean Canopies and deficiency point thresholds.
- Relevant corporate risks and associated assurance were reviewed.
- Positive outputs from an annual review of the Committee Effectiveness were received and the Committee reviewed and approved both the Committee's 2018/19 Objectives and Terms of Reference.

Decisions Made / Items Approved

- Executives to further explore with NHSI, the impact of delivering a financial position in the range of £8.6m to £10.5m deficit.
- The revenue and capital budgets for 2018/19 were approved.

Actions to come back to Committee

- None

Performance Issues to be referred into Executive Performance Management Process
• Delivery of the ED 4 hour target
Areas of Risk to be escalated onto the Corporate or Divisional Risk Register
• None
Items referred to the Board for decision or action
• To note the 2018/19 forecast outturn financial position • To note approval of 2018/19 revenue and capital budgets • To note the positive outputs from the annual review of the Committee's Effectiveness • The Board is asked to give delegated authority to the Finance and Performance Committee at its meeting on 26 April 2018 to approve the submission of the NHSI 2018/19 final plan

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 12th April 2018

TITLE:	Integrated Performance Report for Month 11 (February) 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.

Integrated Performance Report - Board




February 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

Ward Quality Dashboard (Ward Figures Only)

Quality And Risk														
Description	**LYO**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**YTD**
Complaints	-	20	25	30	28	45	33	36	34	29	50	28	-	358
Compliments	-	659	399	315	324	384	492	579	525	862	851	422	-	5,812
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%	4%	-	3.10%
Friends & Family – Community – Recommended %	95.80%	94%	96%	97.40%	98%	98.20%	97.10%	95.10%	95.90%	95.70%	96.30%	97.20%	-	96.50%
Friends & Family – ED – Footfall	7.90%	15.40%	13.70%	17.10%	15.30%	16%	19.60%	28.50%	24.70%	17%	21.20%	22.60%	-	19.10%
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%	75.50%	-	77.50%
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%	34.60%	-	31.90%
Friends & Family – Inpatients – Not Recommended %	-	0.60%	1.10%	0.70%	0.90%	1.40%	1.50%	2%	1.50%	2.60%	1.80%	1.90%	-	1.50%
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%	95.10%	-	95.60%
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%	35.90%	-	40.70%
Friends & Family – Maternity – Not Recommended %	-	0.50%	0.70%	0.50%	0.80%	1%	0.80%	0.60%	0.70%	0%	0.20%	0.50%	-	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%	97.90%	-	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%	4.40%	-	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%	89.30%	-	91.80%
HCAI – Post 48 hour MRSA	0	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	1	0	-	16
HCAI CDIFF – Not Due To Lapses In Care	20	0	0	1	0	0	1	1	4	1	2	0	-	10
HCAI CDIFF – Total Number Of Cases	33	2	1	2	4	1	6	1	5	1	5	0	-	28
HCAI CDIFF – Under Review	0	0	0	0	0	0	0	0	0	0	2	0	-	2
Incidents - Appointments, Discharge & Transfers	724	58	71	65	90	93	90	95	78	82	99	94	-	915
Incidents - Blood Transfusions	128	4	13	6	8	4	5	10	11	5	5	11	-	82
Incidents - Clinical Care (Assessment/Monitoring)	898	80	98	86	99	108	114	112	160	129	125	114	-	1,225
Incidents - Diagnosis & Tests	350	33	31	24	35	39	37	32	31	30	32	37	-	361
Incidents - Equipment	228	32	23	29	23	33	15	21	15	23	25	28	-	267
Incidents - Facilities (Security, Estates, Transport, Fire etc.)	401	38	45	65	52	61	37	42	29	39	24	26	-	458
Incidents - Falls, Injuries or Accidents	1,629	133	132	109	130	101	98	130	139	103	133	136	-	1,344
Incidents - Health & Safety	301	17	24	38	27	34	28	26	27	17	39	29	-	306

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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	12	-	93
Incidents - Medication	4,441	293	334	324	312	226	287	499	608	341	372	260	-	3,856
Incidents - Obstetrics	935	89	73	87	127	102	85	80	78	68	79	64	-	932
Incidents - Pressure Ulcer	2,573	239	253	225	241	315	280	316	302	277	366	315	-	3,129
Incidents - Records, Communication & Information	562	47	52	40	123	64	68	79	68	65	87	65	-	758
Incidents - Safeguarding	638	51	60	63	63	49	78	80	79	76	89	93	-	781
Incidents - Theatres	195	13	11	15	27	18	12	17	10	22	20	20	-	185
Incidents - Venous Thrombo Embolism (VTE)	137	14	17	4	21	11	5	6	11	5	7	11	-	112
Incidents - Violence, Aggression & Self Harm	660	51	91	81	76	62	49	68	73	34	53	43	-	681
Incidents - Workforce	401	30	22	41	58	69	63	54	84	66	47	78	-	612
Maternity : Early Booking KPI: % of women who see midwife/maternity healthcare professional	100%	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%	59.27%	-	57.13%
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%	14.52%	-	15.69%
Mixed Sex Sleeping Accommodation Breaches	62	5	3	0	0	2	6	4	0	10	5	5	-	40
Never Events	1	0	0	1	0	0	0	0	1	0	0	1	-	3
NQA - Matrons Audit	89%	89%	92%	92%	92%	92%	92%	93%	95%	93%	94%	-	-	92%
NQA - Nutrition Audit	96%	96%	95%	93%	95%	96%	95%	95%	93%	95%	92%	93%	-	94%
NQA - Paediatric Nutrition Audit	98%	98%	100%	100%	91%	92%	97%	98%	98%	98%	100%	100%	-	97%
NQA - Safety Thermometer	90	2	11	-	3	-	-	-	-	-	-	-	-	16
NQA - Skin Bundle	96%	93%	97%	94%	96%	95%	96%	93%	95%	96%	94%	96%	-	95%
NQA - Think Glucose - EAU/SAU	-	83%	47%	82%	89%	65%	66%	80%	93%	100%	100%	100%	-	77%
NQA - Think Glucose - General Wards	88%	92%	91%	89%	93%	94%	98%	97%	96%	98%	99%	90%	-	94%
Nursing Care Indicators - Community Childrens	99%	100%	100%	99%	100%	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%	-	100%
Nursing Care Indicators - Critical Care	98%	98%	100%	98%	100%	100%	98%	98%	100%	99%	98%	95%	-	98%
Nursing Care Indicators - District Nurses	94%	91%	98%	94%	96%	97%	94%	91%	93%	92%	95%	95%	-	94%
Nursing Care Indicators - EAU	93%	88%	86%	98%	92%	94%	88%	97%	97%	97%	63%	86%	-	89%
Nursing Care Indicators - ED	88%	91%	86%	93%	72%	92%	92%	92%	91%	86%	83%	90%	-	87%

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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%	93%	-	95%
Nursing Care Indicators - Maternity	92%	100%	94%	97%	95%	95%	95%	95%	97%	94%	97%	96%	-	96%
Nursing Care Indicators - Neo Natal	98%	98%	99%	99%	99%	99%	99%	99%	98%	99%	98%	99%	-	99%
Nursing Care Indicators - Paediatric	98%	94%	100%	97%	84%	95%	95%	97%	96%	97%	95%	97%	-	95%
Nursing Care Indicators - Renal	95%	98%	99%	97%	98%	99%	92%	96%	93%	96%	98%	98%	-	97%
PALS Concerns	-	177	235	234	232	246	189	218	209	197	187	172	-	2,296
Saving Lives - 01a CVC Insertion	98%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	-	99%
Saving Lives - 01b CVC Ongoing Care	99%	98%	98%	98%	93%	100%	94%	100%	100%	100%	100%	100%	-	98%
Saving Lives - 02a Peripheral Lines Insertion	97%	97%	96%	99%	99%	99%	99%	97%	98%	98%	98%	99%	-	98%
Saving Lives - 02b Peripheral Lines Ongoing Care	96%	98%	99%	97%	99%	98%	98%	98%	99%	98%	98%	96%	-	98%
Saving Lives - 03a Renal Dialysis Insertion	98%	100%	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%	-	100%
Saving Lives - 04a Surgical Site Pre Op	99%	100%	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%	100%	-	95%
Saving Lives - 04c Surgical Site Post Op	100%	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%	-	100%
Saving Lives - 06a Urinary Catheter Insertion	99%	100%	100%	100%	100%	98%	100%	98%	100%	100%	100%	100%	-	99%
Saving Lives - 06b Urinary Catheter Ongoing Care	99%	99%	100%	98%	99%	98%	100%	100%	100%	99%	98%	99%	-	99%
Saving Lives - 07 C.difficile	87%	100%	100%	-	75%	100%	88%	75%	75%	75%	100%	100%	-	89%
Saving Lives - 08a Clinical equipment Decontamination Infected	99%	100%	100%	100%	99%	99%	99%	98%	100%	99%	99%	98%	-	99%
Saving Lives - 08b Clinical equipment Decontamination Non Infected	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%	100%	99%	-	99%
Saving Lives - 11 Enteral Feeding (New)	98%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	-	99%
Serious Incidents - Action Plan overdue	206	4	5	5	9	4	11	10	8	-	5	6	-	67
Serious Incidents - Clinical Care (Assessment/Monitoring)	20	1	2	-	1	-	1	2	3	1	1	5	-	17
Serious Incidents - Diagnosis & Tests	10	1	1	-	-	-	-	-	-	-	1	-	-	3
Serious Incidents - Facilities (Security, Estates, Transport, ICT, etc.)	-	-	-	-	-	-	-	1	-	-	-	1	-	2
Serious Incidents - Falls, Injuries or Accidents	32	3	-	2	3	-	2	2	3	2	2	1	-	20

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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	-	2
Serious Incidents - Obstetrics	5	-	1	-	-	1	-	-	-	-	-	1	-	3
Serious Incidents - Pressure Ulcer	150	6	13	9	10	13	7	-	5	6	13	11	-	93
Serious Incidents - Records, Communication & Information	6	-	-	-	-	-	-	-	-	-	1	-	-	1
Serious Incidents - Theatres	3	-	-	-	1	-	-	-	-	-	-	1	-	2
Stroke Admissions : Swallowing Screen	77.02%	72.72%	76.27%	82.22%	82.69%	88.09%	90.24%	89.18%	71.79%	80%	78.26%	91.42%	-	81.70%
Stroke Admissions to Thrombolysis Time	51.24%	100%	55.55%	0%	63.63%	77.77%	71.42%	71.42%	75%	42.85%	62.50%	0%	-	58.90%
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%	98.07%	90%	-	92.57%
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation	79.31%	100%	85.71%	100%	81.81%	100%	100%	100%	90%	100%	100%	93.33%	-	95.74%
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%	92.03%	92.60%	-	86.53%
Time to Surgery : Emergency Procedures (Appendectomy)	94.29%	100.00%	96.96%	95.45%	97.43%	97.05%	100.00%	96.00%	93.33%	90.90%	100.00%	93.75%	-	97.05%
Time to Surgery : Emergency Procedures (Femur Replacement)	94.92%	94.44%	84.61%	80.00%	100.00%	95.23%	94.11%	89.47%	100.00%	100.00%	95.23%	85.71%	-	93.04%
Time to Surgery : Emergency Procedures (Reduction of fracture of bone)	92.80%	94.23%	95.65%	88.09%	95.34%	86.00%	86.48%	95.34%	94.11%	89.28%	97.56%	88.63%	-	92.03%
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%	78.78%	50.00%	-	65.72%
VTE Assessment Indicator (CQN01)	94.75%	92.24%	91.97%	93.50%	94.08%	94.74%	94.37%	95.05%	93.97%	92.12%	91.72%	92.89%	-	93.34%

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Performance Dashboard

Performance														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
A&E - 4 Hour A&E Dept Only % (Type 1)	89.76%	84.93%	86.59%	90.02%	82.74%	80.19%	81.47%	84.94%	73.99%	64.79%	70.21%	67.99%	-	79.12%
A&E - 4 Hour UCC Dept Only % (Type 3)	100%	100%	99.96%	100%	100%	99.41%	99.64%	99.18%	99.88%	98.57%	98.31%	99.48%	-	99.48%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	94.16%	91.69%	92.04%	93.52%	89.11%	87.15%	87.73%	90.06%	83.90%	78.92%	81.70%	80.60%	-	87.02%
A&E - Patients who Left Without Being Seen %	1.90%	2.10%	2.20%	2.20%	3.10%	2.80%	2.90%	2.50%	2.90%	3.80%	3.10%	2.30%	-	2.70%
A&E - Time to Initial Assessment (95th Percentile)	9	19	15	21	32	24	21	20	33	50	35	12	-	12
A&E - Time to Treatment Median Wait (Minutes)	65	63	64	70	74	70	72	68	83	92	79	72	-	72
A&E - Total Time in A&E (95th Percentile)	296	406	388	352	474	472	485	432	610	771	662	705	-	705
A&E - Unplanned Re-Attendance Rate %	1.80%	1.80%	2.10%	1.60%	1.80%	1.20%	1.50%	1.60%	1.50%	1.20%	1.30%	1.20%	-	1.50%
Activity - A&E Attendances	102,696	8,573	9,047	8,867	9,064	8,118	8,565	9,144	8,671	8,425	8,750	7,791	-	95,015
Activity - Cancer MDT	5,489	406	479	459	458	392	415	436	423	381	426	451	-	4,726
Activity - Community Attendances	394,381	27,630	33,233	30,929	31,939	31,808	32,404	31,250	34,138	27,169	33,518	30,088	-	344,106
Activity - Critical Care Bed Days	8,366	686	649	624	626	607	602	610	648	665	554	681	-	6,952
Activity - Day Care Attendances	6,353	278	343	351	271	242	341	424	434	277	423	418	-	3,802
Activity - Diagnostic Imaging whilst Out-Patient	56,516	3,835	4,285	4,364	4,493	4,575	4,484	4,667	4,752	3,725	5,055	4,157	-	48,392
Activity - Direct Access Pathology	1,929,670	143,708	168,459	172,016	164,859	172,090	162,338	174,512	169,262	113,573	184,339	168,156	-	1,793,312
Activity - Direct Access Radiology	73,314	5,659	6,678	6,406	6,476	6,449	6,355	6,619	6,874	5,103	6,775	5,939	-	69,333
Activity - Elective Day Case Spells	45,982	3,805	4,209	4,170	4,190	4,219	3,916	4,224	4,139	3,596	4,214	3,980	-	44,662
Activity - Elective Inpatients Spells	6,029	473	509	479	486	492	493	509	547	411	468	444	-	5,311
Activity - Emergency Inpatient Spells	60,748	4,966	5,202	5,026	5,056	4,888	3,697	3,891	3,542	3,340	3,794	3,297	-	46,699
Activity - Evergreen Bed Days	-	1,013	1,186	1,407	1,197	858	1,089	316	0	0	0	0	-	7,066
Activity - Excess Bed Days	18,931	1,285	953	873	1,011	1,308	1,079	870	748	894	950	506	-	10,477
Activity - Maternity Pathway	7,361	613	628	679	572	703	741	654	656	508	670	422	-	6,846
Activity - Neo Natal Bed Days	6,734	532	529	633	655	665	644	585	637	585	603	475	-	6,543
Activity - Outpatient First Attendances	125,869	8,700	11,090	11,297	11,053	11,373	13,572	13,419	13,612	11,361	14,565	13,111	-	133,153
Activity - Outpatient Follow Up Attendances	310,607	21,003	25,421	25,593	24,627	24,381	25,456	26,331	26,992	20,360	26,840	23,739	-	270,743
Activity - Outpatient Procedure Attendances	59,621	5,013	6,496	6,470	6,155	6,230	5,934	6,395	6,369	4,786	6,268	5,602	-	65,718
Activity - Rehab Bed Days	20,228	1,510	1,373	1,854	1,826	1,705	1,872	1,574	1,608	1,668	2,019	1,393	-	18,402

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Performance														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Activity - Renal Dialysis	48,418	4,170	4,496	4,129	4,192	4,322	4,342	4,298	4,497	4,606	4,481	4,126	-	47,659
Ambulance Handover - 30 min – breaches (DGH view)	1,381	252	190	214	302	273	294	228	560	868	691	448	-	4,320
Ambulance Handover - 30 min – breaches (WMAS view)	1,885	340	261	292	370	376	362	317	696	1,003	842	545	-	5,404
Ambulance Handover - 60 min – breaches (DGH view)	213	33	27	28	64	48	25	11	122	155	109	59	-	681
Ambulance Handover - 60 min – breaches (WMAS view)	284	42	32	34	78	61	29	15	138	187	138	73	-	827
Cancer - 14 day - Urgent GP Referral to date first seen	95.50%	94.70%	97%	97.60%	98%	84.90%	94%	94.70%	95.20%	95.60%	96.20%	95.10%	-	94.90%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	97.40%	97.20%	97.10%	100%	100%	97.10%	97.20%	99.30%	96.30%	94.20%	96.60%	99.10%	-	97.70%
Cancer - 31 day - from diagnosis to treatment	99.10%	98.40%	100%	97.30%	96.50%	98.70%	100%	100%	98.80%	99.20%	98.60%	99.10%	-	98.70%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	100%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	99.60%	100%	100%	100%	96.10%	95.80%	100%	100%	100%	100%	100%	100%	-	99.20%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	99.80%	100%	100%	100%	98.50%	98.70%	100%	100%	100%	100%	100%	100%	-	99.60%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	95.60%	93.70%	94.60%	91.70%	94.50%	90.30%	92%	100%	91%	93.80%	91.40%	92.70%	-	93.30%
Cancer - 62 day - From Referral for Treatment following national screening referral	97.90%	92.30%	100%	100%	95%	90.40%	100%	100%	100%	100%	100%	100%	-	98.20%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85.10%	86.60%	76.70%	78%	82.80%	83.10%	91.10%	93.10%	87.70%	85.20%	89.10%	82.10%	-	85.10%
Cancer: Patients on a 62 day pathway treated on or over 104 days (1: patients treated at DGFT)	17	1	1	1	5	1	0	0	2	2	2	-	-	15
Cancer: Patients on a 62 day pathway treated on or over 104 days (2: patients treated at a Tertiary Centre)	30	1	7	3	0	3	1	1	3	2	2	-	-	23
Cancer: Patients on a 62 day pathway treated on or over 104 days (3: combined)	47	2	8	4	5	4	1	1	5	4	4	-	-	38
Maternity: Breastfeeding Data Coverage Rates	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	-	100%
Number of Births Within the Trust	4,496	391	351	372	403	390	375	404	378	342	372	312	-	4,090
RTT - Admitted Pathways within 18 weeks %	92.40%	86.30%	88.70%	88.60%	90.80%	89.90%	88.60%	88.50%	86.20%	88.70%	87%	86.30%	-	88.20%
RTT - Incomplete Waits within 18 weeks %	95.40%	94.20%	94.60%	95%	94.30%	94.10%	94%	93.70%	93.80%	93.30%	93.50%	94%	-	94.10%
RTT - Non-Admitted Pathways within 18 weeks %	96.50%	93.20%	94.50%	93.10%	92.80%	92.80%	92.80%	93%	90.70%	91.30%	94.10%	93.40%	-	92.90%
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	97.40%	95.98%	94.27%	96.86%	97.79%	97.70%	98.34%	98.56%	99.15%	99.36%	99.29%	99.45%	-	97.72%

The Dudley Group NHS Foundation Trust

Finance Dashboard

Finance														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Agency spend	-	£849k	£979k	£717k	£951k	£896k	£965k	£948k	£660k	£912k	£1,292k	£1,245k	-	£10,415k
Bank spend	-	£1,158k	£1,183k	£1,313k	£1,377k	£1,284k	£1,336k	£1,321k	£1,452k	£1,289k	£1,429k	£1,454k	-	£14,595k
Budgetary Performance	£1,467k	(£72)k	(£369)k	£412k	(£135)k	(£2,185)k	£2,380k	(£2,278)k	(£4,241)k	(£3,804)k	(£3,996)k	(£2,398)k	-	(£16,685)k
Capital v Forecast	63.70%	72.60%	52.70%	49.60%	57.90%	57.10%	64.30%	72.20%	79.10%	88.90%	98.60%	102.90%	-	102.90%
Cash Balance	£17,367k	£20,481k	£18,145k	£18,113k	£20,697k	£18,584k	£16,074k	£18,192k	£16,033k	£14,305k	£9,733k	£8,617k	-	£8,617k
Cash v Forecast	65.60%	80%	74.90%	84.10%	95.90%	99%	98.70%	118.60%	98.90%	92.40%	56.10%	43.50%	-	43.50%
Creditor Days	13.1	13.2	12.1	13.1	12.9	13.4	16.2	15.5	14.8	17	15.8	16	-	16
Debt Service Cover	1.77	0.57	1.06	1.45	1.56	1.34	1.66	1.51	1.44	1.02	0.91	0.79	-	0.79
Debtor Days	19.4	16	17.7	17.6	16.4	16.8	20.3	19.3	18.9	14	15.5	14.4	-	14.4
EBITDA	£32,776k	£137k	£1,645k	£2,653k	£2,171k	£4k	£4,192k	£716k	(£1,551)k	(£2,768)k	(£888)k	(£1,401)k	-	£4,910k
I&E (After Financing)	£10,004k	(£980)k	£514k	£1,541k	£1,043k	(£1,123)k	£3,193k	(£296)k	(£2,660)k	(£3,879)k	(£2,015)k	(£2,478)k	-	(£7,139)k
Liquidity	16.43	14.7	14.56	14.99	15.2	13.16	15.25	13.57	11.94	4.17	0.72	-3.26	-	-3.26
SLA Performance	£1,937k	£108k	£258k	(£469)k	(£362)k	(£926)k	£483k	(£640)k	(£359)k	(£1,511)k	(£87)k	(£248)k	-	(£3,753)k

Staff/HR Dashboard

Staff/HR														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Appraisals	82.90%	81.90%	83.60%	82.90%	83.90%	83.90%	84%	87.20%	88.10%	86.90%	84.40%	79.90%	-	79.90%
Flu Vaccination Rate	-	-	-	-	-	-	-	-	70.22%	-	-	-	-	70.22%
Mandatory Training	83.90%	84.60%	84.80%	84.50%	85%	85.40%	86%	85.90%	86.90%	86.60%	87.10%	87%	-	87%
RN average fill rate (DAY shifts)	89.69%	91.39%	92.12%	91.39%	91.68%	88.40%	89.34%	88.94%	88.87%	88.08%	89.94%	94.37%	-	90.36%
RN average fill rate (NIGHT shifts)	94.25%	94.46%	95.10%	95.81%	95.97%	94.18%	93.36%	90.76%	92.74%	91.18%	94.30%	104.37%	-	94.60%
Sickness Rate	4.02%	3.42%	3.80%	3.93%	4.14%	4.25%	4.18%	4.44%	5.02%	5.07%	5.67%	4.50%	-	4.41%
Staff In Post (Contracted WTE)	4,278.19	4,184.78	4,178.82	4,204.73	4,176.26	4,179.26	4,196.01	4,216.59	4,219.28	4,215.48	4,221.17	4,228.07	-	4,228.07
Turnover Rate (Rolling 12 Months)	8.74%	8.63%	9.13%	9.25%	9.29%	9.21%	9.20%	9.26%	9.19%	9.28%	9.62%	9.68%	-	9.68%
Vacancy Rate	7.89%	8.74%	8.67%	8.77%	9.20%	9.45%	9.14%	8.63%	7.50%	7.53%	7.66%	7.62%	-	7.62%

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 80.60%. Whilst, the Trust only (Type 1) performance was 68.00%.

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

	Attendances	Breaches	Performance
A&E Dept. Type 1	7806	2498	68.00%
UCC Type 3	5211	27	99.48%

Cancer Waits

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

Cancer – 62 Day from Urgent GP Referral to Treatment performed below target for the month at 82.4% (Provisional). Previous month confirmed performance was 89.2%

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 991 patients attended a 2ww appointment with 51 patients attending their appointments outside of the 2 week standard, achieving a performance 95.1% against the 93% target.

Referral To Treatment (RTT)

The performance of the key target RTT Incomplete Waiting Time indicator remained strong, with performance of 94% in month against a target of 92%, a slight increase in performance from 93.53% in the previous month. Urology did not meet the target in month at 89.02%, down from 90.92% in previous month. Ophthalmology is at 82.53%, up from 79.21% in the previous month. Plastic Surgery has failed the target after achieving it in the previous month, at 89.09%. 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 99.45%. The number of patients waiting over 6 weeks was 317.

Of the 31, MRI accounted for 27 (4 other).

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

2 Financial Performance Matters — Committee: F&P

Pre STF, the February position resulted in a £2.478m deficit, which is £1.398m worse than plan. Cumulatively the position was a £9.626m deficit (£11.599m worse than plan). Income performance improved in February and non pay spend was within budget. However, there was a significant adverse variance on pay costs, driven by agency (second highest year to date spend), bank (highest year to date spend) and employed costs (highest WTE and third highest year to date spend). The Trust has submitted a revised forecast of an £8.6m deficit to NHSI. However, the cumulative position to February is £1.366m behind this revised trajectory. There are a number of one-off benefits that are expected in March. However, these are likely to be counter-balanced by the technical impact relating to a recent revaluation exercise and the forward look on agency suggests a continuation of high agency spend within qualified nursing. As such, the estimated forecast at this point is a £10.129m deficit. This still assumes a generous year end settlement with Dudley CCG which may not be forthcoming.

The position on the Trust's liquidity ratio was -3.3 days against a planned position of 11.9 days at Month 11. 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.

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

CQSPE

HCAI

Total No. of C. Diff cases identified after 48hrs for the month was 0. (28ytd.)

	February	YTD
Total No. of cases due to lapses in care	N/A	16
Total No. of cases NOT due to lapses in care	N/A	10
No. of cases currently under review (ytd)	2	N/A
Total No. of cases ytd.	N/A	28

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

Never Events

There was one never event 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 92.89% against a target of 95%. This is a slight increase on the previous month's performance of 92.26%.

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 in the percentage of appraisals undertaken, from 84.4% to 79.9%. Medicine and Integrated Care Division is red at 77.67%. Clinical Support, Corporate/Management, Surgery and are all amber at 881.98%, 81.44% and 81.59% respectively (>80% <90%). All down from last month.

Mandatory Training:

Mandatory Training has fallen slightly from 87.15% to 87% 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 91.03%. Within the Clinical Support Division, Division Management is green at 93.94% and Imaging are red at 79.73%, both up from last month. Within Medicine and Integrated Care, Urgent Care is red at 73.71% 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 decreased from 5.70% in the previous month to 4.50% 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)	Feb-18	Trend	Month Status
Friends & Family Test - Footfall					
Friends & Family Test - ED	14.5%	21.3%	22.6%	↑	
Friends & Family Test - Inpatients	26.0%	35.1%	34.5%	↑	
Friends & Family Test - Maternity	21.7%	34.4%	35.9%	↓	
Friends & Family Test - Outpatients	4.7%	14.5%	4.5%	↓	
Friends & Family Test - Community	3.5%	9.1%	4.1%	↑	
Friends & Family Test - Recommended					
Friends & Family Test - ED	89.9%	93.4%	75.5%	↑	
Friends & Family Test - Inpatients	96.3%	97.4%	95.1%	↑	
Friends & Family Test - Maternity	96.0%	98.1%	98.0%	↑	
Friends & Family Test - Outpatients	94.6%	97.2%	89.4%	↓	
Friends & Family Test - Community	96.4%	97.7%	97.3%	↑	
Complaints					
Total no. of complaints		N/A	37	↓	
Complaints closed within target			100.0%	↔	
Complaints re-opened			0	↔	
PALs Numbers			278	↑	
Ombudsman					
Dementia (1 month in arrears)					
Find/Assess		90%	94.5%	↑	
Investigate		90%	100.0%	↔	
Refer		90%	97.8%	↑	
Falls					
No. of Falls		0	90	↑	
Falls per 1000 bed days		6.63	5.17	↑	
No. of Multiple Falls		N/A	6	↑	
Falls resulting in moderate harm or above			0		
Falls resulting in moderate harm or above per 1000 bed days		0.19	0.00	↓	
Pressure Ulcers (Grades 3 & 4)					
Hospital Avoidable		0	1	↓	
Hospital Non-avoidable		0	0	↓	
Community Avoidable		0	1	↓	
Community Non-avoidable		0	11	↑	
Mixed Sex Accommodation Breaches					
Single Sex Breaches		0	5	↔	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Feb-18	Trend	Month Status
Mortality (Quality Strategy Goal 3)					
HSMR Rolling 12 months (**Latest data Oct 17**)	110	105	103		
SHMI Rolling 12 months (**Latest data Sept 17**)	1.10	1.05	0.98		
HSMR Year to date (**Latest data Oct 17**)			107		
Infections					
Cumulative C-Diff due to lapses in care		15	16		
MRSA Bacteraemia		0	0	↔	
MSSA Bacteraemia		0	0	↓	
E. Coli - Total hospital		0	2	↑	
Stroke Admissions - PROVISIONAL					
Stroke Admissions: Swallowing Screen		75%	91.4%	↑	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	90.0%	↓	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	93.3%	↓	
VTE - PROVISIONAL					
VTE On Admission		95%	92.9%	↑	
Incidents					
Total Incidents			1447	↑	
Recorded Medication Incidents			260	↓	
Never Events			1	↑	
Serious Incidents			21	↑	
of which, pressure ulcers			11	↓	
Incident Grading by Degree of Harm					
Death			1	↓	
Severe			4	↑	
Moderate			9	↑	
Low			236	↓	
No Harm			1147	↓	
Percentage of incidents causing harm		28%	17.9%	↓	
NQA Think Glucose					
NQA Think Glucose - AMU/SAU	85%	95%	100%	↔	
NQA Think Glucose - General Wards	85%	95%	90%	↓	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Feb-18	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)					
All Cancer 2 week waits	93%	95.1%	94.9%	↓	
2 week wait - Breast Symptomatic	93%	96.8%	97.5%	↑	
31 day diagnostic to 1st treatment	96%	99.1%	98.7%	↑	
31 day subsequent treatment - Surgery	94%	100.0%	99.2%	↔	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	↔	
62 day urgent GP referral to treatment	85%	80.9%	85.8%	↓	
62 day screening programme	90%	100.0%	98.3%	↔	
62 day consultant upgrades	85%	94.4%	93.3%	↑	
Referral to Treatment					
RTT Incomplete Pathways - % still waiting	92%	94.0%	94.6%	↑	
RTT Admitted - % treatment within 18 weeks	90%	86.4%	88.2%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	93.5%	92.9%	↓	
Wait from referral to 1st OPD	26	23	313	↓	
Wait from Add to Waiting List to Removal	39	41	460	↓	
ASI List		1826	0	↑	
% Missing Outcomes RTT		0.1%	0.1%	↑	
% Missing Outcomes Non-RTT		6.4%	4.7%	↓	
DM01					
No. of diagnostic tests waiting over 6 weeks	0	31	1606	↓	
% of diagnostic tests waiting less than 6 weeks	99%	99.5%	97.7%	↑	
ED - TRUST					
Patients treated < 4 hours Type 1 (Trust ED)	95%	68.0%	79.1%	↓	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	80.6%	87.0%	↓	
Emergency Department Attendances	N/A	7805	95019	↓	
12 Hours Trolley Waits	0	2	0	↓	
Ambulance to ED Handover Time - TRUST					
30-59 minute breaches		448	4320	↓	
60+ minute breaches		59	681	↓	
Cancelled Operations - TRUST					
% Cancelled Operations	1.0%	1.5%	1.4%	↓	
Cancelled operations - breaches of 28 day rule	0	1	15	↓	
Urgent operations - cancelled twice	0	0	0	↔	

Performance - Key Performance Indicators cont.

	Target	Feb-18	Actual YTD	Trend	Month Status
GP Discharge Letters					
GP Discharge Letters	90%	77.5%	78.5%	↓	
Theatre Utilisation - TRUST					
Theatre Utilisation - Day Case (RHH & Corbett)		77.6%	76.3%	↑	
Theatre Utilisation - Main		88.0%	86.2%	↑	
Theatre Utilisation - Trauma		86.4%	91.3%	↓	
GP Referrals (1 month in arrears)					
GP Written Referrals - made		8912	77892	↑	
GP Written Referrals - seen		7807	66358	↑	
Other Referrals - Made		3135	29585	↑	
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 - %		91%	90%		
Bed Occupancy - % Medicine & IC		95%	95%		
Bed Occupancy - % Surgery, W&C		87%	87%		
Bed Occupancy - Paediatric %		64%	59%		
Bed Occupancy - Orthopaedic Elective %		64%	76%		
Bed Occupancy - Trauma and Hip # %		94%	94%		
Number of Patient Moves between 8pm and 8am		108	1066		
Discharged by Midday		15%	15%		
Outpatients					
New outpatient appointment DNA rate	8%	10.3%	11.1%	↓	
Follow-up outpatient appointment DNA rate	8%	7.8%	8.1%	↑	
Total outpatient appointment DNA rate	8%	8.6%	10.0%	↑	
Clinic Utilisation		82.7%	82.1%	↑	
Average Length of stay (Quality Strategy Goal 3)					
Average Length of Stay - Elective	0.0	3.0	3.2	↓	
Average Length of Stay - Non-Elective	3.4	5.6	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	528	444	-15.9%	-84	6,075	5,348	-12.0%	-727
Day Cases	3,805	3,866	1.6%	61	43,764	44,908	2.6%	1,144
Non-elective inpatients	4,731	3,297	-30.3%	-1,434	56,429	50,552	-10.4%	-5,877
Outpatients	36,275	36,767	1.4%	492	411,165	404,627	-1.6%	-6,538
A&E	7,777	7,805	0.4%	28	93,012	95,019	2.2%	2,007
Total activity	**53,116**	**52,179**	**-1.8%**	**-937**	**610,445**	**600,454**	**-1.6%**	**-9,991**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	137	96	-30.4%	-42	1,238	1,047	-15.4%	-190
Pay	841	-401	-147.7%	-1,242	6,494	2,012	-69.0%	-4,483
Non-Pay	331	357	7.8%	26	3,238	3,768	16.4%	530
Total CIP	**1,310**	**52**	**-96.0%**	**-1,258**	**10,970**	**6,828**	**-37.8%**	**-4,143**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	26,167	25,125	-4.0%	-1,042	300,700	294,833	-2.0%	-5,866
Other Clinical	128	67	-47.4%	-61	1,410	1,181	-16.2%	-229
STF Funding	1,000	0	-100.0%	-1,000	7,574	2,487	-67.2%	-5,087
Other	1,818	2,505	37.8%	687	20,287	21,417	5.6%	1,130
Total income	**29,113**	**27,697**	**-4.9%**	**-1,416**	**329,971**	**319,919**	**-3.0%**	**-10,052**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-17,231	-18,360	6.6%	-1,129	-189,315	-195,748	3.4%	-6,433
Drugs	-2,606	-2,646	1.5%	-39	-30,003	-30,514	1.7%	-510
Non-Pay	-7,516	-7,314	-2.7%	202	-80,287	-80,322	0.0%	-35
Total Costs	**-27,353**	**-28,320**	**3.5%**	**-967**	**-299,605**	**-306,583**	**2.3%**	**-6,978**

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	**1,753**	**-616**	**-135.1%**	**-2,369**	**30,285**	**13517**	**-55.4%**	**-16,769**
Depreciation	-765	-778.24	1.7%	-13	-8,543	-8426	-1.4%	117
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,075	-1,079	0.4%	-4	-12,276	-12084	-1.6%	192
SURPLUS/(DEFICIT)	**-87**	**-2,473**	**2741.6%**	**-2,386**	**9,466**	**-6994**	**-173.9%**	**-16,460**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	676	1,254	85.5%	578	13,904	14302	2.9%	398
Inventory					2,828	3138	11.0%	310
Receivables & Prepayments					18,090	19096	5.6%	1,006
Payables					-27,302	-30704	12.5%	-3,402
Accruals							n/a	0
Deferred Income					-4,656	-3467	-25.5%	1,189
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					19,788	8,617	-56.5%	-11,171
Loan Funding							n/a	0
KPIs								
EBITDA %	6.02%	-2.12%	-8.1%		9.18%	4.22%	-5.0%	
Deficit %	-0.30%	-8.49%	-8%		2.87%	-2.19%	-5.1%	
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	Feb-18	Actual YTD	Trend	Month Status
Workforce						
Sickness Absence Rate	3.75%	3.75%	4.51%	4.34%	↓	
Staff Turnover	0%	0%	9.7%	9.3%	↓	
Mandatory Training	90.0%	90.0%	87.1%	85.8%	↑	
Appraisal Rates - Total	90.0%	90.0%	80.0%	84.3%	↓	

Enclosure 10

The Dudley Group
NHS Foundation Trust

Paper for submission to Trust Board on 12th April 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.

Overview

Based on the Month 11 position (February 2018, Appendix One), the Trust has achieved *c.* £6.83m against the year to date (YTD) plan of £10.94m giving a variance of -£4.11m. This YTD variance is accounted for predominantly by three schemes: nursing bank and agency reduction ; nedical bank and agency reduction and surgery contact income growth.

The full year forecast is for CIP schemes is delivery of £7.43m (i.e. under-delivery of £5.19m).

The shortfall in achievement in CIP schemes will also be adjusted through the income received from the Trust's PFI provider associated with theatre downtime due to technical issues, as well as the winter pressures funding that the trust has received. These will be applied to relevant schemes prior to yearend reporting.

IMPLICATIONS OF PAPER:

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

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

Decision	Approval	Discussion	Other
		Y	

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

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

SO1: Deliver a great patient experience

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

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

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

The Dudley Group NHS
NHS Foundation Trust

Trust Board

Summary Report: Month Eleven (February 2018)

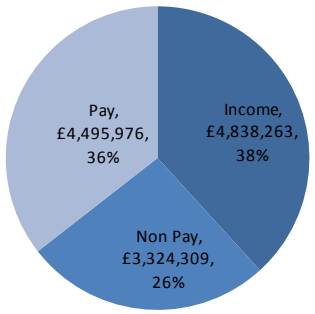
Date of Trust Board: 12th April 2018

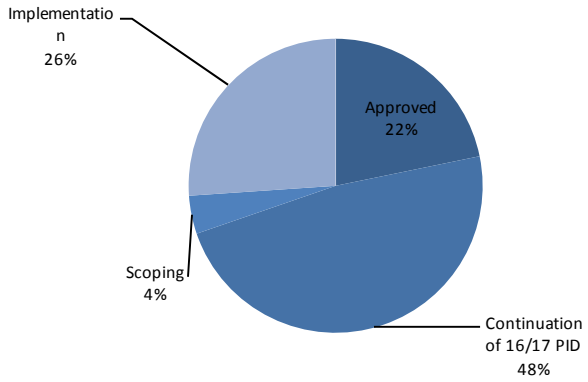
Executive Summary – 2017/18

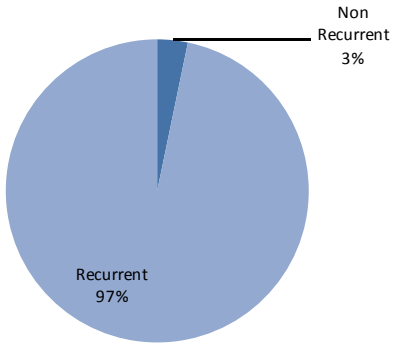
The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18. To support this, there are 57 schemes on the work programme which contribute to the £12.5m identified, and 3% of of the CIP has currently been identified as non recurrent savings.

A summary of CIP performance as at Month 11 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	£12,628,534	£ 128,534	£10,943,554	£ 6,827,548	-£ 4,116,007	£ 7,433,450	-£ 5,195,083







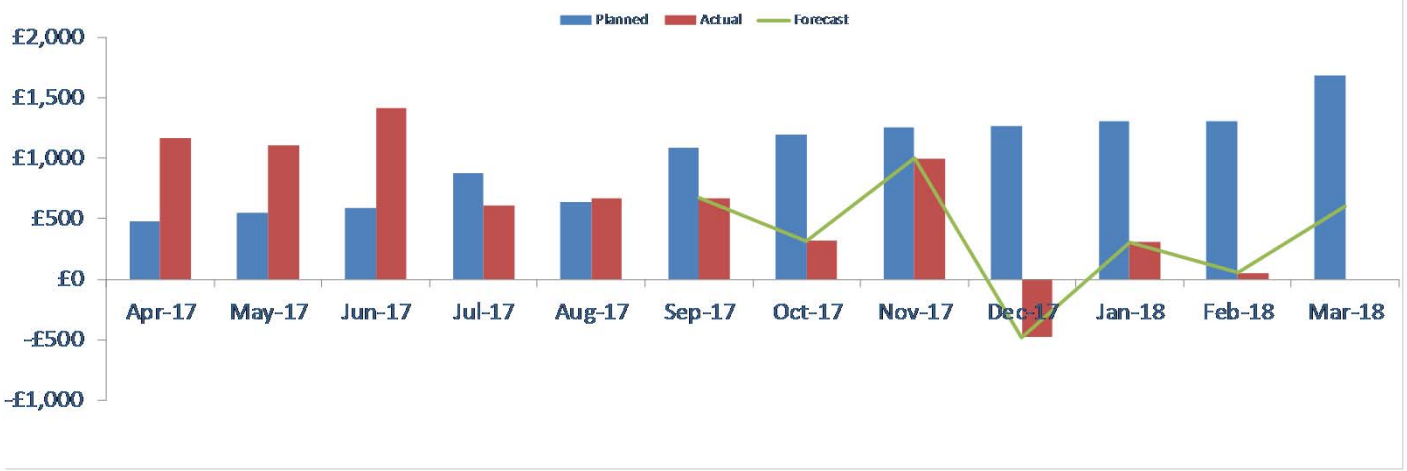
Based on the Month 11 position, the Trust has identified schemes totalling £12.6m against a Full Year (FY) target of £12.5m.
As at Month 11 the Trust is forecasting to deliver £7.4m.

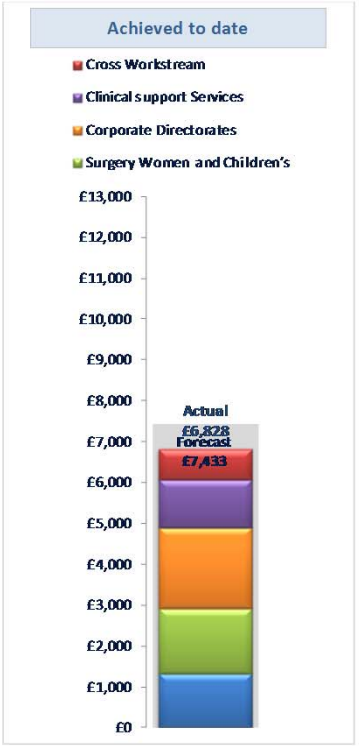
The Sparkline trends in this report give an indication of monthly fluctuations. However, the row height will determine the range, eg, larger row heights will appear to show larger ranges, but this is not the case.

Executive Summary – 2017/18

	YTD	FYE			Submitted Plan
Planned	£10,943,554			Identified	£12,628,534
Actual	£6,827,548			Target	£12,500,000
Forecast		£7,433,450			
Variance	-£4,116,007	-£5,195,083			£128,534

Programme (Click for details)	YTD Plan	YTD Actual	YTD Variance	FYE Plan	FYE Forecast	FYE Variance
Surgery Women and Children's	£2,963,239	£1,587,103	-£1,376,136	£3,232,624	£1,833,530	-£1,399,094
Medicine and Integrated Care	£1,314,730	£1,348,312	£33,582	£1,457,627	£1,472,083	£14,456
Clinical support Services	£908,958	£1,165,781	£256,823	£998,746	£1,294,430	£295,684
Corporate Directorates	£1,837,682	£1,978,026	£140,344	£2,018,331	£2,168,337	£150,005
Cross Workstream	£3,918,946	£748,326	-£3,170,620	£4,921,205	£665,071	-£4,256,134
View all Projects	£10,943,554	£6,827,548	-£4,116,007	£12,628,534	£7,433,450	-£5,195,083





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

Enclosure 11

The Dudley Gro
NHS Foundation Trust

Paper for submission to the Board of Directors on 12th April 2018

TITLE:	**Trust Operating Plan 2018/19**		
AUTHOR:	**Natalie Younes Director and Strategy and Business Development**	**PRESENTER**	**Natalie Younes Director of Strategy and Business Development**

CORPORATE OBJECTIVE: All Strategic Objectives

SUMMARY OF KEY ISSUES:

Appendix One presents the Trust's Operating Plan for 2018/19. The plan describes how the Trust will deliver its key priorities over the next year to achieve our vision of being '*trusted to provide, safe, caring and effective services because people matte*r.' The plan also contains the actions, measures of achievement and timescales for delivery of our goals during 2018/19. The document reflects the actions in place to deliver the Trust Vision, Values and Strategic Objectives.

Our vision: Trusted to provide safe, caring and effective services because people matter	
Our Values: Care, Respect and Responsibility	
Our Six Strategic Objectives:	
Deliver a great patient experience	**Be the place people choose to work**
Deliver safe and caring services	**Make the best use of what we have**
Drive service improvement, innovation & transformation	**Deliver a viable future**

The Operating Plan has been developed by the Executive Directors and takes into account; i) progress on delivery of the Trust's 2017/18 Operating Plan; ii) priorities outlined in the Trust's Clinical Strategy; iii) national planning requirements published in February 2018; iv) requirements of the *5 Year Forward View – Next Steps* document. The document has been shared a number of times with Governors through the Strategy Committee who have input into the development of the document.

A summary Plan on a Page is in development and will be disseminated throughout the Trust.

The plan outlines the metrics to be used to measure progress and these will form the basis for quarterly updates to the Board of Directors as part of the trust's Integrated Performance Report.

The figures provided in sections 6 – 9 of the document are provisional and may change once the annual budget setting exercise is complete. These changes will not alter the strategic direction and overall content of the plan and will be made prior to final publication of the plan through the Trust's website.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	x	x	

RECOMMENDATIONS FOR THE BOARD

Board of Directors is asked to approve the Trust Operating Plan for 2018/19 subject to any minor amendments requested and the figures in sections 6-9 being amended once the budget setting exercise is finalised.

NHS
The Dudley Group
NHS Foundation Trust

The Dudley Group NHS Foundation Trust

Annual Plan
2018/19

Table of content

1. Introduction

This document explains how Dudley Group Foundation Trust (DGFT) will deliver its key priorities over the next year. It outlines our plans for 2018/19 and how we will achieve our vision of being '***trusted to provide safe, caring and effective services because people matter***'.

A number of changes in the environment in which we operate have influenced our direction of travel and the key objectives that we set out for delivery in the coming twelve months. These include NHS I Planning Guidance (February 2018); 'Next Steps on the Five Year Forward View' which was published in March 2017; the Black Country Sustainability and Transformation Plan; CCG commissioning intentions, including the developments relating to the Dudley Multispecialty Community Provider (MPC). In addition, the internal factors that have shaped our plan include progress on delivering our 2017/18 annual plan; the approval of our refreshed Clinical Strategy in August 2017 and our quality priorities. The scale of the change required by the Dudley MCP Vanguard which is part of the Vanguard Programme by NHS England will mean that the Trust will need to reconfigure the way some services are provided. The purpose of the vanguard is to develop a population based health and social care model.

We made good progress in delivering our priorities for 2017/18. It is this success that we wish to build upon in 2018/19 through a further set of challenging objectives which will enable us to continue to deliver safe, high quality care and a positive patient experience, and meet all our operational and financial requirements. The plan-on-a-page maps our key priorities for 2018/19 to our vision and strategic aims, please see appendix one.

Critical to the success of our plan is delivering our services at a time of unprecedented increases in demand within the finances available to us and with a sustainable workforce of suitably skilled staff. A key priority for us will be delivering our 2018/19 cost improvement programme of £20.8m whilst retaining the quality of services.

The Trust's annual plan will be monitored and progress will be reported to the Trust Board on a quarterly basis. These reports will provide an evaluation of what is going well and what plans are in place to accelerate progress to ensure that all of our annual objectives are achieved in a timely way.

2. About Dudley Group Foundation Trust

DGFT is an integrated service provider offering both acute and community services to a population of 315,000 people in the Dudley Clinical Commissioning Group (CCG) catchment area. Services are also provided to other parts of the Black Country, West Birmingham, South Staffordshire and North Worcestershire. The Trust also provides a range of tertiary level services, some of which are accessed by patients from further afield. These include, for example, vascular surgery, endoscopic procedures, stem cell transplants and specialist GU reconstruction. In addition, the Trust provides a range of adult community services including community nursing, end of life care, podiatry, therapies and outpatient services.

Services are provided predominantly from three hospital sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Hospital in Stourbridge along with a number of community sites. Russells Hall Hospital is the largest hospital within the Trust with just over 700 beds. The site provides a full range of planned and emergency surgical, medical and supporting clinical specialties, including a maternity unit. The Corbett and Guest sites provide a range of outpatients and day case services. The trust also provides specialist adult community based care in patients' homes and in a range of centres across Dudley.

3. The strategic context

Vision, values and objectives

The Trust's vision is:

"Trusted to provide safe, caring and effective service because people matter"

The vision is underpinned by three values:

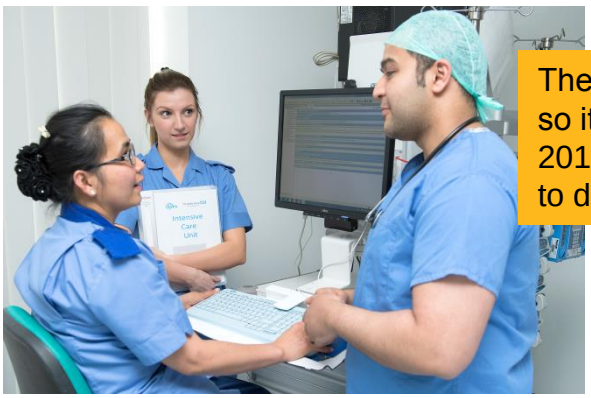
Care	Provide safe, quality healthcare for every person – every time
Respect	Show respect for our patients, our visitors and each other at all times
Responsibility	Take responsibility for everything we do every day

Six strategic objectives outline how the Trust will achieve its vision:

1. Deliver a great patient experience
2. Safe and caring services
3. Drive service improvement, innovation and transformation
4. Be the place people choose to work
5. Make the best use of what we have
6. Plan for a viable future

The Trust also has three clinical 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.



The Trust's strategic and operational planning are linked closely, so it is within this context that that the Trust's annual plan for 2018/19 is set. The annual plan will outline the action necessary to deliver each of the six strategic objectives.

Our vision: Trusted to provide safe, caring and effective services because people matter		
Our Values: Care, Respect and Responsibility		
Our three clinical 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
Our six strategic objectives:		
Deliver a great patient experience	Be the place people choose to work	
Deliver safe and caring services	Make the best use of what we have	
Drive service improvement, innovation & transformation	Deliver a viable future	

i) Our achievements in 2017/18

We have made significant progress across a number of our key initiatives over the past twelve months, all of which are integral to supporting delivery of the organisation's long term vision. These include:

- ✓ Implementation of approaches that engage and involve patients, carers and the public in their care / service developments and provide opportunities for feedback and further developing mechanisms to implement learning from feedback
- ✓ Achieving performance standards for maximum 62 day wait for first treatment for patients with cancer
- ✓ Achieving performance standards for six week wait for diagnostic procedures
- ✓ Achieving performance standards for RTT within 18 weeks
- ✓ Maintaining MRSA and Clostridium difficile (C. diff) rates
- ✓ Reducing the number of avoidable falls that result in harm
- ✓ Reducing the number of omitted medication errors
- ✓ 100% of hospital deaths having a multidisciplinary review
- ✓ Reducing neonatal and avoidable maternal deaths
- ✓ Delivery of elements of the Outpatients and Theatres Transformation Programmes
- ✓ Implementing the GIRFT recommendations for relevant specialities
- ✓ Implementation of the Hospital Pharmacy Transformation Plan
- ✓ Employee development programme and Leadership Forum in place
- ✓ Staff well-being events in place
- ✓ Progress on the delivery of the Digital Trust Programme
- ✓ Opening of the new Urgent Care Centre and A&E waiting facilities

i) The context for 2018/19

DGFT is operating within a national, regional and local context which needs to be taken into account when developing the annual plan. The factors that have been taken into account in the development of the plan for 2018/19 include:

- NHS England's 'Next Steps on the NHS Five Year Forward View' published in March 2017 sets out the 'must dos' for the health economy, including provider trusts. The annual plan sets out what DGFT needs to do in the coming 12 months to implement these requirements, including national standards and seven day services.

- The Black Country and West Birmingham Sustainability and Transformation Plan (STP) was published in Autumn 2016 with the aim of i) improving the health and wellbeing of the population; ii) improving the quality of local health and care services and iii) delivering financial stability and efficiencies throughout the local health care system. The plan involves collaboration from 18 partner organisations. STPs offer a new way of working for health and social care services locally, focusing on delivering health and care services defined by local area boundaries, not local organisational boundaries. Our annual plan for 2018/19 incorporates the ambitions of the Black Country STP which are:

i) Local place-based models of care - for Dudley, this will be delivered through the Multispecialty Community Provider.

ii) Extended collaboration between service providers – to make hospital services stronger through hospitals working more closely together to provide coordinated networks of care across the STP footprint. This will give better value for money, improve efficiency and quality.

iii) Mental health and learning disabilities – to improve people's experience of services and reduce variation in care by integrating services so patients across the area (including those needing specialist support) can expect the same level of services in their local area.

- Maternal and infant health – The DGFT Quality Improvement Board was concluded in October 2017 with the production of the public report. To address challenges relating to maternal and infant health through an STP-wide maternity plan which supports personalisation, safety and choice, as well as the provision of high quality services that improve patient experience and outcomes for mothers and their babies, the Black Country Local Maternity System of which the Trust is part was established in March 2017. The LMS is a coming together of provider and commissioner organisations to plan the design and delivery of maternity services for populations of 500,000 – 1,500,000 people. In February 2018 the final Black Country and West Birmingham Local Maternity System Transformation plan was submitted to NHS England. The three areas of focus for the plan over the next 3 – 5 years include: Improving infant mortality; delivering the 'Better Births Agenda" for the Black Country and West Birmingham and ensuring provision of sustainable services.

The STP partners participating in the development of the STP are:

- Dudley Metropolitan Borough Council
- Dudley Clinical Commissioning Group
- Dudley and Walsall Mental Partnership NHS Trust
- The Dudley Group NHS Foundation Trust
- City of Wolverhampton Council
- Wolverhampton Clinical Commissioning Group
- The Royal Wolverhampton NHS Trust
- West Midlands Ambulance Service
- NHS England
- Black Country Partnership NHS Foundation Trust
- Birmingham Community Healthcare NHS Trust
- Birmingham City Council
- Sandwell and West Birmingham Hospitals NHS Trust
- Sandwell and West Birmingham Clinical Commissioning Group
- Sandwell Metropolitan Borough Council
- Walsall Metropolitan Borough Council
- Walsall Clinical Commissioning Group
- Walsall Healthcare NHS Trust

The Black Country and West Birmingham Sustainability and Transformation Planning group has been meeting regularly since its inception with all partners across the footprint. The leadership of the STP will change in 2018 and it is hoped that one of the existing Chief executive offices amongst the partners will lead the STP in moving forward. The direction for acute providers is for them to work in a more aligned way that allows possibilities in service reconfiguration in collaboration which would allow staff sharing across sites enabling better skill mix and more opportunities for staff.

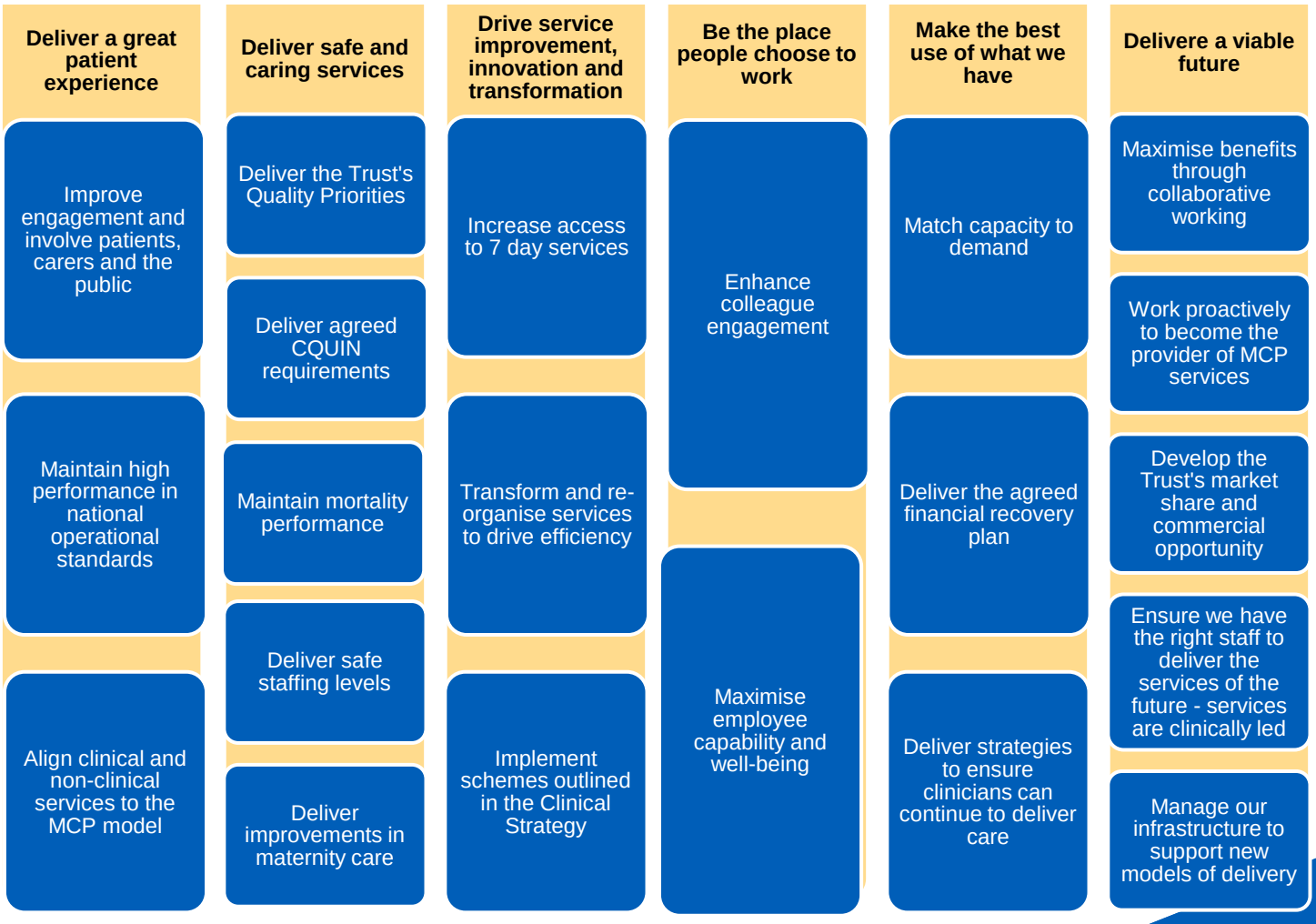
- Last year, DGFT entered into a two year contract with Dudley CCG for 2017/18 and 2018/19 which set out the requirements and deliverables for the two year period following the national NHS Improvement Operational Planning and Contracting Guidance for 2017/19. The Trust CCG has negotiated a refresh of activity and income for Year two following the publication of the CCG's commissioning intentions for 2018/19 in September 2017 and the NHS England and NHS Improvement Joint Planning Guidance published in February 2018 which sets out details of financial and planning assumptions for 2018/19 .

- The CCG are commissioning a Multi-specialty Community Provider (MCP) for Dudley which will join services from April 2018 into one new organisation to integrate care in people's homes and the community, improving access to, continuity, and coordination of care through standardised best practice pathways and practice based Multi-Disciplinary Teams. DGFT has bid for this work with Birmingham Community Health and Care Trust supported by Dudley GPs. Some services currently provided by DGFT will be delivered through the MCP including some out-patient and community based services, intermediate care and end of life services. This will transform the way in which DGFT provides services to patients and the MCP will require significant reconfiguration of services currently provided by DGFT.

4. Our annual priorities for 2018/19

Each year the Trust agrees a set of annual goals which enable the delivery of the six strategic objectives. These are summarised in the diagram below, with further information outlining how these will be delivered and how success will be measured in appendix two. The annual goals have been derived from:

1. National Requirements directed from NHSI, NHSE and central government
2. Commissioners' priorities
3. Quality priorities
4. Financial sustainability
5. Goals brought forward from last year's plan (e.g. because they relate to longer term pieces of work)
6. Identification of new opportunities



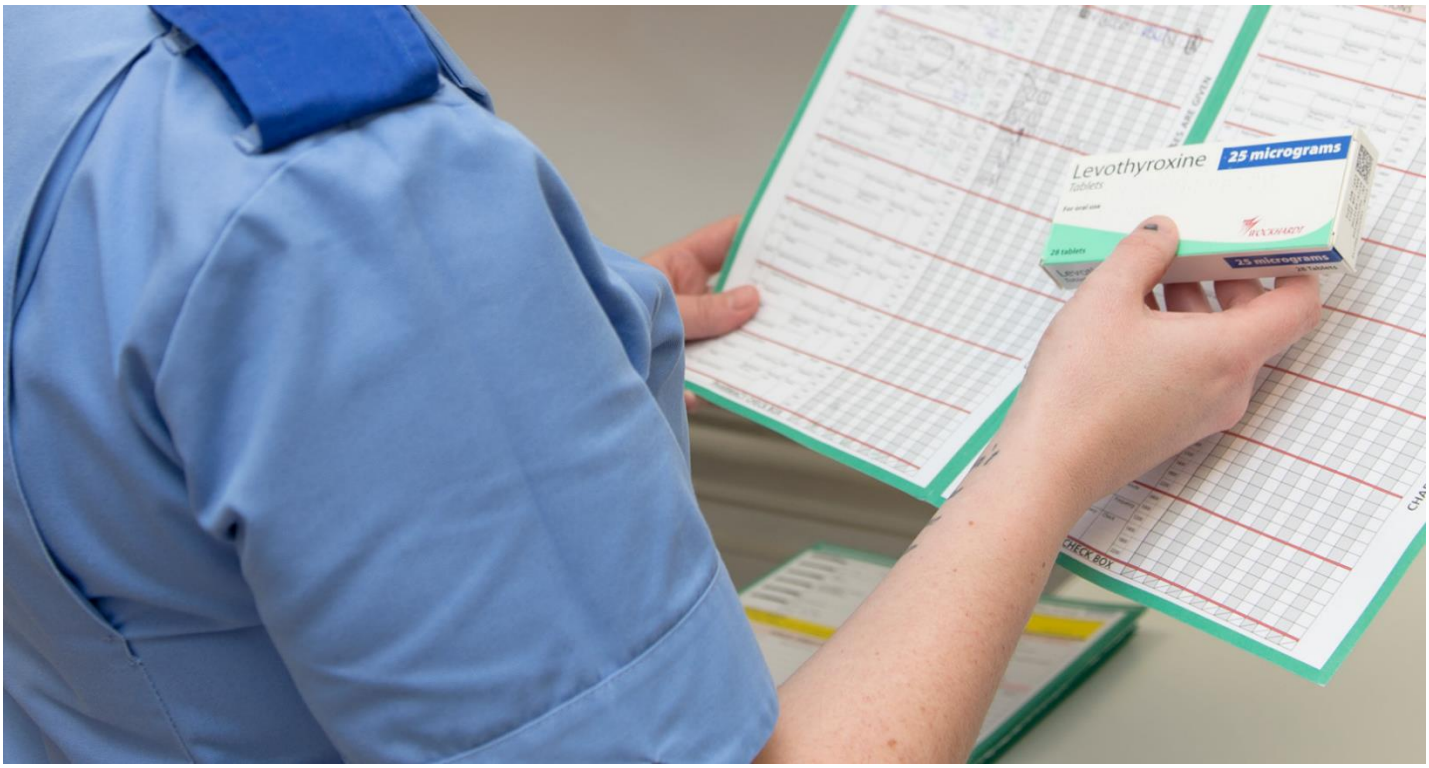
5. Our approach to quality

i) Quality Priorities

The Trust has a Quality Improvement Strategy which describes the Trust's approach to delivering quality improvements which, in turn, improve patient experience. Following consultation with staff, patients and Governors the Trust has agreed quality priorities and will continue to seek improvements in each:

- Patient experience - the NHS Friends and Family Test (FFT) is embedded within the Trust with all patients provided with an opportunity to complete the survey. The FFT provides the Trust with valuable data to improve the patient experience. The recording of pain scores and the monitoring of analgesia efficacy is also an important element of patient experience and integral to this quality priority. Monitoring of patient involvement in decisions about their care was introduced as a new target in this quality priority in 2017/18 in response to recognition that this was an area for improvement and focus will continue into 2018/19. In addition, the Trust is working to strengthen its approach to complaints.
- Infection prevention and control - prevention and control of infections remains a Trust priority. NHS England has a zero tolerance of MRSA bacteraemia and the Trust has a challenging nationally-set target set of no more than 28 C. diff cases for 2018/19. All cases undergo a root cause analysis to determine of there have been lapses in care.
- Pressure ulcer prevention - pressure ulcers are difficult to treat and slow to heal, and prevention is therefore a priority. Although the Trust has continued in the long term to reduce the overall number of pressure ulcers, it aims to move to a zero-tolerance approach in both the hospital and community.
- Nutrition and hydration - poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. An audit tool is in use across the hospital and community to help monitor and improve in this area.

- Medications - patients receiving their prescribed medication appropriately and on time contribute to patient wellbeing and recovery is an indicator of the overall quality of patient care. The recording of 'medications signed and dated as administered' and 'doses with an omission code recorded' are audited as part of the Nursing Care Indicators.
- Falls – The Trust is working towards ensuring that we score equal or better than the National average for the number for all falls and falls with harm. A risk assessment will be carried out within 4 hours of arrival to determine if the patient is at risk of a fall so adequate care plans can be implemented.



In addition, the Trust is working to improve the quality of mortality review and Serious Incident investigation and subsequent learning and action. All deaths in the hospital are reviewed using the unique Mortality Tracking System and the aim is to have 85% of deaths reviewed by the team responsible for that patient's care within 12 weeks. For 2018/19, the mortality review process will continue to be expanded building on the engagement with GP and CCG colleagues to include primary care.

These priorities were agreed due to their importance both from a local perspective (e.g. from patient feedback) and from a national perspective. They will continue to have a key role in providing good quality patient care at DGFT and each priority has an agreed set of specific targets which are monitored through the Trust's Annual Plan. Quality priorities are described in detail in the Trust's Annual Quality Account.

i) Quality improvement and quality governance arrangements

The Trust continues to strengthen its systems of learning to ensure improvement using a variety of methods such as internal risk assessments, internal quality and safety reviews, feedback from incidents, learning events and transformation projects.

The Trust has a wide-ranging clinical audit programme which focuses on national 'must do' activity, including, national clinical audits and those audits that provide assurance of our compliance with NICE guidance. The Trust plans to participate in all of the national audits relevant to its services. In addition, delivering services 24/7 remains a key part of the Trusts strategy. The Trust continues to comply with the relevant national safe staffing requirements, mental health standards and will implement actions from the Better Births review to deliver national standards in maternity care. The Acute Trusts across the Black Country are piloting the provision of seven day Interventional Radiology services locally resourced through a rota system between the Trusts. The provision of safe and effective 7 day services is more achievable through collaborative working with partners. A Trust plan is being developed to drive implementation of seven-day hospital services.

All deaths in the hospital will continue to be reviewed using our Mortality Tracking System with the aim to have 85% of deaths reviewed by the team responsible for that patient's care within 12 weeks. The Deteriorating Patient Strategy aims to policy details how detection of and management of the deteriorating patient is delivered, and the management of cardiopulmonary resuscitation events, as well as the equipment required and audits undertaken and what resuscitation training is required for clinical staff groups. The Trust is re-energising falls prevention, management and reporting within the Trust; is working to increase timely identification and management of sepsis and is committed to transform the quality of end of life care in acute and community settings.

Quality Impact Assessments (QIAs) are undertaken and reported to CQSPE for all transformation projects. These are undertaken using an agreed standard processes within an explicit governance framework and a Standard Operating Procedure.

The reporting system for quality issues is via divisional governance groups, the trust-wide Clinical Quality, Safety and Patient Experience Committee (CQSPE) and then onto Board.

i) DGFT Charity

The DGFT charity is not about providing healthcare. Charitable donations that are received enable us to provide comfort and facilities above and beyond those provided by the NHS, thus enhancing a person's visit to support their well-being, as well as improve their recovery and overall experience. Fund raising has taken place in 2017/18 in support cancer, dementia, paediatrics and rehabilitation and events planned for 2018/19 include the Forget Me Not Ball which will raise awareness of and funds for dementia care; a Neon 5K Dash; Silent Auction and Wheelchair Push Campaign

i) CQUINS

The CQUIN payment framework was introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. Whether the Trust receives its CQUIN payments is dependent on achieving certain quality measures. This means that some of the Trust's income is conditional on achieving certain targets that are agreed between the Trust and our commissioners (Dudley CCG and NHS England). A proportion of the Trust's income for 2018/19 is conditional upon achieving goals agreed for 2017/18 and 2018/19 as outlined below. Delivery of CQUINs are over seen by service leads supported by the Business and Transformation Team who help with the development and monitoring of robust CQUIN delivery plans which ensure that the required changes are delivered.

CQUIN	Description	17/18	18/19
1.	Improving Staff Health & Well Being	✓	✓
2.	Reducing Serious Infections	✓	✓
4.	Improving services for patients with mental health needs attending A&E	✓	✓
6.	Offering Advice & Guidance (A&G)	✓	✓
7.	E-Referral System	✓	✓
8.	Safe & Proactive Discharge	✓	✓
9.	Preventing Ill Health (risky Behaviours)	✓	✓

Specialised Services			
WC5	Neonatal Outreach	✓	✓
MO	Medicines Optimisation	✓	✓

Public Health			
AAA	Aortic Aneurysm Screening	✓	✓
Oral/Dental Surgery	Daycase to Outpatient Procedure	✓	✓

i) Care Quality Commission (CQC) inspection

The trust has been inspected recently by CQC and we await their report. The CQC also undertook their annual Well Led assessment. Whilst we await the CQC report, the Trust has put a comprehensive improvement plan in place which not only address the CQC concerns (many of which were addressed immediately as they were raised), but also planned service improvements. The monitoring of the delivery of this plan is being reported to the Board and the Clinical Quality, Safety and Patient Experience Committee as well as providing formal feedback to the CQC themselves. The Board has placed a specific risk on the Trust's Board Assurance Framework.

In order to support the Board's continued review of the Trust's compliance with the CQC's requirements, management has continued with their regular internal quality and safety reviews. These involve a multi-disciplinary team, including members of our Council of Governors and representatives of the Dudley Clinical Commissioning Group's Quality Team, visiting clinical areas on an unannounced basis to observe clinical practices, question staff on their knowledge and compliance with Trust polices and to secure immediate patient feedback on their experiences. The outcome of these reviews is reported back to the clinical area on the same day allowing them to continue with identified good practice and make any enhancements swiftly. The outcomes of these reviews are also shared across the Trust to allow good practice to be shared, enabling each area to learn from each other which is further assisted by having within the multi-disciplinary team, peer matrons and clinicians from other wards.

The Director of Governance has incorporated both the findings from the external review and the CQC into the main quality and service improvement plan for the Trust for 2018/19. Reporting on progress against this plan is scheduled to be provided to the Board across the forthcoming year.

6. Our workforce

FIGURES TO BE REVIEWED AT YEAR END AND FOLLOWING FINALISATION OF 2018/19 ACTIVITY AND WORKFORCE PLANNING

i) Our approach to workforce planning

The Trust's Workforce Strategy articulates the key actions that the Trust will take in order to ensure that it has a workforce with the capacity and capability to meet the Trust's aspirations, particularly to deliver safe and effective patient care.

DGFT regards workforce planning as an essential part of its operational planning process. Divisions develop workforce plans which take into account their activity and capacity requirements as part of the operational planning process. The Divisional workforce plans for 2018/19 were developed through a process which involved Directors of Operations, Directorate Managers, clinicians, Human Resource Managers and Finance staff. These plans recognise the impact that that staffing levels have on the provision of high quality and safe care and any implications for cross-functional working are recognised and managed.

The Trust plans to have a workforce of 4,677 staff (4,270 clinical, 407 non clinical), including part time staff as at March 2019. This is an increase of 296 whole time equivalents compared to the forecast WTE for March 2018. The increase is generally linked to recruiting to vacant posts coupled with increased establishments linked to approved business cases and quality initiatives. Pay costs will account for 60.5% of our expenditure budget in 2018/19 and the budgeted estimate for workforce in 2018/19 is planned to rise to £214.183m. The planned vacancy rate is expected to average 7.5% during 2018/19 (higher at the outset but reducing throughout the year as vacancies are recruited to). This reflects a slight improvement on the forecast March 2018 vacancy rate of 7.7%.

In 2017/18, the Trust is forecast to spend £11.594m on agency staff which is £2.494m less than the previous year. The Trust has a target to reduce this spend to £6.183m in 2018/19 and a number of initiatives are in place to support recruitment of permanent staff and conversion of agency staff to bank, especially for nursing posts. The Workforce Strategy supports the concept of a sustainable workforce and has particular emphasis on supporting best practice initiatives for staff recruitment and retention. The Workforce and Staff Engagement Committee provides specific support for areas where there are 'hard to fill' or retention issues. Focused recruitment campaigns are planned in 2018/19 for nurses, Allied Health Professionals (Speech & language Therapists, Radiographers) and middle grade medical staff. These campaigns highlight the benefits of working in Dudley and promote the positive development opportunities the Trust provides. The Trust supports cooperative working across the region and is actively involved STP workforce initiatives, enabling sharing of best practice and collaboration for both nursing and Allied Health Professional recruitment.

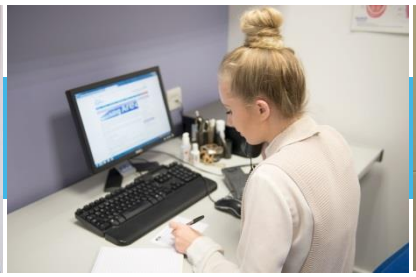
The plan each year for the number of apprenticeships is set nationally as 2.3% of our workforce which in 2017/18 was 111. By the end of 2017/18 we expect to have delivered 85. The plan for 2018/19 is to meet the target of 111.

i) Workforce monitoring and skills development

Key workforce indicators including vacancy, turnover, sickness absence, appraisal and mandatory training compliance are monitored monthly at divisional performance meetings and are also presented to the Trust Board within the Integrated Performance Report.

The appraisal process helps to enable staff to understand how their role relates to service delivery and the Trust's strategic objectives. The appraisal information also provides an understanding of the training needs analysis for the Trust by staff group and by area. Arrangements for appraisal have been developed further such that all appraisals should take place between April and July, following publication of Trust objectives in order that this can inform managers of strategic direction and support clearer local objective setting. Mechanisms for assuring the quality of the appraisal meetings and outcomes will be developed further through the appraisal training programme.

The Trust is currently implementing a variety of programmes to address opportunities for staff development. A new Executive Development programme is being introduced from December 2017 alongside the introduction of the Leadership Forum from November 2016. The Leadership Forum includes the top 100 leaders in the Trust and will also be underpinned by a new leadership development programme that will be run in partnership with NHS Elect and is expected to commence in January 2018. This will provide coaching for medical managers and a cohesive development plan taking consideration of our areas of development, the priorities of the Trust and succession planning.


Workforce engagement

The Trust is aware from the staff survey that there is more work to do on staff engagement. Whilst our overall staff engagement score continues to be better than the national average and 25 of the survey's 32 key findings are on a par with or better than similar type trusts, DGFT are working to:

- Increase the percentage of staff/colleagues reporting most recent experience of violence
- Increase the percentage of staff agreeing that their role makes a difference to patients/service users
- Decrease the percentage of staff working extra hours
- Increase the percentage of staff satisfied with the opportunities for flexible working patterns
- Increase the percentage of staff reporting errors, near misses or incidents witnessed in the last month

Health and wellbeing services and support underpin the Trust's workforce strategy and the first ever Staff Health and Wellbeing Fair, offering staff a free NHS health check and advice on eating and living well took place in February 2016. Further events are planned for 2018/19.

The Trust has improved the way it communicates and engages with staff. Recent changes include monthly team briefings by the Chief Executive, 'Breakfast with the Boss' and Directors' Blogs. The introduction of the quarterly Leadership Forum in November 2017 has helped us take stock on our performance against the Trust's strategic aims and gives opportunity for reflecting on progress. Staff achievements are recognised through 'HealthCare Heroes' and annual 'Committed to Excellence Awards.'

7. Our financial plans

FINANCIAL DETAIL TO BE FINALISED FOLLOWING COMPLETION OF 2018/19 BUDGET SETTING

Our plans for 2018/19

Having achieved its control total and receiving STF funds in 2016/17, the Trust agreed with NHS Improvement a surplus plan of £2.530m for 2017/18. In 2017/18, DGFT is currently forecasting a deficit of £8.6m (£11.130m adrift from the control total). An in-depth financial review is currently in progress to determine the feasibility of reducing this forecast deficit, including the identification of additional saving ideas. The Trust achieved the required finance targets in Quarter One and Quarter Two and the required performance targets in Quarter One, resulting in the receipt of £2.487m Sustainability and Transformation Funds (STF). However, due to the financial position, the remaining £6.087m STF will be lost.

Detailed financial plans are being developed for 2018/19 via budget setting, capacity planning and contract discussions with commissioners at which an underlying activity baseline assumption is set.

The 2018/19 plan takes account of the pressures being experienced in 2017/18 along with in-year developments that have been agreed. A further complication relates to the development of an MCP within Dudley. The vehicle for the delivery of the MCP could have a significant impact upon the Trust financial position and will need to be factored into the long term plans.

The table below shows the latest budget position and forecast for 2017/18 and the original submitted plan for 2018/19. This will require an update based on the final agreed figures.

	Latest Budget 17/18	Latest Forecast 17/18	NHSI Plan 18/19
	£000	£000	£000
Patient Care Income	£328,440	£324,604	£337,141
Other Operating Income	£22,112	£23,213	£21,440
Employee Costs	-£206,521	-£213,522	-£214,183
Other Operating Costs	-£118,799	-£120,203	-£117,072
Operating Surplus/(Deficit)	£25,232	£14.092	£27,326
Finance Costs/Depreciation	-£22,702	-£22,694	-£22,891
Underlying Surplus/(Deficit)	£2,530	-£8,602	£4,435
STF Funding	£8,574	£2,487	£12,057
Final Surplus/(Deficit)	£11,104	-£6,115	£16,492

The Overall Plan Risk Ratings for the Year show that the Trust is anticipating a score of 1 in 2018/19.

Financial Risk Ratings	Latest 17/18	Plan 17/18	Plan 18/19
Capital Service Cover rating	4	2	2
Liquidity rating	2	1	1
I&E Margin rating	4	1	1
Variance From Control total rating	4	1	1
Agency rating	4	1	1
Plan Risk Ratings after overrides	4	1	1

Our divisional financial planning process is driven from the clinically-led activity planning exercise that took place in the autumn of 2017.

Efficiency Savings for 2018/19

The Trust planned to achieve an internal cost improvement programme of £12.420 in 2017/18 (3.5%). The current financial pressures mean that the Trust will need to develop a significantly increased savings plan for 2018/19 of £20.8m in order to develop an overall plan that is consistent with the agreed control total.

Schemes include local efficiency plans as well as ideas developed alongside partners within the Black Country Alliance and the wider STP. The plans seek to embrace the Carter benchmarks and utilise the Model Hospital, whilst best practice tariffs are explored continually for increased income opportunities that deliver an improved patient experience.

iii) Lord Carter

The Lord Carter Review, published in February 2016, looked at how savings can be made by the NHS to make their hospitals safer and more efficient at the same time by removing unwarranted variations. The report outlined potential savings opportunity and recommendations for how they can be achieved. The Business Development and Transformation Team is working with divisions to assess the Lord Carter opportunities by using the analysis within the Model Hospital Portal, and where relevant to include these in the Cost Improvement Programme. A reporting framework is in place in which to disseminate the information from the Model Hospital Portal and identify service areas where improvements in productivity and efficiency can be made. The data that is used to support Get it Right First Time reviews is now available through the Lord Carter portal and is being used to benchmark the trust and support identification of areas for improvement. As a result of analysis of the Lord Carter data, the Trust is exploring additional opportunities for cost efficiencies in both Surgery and Medicine. The Trust is also participating in the NHS England Elective Care Transformation Programme to reconfigure patient pathways in three specialties – Urology, ENT and Cardiology – with the aim of managing demand and improving both patient experience and efficiency of services.

8. Our activity plan

DETAIL TO BE REVIEWED FOLLOWING FINALISATION OF 2018/19 BUDGET SETTING

This section outlines the level of activity (demand) that is expected at DGFT in 2018/19 and indicates the resources (e.g. theatres, bed) that are required to meet the demand (workforce is considered in Section Six) . Activity planning is a bottom up process that is undertaken by divisions. Activity includes elective referrals from GPs and other health professionals and emergency activity (either referred from GPs, brought by ambulance or patient self-referrals).

The revised joint planning guidance and additional CCG allocations places a requirement upon Commissioners to ensure activity plans adequately reflect growth assumptions and ensure maintenance/improvement of RTT levels. However, the CCG will also have several QIPP schemes designed to reduce demand, i.e. procedures of limited clinical value, Urgent Care Centre. The Trust is working actively with the CCG to develop proposals to deliver these, but will be careful to ensure that sufficient capacity exists to deliver higher levels of activity in-year if these schemes are either slow to implement, or do not deliver the reductions in activity that are expected. The modelled activity plans start with a baseline period before applying growth and other relevant amendments. Some of the reductions in the table below reflect current levels of under-performance.

	2017/18 planned	2018/19 planned	% Change
A&E	101,381	105,833	4.4%
Elective	6,630	5,865	-11.5%
Daycase	47,755	48,774	2.1%
Emergency	54,125	41,410*	2.1%*
Outpatient first	125,671	157,413*	6.9%*
Outpatient follow up	322,415	316,232	-1.9%
Outpatient Procedure	67,005	70,854	5.7%
Births	4,518	4,423	-2.1%
Community	391,586	399,562	2.0%

*There was an in-year coding change during 2017/18 which reclassified an element of assessment unit activity from an emergency admission to an outpatient first. The estimated impact within the 2018/19 plan is a reduction of 13,850 emergency admissions and an increase of 23,083 outpatients

Capacity modelling tools developed by NHSI and NHSE are being used to maximise the use of existing facilities. As such, there are no explicit plans to use the independent sector and the Trust viewpoint is that internal plans provide sufficient activity to deliver the key operational standards. The number of available general and acute inpatient beds will flex up to cater for peaks in demand, particularly over the winter period. It is thus expected that beds will range from 633 to 664 during 2018/19. In addition, we will continue to reduce length of stay by focusing on stranded patients and working with the Local Authority to reduce delayed transfers of care (DTOC) through our patient flow improvement programme. There has been national funding of £7m made available to Social Care in Dudley to support winter pressures and reduce DTOCs over the next three years. By ensuring that the Trust matches demand and capacity, we will work to deliver the national operational performance standards:

- ✓ Urgent Care – we will strive to deliver the four hour A&E standard of above 90% by September 2018, and 95% standard for March 2019. To do this, we will expand and reconfigure the Emergency Department; put effective ED triage in place; work towards a 24/7pediatric ED; implement a community response team at the front door; review our site model and escalation processes; review the effectiveness and impact of the new Urgent Care Centre and work in partnership with Dudley and Walsall Mental Health to improve 24 hour access to mental health services in A&E;

- ✓ Referral to treatment times (RTT) - we will continue to meet the 18 week RTT (92% of incomplete pathways) and the new NHS Improvement target of the RTT waiting list being no higher in March 2019 than in March 2018 across all specialties. Specialty-specific plans are in place to achieve this which are monitored through monthly divisional performance meetings.

- ✓ Cancer – the Trust will enhance delivery of the national cancer targets of 85% of patients receive first treatment from within 62 days and 93% of patients seen within two weeks of referral. Our Cancer Strategy will support delivery of these targets.

- ✓ Diagnostics – the Trust is currently meeting the six week diagnostic targets and is developing a five year plan to support timely access to diagnostics.

- ✓ Patient flow – the Dudley health and social care economy are working to reduce delayed transfers of care to ensure that we achieve less than 3.5% bed days each month and reduce stranded and super-stranded patients. Daily conference calls with the local authority relating to complex patients take place and we will utilise Red2Green as a sustainable tool to identify ward delays, whilst also undertaking weekly stranded patient reviews and reducing waiting times for discharge medication through the deployment of ward-based prescribers.

9. Our capital plan

DGFT delivered a number of significant capital schemes in 2017/18 which included the development of a community imaging hub at the Guest Outpatient Centre (£2.083m) and the development of a co-located Urgent Care Centre and ED Department (£2.348m). In addition the Electronic Patient Record project commenced with £7m invested during the year. This will give clinicians fast access to patient information wherever they need it, helping to ensure the highest levels of safety and quality in patient care and will support the NHS Five Year Forward View to become 'paper-free at the point of care' by 2020

The Trust plans to deliver the following major capital schemes in 2018/19:

- Continuation of the Electronic Patient Record project with further investment of £2.3m.
- The development of a hybrid theatre that will assist in the management of emergency vascular patients and provide additional theatre capacity to support additional elective activity. This will involve the creation of new theatre with hybrid facilities (£6m).
- The redevelopment of EAU (£3m). This will involve moving EAU to a more suitable area in the hospital improving facilities. The existing EAU area will be redeveloped to increase the A&E treatment area and re-provide the paediatric emergency area.

In addition, the Trust has a rolling medical equipment replacement programme and a clear replacement structure which includes a medical devices group which oversees the purchase of all medical equipment. There will also be smaller capital schemes relating to the lifecycle of the remaining owned estate and minor capital works in the PFI buildings.

For 2018/19, capital plans total £18.226m with £13.975m funded from surplus cash and depreciation and £4.251m by the PFI provider. The Trust is currently reviewing its non-operational land to see if there is any opportunity for sale. The Trust operates out of PFI buildings, so there is no requirement to fund back log maintenance from capital resources and this is the responsibility of the PFI Company.

10. Risks

The Trust has a risk and assurance framework in place with robust processes in place for identification, recording and monitoring of risks and governance processes that support this. Corporate Risks are supported by a hierarchy of Divisional and Directorate risks which are all reviewed quarterly, but updated as required on a regular basis. The key risks in the delivery of this annual plan are listed below.

Risk	Mitigation
Adverse Financial settlement	Financial Improvement Group in place to rigorously monitor Trust finances and cost improvement measures
Not delivering the Cost Improvement Programme.	Financial Improvement Group in place to rigorously monitor Trust finances and cost improvement measures
Workforce recruitment and retention	Recruitment and retention plans in place, along with workforce development initiatives
Skill mix of staffing	Recruitment plans in place, especially for hard to recruit to posts; skills development programmes in place
Not getting control of agency spend	Robust rules around requesting use of agency staff; recruitment and retention plans in place
Uncontrollable demand for services	Robust directorate planning processes in place to be reviewed regularly; reconfiguration of urgent care and acute medicine services
Changes in external environment	Trust has mechanisms for horizon scanning in place and regular review of ability to deliver
Development of MCP	DGFT is playing a lead role in shaping the form of the MCP and developing MCP services
Non-delivery of CQC inspection requirements	Robust action plan in place with rigorous monitoring

11. Conclusion

There is no doubt that the financial position of the trust will mean that 2018/19 will be a challenging year. However, we are committed to delivering the Cost Improvement Programme and achieving aggregate financial balance. The new Financial Improvement Group will monitor progress, ensure grip and control, challenge any slippage whilst supporting staff to remove any obstacles to achieving their plans.

DGFT are committed to ensuring that the population it serves receive high quality, timely care and considers this plan to be the key vehicle to delivering this. We will strive to implement the priorities and initiatives identified, in particular the national standards and the improvements outlined in our CQC action plan. The Trust will work towards embracing the opportunities and challenges presented by the implementation of the MCP; the Sustainability and Transformation Plan as well embracing opportunities afforded through the implementation of new technologies (particularly the Electronic Patient record), the development of new market opportunities and maximising the benefits of collaborative working. In doing this, the Trust recognises that it needs to continue to invest in and develop its workforce, continue to engage patients and act on their feedback and retain a focus on our quality of priorities.






The plan will be monitored through robust governance processes in line with the Board Assurance Framework and through Governor and Executive Director oversight. This will secure compliance to ensure that the trust delivers against the plan and brings improvements to the care to the population it serves.

The Dudley Group
NHS Foundation Trust

Appendix 1

Our vision

Trusted to provide safe, caring and effective services because people matter

NHS
The Dudley Group
NHS Foundation Trust

Deliver a great patient experience

- Improve engagement and involve patients, carers and the public in their care and the work of the Trust
- Maintain high performance in national operational performance standards:
  - Urgent care
  - Patient flow and delayed transfers of care
  - Deliver the National Cancer Strategy
  - Develop a five year plan for timely access to diagnostics
- Meet the referral to treatment time standards across all specialties
- Align clinical and non-clinical services to the Multi-specialty Community Provider model
- Deliver an improved CQC rating

Deliver safe and caring services

- Quality Priorities focus on:
  - Pressure ulcers
  - Infection control
  - Nutrition and hydration
  - Medication management
  - Incident management
  - The use of the National Early Warning Scores
  - Improve End of Life Care
  - Deliver the actions to reduce patient falls
- Deliver agreed CQUIN requirements
- Maintain good mortality performance
- Deliver safe staffing levels
- Deliver improvements in maternity care

Drive service improvement, innovation and transformation

- Increase access to 7 day services
- Transform and re-organise services to drive efficiency and improve key services
- Implement schemes outlined in the Clinical Strategy

Be the place people choose to work

- Enhance colleague engagement
- Maximise employee capability and well-being

CARE

RESPECT

RESPONSIBILITY

Make the best use of what we have

- Match capacity to demand
- Deliver the agreed financial recovery plan through to 2019/2020
- Develop strategies to ensure the clinical workforce can continue to provide care

2018
2019

Deliver a viable future

- Maximise benefits through collaborative working
- Work proactively to become the provider of MCP services
- Develop the Trust's market share and commercial opportunities
- Ensure we have the right staff to deliver the services of the future
- Manage our infrastructure to support new models of delivery

Integrated care closer to home

High quality hospital based care

Specialist services locally

The Dudley Group
NHS Foundation Trust

Appendix 2

2018/19 Annual Plan

The Dudley Group
NHS Foundation Trust

Operating Plan 2018/19

Our vision: Trusted to provide safe, caring and effective services because people matter	
Our Values: Care, Respect and Responsibility	
Our Six Strategic Objectives:	
Deliver a great patient experience	**Be the place people choose to work**
Deliver safe and caring services	**Make the best use of what we have**
Drive service improvement, innovation & transformation	**Deliver a viable future**

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
Strategic aim one: deliver a great patient experience				
➢ **Improve engagement and involve patients, carers and the public in their care and the work of the Trust**	✓ Implement approaches that engage and involve patients, carers and the public in their care / service developments and provide opportunities for feedback ✓ Improve the FFT response rate ✓ Further develop mechanisms to implement learning from feedback ✓ Increase the use of Listening into Action (LIA) with Patient Groups ✓ *Achieve the Trust's agreed response timeframe for complaints and by Q4 all responses to include action plan details and learning as a result.*	✓ *Percentage positive monthly FFT/patient survey scores equal to or better than the national average for all areas (Adult Inpatient, Children and Young People, Maternity, Emergency Department, Cancer Patient Experience).* ✓ *Response rate for FFT survey better than our previous score for all areas (Inpatients, Outpatients, Maternity, Emergency Department and Community).* ✓ *Improve on our annual National Patient Survey results* ✓ *Improve the overall year score from 2017/18 to 2018/19 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?'* ✓ *Timeframe for complaints response improved from 2017/18 baseline.*	March 2019	Chief Nurse
➢ **Maintain high performance in national operational**	**Urgent care** ✓ Expand and reconfigure the Emergency Department ✓ Effective ED triage in place ✓ 24/7pediatric ED in place	✓ *Four hour A&E standard is above 90% for month of September*	March 2019	Chief Operating Officer

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
performance standards:	✓ Implement a community response team at the front door ✓ Review site model and escalation processes ✓ Review surgical and paediatric pathways ✓ Review the effectiveness and impact of the new Urgent Care Centre ✓ Work in partnership with Dudley and Walsall Mental Health to improve 24 hour access to mental health services in A&E ✓ Review the Acute Medical Model	*2018, and 95% standard is met for March 2019 (refer to 2018/19 NHS I Planning Guidance)* ✓ *New Acute Medical Model in place (Quarter 1)*		
	Patient flow and delayed transfers of care ✓ Deliver the Dudley Health Economy Delayed Transfers of Care Improvement Plan ✓ Engage partner Local Authorities in daily conference calls relating to complex patients ✓ Utilise Red2Green as a sustainable tool to identify ward delays ✓ Undertake weekly stranded patient reviews ✓ Reduce waiting times for discharge medication through the deployment of ward-based prescribers	✓ *Reduce Delayed Transfers of Care from March 2018 achieving < 3.5% bed days each month (refer to 2018/19 NHS I Planning guidance).* ✓ *Reduce stranded and super-stranded patients from March 2018 baseline (refer to 2018/19 NHS I Planning Guidance).*		
	Cancer ✓ Deliver the national Cancer Strategy ✓ Design Dudley GP Strategy ✓ Improve PTL tracking ✓ Cancer patient meetings in place	✓ *85% of patients receive first treatment from: i) urgent GP referral for suspected cancer ii) NHS cancer screening service referral within 62 days* ✓ *93% of patients seen within two weeks of referral* ✓ *Cancer Strategy launched (Quarter one)*		
	Imaging ✓ Develop a five year plan for timely access to diagnostics.	✓ *Six week wait for diagnostic procedures (99%) (DM01)*		
	Referral to treatment time ✓ Make improvements to individual pathways that are not meeting national RTT standards	✓ *18 week RTT – 92% of incomplete pathways for all specialties* ✓ *RTT waiting list will be no higher in March 2019than in March 2018 (refer to 2018/19 NHS I Planning guidance).*		
➢ **Align clinical and non-clinical services to the MCP model**	✓ Implement revised pathways for all MCP work streams ✓ Reconfigure services remaining at DGFT ✓ Work closely with primary care to optimise the outcomes of the MCP	✓ *To be determined on the outcome of procurement* ✓ *Regular discussion in place with practices and localities*	March 2019	Medical Director/Chief Operating Officer
Strategic aim two: deliver safe and caring services				

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
✓ **Deliver the Trust's Quality Strategy Priorities**	✓ Implement the priorities within the Trust's Quality Strategy: • Patient Experience • Pressure ulcers • Infection control • Nutrition and hydration • Medication management • Discharge processes • Improve delivery in incident management	✓ *Targets outlined in the Trust's Quality Strategy achieved.* ✓ *Fluid Balance* – Ensure that in 95% of cases documentation related to fluid balance is filled in fully. ✓ *Achieve equal to or better than 90% compliance for sepsis screening.* ✓ *Achieve equal to or better than 90% compliance for antibiotic treatment within an hour of time zero for red flag sepsis.* ✓ *Incident reporting rate will be in the top 50% of acute non-specialist Trusts each six months.* ✓ *All serious incidents to be managed in line with national Standards: All Serious incidents, including Never Events, sent to commissioners within 60 days*	March 2019	Chief Nurse Director of Governance
	✓ Monitor the use of the National Early Warning Scores to ensure it is being utilised effectively in order to identify deteriorating patients and minimise impact	✓ *Monthly Quality Indicators for NEWS, PEWS and MEOWS will demonstrate equal to or better than 95% compliance*	March 2019	Chief Nurse
	✓ Improve End of Life Care	✓ *85% of staff on adult wards will have signed up, attended training and started to implement the Gold Standards Framework (GSF)* ✓ *60% of deaths will have the Priorities for Care of the Dying Person Communication Document in place*	March 2019	
	✓ Deliver the action plan on the reduction in patient falls within the Trust	✓ *Ensure that the Trust is equal to or better than the national average for number of; falls and falls with harm.* ✓ *A minimum of 95% of patients will have a falls risk assessment completed within 4 hours of admission*	March 2019	Chief Nurse
✓ **Deliver an improved CQC inspection rating**	✓ Implement and monitor the post-inspection action plan ✓ Provide feedback on progress to CQC	✓ *Internal mechanisms for ongoing monitoring of action plan in place* ✓ *Progress reported to CQC and feedback received incorporated and implemented* ✓ *Improved inspection rating awarded*	March 2019	Chief Executive
✓ **Deliver agreed CQUIN requirements**	✓ Develop and deliver all CQUIN schemes	✓ *CQUINs reviewed in line with 2018/19 guidance (refer to 2018/19 NHS I Planning Guidance).* ✓ *CQUIN schemes are delivered to expected levels*	March 2019	Chief Operating Officer
✓ **Maintain good mortality performance**	✓ Continue to develop arrangements for learning from the death of patients in our care	✓ *SHMI/HSMR within expected range* ✓ *100% of hospital deaths have a multidisciplinary review*	March 2019	Medical Director
✓ **Deliver Safe staffing levels**	✓ Ensure all clinical areas are safely staffed, including all ward and community teams ✓ Ensure that substantive staffing is in place to cover agreed establishment requirements in both the	✓ *Reduction in nurse vacancy rates from 2017/18 baseline* ✓ *Working towards 0% CSW Agency Usage* ✓ *Continued reduction in non-framework qualified agency staff* ✓ *Reduction in agency usage from 2017/18*	March 2019	Chief Nurse Medical Director Director of HR

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
	community and hospital areas. Ensure that there is a reduction in vacancy rates. ✓ Undertake nurse staffing reviews for medicine, surgery and the community. ✓ Appoint a Recruitment and Retention Lead to drive nursing recruitment campaign. ✓ Continue to develop a junior/middle grade doctor recruitment and retention plan ✓ Implementation of Job Planning for all Consultant posts	✓ *Working towards achievement of NHSI cap for agency nursing/midwifery usage* ✓ *Extended acuity tools in place* ✓ *Job Plans in place for consultants* ✓ *Job plans saved on the Allocate system* ✓ *Annual Reviews in Job Plans.*		
✓ **Deliver improvements in maternity care**	✓ Develop and implement the Maternity Transformation Programme (Better Births) ✓ Implement the new national maternity dashboard once it is published ✓ Aspire to meet national emergency caesarean section rates	✓ *Reduction in babies with brain injuries that occur at or soon after birth* ✓ *Zero avoidable maternal deaths* ✓ *Achieve national average for non-elective caesarean rates*	March 2019	Chief Nurse
Strategic aim three: drive service improvement, innovation and transformation				
➢ **Increase access to 7 day services**	✓ Implement plans to deliver key standards ✓ Actively contribute to appropriate clinical networks to deliver seven day services for emergency vascular surgery, stroke, major trauma, heart attacks and paediatric intensive care.	✓ *Inpatients seen by a consultant within 14 hours in priority specialties* ✓ *Diagnostic services available 7 days a week* ✓ *Interventional services available 7 days a week* ✓ *On-going review of patients by consultants*	March 2019	Chief Operating Officer
➢ **Transform and re-organise services to drive efficiency and improve key services**	✓ Deliver Outpatients Transformation Programme	✓ *Booking processes redesigned to reduce DNAs and empty slots* ✓ *Review of Health Records and streamlining of library*	March 2019	Chief Operating Officer
	✓ Implement theatres transformation plans ✓ Implement hybrid theatre ✓ Address performance challenges in ophthalmology	✓ *Reconfigure half-day theatre lists* ✓ *Embed scheduling tool* ✓ *Review pre-assessment process*		
	✓ Implement the GIRFT recommendations for relevant specialities: Vascular Surgery, Urology, Ophthalmology, ENT, Oral and Maxillofacial Surgery; Trauma and Orthopaedics; Spinal surgery, Obstetrics and Gynaecology	✓ *Hip prosthesis rationalised* ✓ *ENT day case rates improved* ✓ *Consultant physician input to vascular surgery in place*		
	✓ Redesign and implement Single Point of Access aligned to the MCP frailty pathway	✓ *Increased admission avoidance* ✓ *Reduced ambulance conveyance for over 75s* ✓ *Receive referrals from primary care, community services and WMAS*		
	✓ Implement the Hospital Pharmacy Transformation Plan (HPTP)	✓ *Increase clinical pharmacy time by 80%* ✓ *Increase pharmacy prescribers to 70%* ✓ *Implement e-chemo prescribing system (October 2017)*		
Implement schemes outlined in the	Expand the following services • Orthodontics	✓ *Increase in number of new Orthodontics referrals per month* ✓ *Increase in number of referrals to Quetenza Pain Service*	March 2019	Chief Operating Officer/Medical

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
Clinical Strategy	• Specialist endoscopic services • Quetenza Pain service • Level 3 Haematology • Difficult asthma clinics • Ophthalmology			Director
	Redesign the following services: • Cardiology • Integrated Therapies services • Paediatric services (to improve flow) • Managing the unwell child • Pathology • MCP services	✓ *Increase number of day case cardiology patients* ✓ *Implement level 2 model of care for cardiology patients* ✓ *Integrated therapies into community SPA to reduce admissions and reduce LOS* ✓ *Reduced Paediatric overdue follow up appointments*		
Strategic aim four: be the place people choose to work				
➢ **Enhance staff engagement**	✓ Improve staff engagement through staff surveys/exit interviews/Friends and Family Tests/social media ✓ Embed the Staff Survey as a tool to help managers share best practice and make improvements to staff engagement ✓ Review of staff benefits and development of a unique staff benefits platform	✓ *Improvement in the national Staff Survey engagement score from 2017/18 baseline (to be set when baseline known)* ✓ *Action plans in place to support improvement in national staff survey for 2018.* ✓ *To achieve a return rate that is above the national average for 2017.* ✓ *Extend staff Friend and Family Test update* ✓ *Staff story presented at Board*	March 2019	Chief Nurse/ Director of HR
➢ **Maximise employee capability and well-being**	✓ Improve workforce performance in sickness, mandatory training, appraisal	✓ *Work towards improved Sickness absence rates for 2018/19 that are towards the target 3.5%.* ✓ *Achieve 5% improvement in two of the 3 health & well-being staff survey questions* ✓ *staff well-being events are held at least four times a year focusing on physical and mental health* ✓ *Mandatory training target of 90% met be end of year* ✓ *Appraisal target of 90% met by end of year* ✓ *Information Governance training target of 95% met by end of the year* ✓ *Site smoke free by December 2018*		
Strategic aim five: make the best use of what we have				
➢ **Match capacity to demand**	✓ Agree core contract for each service ✓ Identify underperforming services and develop mitigation plan ✓ Develop and Implement an operational demand/capacity management tool	✓ *Activity and income plans met* ✓ *Adequate capacity plans in place to meet activity in each area* ✓ *Decrease in WLIs* ✓ *Consultant and ANP Job planning in place to support capacity template*	March 2019	Chief Operating Officer

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
	✓ Review demand and capacity models for elective and outpatient activity ✓ Undertake a bed utilisation review ✓ Performance reviews for demand and capacity			
➢ **Deliver the agreed financial recovery plan through to 2019/2020**	✓ Set budgets that will achieve a £4.5 m surplus and monitor progress. ✓ Set a cost improvement programme of £20.8m	✓ *Budgets set that achieve a 4.5m surplus* ✓ *Deliver a cost improvement programme of £20.8m*	March 2019	Director of Finance/ Director of Strategy & Business Development
➢ **Develop strategies to ensure the clinical workforce can continue to provide care**	✓ Develop a Patient Safety Strategy ✓ Develop a Medical Workforce Strategy ✓ Develop a Research Strategy	✓ *Strategies written and approved by Trust Board*	May 2018	Medical Director
Strategic aim six: deliver a viable future				
✓ **Maximise benefits through collaborative working**	✓ Implement the agreed model for Black Country Pathology Services ✓ Develop opportunities for pharmacy benefits across Black Country Trusts ✓ Maximise Black Country back office opportunities ✓ Implement the Sustainability and Transformation Plan ✓ Lead on the Urgent Care Work Stream for the Sustainability and Transformation Plan (STP) ✓ Continue working on the ICS (Integrated care System) ✓ Create an internal MCP Division	✓ *Identified savings relating to BCA work streams (Procurement, Pathology, Pharmacy) achieved* ✓ *BCA procurement, Pathology and work streams implemented* ✓ *Dudley ICS developed* ✓ *MCP Division created*	March 2019	Chief Executive
✓ **Work proactively to become the provider of MCP services**	✓ Further invest in the MCP vanguard programme and continue to embed DGFT services within the model ✓ Implement revised care pathways ✓ Support and engage staff in the change process	✓ *MCP procurement process supported* ✓ *Revised care pathways in place*	March 2019	Chief Executive
➢ **Develop the Trust's market share and Commercial Opportunity**	✓ Identify and exploit opportunities for increasing the Trust's market share locally, regionally and nationally ✓ Review alternative income schemes and focus on business development activity	✓ *Market share opportunities identified and developed* ✓ *Income generation activities in place*	March 2019	Director of Strategy & Business Development
➢ **Ensure that we have the right staff to deliver the services of the future**	✓ Continue to implement Organisational Development Programme ✓ Enhance mechanisms to identify potential to support succession planning opportunities ✓ Complete nurse staffing review for Medicine, Surgery and the Community and recruit to new establishment. ✓ Continue to implement the nurse recruitment campaign ✓ Improve recruitment to 'hard to recruit' posts ✓ Boost staff retention through structured support	✓ *Organisational development programme in place* ✓ *Leadership Forum established.* ✓ *New roles in place and part of workforce planning process* ✓ *Reduce turnover rate to better than national average* ✓ *Monthly nurse recruitment events to take place with an average target of 10 recruits per event.* ✓ *Nursing associate program supports at least 20 staff a year* ✓ *Improved performance in Recruitment and Retention KPIs*	March 2019	Director of HR Chief Nurse

Goal	Key Actions	KPIs/Milestones	Timescale	Lead
➢ **Manage our infrastructure to support new models of delivery**	✓ Implement the core foundation systems for the Digital Trust	✓ *Each phase of the Digital Trust plan delivered in line with project plan*	March 2019	Chief Information Officer
	✓ Deliver a Shared Record between GPs and DGFT	✓ *Shared Record delivered*		
	✓ Align the Trusts strategy to the Dudley Local Estates Forum (LEF) and the Black Country STP Estates Strategy	✓ *Estates Strategy aligned*	Sept 2018	Director of Finance

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 12 April 2018

TITLE:	**19 March 2018 Audit Committee Summary Report to the Board**		
AUTHOR:	Richard Miner – Committee Chair	**PRESENTER**	Richard Miner – Committee Chair

CORPORATE OBJECTIVES

ALL

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		**Y**

RECOMMENDATIONS FOR THE BOARD

To note the assurances received via the Committee, the decisions taken in accordance with the Committee's terms of reference and action any items referred to the Board.

To confirm delegated powers to the Audit Committee for approval of the Trust's accounts and accompanying reports at its meeting on 22 May 2018.

Enclosure 13

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board
April 2018

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

CORPORATE OBJECTIVE:

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

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

A summary of the Digital Trust Programme Committee (DTPC) March 2018. Given the pending go-live and dynamic nature of the project dates have been updated with from subsequent meetings

- The Go-Live date for eObs is moved from Monday 23rd April 2018 to Thursday 26th April 2018 to coincide with reduced operational pressures.
- June and October Go-live dates remain as per the plan, exact dates within the month to be defined.

IMPLICATIONS OF PAPER: (***Please complete risk and compliance details below)***

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

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

Decision	Approval	Discussion	Other
	X	X	

RECOMMENDATIONS FOR THE COMMITTEE

The Board is asked to support a proposed Go-live of eObS on the 26th April 2018

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

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

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

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Digital Trust Programme Committee	21st March 2018	Ann Becke	yes	no
			X	

Declarations of Interest Made

None

Assurances received

Project status – Digital Trust

In the March DTPC meeting, a new rollout plan was approved in response to the CQC concerns about care of deteriorating patients.

- Spring rollout (April 26th) - Vital Signs recorded electronically at the bedside on tablet devices immediately calculating NEWS scores and providing decision support.

- Summer rollout – Inpatient clinical documentation, Order and Results Management (ORM), Electronic Prescribing and Medicines Administration (ePMA)

- Autumn rollout – Outpatients, Community, Maternity, Theatres and Critical Care. Readiness assessments have been conducted by both Trust project staff and the supplier, these both show that a number of critical dependencies have not been met which threaten the ability to go live on 26th April. Staff engagement – although there is no doubting staff support for the project, capacity and staff level pressures have resulted in project meeting cancellations due to lack of attendance, key decisions and approvals being delayed, and training attendance being far below required levels.

- Go-live issues that need resolving before 26th April 2018 :-

    1. First round testing issues identified 3 priority level one, with no fix yet identified.

    2. Training attendance levels for eObs (e-learning module are projected to reach 40% of staff instead of 85% threshold by 26th April. This requires ownership at departmental level supported by IT. Operational directors have accepted

ownership, but more work is still required.

- The cutover plan includes Go/NoGo decision points at one month, one week and one day prior to go live. This governance is designed to minimize the effects of EPR cutover to both patient safety and operational efficiency. Should criteria not be met at these decision points, go live would not be permitted.
- The Real Time ADT strategic gap has been owned by the Divisions and mitigated with 24/7 Ward Clerks in the assessment areas.
- The role of Clinical Safety Officer has been added the reasonability's of the Digital Architect
- It was noted that the Trust was awarded £298k from NHS Digital Cyber Security Fund

Decisions Made / Items Approved

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

Items referred to the Board for decision or action

None

Comments relating to the DTPC from the CCIO

N/A

Comments relating to the DTPC from the CNIO
N/A

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board 12 April 2018

TITLE:	**Board Assurance Framework – Quarter 4**		
AUTHOR:	Sharon Phillips – Deputy Director of Governance (Risk and Standards)	**PRESENTER**	Glen Palethorpe – Director of Governance

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

CORPORATE OBJECTIVE: All Objectives

Attached is the year end positon with regards to the Trust's Board Assurance Framework (BAF). The current framework shows the executive team's prediction that there will be a further reduction in risk across two objectives by the end of Q1 2018/19.

The previous report showed a prediction that within two objectives, the current risk would reduce within quarter 4, this was achieved for one objective only with the other objective's risk score actually increasing based on the negative assurance received in the quarter.

The BAF and its component processes have been reported to the Audit Committee ahead of its reporting to the Board. The other Committees of the Board have undertaken reviews into specific risks they have oversight of and these reviews confirmed the assessed score as being reasonable.

The Trust intends to review the structure of the BAF for next year to draw out in more detail the controls and progress being made by management on the mitigation of the risk that underpin the direction of travel predicted for the next quarter. The BAF will also see the key risks grouped around the annual plan goals and thus make a clear distinction between the BAF and the Corporate Risk Register which is one of the agreed actions from the Trust's two well led reviews.

Not all the Corporate risks have detailed underpinning divisional risks that clearly identify robust actions and record the assurances mitigating these risks or risk assessments supporting that no underpinning risk exists within that specific division. As part of the revisions to the BAF this issue will be addressed at the same time providing more comprehensive reporting to the Risk and Assurance Group and Audit Committee.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED:

Decision	**Approval**	**Discussion**	**Other**
X		**X**	

ACTION FOR BOARD:

- To note the endorsement of the Trust BAF by the Audit Committee from its last meeting on the 19 March 2018, and therefore not the year end positon in respect of the Trust's key risks.
- To note that the outcome of the respective Committee reviews of a sample of risk confirmed the assessed risk levels.
- To note that the Trust's annual governance statement will reflect the Trust key risks across 2017/18.
- To endorse the proposed action by the Executive to revise the format of the Trust's Board Assurance Framework for 2018/19.

BOARD ASSURANCE FRAMEWORK

1. Introduction

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

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

The BAF at **Appendix 1** brings those components together focusing on those KEY risks.

2. Summary of the Trust's risk profile against each of the Trust's objectives

	Total number of risks	Total inherent risk score	Total value of risks at Q3	Predicted movement in these risks by end of next quarter (Q3)	Current value of risks at Q4	Expected movement in these risks by end of next quarter (Q1)	Total target risk score
Objective 1 – deliver a great patient experience	9	180	133	↓	119	↓	92
Objective 2 – safe and caring services	8	165	125	↓	130	↑*	73
Objective 3 – drive service improvement, innovation and transformation	1	20	16	→	16	→	15
Objective 4 – be the place people choose to work	Key risks relating to "people" are in effect recorded across many of the other Trust objectives, to prevent duplication they are not repeated within this objective.		20 (new risk)	→	20	→	10
Objective 5 – make the best of what we have	3	65	48	→	48	→	31
Objective 6 – deliver a viable future	3	65	60	→	60	→	29

The predicted downward movement was not achieved in response to COR096 CQC (The deteriorating patient) feedback and enhanced assurance request which had an increased risk score

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

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

3. Review of the BAF risks

In support of the work of the Audit Committee the various committees of the Board are undertaking a series of reviews into risks they have committee oversight for, where they do not get routine reports within their cycle of business. For Finance and Performance these specific deep dive reviews covered 2017/18 the risks in relation to Major Incident Planning and Delayed Transfer of Care, for Clinical Quality, Safety and Patient Experience they considered the risks in relation to the new Learning from Deaths process, ophthalmology waiting times. Clinical Quality, Safety and Patient Experience also reviewed a risk from the Trust's corporate risk register in respect of the compliance with the accessible information standard. The outcome of these risk reviews supported the assessed current scores within the BAF and the corporate risk register.

3.1 The Risk and Assurance Group

The Risk and Assurance Group has changed its meeting frequency, to now meet monthly. These meetings consider issues that may affect the Trust's current risks such as Trust performance, Serious Incidents, NPSA Alerts, Coroners outcomes etc. This Group reports to both Clinical Quality, Safety and Patient Experience and the Audit Committees. This Group supports support the Audit Committee's oversight of the Trust's BAF and Clinical Quality, Safety and Patient Experience Committee oversight of quality improvement.

4. Movements within quarter 4

Executive management forecast to see movement in a number of risks over the fourth quarter of the year, these included

Strategic Objective 1 – deliver a great patient experience

- COR069 in relation to the Diagnostic Standard. The Trust has improved the Trust performance activity of the 99% and presently performing at 99.26%. In response the risk score was reduced as predicted (now 12).
- COR244 in relation to the Trust being prepared for the increased requirements in respect to the national learning from deaths programme. The Trust has presented reports to both the March 2018 Board meeting, has strengthened its review process

and commissioned AQUA mortality instrument. There has been further embedding of learning. In response the risk score has reduced as predicted (now 9).

- COR121 in relation to ophthalmology outpatient capacity. Positive assurance of overdue follow ups being reduced and away days held with the team to progress the actions were received but there was negative assurance of not meeting the March trajectory. Although it is anticipated the end trajectory will be met. The risk in response was not reduced as predicted and maintained its risk score of 16.
- COR101 in relation to Capital schemes failing to be delivered and impacting on the patient experience of the trust. Positive assurance was received of both major schemes have been completed and are now operational. The risk was closed.

Strategic Objective 2 – safe and caring services

- COR096 in relation to the failure to prevent avoidable deterioration of patients leading to cardiac arrest. Negative assurance was received following the CQC inspection feedback and the requirement for enhanced assurance requests. In response the risk was increased (now 15).
- COR100 in relation to failure to comply with fire safety requirements. The risk was anticipated to be reduced following a positive independent review was completed of North block on the 4th November 2017. A full survey of by the SHA is to be completed which will provide detailed work plans to complete the 3 outstanding remedials. The risk was not reduced as anticipated with the review outstanding.

5. Forecast movements for quarter 1 2018/19

Executive view of the movement of risk from Quarter 4 to Quarter 1.

- COR069 in relation to the Diagnostic Standard. The score is anticipated to reduce in Q1 with sustained improved performance.
- COR244 in relation to the Trust being prepared for the increased requirements in respect to the national learning from deaths programme. It is anticipated further embedding of learning and reporting will result in the further reduction of the risk score in Q1.
- COR121 in relation to ophthalmology outpatient capacity. It is anticipated that the successful delivery of identified actions plus the successful sustained management of the outpatient capacity will further reduce the risk score in Q1.
- COR100 in relation to failure to comply with fire safety requirements. A positive independent review was completed of North block on the 4th November 2017. It is anticipated the completion of a full survey by the SHA , identification and completion of work plans will result in the further reduction of the risk score.
- COR259 in relation to the patient experience survey outcome scores being really low. It is anticipated work to work to improve the FFT footfall and completion of the Patient Experience action plan will reduce the score in Q1.

6. Wider risk management

The Divisional/Directorate Risks are risks that impact on the delivery of the trust objectives at a local level. These are managed through local governance and risk management arrangements. These have been reported though the Audit Committee as part of the routine reporting to this Committee from the Risk and Assurance Group.

A Corporate risk is an overarching risk which has been identified as directly impacting on the delivery of the corporate aims and are owned by an Executive Director. Each Corporate risk should have linked to it underpinning Divisional risks which clearly identify robust actions and record assurances, from these assurance can be pulled up to the Corporate risk. It must be noted that not all the Corporate risks have detailed underpinning divisional risks that clearly identify robust actions and record assurances mitigating these risks or risk assessments supporting that no underpinning risk exists within that specific division.

7. Conclusion

The BAF and its component processes have been reported to the Audit Committee ahead of its reporting to the Board. The other Committees of the Board have undertaken reviews into specific risks they have oversight of and these reviews confirmed the assessed score as being reasonable.

The Trust's Executive intends to review the structure of the BAF for next year to draw out in more detail the controls and progress being made by management on the mitigation of the risks that underpin the direction of travel predicted for the next quarter.

Appendix 1 Board Assurance Framework March 2018

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Q3 Risk Score 27/12/17	Q4 Current Risk Score 19/0317	Movement in risk	Expected movement by next quarter	Target Risk Score
Objectives: SO1 Deliver a great patient experience											
F	COO	COR069	**Risk Title** The Diagnostic Standard is at risk due to continuing demand for Imaging to support multiple pathways	**20**	**20**	**20**	16	12	↓		8
			Key Controls • *Weekly PTL review* • *Regular maintenance of scanners* • *Use of external provider for review of scans over night*		+Pos level 1 New Capacity at Guest -Neg level 1 DMO1 report to F&P 1	+Pos level 1 New Capacity at Guest -Neg level 1 DMO1 report to F&P 1	+Pos level 1 - Breach list reviewed and managed weekly +Pos level 2 - F&P -Improved performance standard delivery of the 99%. - DMO1 target achieved Nov 2017 - F & P Internal Audit = controls to manage risks are suitably designed, consistently applied and operate effectively -Neg level 2 - F&P Paed GA and Musculoskeletal USS - lack of capacity Not expected delivering before end of Dec 2017	+Pos Level 2 Performance of 99.26% against a national target of 99%.			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**	G **A**	G		↓	
F	COO	COR376	**Risk Title** Failure to meet the key ED performance target	**20**	**20**	**20**	20	20	→		8
			Key Controls • *Capacity monitoring 4 times a day* • *Daily reviews of discharges* • *Weekly EAS assurance meeting*		-Neg level 2 failure to meet the ED Performance target discussed at F&P	-Neg level 3 nationally produced data confirms consitent failure to meet the ED Performance target discussed at F&P	+Pos level 1 Identification of 5 priority actions to support improvement in emergency care PIDs developed for core Key Priorities +Pos level 2 Appointment of project lead for Ed layout – External support from NHSI -Neg Level 2 Failure to meet the ED Performance target discussed at F&P	-Neg Level 2 Report F& P Feb 2018 Performance did not achieve target with 81.71**%** for combined Type 1 and Type 3 up from 78.93% in the previous month. The Trust's ED department (Type 1) was 70.21% up from 64.79%.			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A** **R**	G **A**	R		→	
F	COO	COR377	**Risk Title** Failure to meet the key cancer performance targets	**20**	**20**	**20**	12	12	→		8
			Key Controls • *Weekly PTL reviews*		+Pos level 1 Weekly PLT meetings -Neg level 2 Cancer performance targets not met, discuused at F&P	+Pos level 1 Weekly PLT meetings +Pos level 2 cancer targets now being met -Neg level 2 2 weekly waits not being achieved	+Pos level 2 Report to F & P - Reported delivery for Sept, Oct, Nov and Dec	+Pos level 2 Report to F& P Feb 2018 – delivery target February (87%) Cancer Sustainability Plan developed			
			Strength of assurance logged (L1 / L2 / L3)		**G** **A**	**G** **A**	**G**	G		→	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Q3 Risk Score 27/12/17	Q4 Current Risk Score 19/0317	Movement in risk	Expected movement by next quarter	Target Risk Score
F	COO	COR378	**Risk Title** Failure to meet the 18wk performance target	20	**10**	**10**	**10**	10	➔		10
			Key Controls • *Review of theatre productivity* • *Review of performance*		+Pos level 2 Report to F&P	+Pos level 2 Report to F&P	+Pos level 2 Report to F&P	+Pos Level 2 in month with a performance of 93.5% against a target of 92%, -Neg Level 2 Performance 3 specialities fell below the expected. Urology(90.91 and Ophthalmology (79.21%)			
			Strength of assurance logged (L1 / L2 / L3)		G	G	G	A		➔	
F	COO	COR099	**Risk Title** Failure to reduce the number of delayed transfer of care may result in poor patient experience	20	**20**	**20**	20	20	➔		16
			Key Controls • *Dudley economy MoU* • *Daily review of discharges* • *Application of Red 2 Green initiative*		+ Pos level 1 A&E delivery plan	+ Pos level 1 A&E delivery plan	- Neg level 1 Local reporting/coding is not consistent with other organisations + Pos level 2 -Apt three month secondment for managerial lead -Agreed escalation of non-achievement of the MOU (inc out of area) and Action Plan for Integration of actions between Dudley Group/ CCG / Local Authority. -CQSPE Dec 2017 unable to demonstrate improvement/embedding across organisation of red to green	- Neg Level 2 January 2018 has seen a decrease against target to 4.3%, +Pos Level 2 Feb 2018 - Presented at ED Board Sandwell, Worcester and South Staffs have highest delays +Pos Level 2 Appointment of new Discharge Lead		
			Strength of assurance logged (L1 / L2 / L3)		G	G	R A	A		➔	
CQSPE	MD	COR244	**Risk Title** Failure to Monitor and to Learn From Deaths	20	**20**	**20**	15	9	➘		9
			Key Controls • *Mortality review process* • *Mortality Surveillance Group* • *Learning from deaths policy*		+Pos level 2 Policy approved and presented to CQSPE	+Pos level 2 New report in line with national guidance. Policy approved and presented to CQSPE	+Pos Level 2 Reports presented to CQSPE Oct 2017/Nov 2017. Learning demonstrated through audit Reports presented to Board Dec 2017. focus on learning to be picked up within audits	+Pos Level 2 Reports presented to Board March 2018 Strengthened review process +Pos Level 3 AQUA mortality instrument commissioned			
			Strength of assurance logged (L1 / L2 / L3)		G	G	G	G G		➔	
CQSPE	CN	COR259	**Risk Title** Friend and Family (Patient Survey) outcome scores extremely low	20	**20**	**20**	**12**	12	➔		9
			Key Controls • *Review of real time surveys* • *Oversight of action plans through Patient Experience Improvement Group*		+Pos level 1 Patient Experience Improvement group overseeing improvement plan.	Pos level 1 Patient Experience Improvement group overseeing improvement plan. Positive engagement across Trust. +Pos level 2 FFT response rates improving.	Pos level 1 Pt Experience inpatient survey action plan completed (exc 5 actions which are ongoing)	-Neg Level 2 Report to F&P Feb 2018 Performance Report – Reduction in FFT footfall			
			Strength of assurance logged (L1 / L2 / L3)		G	G G	G	R		➘	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Q3 Risk Score 27/12/17	Q4 Current Risk Score 19/0317	Movement in risk	Expected movement by next quarter	Target Risk Score
CQSPE	COO	COR121	**Risk Title** Ophthalmology Outpatient Appointment Capacity	20	**20**	**20**	**16**	16	➔		16
			Key Controls • *Review of RAG rating for each appointment* • *Application of formal escalation for delayed appointments* • *Project management of procured extra resource to deal with backlog*		+Pos level 2 External resources approved -Neg level 2 increase in delays reported to F&P	+Pos level 2 Reduction in delayed FU appt. ASI extract confirms reduction -Neg level 2 May-Aug - increase in delayed FU appt.	+Pos Level 2 Repatriation of 2 consultants/ Increased orthoptic combined clinics / Macular Nurse led clinics CQSPE – new ophthalmologist starting Jan 2018 -Neg Level 2 CQSPE Nov 2017 behind trajectory due workforce	+Pos Level 2 20/02/18 report to CQSPE – Overdue follow ups have reduced to 1106. This has reduced to being 307 slots behind trajectory. Ophthalmology away day held with team to progress actions -Neg Level 2 Will not m eet March tragectory but anticpate will meet end trajectectory			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**	A	A		➔	
F	DF	COR101	**Risk Title** Capital Schemes fail to be delivered impacting on patient experience of the Trust	20	**12**	**12**	12	8	➔		8
			Key Controls • *Capital programme project management process*		+Pos level 1 Project Boards for Capital Programme for UCC and Guest imaging +Pos level 2 Capitol report to F&P	+Pos level 1 Project Boards for Capital Programme for UCC and Guest imaging +Pos level 2 Regular reports to F&P -Neg level 2 Report to F&P detailing UCC programme 5 weeks behind plan; review of plan due to be reported Oct 17	+Pos Level 2 Report F&P imaging HUB at Guest on track to complete 20 Nov 2017 -Neg Level 2 UCC scheme not complete until late Jan 2018	+Pos Level 2 Report to F&Pjan 2018 Pos assurance EPR, Guest Imaging and UCC schemes. The later two only having very minor forecast over-spends against approved budget. Feb 2018 – Both major schemes complete and now operational. **This risk is now closed.**			
			Strength of assurance logged (L1 / L2 / L3)		**G** **G**	**G** **A**	A	G			
			SUMMARY	**180**	**162**	**162**	**133**	**119**	➔	➔	**92**
Objectives: SO2 Safe and Caring services											
F	DF	COR241	**Risk Title** Failure of the PFI provider to maintain the building in line with statutory requirements and to ensure a resilient estate	25	**20**	**20**	20	20	➔		8
			Key Controls • *Board to Board meetings* • *Contract management processes*		+Pos level 2 Regular senior management meetings with provider, incorporating rigorous review of contract improvements	+Pos level 2 Quarterly Board to Board meetings; performance of estates discussed. Monthly reports to CQSPE and F&P Performance of estates improved but still requires improvement. Rigorus monitoring and reporting to continue until at least Dec	-Neg Level 2 Performance to F& P continues show issues with estates service and PFI contract. Large nubmer deductin and def points being applied +Pos level 2 F&P Dec 2017 – impoved performance Nov – needs to now be sustained	-Neg Level 2 Delayed notification of theatre air filters not compliant national standard – reported to F & P and Trust Board			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**G**	A	R		➔	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Q3 Risk Score 27/12/17	Q4 Current Risk Score 19/0317	Movement in risk	Expected movement by next quarter	Target Risk Score
CQSPE	CN	COR436	**Risk Title** Reduced capacity within safeguarding adults/children team due to infrastructure vulnerabilities	**20**		**New 06/11/17**	20	20	➔		15
			Key Controls • *Matron has oversight and two weekly operational meeting* • *Mand/stat Training programme in line with ICD* • *Framework/KPIs for safeguarding investigation process* • *Framework for reporting and learning from incidents* • *Framework for internal and external investigations* • *Network meetings/working*				+Pos level 2 Interview scheduled safeguarding lead CQSPE Nov 2017 – New Safeguarding Lead appointed (commence March 2018) - Maternity now reporting all safeguarding incidents	+Pos level 2 New safeguard lead in post -Neg Level 2 CQSPE compliance safeguarding training 88.71%..Mental Health Awareness 81.87% (medics only 49.12%)…PREVENT Wrap 90.95% (Medics only 62.95%)..WRAP 69.25%. Children Level 3 83.03% -Neg Level 3 Jan 2018 identified by CQC as major area of concern safeguarding in ED			
			Strength of assurance logged (L1 / L2 / L3)				G	A R		➔	
CQSPE	CN	COR085	**Risk Title** An inability to maintain the delivery of the safer staffing levels in relation to ward nurse staffing	**20**	**20**	**20**	20	20	➔		10
			Key Controls • *Established staff banks* • *Review of staffing dashboards* • *Recruitment plan*		+Pos level 2 Approved recruitment for substantive staff Report to Board -Neg level 2 Attrition of staff higher than recruitment	+Pos level 2 Report to F&P; recruited 35 RNs. Approved recruitment for substantive staff -Neg level 2 Attrition of staff higher than recruitment	+Pos level 2 Completed staffing review for med/surgery 9 additional nurses recruited	+Pos Level 2 Recruitment event Feb 2018 8 nurses and 4 OPDs gien conditional offers Ward/dept specific recruitment commences March 2018 -Neg Level 2 High capacity has resulte din rise of RN and CSW agency usage			
			Strength of assurance logged (L1 / L2 / L3)		A	A	G	A		➔	
CQSPE	CN	COR096	**Risk Title** Failure to prevent avoidable deterioration of patients leading to cardiac arrests	**20**	**15**	**15**	10	15	➔		10
			Key Controls • *Use of track and trigger tool* • *Mandatory training* • *Post MET call review of processes followed*		+Pos level 1 Launch of NEWS track & trigger	+Pos level 1 Launch of NEWS track & trigger	+Pos level 2 Audit comfimred embedding Tradk trigger complete. Review completed of MET calls shows no significant changes to activity	+Pos Level 2 Cardiac arrests now presented to the deteriorating patient group mapped against the MET calls and DNACPR'S. All in patient areas complete daily review of a sample size of NEWS/PEWS scores this is reported through Quality and Safety Group. Revision of VTE Norse and Sepsis pathway -Neg level 3 CQC feedback and enhanced assurance request			
			Strength of assurance logged (L1 / L2 / L3)		G	G	G	G R		➔	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Q3 Risk Score 27/12/17	Q4 Current Risk Score 19/0317	Movement in risk	Expected movement by next quarter	Target Risk Score
CQSPE	CN	COR093	**Risk Title** Delays in the management of young people requiring section under the Mental Health Act (Tier 4)	20	**12**	**12**	**12**	**12**	➲		8
			Key Controls • *CAMHS tier 3.5 service commissioned* • *Conflict resolution and safeguarding staff training programmes*		+Pos level 2 Report to Children's services group – improvement for children not requiring Tier 4 care. -Neg level 2 Report to Children's services group-no improvement for children requiring Tier 4 care	+Pos level 2 Report to Children's services group – improvement for children not requiring Tier 4 care. -Neg level 2 Report to Children's services group – no improvement for children requiring Tier 4 care	+Pos level 2 Report presented to CCG by Dudley and Walsall Mental Health identified positive impact of commissioned 3.5 tier service -Neg level 2 Report to Children's services group – no improvement for children requiring Tier 4 care	No new assurances			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**	A			➲	
F	DF	COR100	**Risk Title** Failure to comply with fire safety requirements	20	**12**	**12**	**8**	**8**	➲		4
			Key Controls • *Fire Safety risk assessments* • *Electric fire detection system designed to provide early warnings of fire* • *Regular maintenance of the system*		+Pos level 1 Reviews of building cladding, verbal positive feedback – awaiting report	+Pos level 1 Reports received and reviewed, confirm cladding adheres to NHSI requirements. +Pos level 3 Independent report confirms cladding on PFI buidlings meets NHSI requirements – P	+Pos level 1 Independent review of North Block 4th November 2017.	+Pos level 1 Jan 2018 – Variation placed with PFI Company to carry out remedial work identified on North Block. Risk remains at current level until work completed. Feb 2018 – Full survey to be carried out by SHA which will then provide detailed work plans to complete the 3 outstanding remedials			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**G** **G**	**G**	G		➲	
F	COO	COR032	**Risk Title** Trust Major Incident Plan does not deliver intended business continuity	20	**10**	**15**	15	15	➲		10
			Key Controls • *Trust has developed a major incident plan and processes* • *Periodic test of the plan*		+Pos level 1 Action plan being monitored and reported	+ Pos level 1 Awareness sessions for emergency preparedness and workshops for portering and security staff -Neg level 1 Several partners were unable to attend the sessions	+Pos Level 2 Pandemic flu, mass casualty and evacuation workshops held – action plans developed Development of EPRR exercise training and exerciseing strate2 Development of EPRR exercise training and exerciseing strategyDevelopment of pandemic flu	+ Pos level 1 New EPRR Manager appointed in January 2018. Work commenced to support further developments in business continuity			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**A**	G	G		➲	
CQSPE	COO	COR501	Ability to provide a safe, caring and effective service within ED at all times	20			20	20	➲		8
			Key Controls • *Daily quality audits and assurance provided to Chief Exec.* • *Policies and guidelines to support deteriorating patient and Sepsis management* • *Duty rosters singed off*				-Neg Level 3 Concerns flagged by CQC during inspection review -Neg Level 2 Concerns verified by increased scrutiny by MD, COO and CN.	+Pos Level 1 Exec Level presence in ED Triage training iniated +Pos Level 2 Procedural documents to support triage developed and in place -Neg Level 2 Serious incidents reported			
			Strength of assurance logged (L1 / L2 / L3)				R R	G A		➲	
			SUMMARY	**165**	**89**	**94**	125	130	➲	➲	**73**

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Q3 Risk Score 27/12/17	Q4 Current Risk Score 19/0317	Movement in risk	Expected movement by next quarter	Target Risk Score
Objectives: SO3 Drive Service improvements, innovation and transformation											
CQSPE	MD	COR083	**Risk Title** Failure to have a workforce/infrastructure that supports the delivery of 7-day working		**16**	**16**	16	16	➔		
			Key Controls • *Use of nerve centre to direct tasks out of hours* • *Delivery of 7/7 audit action plan*	**20**	+Pos level 1 Clinical audit shows positive delivery against standards in Medicine -Neg level 1 Clinical audit shows negative delivery against standards for surgery, T&O & O&G – N	+Pos level 1 Clinical audit shows positive delivery against standards in Medicine -Neg level 1 Clinical audit shows negative delivery against standards for surgery, T&O & O&G – N	-Neg Level 2 Business cases to be developed by each of divisions Audit results presented CQSPE confirming poor delivery	+Pos level 2 Introduced electronic job planning BUT yet to be completed Electronic observations and esepsis trust to support streamlined working Increased consultant recruitment consultants yet to start Deputy Medical director to lead on 7 day servicess			15
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**	R	G		➔	
			SUMMARY	**20**	**16**	**16**	16	16	➔	➔	**15**
Objectives: SO4 Be the place people choose to work											
CQSPE	MD	COR461	**Title Risk** Competing demands on clinicians time lead to lack of quality clinical input across key Trust projects			**New 17/11/17**	20	20	➔		
			Key Controls • Job planning	**20**			Level 1 assurance work on job planning commenced – have as amber as not all done yet	+Pos level 2 Expanded medical leadership team Appointment of patient Safety Lead Phasing of responsibility payments into standard PA payments			10
			Strength of assurance logged (L1 / L2 / L3)				**A**	G		➔	
			SUMMARY	**20**			20	20		➔	**10**
Objectives: SO5 Make the best use of what we have											
F	DF	COR080	**Risk Title** Failure to deliver 2017/18 Cost Improvement Programme		**16**	**20**	20	20	➔		
			Key Controls • *Programme governance structure monitored by TEC* • *Programme PID and QIP process*	**25**	+Pos level 2 Report to F&P - achieving plan	+Pos level 2 Transformation and CIP report to F&P. Month 4 on track, forcast to deliver by year end -Neg level 2 F&P increased risk score to 20. September report identifies £2.5m shortfall due to agency spend	-Neg Level 2 F&P Dec 2017 - highlighted £2.3m shortfall forecase on delivery for 2017/18	-Neg Level 2 F&P Jan highlighted £3.4 m shortfall on delviery. Feb 2018 reported highlighted adeficit of £4.7m.			12
			Strength of assurance logged (L1 / L2 / L3)		G	A	R	R		➔	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Q3 Risk Score 27/12/17	Q4 Current Risk Score 19/0317	Movement in risk	Expected movement by next quarter	Target Risk Score
F	DF	COR234	**Risk Title** Trust plans assume a significant level of income at risk from commissioners	20	20	20	20	20	➔		15
			Key Controls • *Monthly reconciliations of activity and coding* • *Regular dialogue through formal meeting with CCGs*		+Pos level 2 Monthly report to CCG contract review meetings; agreed process with CCG	+Pos level 2 Monthly report to CCG contract review meetings; agreed process with CCG -Neg level 2 Month 5 income fell; reduced forecast outurn. Additional F&P meeting in Oct to review position	-Neg Level 2 F&P Dec 2017 - Current gap between DGFTs income over acvitiy with CCG is circa £2 million.	+Pos Level 2 Report to F&P stated that the healthcare over activity position with Dudley CCG is now significantly lower than previously reported. The risk of Dudley CCG being able to afford the over activity is now reduced. -Neg Level 2 Report to F&P stated an adverse variance of £4.549m at the end of January for healthcare income. The Trust will not achieve its healthcare income target for 2017-18			
			Strength of assurance logged (L1 / L2 / L3)		G	A	R	A		➔	
F	DIT	COR091	**Risk Title** The IT DR arrangements are not effective	20	8	8	8	8	➔		4
			Key Controls • *Established BC Plans* • *System backups taken and tested* • *Patient Information back up system in operation*		+Pos level 1 Recovery time for top 5 systems would be 2-24 hrs +Pos level 2 Datacentre refresh programme approved by Board	+Pos level 1 Recovery time for top 5 systems would be 2-24 hrs +Pos level 2 Datacentre refresh programme approved by Board	-Neg level 2 Trust does not have assurance of tested disaster recovery for all key systems	+Pos level 1 DR times will be significantly reduced on implementation of the new EPR and the Likelihood will be reduced			
			Strength of assurance logged (L1 / L2 / L3)		G G	G G	R	G		➔	
			SUMMARY	65	44	48	48	48	➔	➔	31
Objectives: SO6 Deliver a viable future											
F	MD CN	COR116	**Risk Title** High dependency on agency staff particularly in clinical areas	25	20	20	20	20	➔		4
			Key Controls • *Review of agency use by Executives* • *Nursing and Medic STAR chamber review and approval* • *VAR panel review and approval*		+Pos level 1 Recruitment of staff to ED +Pos level 2 Approved resources for substantive nurse recruitment -Neg level 2 Report to Workforce committee shows higher attrition to recruitment.	+Pos level 2 Approved resources for nurse recruitment -Neg level 2 Report to F&P – trajectory suggests full year target will not be met . -Neg level 2 Report to Workforce committee shows higher attrition to recruitment.	+Pos Level 2 - Nurse staff reviews completed for medicine / Surgery / Paeds - Report to F&P medical agency reduction trajectory and actions presented to the Committee -Neg level 2 Report to F&P Medical Staff Agency Spend in ED	+Pos Level 2 Medical agency spend has fallen because (substantive recruitment, and agency caps). Banned use of expensive off frameworks agencies -Neg Level 2 High capacity has resulted in rise of RN and CSW agency usage			
			Strength of assurance logged (L1 / L2 / L3)		G A	A	A	A		➔	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Q3 Risk Score 27/12/17	Q4 Current Risk Score 19/0317	Movement in risk	Expected movement by next quarter	Target Risk Score
F	DF	COR061	**Risk Title** Failure to remain financially sustainable in 2017-18 and beyond	**20**	**20**	**20**	20	20	➔		16
			Key Controls • *Trust's business planning and budget setting process* • *Regular up to date financial reporting reviewed* • *Developed CIP Programme* *Agency controls*		+Pos level 2 Report to F&P include schemes to achieve control. Total surplus at month 4 above forecast. Report to F&P on achievemnet of Q1 STF money. -Neg level 2 Month 5 financial position below plan. Directorates asked to find addition CIP. Additional F&P meeting Oct to discuss remedial plan.	+Pos level 2 Report to F&P include schemes to achieve control. Total surplus at month 4 above forecast. Report to F&P on achievemnet of Q1 STF money. -Neg level 2 Month 5 financial position below plan. Directorates asked to find addition CIP. Additional F&P meeting Oct to discuss remedial plan.	-Neg Level 2 - F&P reported a £7.5m deficit whti is £10M away from control total	-Neg Level 2 Report to F&P finance report on 25th January 2018 which reported a £8.6m deficit Report to F & P on 22 Feb ruary 2018 finance report which reported a £8.6m deficit which is £11.1m away from control target. Report highlighted risk to achieving this forecast.			
			Strength of assurance logged (L1 / L2 / L3)		A	A	R	R		➔	
W	COO	COR421	**Risk Title** Lack of paediatric medical workforce capacity to meet service demands, standards and recommendations resulting in overdue follow up appointments	**20**		**New 01/11/17**	20	20	➔		9
			Key Controls • **Job plans** • **Validation of children whose appointment over target** • **Notes review post validation by a consultant**				+Pos Level 1 3 new consultants in post +Pos Level 2 Nov 2017 (CQSPE) ahead of trajectory	+Pos Level 1 All four new Consultant Paediatricians have now commenced. All 3 CNS posts have been appointed +Pos Level 2 Report to Feb CQSPE - Paediatric overdue FUs without an appointment are marginally behind trajectory to be eradicated by May 2018			
			Strength of assurance logged (L1 / L2 / L3)				G G	G G		➔	
			SUMMARY	**65**	**40**	**40**	60	60	➔	➔	*29*

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

Enclosure 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors
On 12 April 2018

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Summary of key issues discussed and approved at the Charitable Funds Committee on 8 March 2018.

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

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

MATTERS ARISING FROM PREVIOUS MEETING

An update was provided in respect of the Fundraising Manager's progress in contacting local companies for fundraising support. A fundraising strategy document was requested.

FUNDRAISING UPDATE

Mrs Abbiss gave a verbal update in Mrs Phillips' absence. It was reported that good progress was being made with grant applications and in particular that the Goodyear fund has committed £37,000 to support the purchase of an isolation pod in ITU and the refurbishment of the stroke day room.

A volunteer has been recruited to help with administration.

FINANCE UPDATE

Mrs Taylor presented the Finance update. She reported that the total fund balance stood at £2,138,720 whilst the general funds balance was £48,000. Income for the quarter was reported to be £165,000 whilst expenditure was £233,000.

FUND RAISING REQUESTS

One bid was approved :-

Pharmacy – extra seating and special seating for patients with limited mobility.

A bid from the Children's Ward, for £30,205 for full motion TV brackets for twenty beds, was deferred pending further information.

ANY OTHER BUSINESS

Mrs Abbiss raised the possibility of introducing 'Pennies from Payroll'. The Committee were supportive of this idea and Mrs Abbiss agreed to investigate it further.

The Committee discussed the Committee's objectives as set out in the Terms of Reference with respect to their clarity and agreed that they are sufficiently clear.

Meeting	Meeting Date	Chair	Quorate	
Charitable Funds Committee	**8 March 2018**	**Julian Atkins**	**yes**	**no**
			Yes	
Declarations of Interest Made				
None				
Assurances Received				
None				
Decisions Made / Items Approved				
One bid for funding approved for additional seating in the Pharmacy department				
Actions to come back to Committee				
Bid from the Children's Ward for TV brackets				
Items referred to the Board for decision or action				
None				

Enclosure 16

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 12th April 2018

TITLE:	**Fit and Proper Persons Requirement – Annual Re-Check**		
AUTHOR:	**Andrew McMenemy, Director of Workforce**	**PRESENTER**	**Andrew McMenemy, Director of Workforce**

CORPORATE OBJECTIVE:

SO4: Be the place people choose to work

SUMMARY OF KEY ISSUES:

Background

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 deal with the fit and proper persons test which came into force in November 2014. From May 2015, the Trust has complied with this requirement both upon appointment as well as providing an annual re-check.

Compliance for 2018

This paper confirms that the fit and proper persons checks and re-checks have been completed for those within the attached list. The compliance has been verified and confirmed as an accurate statement of compliance by the Director of Workforce.

It should be noted that the Trust takes a broad view of those staff subject to the fit and proper persons test and therefore includes voting executive and non-executive posts as well as non-voting Directors and those 'in attendance' at Board meetings.

Conclusion

The checks did not identify any issues that would call into doubt that any of the individuals named would be a fit and proper person under these regulations.

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

That the outcome of the fit and proper persons annual checks for the named staff in the attached list is noted and that based on their outcome it is agreed no further action is required.

NAME	JOB TITLE	F&PPR Declaration provided	Bankrupty check complete	Disqualified Directors check complete	Prof Reg (if app)	DBS check complete	Notes
Anne Becke	Non-executive Director	Yes	Yes	Yes	not applicable	Yes	
Richard Miner	Non-executive Director	Yes	Yes	Yes	Yes	Yes	
Jonathan Fellows	Non-executive Director	Yes	Yes	Yes	Yes	Yes	
Douglas Wulff	Non-executive Director	Yes	Yes	Yes	Yes	Yes	
Glen Palethorpe	Associate Director of Goverance/Board Secretary	Yes	Yes	Yes	Yes	Yes	
Liz Abbiss	Head of Communications	Yes	Yes	Yes	Yes	Yes	
Jennifer Ord	Chairman (from October 15)	Yes	Yes	Yes	not applicable	Yes	
Mark Stanton	Director of IT	Yes	Yes	Yes	not applicable	Yes	
Julian Atkins	Non-executive Director	Yes	Yes	Yes	not applicable	Yes	
Andrew McMenemy	Director of HR & OD	Yes	Yes	Yes	not applicable	Not required this year	**Covered by valid DBS completed in last 3 years**
Diane Wake	Chief Executive	Yes	Yes	Yes	not applicable	Not required this year	**Covered by valid DBS completed in last 3 years**
Mark Hopkin	Associate Non-Exec Director	Yes	Yes	Yes	not applicable	Not required this year	**Covered by valid DBS completed in last 3 years**
Andrea Gordon	Black Country Alliance Programme Director	Yes	Yes	Yes	not applicable	Not required this year	**Covered by valid DBS completed in last 3 years**
Siobhan Jordan	Chief Nurse	Yes	Yes	Yes	Yes	Not required this year	**Covered by valid DBS completed in last 3 years**
Anne-Marie Williams	Director of Operations - Clinical Support						**AMcMenemy said not required 15.3.18**
Natalie Younes	Director of Strategy & Improvement	Yes	Yes	Yes	not applicable	Not required this year	**Covered by valid DBS completed in last 3 years**
Karen Kelly	Chief Operating Officer	Yes	Yes	Yes	not applicable	Not required this year	**Covered by valid DBS completed in last 3 years**
Julian Hobbs	Medical Director - Operations	Yes	Yes	Yes	Yes	Not required this year	**Covered by valid DBS completed in last 3 years**
Tom Jackson	Director of Finance	Yes	Yes	Yes	Yes	Not required this year	**Covered by valid DBS completed in last 3 years**

Bankruptcy check - Yes indicates NOT declared bankrupt, check undertaken via on-line registe

Disqualified Directors check - Yes indicated NOT disqualified, check undertaken via on-line registe

Professional Registration - Yes indicates holds professional registration required for the post, either on-line check undertaken or evidence provided by individu

DBS check - Yes indicates NO issues were identified on a standard DBS chec