The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 7th June, 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 Fellows, J Hodgkin, R Welford, J Hobbs, N Younes**		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 3 May 2018	Enclosure 1	J Ord	To Approve	8.30
	4.2 Action Sheet 3 May 2018	Enclosure 2	J Ord	To Action	8.35
5.	**Patient 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	Enclosure 4	D Wulff	To note assurances & discuss any actions	9.00
	7.2 2017/18 Infection Prevention and Control Annual Report	Enclosure 5	E Rees	To note assurances & discuss any actions	9.10
	7.3 Nurse/Midwife Staffing Report	Enclosure 6	S Jordan	To note assurances & discuss any actions	9.20
	7.4 Learning from Deaths Report	Enclosure 7	P Hudson	To note and discuss assurances	9.30
	7.5 2017/18 Trust Annual report including the Quality Accounts Report	Enclosure 8	L Abbiss	To note	9.40

	7.6 Maternity CNST scheme	Enclosure 9	G Palethorpe / D Lewis	To note assurances & discuss any actions	9.50
	7.7 2017/18 Annual Safeguarding Report	Enclosure 10	S Jordan	To note assurances & discuss any actions	10.00
8.	**Responsive and Effective**				
	8.1 Integrated Performance Dashboard	Enclosure 11	K Kelly	To note assurances & discuss any actions	10.10
	8.2 Finance and Performance Committee Exception report	Enclosure 12	T Jackson	To note assurances & discuss any actions	10.20
	8.3 Annual Plan summary	Enclosure 13	L Peaty	To note	10.30
9.	**Well Led**				
	9.1 Digital Trust Committee Exception Report	Enclosure 14	M Stanton/ A Becke	To note assurances & discuss any actions	10.40
	9.2 Audit Committee Exception Report including audit committee annual report	Enclosure 15	R Miner	To note assurances & discuss	10.50
	9.3 Research and Development Report	Enclosure 16	J Neilson	To note & discuss	11.00
	9.4 Guardian of Safe Working Report	Enclosure 17	B Elahi	To note assurances & discuss	11.10
10.	**Any other Business**		J Ord		11.20
11.	**Date of Next Board of Directors Meeting** 8.30am 5th July, 2018 Clinical Education Centre		J Ord		11.20
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		11.20

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

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 3rd May, 2018 at 8.30am 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, Medical Director
Karen Kelly, Chief Operating Officer
Tom Jackson, Director of Finance
Siobhan Jordan, Chief Nurse
Ann Becke, Non Executive Director
Jonathan Fellows, Non Executive Director
Richard Welford, Non Executive Director
Diane Wake, Chief Executive

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 Mark Hopkin, Associate Non Executive Director
Liz Rees, Director of Infection Prevention and Control (Item 18/057.2)
Jonathan Hodgkin, Non Executive Director

18/050 Note of Apologies and Welcome
8.33am

No apologies received. The Chairman welcomed Arthur Brown, Governor, and members of the public , who were in the public gallery.

18/051 Declarations of Interest
8.34am

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

There were no other declarations of interest.

18/052 Announcements
8.34am

The Chairman congratulated Dr Julian Hobbs on his appointment to substantive Medical Director.

No other announcements to note.

18/053 Minutes of the previous Board meeting held on 12th April, 2018 (Enclosure 1)
8.35am

The minutes were amended as follows:

Page 10, 2nd paragraph to read "The Director of HR confirmed that the Trust rate was just under 10%."

Page 13, item 18/047 to read "Well Led".

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.

18/054 Action Sheet, 12th April, 2018 (Enclosure 2)
8.37am

18/054.1 Theatre Scheduling

This is to be presented to the Finance and Performance Committee to consider (outside of the meeting) if it needed to be presented to the Clinical Quality, Safety, Patient Experience Committee. The original action was therefore to be revised.

18/054.2 Utilisation and Retention of Staff

To be presented to the next Workforce Committee, therefore this action remained open

18/054.3 Integrated Performance Report

The Trust was moving forward with actions and as the report would be presented to the Board and its Committees this specific item was agreed to be closed.

18/054.4 Annual Plan

The Board noted that this was not included in the papers and had been presented to the Finance and Performance Committee so this item was agreed to be closed.

18/054.5 Elective Income

The Trust's 2018/19 plan and budget had been submitted to NHSI. The Finance and Performance Committee had scheduled a further review of the detail behind these plans including the income forecast at their meeting in May. The Board noted that an Audit of plans was taking place.

18/054.6 Quality Priority Targets

A target had been set which was to see a reduction of 10% for the Grade 3 pressure ulcers, therefore this action was agreed to be closed.

18/054.7 Free Wifi

Communications are working on the publication of the launch. Posters were due to arrive the following week. The Board were informed that around 350 people connected to the wifi on average each day.

Mr Welford, Non Executive Director, stated that he had not received the email update regarding the go live date in respect of the digital trust first phase. The Chief Executive queried the detail requested in the update. Mr Fellows, Non Executive Director stated that the Board members wanted to receive an update on the position regarding training as this was seen as key milestone for the go live decision. Mr Welford also stated that they needed to be aware of the position regarding any project blockers. The Chairman asked that an email update is circulated with the main headlines in respect of the project progress. The Chief Executive confirmed that she would pick this up outside of the meeting.

Finance and Performance Committee to consider if Theatre Scheduling is required to be presented to the Clinical Quality, Safety, Patient Experience Committee.

Utilisation and retention of staff to be presented to the next Workforce Committee.

The Finance and Performance Committee once it had considered the income forecast within the 2018/19 Plan at its May meeting to report to Board on any considered risks.

Chief Information Officer to email an update to Board members with the Digital Trust Programme key headlines.

18/055 Patient Story
8.46am

The Head of Communications presented the patient story which was given by a patient who was in the care of Maternity Services. The patient had given birth by emergency C-Section. The patient had overall received a positive experience but had some concern around the options available for partners to spend the night with patients.

The Chief Nurse confirmed that partners are sent home at night when patients are not in labour so they can rest before labour commences. The Chief Executive stated that there needs to be some flexibility for partners that want to stay the night.

Dr Hopkin asked that we look at the value of patient stories before they are shown at Board meetings.

The Chief Executive stated that the Trust sometimes needs to show a positive story but agreed we needed to be clearer on the purpose of the story and what patient experience the Board would expect is maintained or changed.

The Medical Director commented that the whole patient journey is important when considering stories. This should be looked at, for example, within this story asking for the patient's views on our early intervention on breast feeding. This approach could provide vital information on our overall service.

The Chairman and Board noted the story and comments made. The Chairman asked that the Board's thanks are passed on to the patient.

Board's thanks to be passed on for patient story.

18/056 Chief Executive's Overview Report (Enclosure 3)
8.57am

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

- CQC: There was ongoing dialogue with the CQC, who had enquired when we would be in a positon to ask for some restrictions to be lifted given the level of assurance the Trust is routinely providing. The Chief Executive reminded the Board that a re-inspection of the Emergency Department would be taking place this year. The Board noted that 3 service areas had not been inspected in the last round, so the Trust needed to be prepared for this. The Chief Executive confirmed that the End of Life Care Strategy had been launched publically and this was a key development for end of life care across the borough Mr Fellows asked if ED would be re-rated if the Trust was re-inspected. The Chief Executive confirmed that an inspection could generate a new rating.

The Chairman and Board noted the report and the CQC update.

18/057 Safe and Caring

18/057.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
9.01am

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

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

- The Committee received a report from the Medical Director looking at the past 5 year's never event activity. This analysis confirmed that there was no specific pattern but rather reflected incidents that happen in all hospitals.

As each incident had been investigated the issues had been addressed and actions taken to prevent recurrence. The Committee were assured that this year the clinical audit programme now seeks to provide assurance over the maintenance of such improvement actions.

- The Committee continues to monitor Ophthalmology and Paediatric waiting lists, with regard to performance being behind trajectory for removal of any backlogs.

- The Committee had questioned the red areas on the CQC action plan and have asked for the issue on extended consultant cover to come back to the Committee.

- Actions in respect of the management of deteriorating patients were presented and the Committee will continue to actively monitor this area.

There were no matters referred to Board.

The Director of Governance/Board Secretary confirmed that the Clinical Audit Programme was focussed on being more proactive. It would consider all never event areas to ensure our processes are working to prevent such event occurring.

Mr Miner, Non Executive Director, asked if within Committee reports information on issues escalated from the Committee's reporting groups could be provided. This could generate improved assurance . The Director of Governance/Board Secretary confirmed that no issues had been raised from reporting groups at the last meeting. The Chief Executive confirmed that the Chairs log from those reporting groups should be used to provide a summary for future committee meetings thus providing a robust trail of assurance and actions being undertaken at a group level.

Mrs Becke, Non Executive Director, stated that issues with Paediatrics and Ophthalmology waits was still a concern. The Chief Executive confirmed that the Chief Operating Officer was addressing issues directly with the Divisions as the action plan to reduce waits was not securing the outcome required in the time frame initially agreed.

The Chairman and Board noted the report and assurances received.

18/057.2 Infection Prevention and Control Update (Enclosure 5)
9.26am

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

There had been 19 C.Diff lapses of care against the target of 29 cases. The Board noted that the target for next year was set at 28 cases of lapses in care.

There had again this month been no post 48 hour MRSA cases.

A full statement on the Trust's compliance with the Hygiene Code will be presented to the Board in June.

There were two standards judged as amber. These were providing and maintaining a clean and appropriate environment, and patients with infection being safely managed. This was due to a change in the Cleaning Policy and the work being done with Interserve on consistent implementation, and an issue identified from a recent NHSI visit in the NeoNatal Unit where actions were required. The Board noted that immediate action had been taken based on the NHSI recommendations. The Director of Infection Prevention and Control confirmed that as these actions are completed the standards would be met. She confirmed there is a clear plan in place to ensure that patients with infections are safely managed.

The Board noted that in relation to MRSA screening the Trust had achieved 97% for elective patients and 93% for emergency admissions. This was an internal target.

Mrs Becke, Non Executive Director, asked that under the key issues reported C.Diff is clearly identified.

Mr Miner, Non Executive Director, thought there were more green areas in this report than in previous reports. The Director of Infection Prevention and Control advised the report related to all previous standards. Looking forward the biggest challenge is annual training. Poorest performing areas were being targeted though creating one click access to training and putting on daily training sessions. The Trust is on track for delivering all annual training within 6 months.

Dr Wulff, Non Executive Director, raised data extraction around MRSA screening and confirmed that the Clinical Quality, Safety, Patient Experience Committee had asked for a clear target date to be set to produce accurate data. This would allow more meaningful discussion to take place about the performance regarding screening for emergency patients.

The Chairman stated that the Trust was still under scrutiny by NHSI based on the findings of their past visits. The Director of Infection Prevention and Control confirmed that they were re-visiting the Trust in July and active preparation was underway. The Chief Executive confirmed that she would have a pre-meet and review meeting with Dr Adams from NHS I to ensure that any issues identified are given the highest support.

The Chairman stated that the compliance action plan will need to be revisited to provide the necessary assurance that all actions were being addressed in a timely way.

The Chairman and Board noted the report and the positive work being undertaken around training and the plans in place for the next NHSI visit.

Full Hygiene Code statement to be presented to the June Board.
The Chief Executive to have a pre-meeting and feedback meeting with Dr Adams when she next visits the Trust in July.

The Director of Infection Prevention and Control to revisit the compliance action plan and ensure that it included the detail on assurances and actions being addressed.

18/058.3 Monthly Nurse/Midwife Staffing Report (Enclosure 6)
9.10am

The Chief Nurse presented the monthly Nurse/Midwife Staffing Report given as Enclosure 6, for information.

The Board noted the following key issues:

- The Trust was continuing to achieve its safe staffing levels.
- The Trust is committed to recruitment and retention and had a series of actions to secure more staff.
- The percentage fill rate against benchmarking data shows the Trust is performing reasonably well in this area

The Chairman asked that further reflection on how data is given on all aspects of quality can be brought together into an overarching Chief Nurse report.

The Chief Executive confirmed that the Trust is nationally mandated to present the report in the current format regarding safer staffing. Mr Welford, Non Executive Director, stated that he was struggling to see the value of the report and agreed to meet with the Chief Nurse to further understand the staffing position.

The Chairman and Board noted the report and the ongoing work to ensure that the Trust maintained safe staffing levels.

Chief Nurse to reflect on how data on all aspect of quality can be brought together into an overarching Chief Nurse report.

Mr Welford to meet with the Chief Nurse to further understand the staffing position.

18/059 Responsive and Effective

18/059.1 Finance and Performance Committee Exception Report (Enclosure 7)
9.14am

Mr Fellows, Non Executive Director, presented the Finance and Performance Committee Exception Report, given as Enclosure 7.

The Board noted the following key issues, in respect of the Trust's performance for March:

- The Board noted the £10.5M deficit for the end of year which was in line with the NHSI expected position.

- The deficit had been mitigated by the receipt of additional STF funding.
- The Trust was reporting a net deficit of £5.7M after STF monies.
- For 2018/19 NHSI has set a revised control total for the Trust of a £0.8M deficit before STF funding.
- The Trust's annual CIP target had been set at a stretching £25M and the Trust still needed to do more to have fully worked up schemes to deliver this programme.
- Phasing of the Trust income will be presented at the next Finance and Performance Committee meeting where they intend to consider income risks.
- The Committee had noted the revision of the Terafirma Sales Manager job to focus on greater opportunities for growth. A more detailed business case would be prepared.

The Director of Finance confirmed that in discussions with NHSI it had been made clear that the Trust was expected to have a stretching and ambitious plan to deliver the set control total of £0.8m deficit.

Dr Wulff, Non Executive Director stated that the Trust needs to manage its budgets and spending to meet targets. There was concern around the Trust exceeding ward establishment budgets and the continued use of costly temporary staff.

The Chief Executive stated that budget holders had never previously signed off their budgets at ward level and the Trust was working on improving budget oversight and control at this level. The Chief Nurse and Director of Finance had met with lead nurses and budget management training is being provided.

The Chairman stated that there needs to be greater clarity in the organisation regarding the financial challenge facing the Trust.

Mr Atkins, Non Executive Director, asked if performance against budgets will be part of the performance management process. The Chief Executive confirmed that it will be very much in focus.

Mr Miner, Non Executive Director, commented that the Board needs absolute clarity around staffing levels and the associated budgets that Divisions were working to.

The Chief Executive confirmed that at the Board Workshop on 10th May, 2018, Board members could spend some time looking at the staffing establishment.

The Chairman and Board noted the report and the required actions on staffing and budgets.

CIP and income phasing to be presented at the May Finance and Performance Committee.

Discussion on staffing establishment to take place at the next Board Workshop.

18/059.2 Integrated Performance Report (Enclosure 8)
9.38am

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

The Board noted the following key issues in respect of the Trust's performance in March:

- The Clinical Quality, Safety, Patient Experience Committee received an update on VTE at its last meeting and the plans in place to secure improvement.

- Emergency Access : Focus remains on the emergency access standard and the Trust had not been able to sustain its trajectory. Overall performance is improving and work is ongoing on the Acute Frailty Model and Acute Medical Assessment pathway. The 2 Physicians working in ED were having a positive impact and the Ambulatory Care area is working well. Ambulance turnround times had improved and the Trust is working with the Ambulance Service and CCG on conveyances. ED ambulance turnaround and CQC recovery plans are in place and the Emergency Care Intensive Support Team is providing support to the Trust.

- 18wk Referral to Treatment (RTT): Good performance has been maintained.

- Diagnostics (DM01): Good performance has again be maintained in this area.

- Cancer: The Trust had seen unprecedented demand for Urology, Breast and Colo-rectal services. There were also issues with Consultants' illness, bereavement leave and specialist nurse absence. There were daily meetings with Directorate Managers and new daily reports produced. A meeting had taken place the previous day, Chaired by the Chief Executive. This will be followed up in writing as the Trust cannot fail the cancer target again. A number of key actions were being put in place. The Chairman raised the recent media coverage around breast screening and queried whether this will produce further demand. The Chief Operating Officer confirmed that the Trust was looking at what extra capacity could be provided to meet demand. The Board noted that Paul Stonelake was attending a national event on 15th May on screening. The Chairman confirmed that the Trust will continue to monitor the position through the Finance and Performance Committee and Board reports.

- Workforce and Appraisals: About 90% of appraisal appointments had been booked between April and June. The Director of Human Resources was writing to all managers that had yet to arrange appraisal. In relation to its turnover rate the Trust was performing well compared to other organisations and significant progress had been made with staff engagement, experience and development initiatives.

Mrs Becke, Non Executive Director, asked about Think Glucose performance. The Chief Operating Officer confirmed that a "deep dive" will be undertaken and the results shared in future performance updates.

Mrs Becke asked about the effect of the new build on the flow of patients through the emergency department. The Chief Operating Officer confirmed that the streaming of patients at the front door was working well. The Trust had moved ambulance triage from the new build and put "minors" in this area and the new location for ambulance triage was working well.

The Medical Director commented ambulance handover times were good and delayed transfers of care had improved. There were also fewer "outlier" patients. The focus for improvement was needed on the middle of the pathway. The Board noted that the Royal College of Physicians was undertaking a review and that the Medical Director will report back their findings and any immediate actions required.

The Chairman asked about the work to support deteriorating patients. The Medical Director confirmed that this work was being reported to the Clinical Effectiveness Group and improvements will be enhanced through the launch of e-Obs on 17th May. The Chief Executive commented that this issue was on both the Risk and Assurance and Deteriorating Patient Group's agendas and progress will be reported up to the Clinical Quality, Safety and Patient Experience Committee.

The Chairman stated that there were some really positive trends within the report, especially on comparative year end performance.

Mr Atkins, Non Executive Director, asked about breast feeding and smoking in pregnancy levels and if the Trust could get traction to improve its performance. The Chief Nurse confirmed that targets are nationally set but the Trust believes it can improve its performance and a number of actions are being put in place around these metrics. Mr Atkins said that he would like to see further detail. The Chief Nurse confirmed that she would share this with him. The Chief Executive suggested Mr Atkins undertakes a walkround in that area to also add an extra dimension to the reported performance.

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

Cancer performance to continue to be monitored through the Finance and Performance Committee and Board.

Results of the Think Glucose deep dive to be shared through performance updates.

Mr Atkins to undertake a walkround within the Womens and Childrens Division.

18/059.3 Cost Improvement Programme and Transformation Overview Report (Enclosure 9)
10.05am

The Director of Strategy and Business Development presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 9.

The Board noted the following key issues:

- Detailed analysis on lessons learnt which were included in the report is allowing the Trust to improve its processes this year.

- The financial control total had changed and the Trust needs to decide how this is managed and communicated across the organisation. The Trust had identified £14m of its CIP so far but recognised that more work is needed to develop the full programme

- Performance to date for 2018/19 will be available on 11th May, 2018.

- The Trust was working closely with the Divisions on instilling greater control over the delivery of the identified schemes.

The Director of Finance commented that by including maturity levels against each scheme the Trust could be more confident about forecasting delivery. The Trust is starting the year in a reasonably strong position compared to last year. However, the challenge this year is greater so the Trust is also focusing on progressing pipeline schemes too.

The Chief Executive confirmed that the Trust did need to communicate sensitively with staff about the new control total so as not to detract attention from the challenge facing the Trust. In relation to Theatre productivity the Trust was working with FourEyes and the 33% Theatre efficiency opportunity had reduced down to 22% after further validation work. The Trust needs to accelerate elective work in the first 9 months of the year to minimise the risk of income loss due to winter pressures.

Mr Hodgkin, Non Executive Director, asked about accountability for delivery of the schemes. The Director of Strategy and Business Development confirmed that there were Executive sponsors for each programme including accountable for their delivery in conjunction with Divisions. There was some discussion about cross-cutting schemes and how these would be managed.

Mr Hodgkin asked when budgets will be signed off. The Director of Finance confirmed that they would be signed off or identified as disputed by the following day. The Chief Executive confirmed that there were always some areas of contention. An example was the Acute Medical Unit where the historic budget was not representative of new ways of working.

The Chairman confirmed that a paper will be presented to the Finance and Performance Committee clearly laying out budget delegations and accountability for delivery. As mentioned previously in the meeting a discussion on Trust's establishment would also take place at the Board workshop.

Mr Welford, Non Executive Director, stated that the lessons learnt analysis was encouraging but there was a need for probability tracking with an escalation process for underperformance. The Director of Strategy and Business Development confirmed that the new Finance Improvement Group had been established to hold Divisions to account and then escalate into the Finance and Performance Committee. Mr Welford asked about performance KPIs. The Chief Executive confirmed that there will also be accountability around performance.

Mr Miner, Non Executive Director, asked if budget holders were aware of FourEyes productivity analysis. The Director of Finance confirmed that they were and the Trust was working with budget holders around productivity expectations.

The Chairman and Board noted the report and the new arrangements to support delivery of the control total and CIP.

Paper on budgets to be presented to the Finance and Performance Committee and a discussion on staffing establishments to take place at the next Board Workshop.

18/059.4 Annual Plan
10.21am

The Board noted that the Annual Plan had been presented to the Finance and Performance Committee which consisted of the standard grid identifying goals, actions and metrics.

The narrative to support the Plan on a Page is work in progress and will come back to the Board in due course but is likely to be a short summary only.

Narrative to support the Plan on a Page to be presented back to the Board.

18/059.5 Q4 Monitoring of 2017/18 Annual Plan (Enclosure 11)
10.24am

The Director of Strategy and Business Development presented the Q4 Monitoring of the 2017/18 Annual Plan Report, given as Enclosure 11.

The report had been discussed in detail at the Finance and Performance Committee.

The Board noted that there were 5 additional red rated goals in the quarter. Mitigations were included on the grid against each goal.

The Chief Executive stated that areas not achieved were still a priority. ED had been discussed earlier on the agenda along with the actions being taken to deliver their goals.

In relation to incident reporting, a lot of work was being undertaken and the Trust was increasing the resources available to the central Governance Team which forms part of the commitment to the delivery of this new quality priority. Incident reporting was increasing, which was a positive means of enabling learning and continuous improvement.

The Trust was no longer using agency clinical support workers or non framework agency staff. The aspiration was to have no agency staff in the organisation.

Mr Welford, Non Executive Director, commented that there were 97 goal objectives active and only 42 had been closed. The Chief Executive confirmed that the Trust had reset its goals and targets for the new year. The Chairman reminded the Board that a number of these goals are centrally directed or were driven by regulatory requirements set on FT providers. Mr Welford commented that the way the data is presented could be demotivating if we are not able to highlight the key goals and how well we are achieving them from the breadth of reported goals. The Chief Executive confirmed that the Trust would look at revising the report to bring to the fore the key performance deliverables.

Mr Welford asked how the impact of the delivery of some of these objectives was tested. The Chief Executive advised that some areas were difficult to test.

The Chairman commented that in planned future workshops on the development of the Trust's medium to long term strategy then the format, number of annual goals and how their effectiveness could be tested could be debated .

The Chairman and Board noted the report, results from last year's Plan, opportunities for further improvement and the need to re-visit the future strategy plan.

Trust to look at the way the report is presented and consider revising to bring key performance deliverables to the fore.

In future workshops on the development of the Trust's strategy then the format, number of annual goals and effectiveness metrics would be considered.

18/059.6 Patient Experience Quarterly Report (Enclosure 12)
10.33am

The Chief Nurse presented the Patient Experience Quarterly Report, given as Enclosure 12.

The Chief Nurse stated that the Trust is continuing to embrace patient experience and taking a number of actions to improve in this area.

An update on the national survey programme was included in the report, along with the outcome of the latest Friends and Family Test results. The Trust rates itself against the top quintile to demonstrate comparative achievement.

Mr Hodgkin confirmed that he was unclear on the key messages within the report and which metric was the most crucial. The Chief Nurse stated that the Friends and Family Test question is the key indicator on patient experience.

The Chief Executive agreed that the report needs to be highlighting to the Board what things patients are dissatisfied with in order for the Board to then decide on a course of action. The format of the report should therefore be reviewed .

Mr Welford, Non Executive Director asked why there was a marked difference in response rates across wards. The Chief Nurse confirmed that a key differentiator was the activity and approach of the Ward Clerk. On the ward that had achieved 100% the Clerk takes on sole responsibility to engage with every patient and as a Trust we need to share this good practice across to the other wards.

Mr Miner, Non Executive Director, asked about the lack of complaints in the Community. The Chief Nurse confirmed that booklets have been produced for patients and families on how to raise concerns. Mr Miner asked what major actions would improve patient experience. The Chief Nurse stated that the main issue is culture and being an open and transparent organisation. Mr Miner commented that we need to improve patient communication to make us an outstanding organisation.

Mr Fellows, Non Executive Director, commented that the Friends and Family Test response results were below the national average and the Trust needs to continue to give focus to securing feedback.

Mr Atkins, Non Executive Director, stated that complaints are a rich source of information for improvement and asked about the outcome of complaints meetings with the Divisions. The Chief Nurse confirmed that Divisions look at actions and the Trust meets with individual leaders to gain assurance. Mr Atkins stated that there needs to be corporate oversight of actions.

Mr Welford, Non Executive Director raised the data on page 7 of the report and that the processing of complaints appeared to be an issue. This had been discussed at the Clinical Quality, Safety, Patient Experience Committee and there was a significant backlog with more complaints coming in than were being closed. The Chief Executive confirmed that additional resource was being provided to the divisions. The Chief Nurse confirmed that the Deputy Chief Nurses were also assisting with the processing of complaints.

The Chairman asked for a timeline for achieving the 40 day response rate and for the repot to be re-written to stratify the key areas for improvement.

The Chairman and Board noted the report, the increased focus on obtaining feedback and the work required to improve response times on complaints.

Report to be revised to include a timeline for achieving the 40 day complaints response rate and to stratify the key areas for improvement.

18/060 Well Lead

18/060.1 Digital Trust Committee Report (Enclosure 13)
11.01am

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

The Board noted the following key highlights:

- Roll out of 1st phase: Go live had been re-arranged to 17th May, due to significant product deployment issues. The product is now technically ready to go live and the Trust will commence the final 2 week testing stage.

- Training: The target is set at 85% of staff compliance for the go live to be deemed viable. The Trust has trained 1,600 staff including just under 50% of the clinicians in the organisation. More in depth analysis of clinical users was required to confirm the overall figures. There will be a big push over the next 2 weeks to increase numbers further.

The Chief Executive asked that agreement is reached regarding which staff must be trained to allow safe deployment before informing the organisation of numbers outstanding.

The Chairman asked that the Board receives an emailed update on the final decision on go live delivery.

The Medical Director asked about floor walking capacity. The Chief Information Officer confirmed that 600 super users had been trained and the Trust was bringing in external resource during the go live period to support with this crucial activity.

The Chief Information Officer advised that 2 Divisional Chief Clinical Information Officer posts has been recruited to. The Trust had appointed the Clinical Safety Officer previously so will have a strong clinical leadership team in place supporting the further planned roll out of the digital trust programme

The Trust went live the previous week with a number of GP surgeries for live communication through EMISS. Roll out will take place after the trial period and this will provide the platform for the MCP.

Dr Wulff, Non Executive Director confirmed that the interoperability functions will be highly supported as this connectivity had been raised as helpful at the Palliative Care Strategy launch.

The Chairman and Board noted the report and the current position regarding “go live” readiness.

Board members to receive an update on final go live decision.

18/060.2 Trust Annual Declarations (Enclosure 14)
11.10am

The Director of Governance/Board Secretary presented the Trust Annual Declarations Report, given as Enclosure 14.

The Board noted the following key highlights:

- The Trust is required to make a public declaration on its website by the end of May that as a Trust it is not in breach of its licence and can provide continuity of service.

- Requirement 1 is based on information and can be signed as compliant.

- Requirement 2 is for Corporate Governance and training for governors and the Board is recommended to sign as compliant.

The Chairman and Board noted the report and agreed compliance with both declarations, acknowledging the limitations as set out in the defined standards.

18/060.3 Workforce Committee Exception Report (Enclosure 15)
11.12am

Mr Atkins, Committee Chair, presented the Workforce Committee Exception Report given as Enclosure 15.

The Board noted the following key highlights:

- It had been confirmed that all new nursing staff are automatically enrolled on the Trust Staff Bank so that agency spend can potentially be minimised.

- The Committee reviewed Workforce risks. Staff engagement was discussed and the risk rating increased. This will be looked at further at the next meeting.

- The Committee discussed apprenticeships and the opportunity for nurse apprenticeships and this will be brought back to the next meeting.

- The Committee noted the implementation of the new band 6 leadership development programme. There were 2 cohorts running with a 3rd cohort being established. This was a pleasing response from staff.

The Director of Human Resources commented that he felt the regular scheduling of this item towards the end of the meeting resulted in limited time spent on this crucial area. The Chief Executive reminded the Board that within the integrated performance report there is as separate section on workforce which is early in the meeting agenda which allows crucial items to be raised and debated. The Chief Executive stated that the report would benefit from the inclusion of more metrics to allow the conversations to be framed within the wider context of trust performance

The Chairman and Board noted the report and work of the Committee to date.

18/061 Any Other Business
11:16am

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

18/062 Date of Next Meeting
11:16am

The next Board meeting will be held on Thursday, 7th June, 2018, at 8.30am in the Clinical Education Centre.

Signed ……

Date …….....

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 3 May 2018

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
18/054.7	Action Sheet – 12th April 2018	Chief Information Officer to email an update to Board members with the Digital Trust Programme key headlines.	MS	17/5/18	9th May Go-Live status email sent to Board.
18/060.1	Digital Trust Committee Report	Board members to receive an update on final go live delivery.	MS	17/5/18	16th May Final pre Go-Live report update issued to Board via email
18/054.7	Action Sheet – 12th April 2018	Finance and Performance Committee to consider if Theatre Scheduling is required to be presented to the Clinical Quality, Safety, Patient Experience Committee.	JF	31/5/18	No performance issues have been identified from information provided to the Finance and Performance Committee that require referral at this time to the Clinical Quality, Safety, Patient Experience Committee.
18/054.7	Action Sheet – 12th April 2018	The Finance and Performance Committee once it had considered the income forecast within the 2018/19 Plan at its May meeting to report to Board on any considered risks.	JF	31/5/18 & 7/6/18	On Agenda within Finance and Performance Committee and Integrated Performance Reports.
18/059.1	Finance and Performance Committee	CIP phasing to be presented at the May Finance and Performance Committee.	JF	31/5/18	CIP maturity discussed at Finance and Performance Committee. Phasing to be in subsequent report.
		Discussion on staffing establishment to take place at the next Board Workshop.	All	10/5/18	Discussed Workforce matters at Board Workshop.

18/059.2	Integrated Performance Report	Cancer performance to continue to be monitored through the Finance and Performance Committee and Board. Results of the Think Glucose deep dive to be shared with the Board. Mr Atkins to undertake a walkround within the Womens and Childrens Division.	KK KK JA	31/5/18 & 7/6/18 7/6/18 7/6/18	On Agenda There have been no issues raised with performance within this service and the "Think glucose" measure is not a key metric for the diabetes service and therefore this is being removed from the corporate performance report as part of the planned revision to the IPR as agreed at a previous board meeting. Therefore this element of this action is recommended to be closed. Walkround undertaken in May – item now closed.
18/059.3	Cost Improvement Programme and Transformation Overview Report	Paper on budgets to be presented to the Finance and Performance Committee and a discussion on staffing establishments to take place at the next Board Workshop.	JF	31/5/18 & 10/5/18	Done
17/117	Patient Story	Follow up to the patient story to be presented to the Board.	LA	7/6/18	On Agenda.
18/046.2	Integrated Performance Report	Detailed analysis around crude mortality to be included in the next Leaning from Deaths Report to Board.	JH	7/6/18	On Agenda in Learning from Deaths Report.
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	On Agenda in Learning from Deaths Report.
18/055	Patient Story	Board's thanks to be passed on for the patient story.	LA	7/6/18	Done.
18/057.2	Infection Prevention and Control Update	Full Hygiene Code statement to be presented to the June Board. The Chief Executive to have a pre-meeting and feedback meeting with Dr Adams when she next visits the Trust in July.	ER DW	7/6/18 July 18	On Agenda in Infection Control Report Not due.

		The Director of Infection Prevention and Control to revisit the compliance action plan and ensure that it included the detail of the assurances supporting the view the actions were being addressed.	ER	7/6/18	On Agenda in Infection Control Report.
18/058.3	Monthly Nurse/Midwife Staffing Report	Chief Nurse to reflect on how data on all aspects of quality can be brought together into an overarching Chief Nurse report. Mr Welford to meet with the Chief Nurse to further understand the staffing position.	SJ SJ/RW	7/6/18 7/6/18	Work in progress within the Integrated Performance Report.
18/059.4	Annual Plan	Narrative to support the Plan on a Page to be presented back to the Board.	NY	7/6/18	The Plan narrative has been amended to include comments received at Board and is re-presented for the June Board agenda.
18/054.7	Action Sheet – 12th April 2018	Utilisation and retention of staff to be presented back to the next Workforce Committee.	JA	26/6/18	Not due.
18/029.8	Action Sheet	Board members perspective of the 6Cs to be presented to the Board in May.	LA	5/7/18	To July Board.
18/035.2	Staff Survey Report	Staff Survey action plan to be presented to Board.	JA	5/7/18	To July Board.
18/045.5	Nurse Revalidation Report	Further detail around numbers and quality of evidence relied upon for revalidation to be included in future reports.	SJ	5/7/18	To July Board.
18/059.4	Q4 Monitoring of 2017/18 Annual Plan	Trust to look at the way the report is presented and consider revising. In future workshops on the development of the Trust's strategy, the format, number of annual goals and how their effectiveness could be tested could be debated.	NY NY	6/9/18 2/8/18	A draft format for the report has been produced and was discussed at Directors on 29th May. The revised format will give a summary of the progress of each of the six strategic objectives and will be produced from the end of quarter one. The report will also be included

					in the Integrated Performance Report.
18/059.6	Patient Experience Quarterly Report	Report to be revised to include a timeline for achieving the 40 day complaints response rate and to stratify the key areas for improvement.	SJ	6/9/18	Not due.

Enclosure 3

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th June 2018

TITLE:	**Public Chief Executive's Report**		
AUTHOR:	**Diane Wake, Chief Executive**	**PRESENTER**	**Diane Wake, Chief Executive**

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

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

SUMMARY OF KEY ISSUES:

- Visits and Events
- Healthcare Heroes
- Charity Update
- Celebrate the 70th anniversary of the NHS with a Big 7Tea party
- Diversity and Inclusion Recognition
- National NHS News
- Regional NHS News

IMPLICATIONS OF PAPER:

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

1st May	Dudley End of Life and Palliative Care Strategy Launch
3rd May	Board of Directors
	Dudley System Oversight and Assurance Group
Council	of Governors
4th May	Black Country Chief Executive's/Medical Directors Meeting
9th May	Transition Board
10th May	CQC Never Event Advisory Group
11th May	West Midlands Provider Chief Executive's Meeting
15th May	CHKS Awards
16th May	NHSI Lean Event
18th May	Meeting with MPs
Team	Brief
21st May	Black Country STP Health Partnership Board
25th May	Black Country ICS Meetings
30th May	Dudley Partnership Board
	Black Country Pathology Oversight Group
31st May	Dudley System Oversight and Assurance Group
	Trust/Summit Board to Board Meeting
Healthcare	Heroes Award Presentation
1st June	Healthcare Heroes Award Presentation
Black	Country Chief Executive's/Medical Directors Meeting
4th June	NHSI Quality Visit
6th June	Volunteering for Volunteers Week

Healthcare Heroes

Presenting the monthly Healthcare Heroes Award is one of the highlights of my job. It's always so lovely to see the look of surprise on the faces of the recipients! The individual award this month went to Hashem Elhossamy, specialty doctor for obstetrics. He stood out from the crowd for always going the extra mile to ensure patients' care is individualised and for always involving women in decision making.

The team award was picked up by the clinical guidelines group which meets every month to support directorates develop their guidelines. So far they have developed 21 new guidelines for the Trust, and have also consulted on more than 50 guidelines. They also collaborate with junior and senior doctors on guideline projects. Both recipients this month are very worthy winners.

The Dudley Group
NHS Foundation Trust

Charity Update

Sunday 10th June is our Neon 5k Colour Dash at Himley Hall in Dudley. So far more than 250 members of staff have signed up to take part. Not only will they be running the gauntlet of rainbows, but also raising money for our neonatal unit. To date the event has raised almost £7,000. It is a worthy cause and a fun day out for all the family.

Celebrate the 70th anniversary of the NHS with a Big 7Tea party

This year marks the 70th anniversary of the NHS and we're doing our bit to mark the occasion by joining in the Charity Big 7Tea Party. Although Thursday 5th July is the actual 70th birthday of the NHS, we are asking staff to hold their Big 7Tea on a date that works best for them.

Diversity and Inclusion Recognition

We have been recognised by NHS Employers as a Diversity and Inclusion Partner for 2017/18. This acknowledges our commitment to improving our outcomes for patients and staff in relation to the 9 protected equality characteristics.

We have been accepted by the scheme as Equality Partners for 2018/19 to enable us as an organisation to further develop our commitment to equality and diversity.

National NHS News

Hundreds of deaths linked to NHS breast cancer screening glitch
Up to 270 people may have died as a result of a computer failure that meant hundreds of thousands of women approaching their 70th birthday were not invited to an NHS breast screening appointment. Jeremy Hunt, health secretary, told MPs that the problem, the result of an algorithm malfunction, dated back almost ten years to 2009. "As a result between 2009 and the start of 2018 an estimated 450,000 women aged between 68 and 71 were not invited to their final breast screening," he said. It was unclear whether any delay in diagnosis had resulted in "avoidable harm or death," Mr Hunt said, but he had commissioned an independent review "to establish the clinical impact". ***Financial Times (02.05.18)***

Theresa May 'refused' plea for more Indian NHS doctors
PRIME Minister Theresa May was fighting for her political life last night after it emerged that she had turned down a plea from Cabinet colleagues to allow doctors from India to shore up the NHS. The Evening Standard – which is edited by former chancellor George Osborne – revealed that three ministers asked May to lift her cap on so-called Tier 2 visas to allow in up to 100 doctors from India.

Downing Street point blank refused. The National can reveal that May's veto has affected Scotland's NHS, too. Health Secretary Shona Robison said: "The Home Office cap on Tier 2 visas is having a profound effect on our ability to recruit and retain clinicians. A number of health boards have signalled that applications have been refused since December 2017, resulting in unacceptable delays in filling posts. ***The National (02.05.18)***

Thousands of calls made to breast screen error helpline
More than 8,000 calls have been made to a helpline since it was revealed that 450,000 women were not invited to routine breast cancer screening due to a computer error. Public Health England says it was not aware of a national problem with the screening programme until January. But the BBC understands that two NHS trusts in England raised concerns about IT issues as early as March 2017. The national screening error, which dates back to 2009, meant women aged 68 to 71 were not sent letters inviting them to their final screening appointment. Health Secretary Jeremy Hunt said that up to 270 lives may have been cut short because of the mistake. ***BBC News (03.05.18)***

CANCER COMPO Breast cancer screening shambles could cost NHS £100million in compensation pay-outs for tens of thousands of women
THE NHS could face a £100m compo bill after a breast cancer screening glitch was revealed. Speaking to the Sun Online, Robert Rose, head of clinical negligence at Lime Solicitors, said the claims of the families of women whose lives were lost due to the debacle could quickly rack up to $5.4m. But he said that claims of women who have had to undergo more invasive treatment after not receiving the checkup invitation could see the compensation claims against the NHS to rocket to £100m. The revelations have caused a huge outpouring of fear across the UK, with 8,000 terrified women calling a helpline yesterday over the breast cancer screening scandal.
The Sun (04.05.18)

Poor NHS care contributed to deaths of 13 people with learning disabilities
Detailed studies of 103 deaths in 2016-17 by the NHS Learning Disabilities Mortality Review found that in 13 instances the person's health had been adversely affected by treatment delays, poor care, neglect or abuse. The review was set up in 2015 in response to concern over repeated failings in the care of learning disabled patients, including the death of 18-year-old Connor Sparrowhawk, who drowned in a bath while in the care of an NHS unit in 2014. The review found that, overall, the life expectancy of people with a learning disability lagged far behind a person in the general population – 23 years for men and 29 years for women.
The Guardian (04.05.18)

Trust will not miss out on national funding despite failing to hit financial targets
Oxford University Hospitals (OUH) NHS Foundation Trust will still be awarded around £5million in national funding, despite missing its financial targets. NHS Improvement had promised trusts across the country a share of the £1.8bn Sustainability and Transformation Fund (STF) if budget plans were met by the end of the financial year. OUH had initially been promised £20million through the STF if its 2017/18 financial plan was met, however, under the new formula the trust, which runs all of Oxfordshire's acute health services, will now receive just £5million.
Oxford Mail (10.05.18)

NHS spends almost £1.5bn on temporary nursing staff to plug gap
A Freedom of Information (FoI) request by the Open University for its report, 'Tackling the nursing shortage', revealed that many trusts have been forced to fill staffing shortages through expensive overtime or temporary arrangements, paying for an additional 79 million hours of registered nurses' time in the last 12 months. Of the 241 trusts that were contacted, 141 responded and they collectively spent a minimum of £1.46bn in the past year. If this data is extrapolated to cover all trusts, the cost could be as high as £2.4bn.

Temporary nursing staff are very expensive and the report argues that if this £1.46bn were to be reinvested, the NHS could secure the services of 66,000 newly qualified registered nurses - far above February's vacancy rate of 38,000. ***National Health Executive (15.05.18)***

NHS cost-cutting Capita contract put 'patients at serious risk of harm', find auditors
Patients have been "put at serious risk of harm" by the failure of a £330m outsourcing exercise which NHS England contracted to the private firm Capita in a bid to cut costs, the National Audit Office has warned. Women were dropped from national cervical cancer screening programmes and medical records and supplies have gone undelivered because of NHS England's "deeply unsatisfactory" contract, it said in a report. It follows two-and-a-half years of disruption for GPs, dentists, opticians, pharmacists and their patients as a result of NHS England's ambition to cut its £90m-a-year bill for primary care back office services by a third. The NAO was particularly scathing of NHS England's inability to check Capita's "aggressive" programme of office closures and redundancies, even when it became clear "it was having a harmful impact on service delivery". ***The Independent (16.05.18)***

Court urged to block plan to 'Americanise' health service
"Radical" government plans to allow private companies to play an increased role in the National Health Service should be blocked, the High Court in London was told on Wednesday by campaigners who had been backed by the late Professor Stephen Hawking. Three doctors and an academic have brought a legal challenge against health secretary Jeremy Hunt and NHS England over proposals to let non-NHS bodies, including for-profit companies, run parts of the health service. The campaigners said in court documents that they were "deeply worried" about plans for non-NHS bodies — known as accountable care organisations— to take on some aspects of health and care provision. ***Financial Times (23.05.18)***

NHS needs £2,000 in tax from every household to stay afloat, report concludes
Taxes will "almost certainly" have to rise over the coming years simply to prevent the National Health Service and social care system from slipping further into crisis, a major new report concludes.
The Institute for Fiscal Studies and the Health Foundation state that the NHS, which has been suffering the most severe fiscal squeeze since its foundation over the past eight years, now requires an urgent increase in government spending in order to cope with an influx of older and sicker patients. The two organisations say that state funding growth rate, which has been just 1.4 per cent a year since 2010, will have to more than double to between 3.3 per cent and 4 per cent over the next 15 years if government pledges, such as bringing down waiting times and increasing the provision of mental health services, are to stand any chance of being delivered.
The Independent (24.05.18)

National data opt-out programme comes into force
The national data opt-out replaces the previous 'type 2' opt-out. This allowed patients to tell NHS Digital they did not want their data shared for purposes other than their direct care.

NHS Digital has confirmed that any person with an existing type 2 opt-out will have it automatically converted to a national data opt-out from today and will shortly receive a letter giving them more information and a leaflet explaining the new system. Initially, the opt-out programme only covers data held by NHS Digital. But all other organisations that use health and care information are due to comply by March 2020. ***Digital Health (25.05.18)***

Urgent call for volunteers for NHS clinical trials to aid research
People are being urged to join clinical trials to help the NHS create better treatments after a new survey revealed there were "misconceptions" surrounding such research tests. Although 85% of people say they want to help the NHS find better ways to treat illness and disease only 14% of people have ever taken part in one.
INews (25.05.18)

NHS preparing to offer 'game-changing' cancer treatment
The NHS is preparing to fast-track a "game-changing" cancer treatment into hospitals, its chief executive has said, calling for the manufacturers to help by setting an affordable price. Simon Stevens said CAR-T therapy, which has been licensed in the US but not yet in the UK, could be approved for use this year. The treatments, which are hugely expensive, work by genetically engineering the patient's immune system's killer T-cells to recognise and destroy cancer cells. The cost in the US is $475,000 (£340,000) per patient, which is far in excess of the normal NHS ceiling of £50,000 per year of good-quality life for an end-of-life drug. But Stevens says this is technology the NHS must embrace. Speaking to the Association of the British Pharmaceutical Industry, he appealed for fair prices. ***The Guardian (26.05.18)***

Gender pay gap for NHS doctors stands at £10,000
Health secretary Jeremy Hunt on Monday pledged to eradicate the gender pay gap in medicine after it emerged that male doctors working in the National Health Service are paid about £10,000 a year more on average than their female counterparts. The Department of Health and Social Care said the gender pay gap in medicine was big because the number of higher-remunerated male doctors was a much bigger proportion of the male NHS workforce than female doctors were of the female NHS workforce. Male doctors are currently paid £67,788 on average in basic remuneration each year, compared to the £57,569 that female doctors receive, a gap of more than £10,000. ***Financial Times (27.05.18)***

NHS to spend £150m on cyber security to bolster defences after WannaCry attack
The NHS is to spend £150m to bolster its defences against the "growing threat" of cyber attacks following the chaos caused by the WannaCry virus. Amid warnings that hackers linked to Russia and other countries have been targeting Britain's critical national infrastructure, including power networks, a new security contract has been drawn up with Microsoft. The Department of Health and Social Care said the package would enhance security intelligence and give individual trusts the ability to detect threats, isolate infected machines and kill malicious processes before they are able to spread. ***The Independent (28.03.18)***

NHS England announces £10m cash boost to keep GPs
The fund, announced today part of an NHS England initiative to attract GPs to practices and recruit 2000 GPs into the workforce by 2020, will dedicate around £7m to regional-based schemes by promoting new ways of working and offering additional support through a new Local GP Retention Fund. The remaining £3m will be establish seven intensive support sites around the UK in areas failing to support and retain GPs. ***National Health Executive (30.05.18)***

NHS hospitals ended the financial year almost £1bn in the red
Annual data released on Thursday by health service regulator NHS Improvement showed a "surge in demand" had affected the NHS's performance in key areas, with waiting times slipping and larger-than-expected sums spent on temporary workers to fill staffing gaps. While two-thirds of providers — 156 of 234 NHS trusts — finished the year at or better than where they had planned to be financially, the higher patient numbers contributed to a deficit of £960m at the end of 2017-18 for the sector as a whole. This figure is £464m above the level anticipated by trusts at the start of the financial year, and £30m higher than had been expected as recently as the end of December. But NHS Improvement said this was "an £1.5bn improvement from 2015-16, when the sector's deficit stood at £2.45bn". ***The Financial Times (30.05.18)***

Regional NHS News

Parents told to urgently vaccinate kids as measles cases soar
Mums and dads are being urged to vaccinate children as the region is hit by a spate of cases. The outbreak, which originally focused in Birmingham and Solihull, has now become a West Midlands wide community issue with over 100 cases. NHS England (West Midlands) and Public Health England (PHE) West Midlands are now urgently asking parents to arrange immunisation at their GP surgery. PHE has written to all West Midlands GPs asking them to be on the alert for the symptoms of measles and to take the opportunity to immunise children and adults who may not have received two doses of the MMR vaccine. **Coventry Live (30.04.18)**

Carillion: Midland Hospital could face further two-year delay
The £350m Midland Metropolitan Hospital being built by Carillion prior to its collapse could be delayed by another two years, the NHS trust's chief executive has revealed. In board papers published ahead of a meeting on Thursday, Sandwell and West Birmingham NHS Trust chief executive Toby Lewis said some options being looked at would make a 2022 opening "more likely" than the 2020 date the trust had targeted. However, Mr Lewis said the trust continued to push for a faster restart in order to achieve a 2020 completion. He also warned the site was now "deteriorating", which would result in significant remedial costs. Mr Lewis has previously been quoted as saying there would be additional costs of around £100m-£125m to finish the project. ***Construction News (02.05.18)***

West Midland NHS trusts' fears over breast cancer tests ignored
Two hospital trusts in the West Midlands raised concerns about breast cancer screening invitations last year but were told it was a local issue, it has been claimed. However, as early as March 2017, two breast cancer screening centres in the West Midlands, as well as one in London, raised concerns that some women were not being invited for mammograms. It has not been disclosed, which hospitals the centres are at. Software provider Hitachi Consulting said at the time it was a local problem and the full scale of the issue was not realised until January, Public Health England (PHE) said. ***Express & Star (05.05.18)***

The shocking number of pregnant women in the West Midlands who smoke
Analysis of figures released by NHS Digital shows that in 2017, there were 630 women in Wolverhampton recorded as smokers at the time of giving birth.
That works out as 18 per cent of the 3,461 total maternities recorded during the same period - the highest proportion in our metropolitan area. In Dudley, there were 504 women known to be smokers when they delivered - 15 per cent of the total 3,430 maternities in the area. Walsall saw 456 new mother known to be smokers at the time of giving births, or 12 per cent of the total 3,667 maternities.
Birmingham Live (05.05.18)

The jaw-dropping number of West Midlands patients with no GP access outside working hours
Nearly 400,000 patients in the West Midlands have no access to GP appointments outside normal working hours. There were a total of 66 practices not providing appointments outside normal working hours. Of those, 35 were in Birmingham Cross City CCG, affecting 189,554 patients, nine in Solihull CCG, affecting 92,787 patients, three in Wolverhampton CCG, affecting 16,495 patients, one in Dudley CCG, affecting 6,234 patients, and one in Sandwell and West Birmingham CCG, affecting 3,830 patients. ***Birmingham Live (08.05.18)***

Anger as Stafford Hospital scandal chief gets new NHS job
Healthcare campaigner Julie Bailey has said she is 'appalled' that Sir David Nicholson has been given another job in the NHS after his involvement in the Stafford Hospital scandal. Sir David, aged 63, was head of the West Midlands Health Authority for a short period while patients were mistreated. He was later appointed as NHS England chief executive but then stepped down in 2014. Sir David was last week appointed as interim chairman of Worcestershire Acute Hospitals NHS Trust, which runs Kidderminster Hospital. ***Express & Star (15.05.18)***

Ambulance delays at Shropshire hospitals hit more than 8,500 in one year
Delays mean paramedics cannot respond to fresh 999 calls, bosses have warned. In 1,655 cases, crews waited longer than an hour at Royal Shrewsbury Hospital (RSH) and Telford's Princess Royal Hospital (PRH). NHS rules state it should take no longer than 15 minutes. The figures for 2017/18, which have been reported by Shropshire Clinical Commissioning Group (CCG), also show that 62 patients were left waiting on trolleys for more than 12 hours between October last year and the end of March. The county's emergency departments have been facing high demand and Shrewsbury and Telford Hospital NHS Trust (SaTH), which runs RSH and PRH, has struggled to recruit staff. ***Shropshire Star (15.05.18)***

The Dudley Group
NHS Foundation Trust

Wolverhampton hospital trust fined £770,000 for ambulance delays in two years
The Royal Wolverhampton NHS Trust, which runs New Cross Hospital, has been made to pay huge fines due to the number of ambulances left queuing outside the city hospital's A&E. Hospitals are punished for the number of patients left waiting in ambulances for more than 15 minutes. New figures showed the health trust, which also runs Cannock Chase Hospital, has been paying out thousands of pounds every month over the delays. A total of £772,600 was shelled out in fines since April 2016. The most costly single month during that period was January 2017, when bosses were forced to part with an eye-watering £105,800.
Express & Star (25.05.18)

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 7 June 2018

TITLE:	**29 May 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	**Y**		**Risk Description: covers many risks, nut key are those related to the Trust quality priorities, deteriorating patient and patient experience**
	Risk Register: Y		**Risk Score: numerous across the BAF, CRR and divisional risk registers**
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 Dudley Group
NHS Foundation Trust

The Committee requests that the Board note the Committee's endorsement of the two annual reports relating to Infection Prevention and Control and Safeguarding as they are presented for approval by the Board at its June meeting.

The Committee requests that the Board note the Committee's endorsement of the Trust's self assessment of the Trust Maternity Services compliance against the 10 national actions as that report is presented for approval at the June meeting.

The Committee requests the Board to note the requires for a corporate risk assessment be undertaken in relation to the MRI replacement programme and reflected in a subsequent (July) iteration of the corporate risk register.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	29 May 2018	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- 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 had referred a number of items to the respective divisions for updates to the next meeting and made one recommendation to the Committee, namely, to add to the forward planner the receipt of the SEPSIS mortality review. The Committee agreed to add this to its July meeting agenda.
- The Committee received a summary report of key quality metrics along with the Trust Integrated Performance Report. The summary report highlighted both areas that had improved, including recruitment, NEWS observations, and areas where further improvement is needed including Nutrition.
- The Committee received an update report from the Medical Director on the implementation of the Trust deteriorating patient strategy. The Medical Director agreed that for the next update that the narrative would show the oversight arrangements for each of the key actions and where the delivery of these will be evident to the Committee either directly or through its reporting groups. The Chief Executive reminded the Committee of the complementary work being undertaken to implements 'hospital at night' and that developing this area would support the medics to maintain oversight of deteriorating patients as routine out of hours tasks will be managed via an enhanced out of hours team.
- The Committee received a report on Infection Prevention and Control which included a summary of the Hygiene Code compliance statement for 2017/18 which is to be taken to the next Board meeting. The Committee was informed by the Director of Infection Prevention and Control that the first milestone of ensuring that 500 staff have been training in the first two months of this financial year had been met. The Director of Infection Prevention and Control informed the Committee that she had confidence the annual training commitment could be achieved. The Committee was updated on the work undertaken in respect of MRSA screening and noted that the Trust had achieved a screening rate of 96.4% for elective admissions and 94.2% for emergency admissions. The Committee was updated

as to the latest position with regard to the NHS improvement visit action plan.

- The Committee received the draft of the Trust's Infection Control Annual report and endorsed that this to be presented to the Board for approval.
- The Surgery, Women and Children Divis ion provided an update on the ac tions being undertaken within ophthalmology to ensure sustainably in the delivery of the service. The Divis ion provided verbal assurance that there continued to be no overdue follow up appointments for urgent or "red" categories of patients. The Division also provided an update on the work being undertaken in respect of paediatric outpatient waiting lists and that the Division remained behind its forecast trajectory for recovery of this position. The Chief Executive reminded the Division of the actions agreed at t he last divisional performance meeting in respect curtailing study leave to provide greater capacity for the more appointment slots for overdue patients. The Committee agreed wit h the Executives that the revised trajectory for removal of this back log wa s too long and that a revised action plan with a much shorter recovery trajecto ry be prepared and sent to the Committee ahead of the next meeting in June 2018.
- The Committee received a detailed report month on the actions being taken within the Emergency Department in respect of re sponding to complaints it had received and the improvements it had made as a result of the complaints.
- The Committee reviewed the Maternity Dashboard report and noted the improv ed performance across a range of areas sinc e last month's report. The Committee's attention was drawn to the continued im provement made in resp ect of screening performance. The Committee was reminded of the actions now in place to review caesarian section activity, which had increa sed last month for elective cases but reduced for emergency cases. The Committ ee was informed that regular audits of this area have been added to the clinical audit forward planner and the outcomes will be reported to the Clinical Effectiveness Group.
- An update was provided on t he Maternity Service Improv ement Plan. The report provided assurance of progress and the c ontinued executive oversight of the action tracking process whic h has and will continue to take place within the Division and the Directorate.
- The Committee received a report on the Trus t self-assessment against the Clinical Negligence Scheme for Trusts national 10 maternity safety actions. The Committee was updated as to the Trust position of compliance with each of these actions and that a report was to be pr esented for board approval at the June meeting once the evidence appendix had been populated. The Committee endorsed this report to the Board for approval in June.
- The Committee received reports from the divisions of Medicine & Integrated Care, Surgery and Clinical Suppor t Services. The divis ions updated the Committee on the actions they were taking to improv e patient quality. The Committee were updated as to the planned MRI replacement programme and asked that the risk this poses to activity across the replac ement period be considered for inclusion on the corporate risk register.
- The Committee received an update on a pati ent experience matter raised at the last meeting by one of the Non Executiv es and the actions in progress to improve the appointment communication processes.

- 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 on the actions within the improvement plan. The plans showed progress made across each of the services, which had resulted in a reduced number of at risk items this month. The Committee was updated as to the developing outcome / performance measures in place that will enable the Executive, the Committee and Board to have oversight of the sustainability of the delivery of the actions on patient safety, quality and experience. The development of these measures are being developed for the Emergency Department and once developed would be useful for many of the other service improvement plans.
- 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 further decrease in reported incidents in the month of April and given the Trust's quality priority the central governance team continues to encourage Divisions to push the message for staff to report all incidents including positive incidents (where good practice was identified and can be shared). The Committee was updated on the actions being taken to close investigations in a timely manner and was informed that there was only one Significant Incident where the action plan was not being closed in line with the initial implementation date, which is an improvement from the position in both of the previous two months.
- The Committee received a patient experience report for the month of April. The report provided an update on compliments, friends and family feedback, concerns and complaints activity. The report updated the Committee on the number of open complaints and the actions being taken to improve the Trust's response performance in respect of its set target of 40 days. The report contained information on the changes and lessons learnt as result of a sample of complaints responded to in the month.
- The Committee received a report on the qualitative aspects of the estates contract management processes in respect of estates and facilities. The report provided information on actions taken in respect of water safety, decontamination and cleaning. The Committee were informed of the improved cleaning audit scores.
- The Committee received the Safeguarding annual report for 2017/18 and endorsed that this be recommend to Board for final approval.
- The Committee received reports from a number of its reporting groups. The Internal Safeguarding Board report provided information on the recruitment process for key safeguarding positions within the Trust. The Quality and Safety Group referred to the Committee the issue of oxygen prescribing, lack of medical engagement with the group and that one of its reporting groups did not meet its terms of references as it only met once in the preceding year. The Health, Safety and Fire Assurance Group provided assurance regarding activities at the last meeting and had no issues to refer to the Committee.
- The Committee received an update on the Trust position with respect to Polices, Guidelines and Standard Operating Procedures under review. There are 5 Polices

that have exceeded their review dates, with a further 50 due for review in the next 6 months. There are 74 guidelines and standard operating procedures that are overdue review, with a further 84 due for review before November 2018. The Executives provided assurance to the Committee that they are working to support the review of the Polices for which they have executive oversight.

- The Committee reviewed the Board Assurance Framework for those risks it has oversight of along with the Trust's corporate risk register. The Committee agreed that the MRI replacement programme should be considered for inclusion on the corporate risk register to enable effective tracking of the risk management action plan being applied to this project.

Decisions Made/Items Approved

- The Committee endorsed that the Infection Prevention and Control annual report and the safeguarding annual report be presented to the June Board for approval.
- The Committee endorsed that the report showing the Trust position of compliance with each of the national 10 actions for maternity be presented for Board approval at its June meeting.
- The Committee ratified one new policy based on the recommendations of the Policy Group.
- The Committee agreed to add the review of Mortality themes including SEPSIS to its forward planner.

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

The review of lessons learnt form mortality reviews.

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

The work in respect of quality improvement flowing from the work with AQUa.

Items referred to the Board for decision or action

The annual reports relating to Infection Prevention and Control and Safeguarding be recommended to the Board for approval.

The Trust self assessment of Maternity Services compliance against the 10 national actions be recommended to the Board for approval.

The Committee requests the Board to note the requires for a corporate risk assessment be undertaken in relation to the MRI replacement programme and reflected in a subsequent (July) iteration of the corporate risk register.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

TITLE:	Infection Control Annual Report 2017- 2018		
AUTHOR:	Dr E Rees, Director of Infection Prevention and Control	**PRESENTER:**	Dr E Rees, Director of Infection Prevention and Control

CORPORATE OBJECTIVE:

SO1 – Deliver a great patient experience

SO2 – Safe and caring services

SO3 – Drive service improvements, innovation and transformation

SO4 – Be the place people chose to work

SO6 – Plan for a viable future

SUMMARY

The Dudley Group NHS Foundation Trust is committed to ensuring that a robust infection prevention and control function operates within all clinical areas of the organisation which supports the delivery of high quality healthcare and protects the health of its service users and staff.

The Annual report seeks to provide assurance to the organisation with regards to the progress of the prevention, control and management of infection from April 2017 to March 2018.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		√	

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

CONTENTS

LIST OF ABBREVIATIONS

C.diff	Clostridium difficile
CQC	The Care Quality Commission – the integrated regulator of health and adult social care
DH	Department of Health
D and/or **V**	Diarrhoea and/or Vomiting
DIPC	Director of Infection Prevention and Control. An individual with overall responsibility for infection control and accountable to the registered provider
E-Coli	Escherichia coli
ESBL	Extended-Spectrum Beta-Lactamases (ESBLs) are enzymes that can be produced by bacteria making them resistant to cephalosporins e.g. cefuroxime, cefotaxime and ceftazidime - which are the most widely used antibiotics in many hospitals
GQC	Governance and Quality Committee
GRE	Glycopeptide-Resistant Enterococci
HCAI	Health Care Associated Infections
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IPCLN	Infection Prevention and Control Lead Nurse
IPCT	Infection Prevention and Control Team
MRSA	Meticillin-resistant Staphylococcus aureus
MSSA	Meticillin-sensitive Staphylococcus aureus
OHD	Occupational Health Department
PLACE	Patient Led Assessment of the Care Environment
PPE	Personal Protective Equipment
SLA	Service Level Agreement
UTI	Urinary Tract Infection

1.0 EXECUTIVE SUMMARY

The Dudley Group NHS Foundation Trust is committed to ensuring that a robust infection prevention and control function operates within all clinical areas of the organisation which supports the delivery of high quality healthcare and protects the health of its service users and staff. Effective prevention and control of infection must be part of everyday practice and applied consistently by everyone.

The report provides assurance that systems are in place and working effectively to minimise and avoid hospital acquired infection and that the Trust is compliant with the Hygiene Code.

2.0 INTRODUCTION

The Dudley Group NHS Trust continuously strives to improve infection prevention and control practice and has engaged with other organisations and partners to ensure there are robust infection prevention plans, policies and capacity to reduce healthcare associated infections (HCAI) across the healthcare community. Infection prevention and control is the responsibility of everyone in the healthcare community and is only truly successful when everyone works together. The Infection Prevention Team (IPT) continues to develop innovative ways of delivering important messages across to our staff, patients and visitors. The work programme is aligned with the Hygiene Code.

The Health and Social Care Act 2008 (2015): *Code of practice for the prevention and control of healthcare associated infections (Hygiene Code)* details 10 compliance criteria to which the Trust must adhere to in relation to preventing and controlling the risk of avoidable healthcare associated infections (HCAIs).

The criteria are listed below against which is the Trust's assurance that it meets the requirements as stated in the Hygiene Code.

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.	Cleaning is actively audited and any deficiencies are rectified within 1 hr.
Assurance: A Cleaning Policy and associated environmental audits provide assurance that a clean and appropriate environment is maintained.		

3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.	Antimicrobial CQUIN – the elements regarding reduction high risk antimicrobial usage has been met.
Assurance: There is an Antimicrobial Policy in place with appropriate stewardship recommendations. Audits demonstrate compliance with policy.		
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.	MRSA elective screening 96.4% compliance and emergency screening 94.2% compliance for April
Assurance: Patient records are flagged with information about previous healthcare associated infections. Patient admission documentation includes screening questions to identify patients at risk.		
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mandatory IC training has moved to an annual programme for clinical staff. Work is being undertaken to achieve compliance by March 2019.
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.	A business case for the isolation pods for critical care areas has been created and funding the

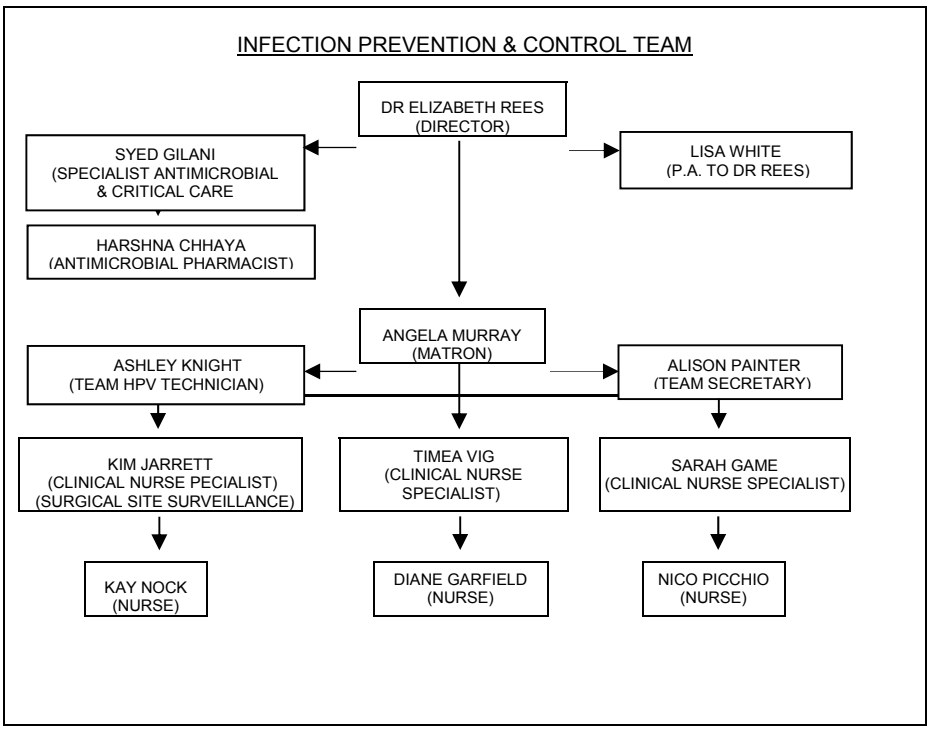
		for the ITU pod secured.
Assurance: There is a policy in place to ensure that patients are isolated appropriately. 25% of the inpatient beds take the form of single ensuite rooms.		
8	Secure adequate access to laboratory support as appropriate.	
Assurance: The Trust has access to a CPA/UKAS accredited 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 to present.
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.		

3.0 INFECTION PREVENTION AND CONTROL ARRANGEMENTS

Within the Trust the DIPC role is within the portfolio of the Consultant Microbiologist / Infection Control Doctor. A key responsibility of the DIPC is to produce an annual report. Additional support is provided by the antimicrobial pharmacists and Matron for Infection Prevention and Control.

The role and function of the IPC Service is to provide specialist knowledge, advice and education for staff, service users and visitors. All work undertaken by the service supports the Trust with the full implementation of and on-going compliance to the Code.

INFECTION PREVENTION & CONTROL TEAM



4.0 THE INFECTION PREVENTION AND CONTROL FORUM

The Infection Prevention and Control Forum meets monthly and is chaired by the DIPC.

The purpose of the forum is to oversee compliance of the Health Act 2008 Code of Practice for the Prevention and Control of Healthcare Associated Infections. The Forum provides assurance that risks are appropriately managed and that appropriate arrangements are in place to achieve a safe clinical environment.

The membership of the forum is multidisciplinary and also includes representatives from The Office of Public Health at Dudley Metropolitan Borough Council and Public Health England. This forum provides assurance to The Board that the infrastructure for infection prevention and control is in place. In addition to this there is representation from the Trusts private finance initiative partners.

As of April 2018 the forum will be renamed as the Infection Prevention and Control Group.

5.0 SURVEILLANCE

The Department of Health requires mandatory surveillance of:

1. MRSA positive blood cultures (bacteraemia)
2. *Clostridium difficile* toxin positive results
3. MSSA positive blood cultures (bacteraemia)

4. E-coli positive blood cultures (bacteraemia)

The above are reported monthly via HCAI data capture system which is managed by Public Health England and signed off on behalf of the Chief Executive.

5.1 MRSA Bacteraemia

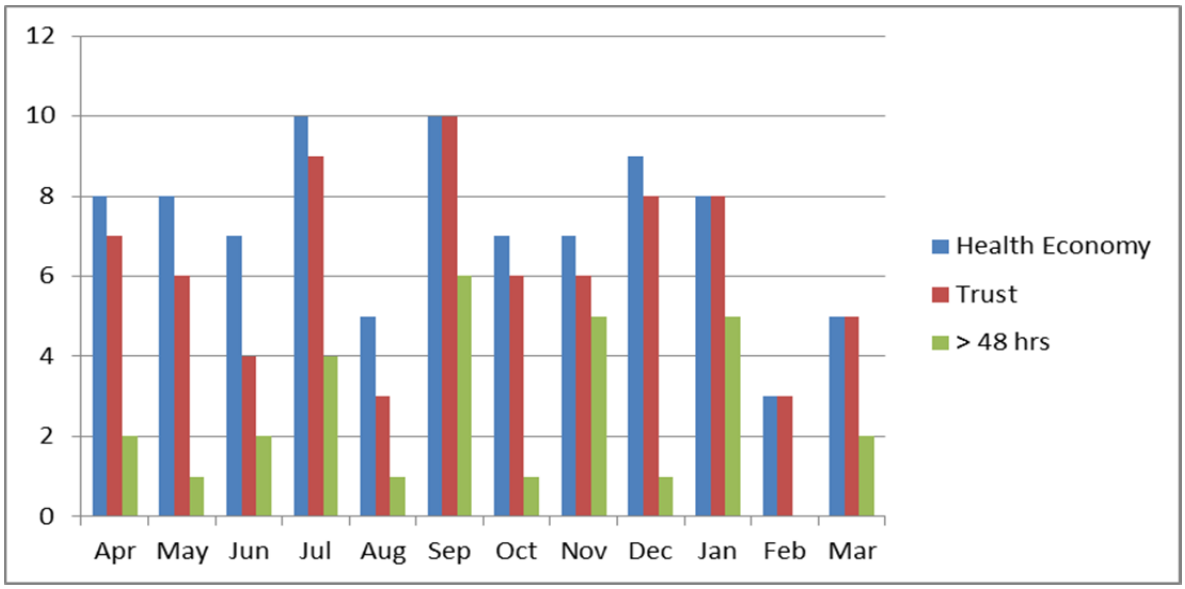
The NHS has set a zero tolerance approach to MRSA bloodstream infections. For the purposes of this report **zero** cases have been attributed to The Trust in the last year. Indeed, no MRSA bacteraemia cases have been assigned to the Trust since 27th September 2015. A pre 48 hour MRSA bacteraemia was identified in March 2018. This patient had recently received care in a neighbouring trust in the community. The case was assigned to the Sandwell and West Birmingham following a root cause analysis

5.2 Clostridium difficile

The Trust reports all cases of Clostridium difficile toxin positive disease identified in the hospital laboratory. For this financial year we have reported a total of 30 cases of Clostridium difficile of which 19 have been recognised as being due to a lapse of care and attributed to the Trust. Lapses in care were identified as being associated with failure to meet the mandatory training compliance, reduced environmental scores, antimicrobial stewardship and bowel habit not recorded on admission.

The Trust objective was to have no more than 29 cases where a lapse in care was identified. All cases were scrutinised using a robust root cause analysis process in conjunction with the Office of Public Health Dudley Metropolitan Borough Council and Dudley CCG. The learning from these cases was shared across the organisation in order to improve practice.

The table below demonstrates the number of Clostridium difficile positive cases identified at The Dudley Group NHS Foundation Trust for this reporting period.

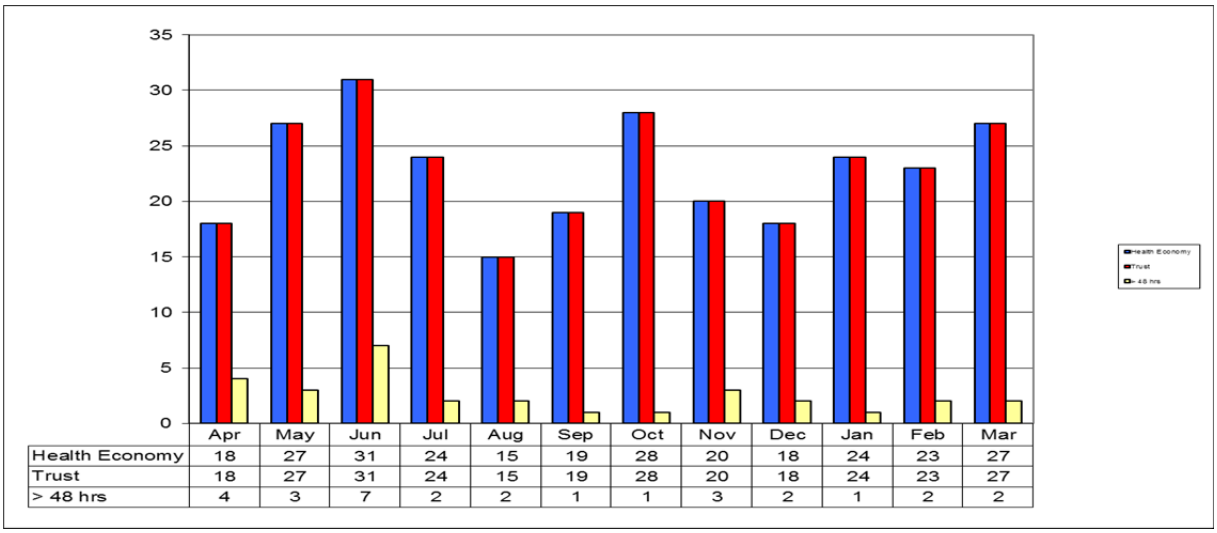


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	8 7		10	5	10	7	7 9		8	3 5	
Trust	7	6 4		9	3	10	6	6 8		8	3 5	
> 48 hrs	2	1 2		4	1 6		1	5 1		5	0 2	

5.3 Escherichia Coli Bacteraemia.

Approximately three-quarters of E. coli bacteraemia occur before people are admitted to hospital. The Trust continues to fulfil its mandatory require ment and contributes to the enhanced national surveillance programme.

The table below demonstrates the number of E. coli positive cases identified at The Dudley Group NHS Foundation Trust for this reporting period. As of April 2017 the Trust undertook enhanced surveillance of E. coli bacteraemia as part of a whole health economy ambition to reduce Gram-negative bloodstream infections. Themes identified as sources of bacteraemia were urinary tract and hepatobiliary infection which is in line with national data. The Health Economy Partnership Group has developed a urinary catheter passport which is in the final stages of ratification. The Urinary Catheter Passport has been developed to ensure catheterised patients receive the optimum standard of care by improving communication between hospital, community and the service user. The Passport will be issued to service users after insertion of a urinary catheter. This work is to support the national agenda of preventing healthcare associated Gram-negative bloodstream infections with an initial focus on E. coli.

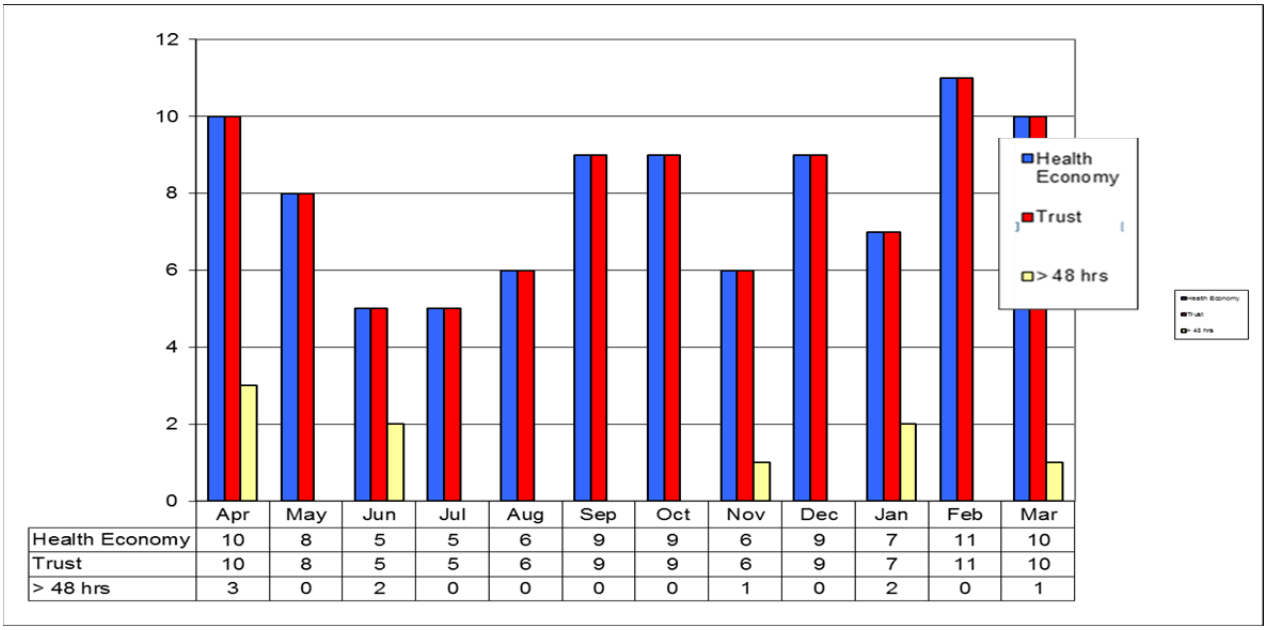


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	18	27	31	24	15	19	28	20	18	24	23	27
Trust	18	27	31	24	15	19	28	20	18	24	23	27
> 48 hrs	4	3	7	2	2	1	1	3	2	1	2	2

5.4 Meticillin Sensitive Staphylococcus aureus (MSSA) Bacteraemia.

MSSA is a type of bacteria which lives harmlessly on the skin and in the nose, in approximately one third of people. MSSA usually causes no problems, but can cause an infection when it gets the opportunity to enter the body. This is more likely to happen in people who are already unwell. MSSA can cause local infections such as abscesses or boils and it can infect any wound that has caused a break in the skin e.g. surgical wounds. The Trust continues to fulfil its mandatory requirement and contributes to this enhanced national surveillance scheme.

The table below demonstrates the number of MSSA bacteraemia cases identified at The Dudley Group NHS Foundation Trust for this reporting period. 9 of the cases had been inpatients for more than 24 hours. No reduction trajectory for MSSA has been set nationally. Issues were identified around the documentation of cannulae. To highlight the importance of cannula care the IPCT organised a day to promote cannula awareness and there was a display at the Health Hub supported by the supplier of the cannulae. Data on MSSA bacteraemias has been presented to the HCAI Health Economy Group to support work being undertaken in the community to address the underlying causes of those infections.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	10	8	5	5	6	9	9	6	9	7	11	10
Trust	10	8	5	5	6	9	9	6	9	7	11	10
> 48 hrs	3	0	2	0	0	0	0	1	0	2	0	1

6.0 SURGICAL SITE SURVEILLANCE

Surgical site infections (SSIs) are an important cause of Healthcare Associated Infections (HCAI), accounting for 20% of all HCAIs, and have serious consequences for both the patient and the Healthcare organisation.

Surveillance of surgical site infection following orthopaedic surgery has been included in the mandatory healthcare-associated infection surveillance system in England since April 2004. The National Surveillance Scheme enables hospitals in England to undertake surveillance of healthcare associated infection, compare their results and national aggregated data, and use the information to improve patient outcomes.

All NHS Trusts where orthopaedic surgical procedures are performed are expected to carry out a minimum of three months surveillance in at least one of four orthopaedic categories:

- Total hip replacements
- Knee replacements
- Repair of neck of femur
- Reduction of long bone fracture

<u>Summary of Orthopaedic SSI rates April to June 2017</u>

The data has been submitted to Public Health England and the official reports are now available to view on the PHE Surgical Site Surveillance database. The results of the surveillance are detailed in the table below. This includes the trust percentage for the period of surveillance undertaken by DGH and also the national average over the last 5 years.

Surgery	Total operations	Inpatient/ readmission SSIs	Trust Rate %	National Average %
Repair of neck of femur	67	1	1.5%	1.3%
Knee	144	0	0%	1.4%

The Surgical site infection that was identified is detailed below:

Surgical Site Infections

*Neck of femur repair (identified during admission)

- 1 Deep incisional
- Microorganisms detected – Proteus mirabilis Staph aureus (MSSA)

7.0 OUTBREAKS / PERIOD OF INCREASED INCIDENCE (PII)

Incidents and outbreaks occurring in 2017 /18 were reported to the hospital Infection Prevention and Control Group throughout the year.

Different outbreaks / incidents demand different responses but are managed with collaborative working between the multi-disciplinary teams across the Health Economy.

Norovirus

Norovirus is a self – limiting diarrhoea and vomiting bug that usually lasts 48-72 hours and is more prevalent during the winter months

In common with other acute trusts, DGFT experienced outbreaks of diarrhoea and /or vomiting which required restrictions to the movements of patients into and out of ward areas. The IPCT monitor these outbreaks at least once each day where they provide advice to ward staff and advise the Trust on the restrictions that should be introduced.

In October 2017 on our Trauma Orthopaedic ward Norovirus was confirmed in 1 patient, with 18 unconfirmed cases. The incident was identified on 15.10.17 and concluded on 02.11.17 In order to contain the spread, stations with patients with symptoms were closed and enhanced cleaning was undertaken. The infection was contained to the area with no spread to any other areas of the hospital.

In November 2017 on short stay ward a confirmed case of Norovirus was identified. The incident was identified on 06.11.17 and concluded on the 13.11.17 More than 20 patients were symptomatic. All the above was undertaken, restrictions put on staff movements around the hospital and cleaning of equipment with hydrogen peroxide vapour was undertaken. The closure of bays rather than whole wards in most incidents has less impact on the overall delivery of a high-quality clinical service by the Trust. The infection was contained to the area with no spread to any other areas of the hospital.

Clostridium Difficile

Clostridium difficile is a bacterium that is found in the intestines. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies). *Clostridium difficile* causes disease when the normal bacteria in the gut are disadvantaged, usually when taking antibiotics. This allows *Clostridium difficile* to grow to unusually high levels. It also allows the toxin that some strains of *Clostridium difficile* produce, to reach levels where it attacks the intestines and causes mild to severe diarrhoea. *Clostridium difficile* can lead to more serious infections of the intestines with severe inflammation of the bowel such as pseudomembranous colitis.

Occasionally a period of increased incidence of *clostridium difficile* this is defined as 2 cases of toxin positive *clostridium difficile*, acquired post 48 hours, on the same ward, within a period of 28 days. In September 2017 this occurred on our Renal/ Endocrinology ward. A meeting was held, ward audits were conducted, and cleaning scores reviewed and typing of specimens was requested. Investigation concluded that there were no contributing factors and ribotype of each case was different, confirming that the cases were not linked. No further cases were identified.

8.0 INFECTION PREVENTION LINK WORKERS

Link workers in the Trust are recognised as important components of the organisational structure whereby skills, professional practice standards and knowledge are disseminated via motivated and active staff with an interest in IPC. There is a link worker in every department both inpatient and community areas. Link workers meet with the IPCT bi-monthly to discuss best practice and share their learning and experience.

9.0 AUDIT

Saving Lives Audit

The Saving Lives programme (DH, 2008) was introduced to support healthcare providers in reducing healthcare associated infections. It identified high-impact interventions (HIIs) relating to areas of clinical practice where patients are at increased risk of infection, with the aim of reducing variations in care. The Saving Lives Audit within the Trust is undertaken on a monthly basis.

This system can be accessed by Heads of Nursing, Matrons and Lead Nurses enabling users to review and monitor individual performance.

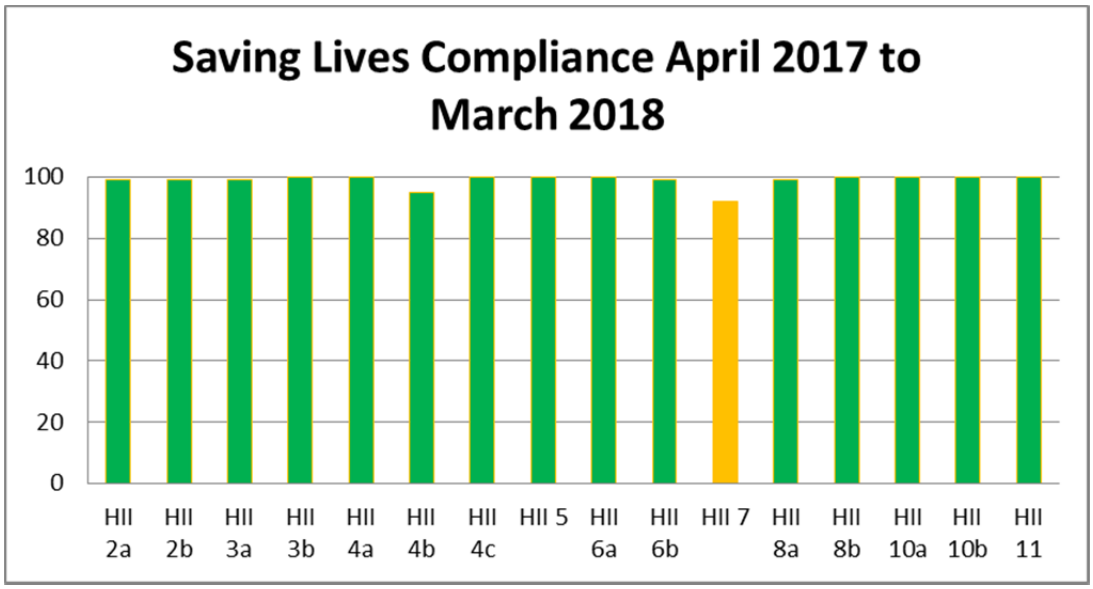
Areas that submit scores of less than 95% are required to complete an action plan to identify how they will rectify the overall score and how this will be cascaded across the areas.

The HIIs audits include:

- HII 1a CVC Insertion
- HII 1b CVC Ongoing Care
- HII 2a Peripheral Lines Insertion
- HII 2b Peripheral Lines Ongoing Care

- HII 3a Renal Dialysis Insertion
- HII 3b Renal Dialysis Ongoing Care
- HII 4a Surgical Site Pre Op
- HII 4b Surgical Site Intraoperative
- HII 4c Surgical Site Post Op
- HII 5 Reducing Ventilation associated pneumonia
- HII 6a Urinary Catheter Insertion
- HII 6b Urinary Catheter Ongoing Care
- HII 7 C.difficile
- HII 8a Clinical equipment Decontamination Infect
- HII 8b Clinical equipment Decontamination Non Infected
- HII 10a Chronic Wounds: Wound care
- HII 10b Chronic Wound Patient Management
- HII 11 Enteral Feeding

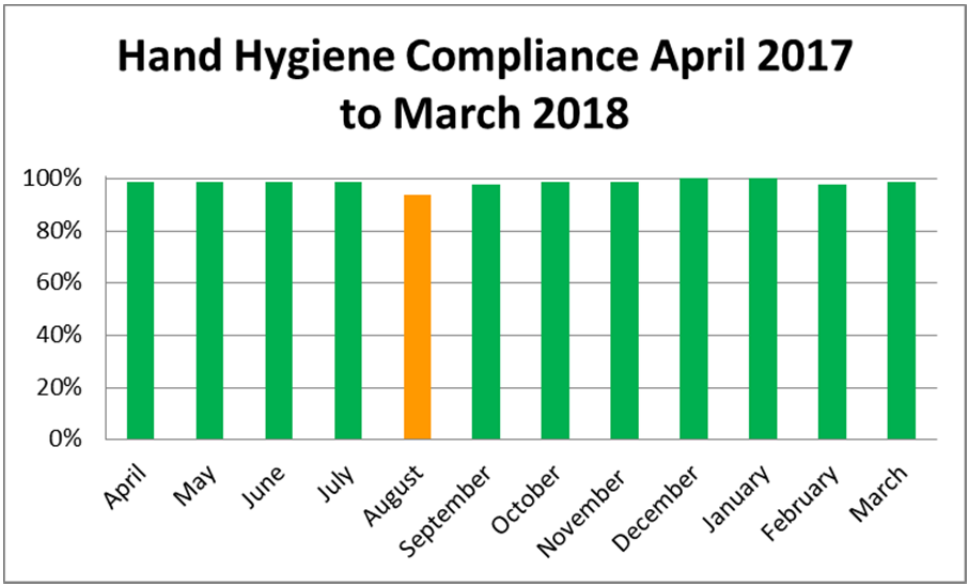
The graph below demonstrates overall Trust compliance with Saving Liv es Audits for the year April 2017 to March 2018. The Trus t overall compliance for HII7 Clostridium difficile risk reduction was 92%. Issues iden tified included patients not isolated within the 2 hour period following collection of a stool samp le. This has now been included in infection control mandatory training and included in local action plans where iss ues were identified.



Hand Hygiene Audit

It is important that staff take precautions to prevent transmission of micro-organisms. All wards and departments have been required to undertake an audit each month, observing staff members in their clinical area. Hand hygiene continues to be a top priority in the Trust. Monthly audits of hand hygiene compliance are undertaken. The Trust target for hand hygiene compliance rates is 95%. For the month of August the compliance dropped to 94%. Compliance with bare below the elbow was identified as an issue. Hands can only be decontaminated effectively by ensuring that the correct technique is used which encompasses the wrists and therefore it is imperative that staff

comply with ‘Bare Below the Elbow’ in order to facilitate this. Reminders were given to staff to ensure compliance with the Trust policies.



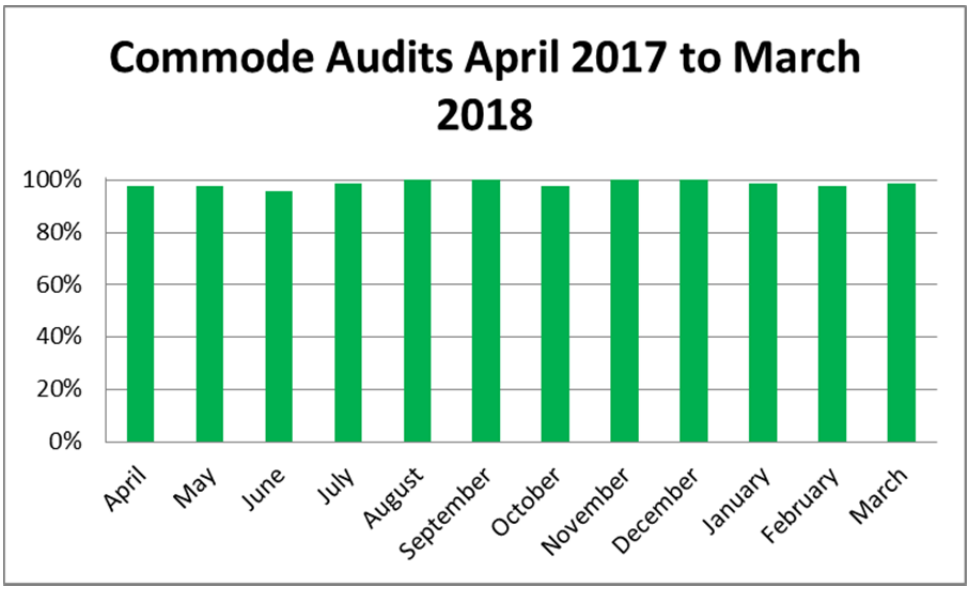
Hand Hygiene Promotional Work

Staff Health and Wellbeing reported an increase in staff raising concerns with their skin health during 2017. The Health and Safety Manager advised the IPC Forum that all trusts had to ensure hand hygiene was managed effectively and safely. A review of the hand hygiene products used within the organisation concluded that there was no single supplier of hand hygiene products and that skin moisturiser was not readily available therefore increasing the risk of dermatitis to staff. Following this report the Trust supported the move to a single supplier of hand hygiene products including availability of hand moisturiser for staff. Ongoing skin surveillance is being undertaken by Staff Health and Wellbeing.

Commode Audit

Commodes are in use constantly and their surfaces are constantly being handled, which provides an opportunity for many pathogens present to be transferred to not only other surfaces but also more importantly to our patients. It is important that all parts including underneath is visibly clean with no blood and body substances, dust, dirt, debris or spillage and that there is no damage to the commode. Damage prevents the equipment from being thoroughly cleaned and decontaminated. Monthly commode audits are undertaken to ensure the condition and the cleanliness of commodes are monitored. Broken commodes are removed and replaced as necessary.

The graph below demonstrates overall Trust compliance for commode audits for the year April 2017 to March 2018.

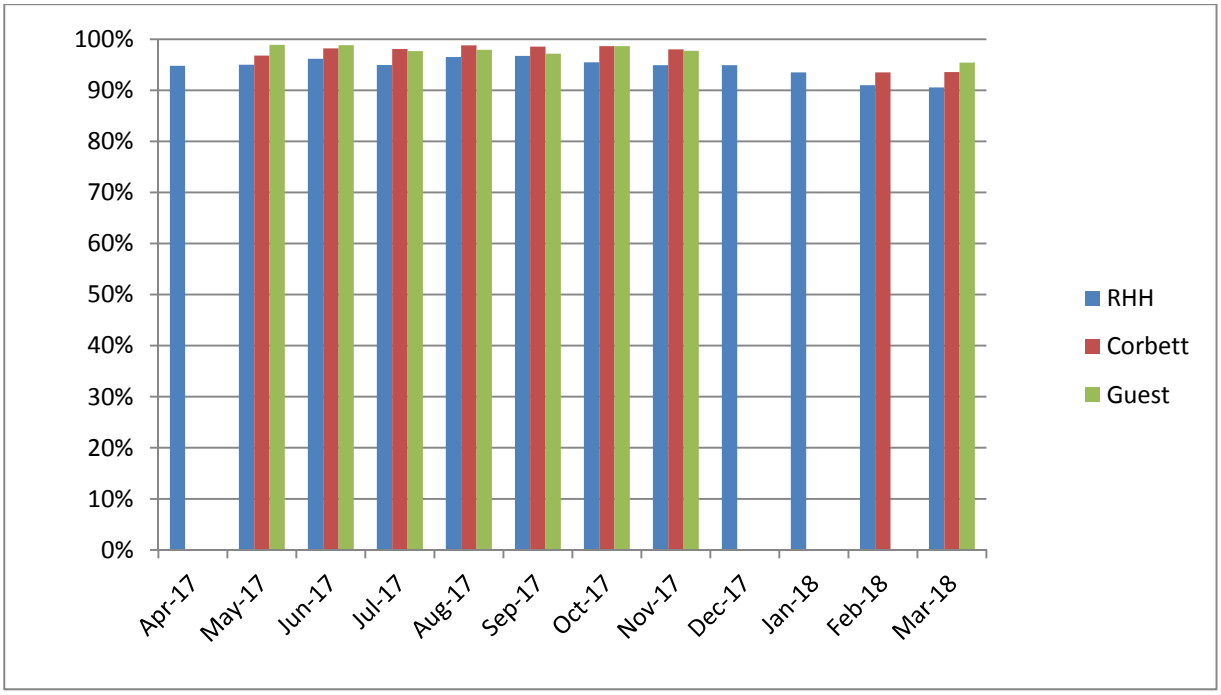


10.0 ESTATES & FACILITIES

10.1 Environmental Audits

The Trust recognises its duty to provide safe and clean environments where patients, staff and other visitors can expect to be protected from the risk of Infection. The environmental cleaning service is provided by Interserve (Facilities Management) Ltd (IFM) as part of the Trusts PFI contract with Summit Healthcare (Dudley) Ltd (Summit). The contract is managed by the Trust's Facilities and Property Development Department. Environmental audits are undertaken by the Trust Auditors in partnership with IFM and clinical staff.

The table below outlines the cleaning scores for The Trust for this reporting period.



Shortly after the full introduction of the co mbined cleaning/catering service, the Trust Facilities Management Audit Team identified deterioration in the cleaning scores across a number of areas. In response to this the Trust increased the cleaning audits in the affected areas and applied the performance management me chanisms within the PF I contract. This resulted in the c leaning scores improving howev er, it became apparent towards the end of 2017 that t he cleaning scores were deteriorating again and the Trust again applied the performance management mec hanisms within the PFI c ontract. In addition, the Trust's Facilities Contract Manager has worked closely with I FM and a cleaning action plan has been produced to include reviews of cleaning equipment, staffing, training etc. Although the pictur e up until the end of March 2018 has been a disappointing one, during Apri l 2018 the Tr ust has seen a s ignificant increase in the number of audits achieving above the 95% threshold.

On 1 March 2018 the Trust Monitoring Team implemented the updated ver sion of the Servicetrac auditing s ystem on the recommendat ion of Royal Liverpool & Broadgree n University Hospital NHS Trust who were a sked to review our systems and advise. The Infection Control team have access to this system.

The Trust has als o reviewed and updated its Cleaning and disinfection of the environment and non-invasive e quipment policy, which has been subsequently agreed by all relevant parties including the Trust's Infection Prevention & Control Team, Summit and IFM. This policy assesses the risk asso ciated with functional areas and clear ly identifies responsibilities for cleaning, fr equencies of cleaning as well as cleaning methods. It is anticipated this will deliver improvements in cleaning scores over the next year.

10.2 Place 2017

Patient-Led Assessments of the Care Envi ronment (PLACE) is t he national system of assessing the non-clinical aspect s of patient care. All Trusts are required to undertak e these inspections annually to a prescribed timescale.

As the name suggests the PLACE team is led by Patient Assessors, of which 12 participated in 2017, who made up at least 50 per cent of the assessment team, with the remainder being Trust and Summit Healthcare Staff. The inspection covers wards, outpatient areas, communal areas and external areas, as well as the Emergency Department and generates scores for the following:

- Cleanliness
- The quality and availability of food and drinks
- How well the environment protects people's privacy, dignity and wellbeing
- Condition, appearance and maintenance of the buildings (inside and out)
- How the premises are equipped to meet the needs of patients with disability and dementia

PLACE by its very nature is a snap shot of one day and can be influenced either way by what is seen on the day where ultimately the Patient Assessors can decide what areas are assessed. At the end of the assessment period, Patient Assessors are required to complete their own assessment form on how the overall assessment has been undertaken. This includes questions such as were their views taken on board and was sufficient time given to undertake the assessment etc.

The PLACE Scores for 2015 / 2016 / 2017 were as follows.

	2015 Score	2016 Score	2017 Score
Cleanliness	99.06%	99.14%	98.09%
Food (Combined)	86.08%	80.74%	88.76%
Food (Organisational)	75.19%	83.46%	87.04%
Food (Ward)	88.47%	80.01%	89.21%
Privacy, Dignity and Wellbeing	85.87%	84.01%	88.89%
Condition, Appearance and Maintenance	94.97%	96.59%	93.35%
Dementia	74.13%	80.95%	77.60%
Disability	-	-	83.99%

The Dudley Group NHS FT were shown to be better than the national average in the following areas; privacy, dignity & wellbeing, disability and dementia. As a Trust we were just below the national average for condition, appearance and maintenance, cleanliness and food. There was an improvement in the 2017 scores compared with those in 2016 for privacy, dignity and wellbeing as well as food.

In readiness for the 2018 national place assessment, the Trust has implemented a programme of mini-PLACE assessments. The programme commenced in February 2018 and in addition to Trust and IFM/Summit involvement, these assessments are supported by patient assessors including Trust Governors, local Healthwatch and also the Trust's volunteers. Actions arising from each of the assessments are recorded and monitored via the Patient Experience Improvement Group (PEIG).

10.3 Hydrogen Peroxide Vaporisation.

Hydrogen Peroxide Vaporisation (HPV) is a method of environmental bio-decontamination whereby a machine creates a fine vapour which is released into the atmosphere of a sealed space (i.e. room on a ward). The vapour will circulate and settle on surfaces, providing a highly effectively means of surface disinfection and decontamination.

HPV decontamination is advised whenever the spread of infection is considered a risk. It is highly recommended that HPV decontamination of single or multi-bedded rooms is undertaken where patients have been known to have had infections that are easily transmitted.

A business case was approved to fund an enhanced service as compared to the historical service for 6 months. The objective is to obtain robust information regarding the number HPV cleans required against those delivered in order to review the effectiveness of the service. The service will be offered between 9 am and 7 pm 7 days/week. The recruitment process is underway for the team with an implementation date of the revised service of end of June 2018.

11.0 ANTIBIOTIC STEWARDSHIP

Antimicrobial Stewardship Report 2017-18

This paper provides an update and an assur ance of compliance with standards set out by Health and Social care IPC code of pr actice for Antimicrobial stewardship, Department of Health “Start Smart then Fo cus” and NICE NG15 (2015) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicines use.

CQUIN: Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)

For 2017-18 Dudley participated in the national CQ UIN: Reducing the impact of serious infections. The goal of this CQUIN was to reduce an tibiotic consumption with a focu s on antimicrobial stewardship and ens uring antibiotic review within 72 hours. Indiscriminate and in appropriate antibiotic prescribing has been identified as a key driver for antibiotic resistance t herefore the CQUIN aimed to r educe total antibiotic usage and usage of key broad-spectrum ant ibiotics and ensure antibiotics ar e appropriately reviewed after initiation.

Part 2 c of CQUIN: **Antibiotic review between 24-72 hours of initiation in patients with sepsis who are still inpatients at 72 hours.**

Dudley achieved all f our milestones for ant ibiotic review within 72 hours, with a final result of 91.3% (internal calculations) of antibiotic prescriptions receiving a review within 72 hours.

In order to further the excellent achievements to date, the Trust has rec ruited an additional sepsis nurse and ant imicrobial pharmacist to support initiatives to improve sepsis and stewardship.

An online sepsis database/ sepsis report has been created for Pharmacists on the Hub for identifying patients who are due for antibiotics review.

Part 2d Antimicrobial Consumption

Part 2 d of CQUIN is further divided into 3 individual targets,

1. Reduce Total antibiotics consumption by 1%.
2. Reduce Carbepenem consumption by 2%.
3. Reduce Pip/Taz consumption by 2%.

When compared with National c onsumption data reported on Public Health England Fingertips, Dudley falls in the 2 nd lowest percentile for total antibiotic usage (4363 Defined Daily Dos es (DDDs)/1000 admis sions vs. 4853 DDDs/1000 ad missions for Dudley and national average, respectively).

The antibiotic consumption targets and local achievements are detailed in table below.

Indicator (per 1000 admissions)	Target reduction	Reduction achieved(internal)
Total Antibiotic consumption	1%	16.42%
Total carbapenem consumption	2%	-28.70%
Total piperacillin / tazobactam consumption	2%	-69.16%

Compared to similar Trusts Dudley perfo rmed at a high level in reducing Carbapenem and Pip/Taz use but because of the switch to triple therapy, as a result of an international shortage of the monotherapy drug previous ly used and changes in definitions of admission data during 2017/18, the total antib iotic consumption figure has increased. There will be a fu rther policy review in 20 18/19 to reflect current antimicrobial availability internationally.

Learning from 2017/2018 will be to review all our antibiotic gu idelines individually and change to single agent or alte rnative agents if required, aim for higher target to compensate for any unforeseen changes in current year.

Following Figures (1 and 2) are from Define benchmarking software

Figure 1, Total Carbapenem Consumption (DDDs/1000 admission) compared to similar Trusts.

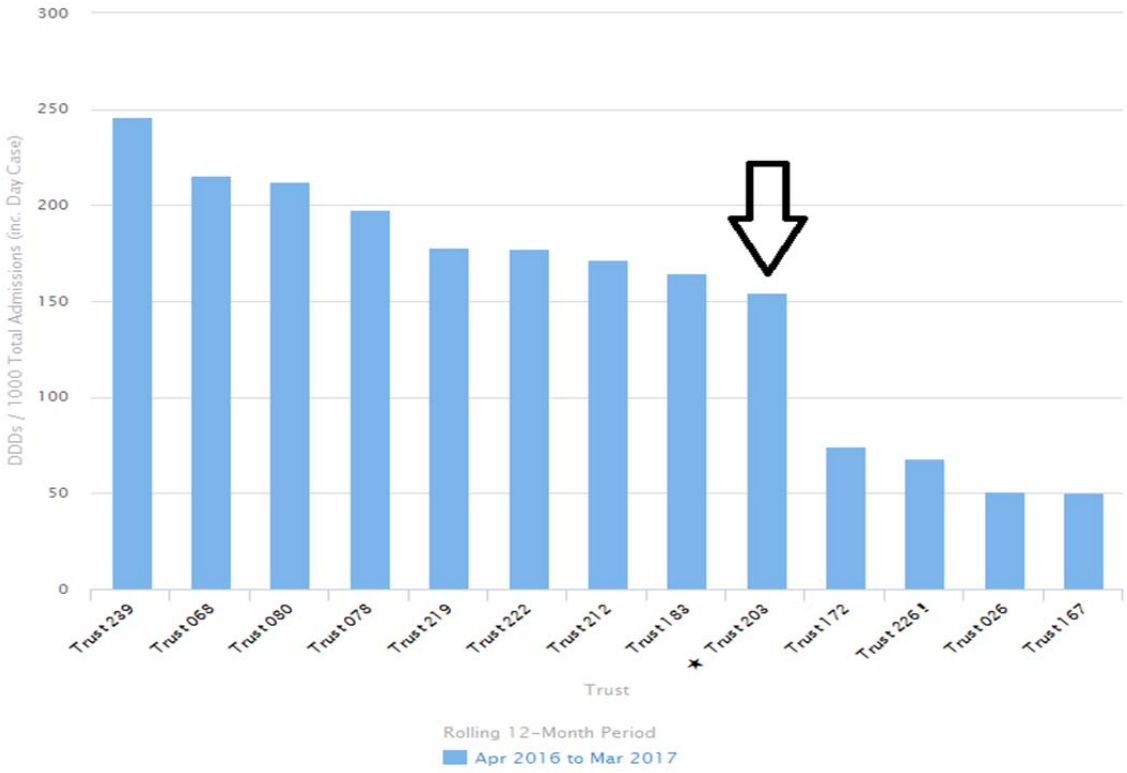
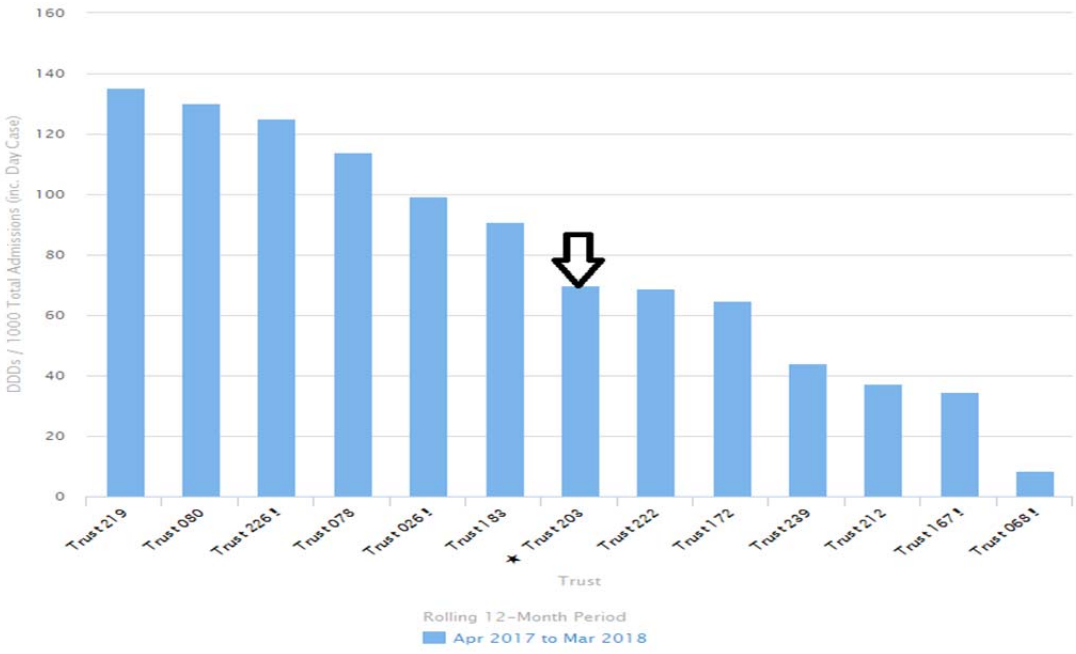


Figure 2, Total Pip/Taz consumption (DDDs/1000 admission) compared to similar Trusts



Antimicrobial Prescribing Audit

An antimicrobial snap shot audit was carried out in September 2017.

A new snap shot audit is currently under way (23-27 th April 2018) to assess areas of improvement for 2018/2019.

Dudley Group NHS Foundation Trust - Snap shot audit			
		Percentage	Regional target
Number of occupied beds	517	-	
Allergy Status recorded on chart (NKDA, Yes, No)	509	98.5	> 98%
Number of patients with an allergy who have the nature of the allergy documented	69	42.1	> 98%
Number of patients on Antibiotics	227	43.9	
Number of Patients on intravenous antibiotics	102	19.7	
Number of patients on intravenous antibiotics over 48 hours (>72hrs Jan 2013)	40	39.2	
Number of patients where total course over 5 days (>7days Jan 2013)	14	6.2	
Number of patients where stop / review date documented on the prescription chart	80	35.2	> 70%
Has the indication been documented on the chart?	161	70.9	> 70%
Is patient on Meropenem/Ertapenem? (Of those patients on an IV abx)	13	12.7	< 10%

The audit tool has been modified to collect more useful information i.e. indication and compliance with Trust guidelines . The nature of allergy is further clarified during the medicines reconciliation process by the ward Pharmacy team.

The documentation of stop/review date is only counted for the purposes of this audit if present on the drug chart. However, this appears falsely low as this does not include the documentation in the medical notes.

Patients prescribed Meropenem (not recommended in Trust guidelines or approved by Microbiology) are referred to the Antimicrobial Pharmacist for further review.

The Pharmacy team monitor and raise awareness at ward level on how to document allergy status on the drug chart.

Interventions over past 12 months to improve Antimicrobial Stewardship at DGFT

The target was achieved with help of multiple initiatives i.e.

- A project group was formed including the medical director, chief pharmacist, AMS team, Sepsis leads and service improvement
- IV to oral switch stickers.
- Drs and Nurses awareness via teaching programs and internal communications.
- Collaboration with sepsis team.
- Collaboration and feedback to the Divisions.
- Executive level reporting to influence change.
- Review section on drug chart.
- Referrals to Antimicrobial Pharmacists.

- Review of OPAT use of IV antibiotics
- Complete review of antibiotic treatment guideline choices, reducing large proportion of pip/taz use.
- Course lengths in antibiotic guidelines reviewed
- Teaching with pharmacists to empower challenge of prescriptions
- AMS ward rounds

Updated/new Guidelines

Several new guidelines were changed in 2017-18. Many of the existing guidelines were reviewed and updated to address global antibiotic shortages. Guidance is produced between the microbiology and pharmacy departments with input from the relevant specialties. Clinician engagement in guideline compliance is clear from the excellent rate of compliance demonstrated in the audits.

Planned review/update of guidelines

The antimicrobial prescribing policy is constantly under review via the Antimicrobial Stewardship Group. Key guidelines will be reviewed this year in light of the 2018/19 antimicrobial CQUIN requirement and ongoing antimicrobial shortages.

Education and Training

Mandatory training for clinicians in antimicrobial prescribing and stewardship continues to take place. All doctors new to the Trust are provided with antimicrobial training at induction. Better Training Better Care for FY1 and FY2 doctors in Antimicrobial Prescribing received excellent feedback from the participants. Additional training sessions have also been carried out through the year when guideline changes have occurred.

Pharmacists receive regular feedback on antimicrobial prescribing in their clinical areas after the snapshot audits, Pharmacist prescribers complete online modules on antimicrobial prescribing.

Current Challenges

- Encouraging already stretched clinicians to represent their areas at ASG meetings.

- Capacity of AMS team is limited therefore ward presence is low. Currently 1 x Consultant Microbiologist vacancy with one substantive and one Locum in post.

- Antibiotic shortages are unpredictable and require frequent guidance changes leading to prescriber confusion.

- Lack of e-PMA to support real time tracking of antibiotic consumption, guidance compliance and improved data reporting / time management on reporting. Roll out of chosen e-PMA (Sunrise – Allscripts) is planned for July 2018.

- Re defined criteria of antibiotic review by NHSE (stricter than last year).

- Introduction of new target i.e. removal of pip/taz from 2018/19 CQUIN and introduction of AWARE antibiotics list (Access, Watch, Reserve).

Plans for 2018/2019

- Review guidelines as outlined previously.

- Close links with sepsis work streams: created “Sepsis team” (2x sepsis nurses + 2 x antimicrobial pharmacists)

- Focus on drive for IV2PO switch – septic patients flagged to sepsis nurses by ward clinical staff. Antibiotics flagged on electronic database which turns “red” on day 2 indicating the need to review and complete IV2PO decision tool. Reinforce the use of tool at Pharmacist Clinical huddles.

- Training session with all Pharmacists to highlight the changes in review criteria.

- Engage Clinicians from Medical and Surgical divisions to attend ASG meetings and feedback to respective directorates.

- Regular snap shot audits to assess antimicrobial prescribing.

- Start AMS rounds (starting with critical care and extending to acute wards when feasible).

- Regular communication in the form of patient safety alerts, screen savers, trust wide comms emails on changes in processes and guidance.

- Develop antimicrobial review page on upcoming electronic prescribing system (sunrise) to help achieve required standards of antimicrobial review.

- To establish a suitable platform for middle grade/senior Drs teaching on antimicrobial prescribing.

12.0 NHSi Infection Control Visit

In November 2017 the Trust invited Dr Debra Adams, Senior Infection Prevention and Control Advisor NHSi to visit and review infection control arrangements and practice within The Dudley Group NHS Foundation Trust. This visit was undertaken on 8th November 2017.

Prior to the visit the Trust provided evidence of current policies, procedures and structures in place to support infection prevention and control within The Dudley Group NHS Foundation Trust. These were reviewed and minor amendments required eg. the annual report was available publically on the Trust website but not easily located within the Infection Control section. These were all immediately addressed.

There followed a visit to the Russells Hall Hospital site. The visit identified failings in compliance with some basic practices within the 2 ward areas visited. One ward was a medical ward and the second was a surgical ward. It was noted upon observation that staff did not always appear to be aware of their roles and responsibilities towards infection prevention. Following this visit the Trust was RAG rated red.

The visiting team noted that there was a plan under development regarding the health economy approach. They also commented that the IPC team worked well with the Matrons' team.

Following this visit a Trust wide action plan was developed to address issues identified. The main action being to move mandatory infection control training for clinical staff from a three yearly to annual cycle to ensure all patient facing staff are aware of their responsibilities with this agenda. The action plan has been cascaded, discussed, actioned and monitored at the Infection Prevention and Control Group, CQSPE and at Trust Board.

A second visit was undertaken by Dr Adams on 20th March 2018. Dr Adams commented on the improvements she noted in the general ward areas following her first visit but identified concerns within the Neonatal Unit. These issues have been added to the existing action plan. A further visit is scheduled for 20th July 2018.

13.0 EDUCATION AND TRAINING

Mandatory Training is training that has been identified by the trust as those that cover the risk management subjects that are required by all employees.

Infection Prevention and Control is identified as a Priority 1 mandatory core subject that all employees are required to receive. As of March 2018 Infection Prevention and Control Training for Clinical Staff is required to be completed on an annual basis with a KPI of 90%. The training for non-clinical staff continues to be required 3 yearly. A report is published each month by Learning and Development identifying compliance across the 4 divisions.

In order to support staff with training the DGFT are committed to developing a 70/20/10 learning approach. The model provides a framework of learning opportunities; this is broken down as indicated below:

70% - Experience and experiential learning on the job through day to day tasks/activities
20% - Learning from peers and colleagues within a social exposure, this could be within a team environment or learning from those that are more experienced
10% - Learning from specific courses or education programs

The Infection Prevention and Control Team delivers training sessions during Trust induction and Mandatory refresher training each month to various staff groups across the Trust. Following the session there is a requirement for all staff to complete a competency test, and the pass rate for this is 80%.

Due to the new requirement to ensure all clinical staff receive Infection Prevention and Control Training annually additional training sessions have been organised by the Infection Prevention and Control Team in order to support wards and departments to achieve the KPI this year.

Staff also have access to an eLearning module for Infection Prevention and Control which can be located on the Learning and Development Page of the hub. It is also necessary for staff to complete a competency test if they choose to complete the session via this route and again the pass rate is 80%.

The table below indicates the mandatory training figures for Infection Prevention and Control the period 2017/2018, broken down by division.

	Infection Control – Clinical	**Infection Control – Non Clinical**
Division	>=90% >=80%	>=90% >=80%
Clinical Support	91%	90%
Corporate / Mgt	91%	92%
Medicine & Integrated Care	91%	97%
Surgery	93%	97%
Trust Compliance	**92%**	**94.8%**

14.0 INFLUENZA VACCINATION PROGRAMME

This year the Trust made excellent progress with regard to the 2017/18 flu vaccine campaign having achieved **74%** of front line staff vaccinated. The CQUIN target was therefore achieved. Peer vaccinators were identified in all ward areas and departments to increase the number of opportunities for staff to receive the vaccination along with additional sessions held at the Health Hub.

15.0 POLICIES

The IPCT recognises the importance of providing staff with easy access to a full range of IPC policies and guidelines. Throughout 2017-18 the IPCT continued to review and revise these documents to take account of the latest IPC best practices.
Polices for IPC are reviewed and monitored collaboratively with. Public Health England, the Office of Public Health in Dudley and Dudley CCG. Consideration of new national guidance such as National Institute for Clinical Excellence (NICE) Quality Standards, Department of Health directives and developments in practice for IPC are considered for inclusion.

There is an ongoing programme of policy review and for new policies to be added as required. All policies subject to consultation through the Infection Prevention and Control Group prior to submission to the Trust's Guidelines Group.

16.0 CONCLUSION

Avoidable healthcare associated infection is deemed as avoidable harm and as such all staff have a responsibility to comply with infection, prevention and control policies and procedures to protect patients.

Despite a challenging year the Trust were able to report below threshold figures for cases of Clostridium difficile infection.

The Infection Prevention and Control Team do not work in isolation and the commitment for infection prevention and control that is demonstrated at all levels within the organisation is crucial to maintain high standards in the future.

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th June 2018 (Public Board)

TITLE:	Monthly Nurse/Midwife Staffing Position – June 2018 report containing April 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: 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

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. The same table includes the Care Hours Per Patient Day (CHPPD). The fill rates against the historic establishments are also tabled. It can be seen that in general these fill rates are close to but less that 100 percent of the historic establishment. While there was some increase in the rates as 2017 progressed and a reduction from November/December onwards, this month the rates have increased to previous levels.

- There remains a continuing reliance on temporary staff both bank and agency. However it is noted there has been an improvement in nursing pay expenditure over the last 4 week period.

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 March.

Monthly Nurse/Midwife Staffing Position

June 2018 Report containing April 2018 data

Safer Staffing

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 April 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.

The report shows that the overall fill rates for the Trust is 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 but the fill rates reduced from November/December 2017 onwards. This month (April) the rates have improved to those in early 2017. It should be noted:

- 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. B4 (Colorectal Surgery) and the Medical High Dependency Unity (MHDU).
- The low fill rate in a) Coronary Care Unit/Post Coronary Care Unit reflects the problems in recruiting staff to this particular area and b) EAU reflects the continuing winter pressures, the opening of the new larger EAU and the historic establishment has not been reviewed yet which is awaiting decision on the format of the area.

Table 1. Percentage fill rates March 2017 to the present

	Qualified Day	Unqualified Day	Qualified Night	Unqualified Night
March 2017	95%	97%	97%	100%
April 2017	97%	96%	98%	98%
May 2017	97%	97%	99%	98%
June 2017	96%	96%	98%	99%
July 2017	96%	97%	98%	100%
August 2017	96%	97%	97%	101%
September 2017	96%	97%	98%	100%
October 2017	96%	97%	97%	99%
November 2017	95%	97%	96%	101%
December 2017	95%	93%	95%	96%
January 2018	95%	94%	97%	97%
February 2018	93%	94%	96%	96%
March 2018	92%	92%	96%	96%
April 2018	97%	96%	98%	98%

With regards to the CHPPD, as has been explained in previous monthly reports: a) this is the national indicator that is intended to be utilised to benchmark the Trust and b) comparisons by individual wards/units is seen to be more useful than comparing the overall Trust value

with other Trusts. In last month's report comparison by wards made with the latest Model Hospital data available (January 2018). Once the Model Hospital data is updated, further comparisons by ward will be made.

Staffing Reviews

A chart is attached below of the situation with the various staffing reviews that have been occurring over the last year. Most recently, the review of community nursing (during the day) was completed and it was agreed by the Executive Directors that discussions regarding funding will be undertaken by the newly formed Transition Board of the Multispecialty Community Provider (MCP). The staffing review for the Emergency Department (ED) was also completed and will be finalised imminently.

Area	Position
General Medical/Surgical Wards	Completed, agreed and implemented.
Critical Care	Completed, agreed and implementation in progress.
Neonatal Unit	Completed, agreed and implemented. Due for review later in the year.
Paediatrics (C2)	Completed, rejected by Executive Directors and required further review.
Emergency Department	Completed, presented to Executive Directors and agreed on 2nd May 2018.
Acute Medical Unit	Completed, awaiting decision on configuration
Outpatients Department	Completed, to be presented again to Executive Directors
Medical Day Case	Completed, to be presented again to Executive Directors
Renal Unit	Completed, will be presented to Executive Directors in June.
Frailty Assessment Unit (FAU)	Completed, shared with Karen Kelly and to be considered as part of the first floor review.
Community Nursing (Days)	Completed, agreed by Directors and to be presented at the newly formed Transition Board of the MCP.
Community Nursing (Nights)	In progress
Specialist Nurses	In draft, to be presented to Executive Directors in June.

Lead Nurses and Matrons continue to be given the opportunity to discuss staffing challenges, whilst maintaining patient safety and sustaining financial balance. Timely filling of bank shifts continues to be a challenge however the Associate Chief Nurses are reviewing this daily to avoid late requests for staff that cannot be filled.

Agency Controls

All bank and agency requests continue to be risk assessed by the Associate Chief Nurses to ensure continued patient safety and financial balance supporting the overall reduction in agency use. Requests for non-framework agency can only be made in exceptional circumstances and authorised only by an Executive Director.

The graph on page 4 shows the agency usage; this month has seen a slight decrease in the use of registered nurse agency shifts and the use of agency clinical support workers (CSWs) remains nil in line with current agency controls.

The table below shows the five main areas using agency staff over the past four weeks. ED remains the highest user of registered nurse agency staff. The timely filling of bank shifts continues to be challenging and some framework agency staff have been used to maintain patient safety across the hospital.

Top 5 Areas of Nursing Agency usage

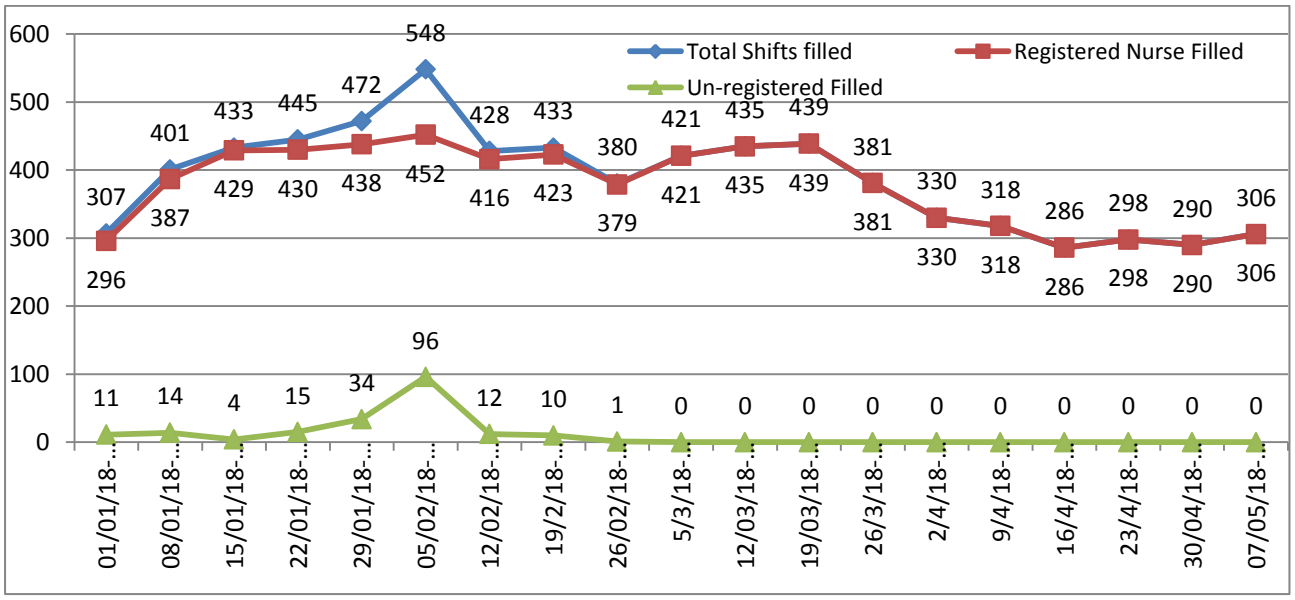
16/4/18 – 22/4/18		23/4/18-29/4/18		30/4/18-06/05/18		07/05/18 – 13/05/18	
ED	47	ED	49	ED	54	ED	61
AMU	33	B3	33	Critical Care	30	Critical Care	29
B3	32	Critical Care	32	B3	27	B3	26
Coronary Care	20	Coronary Care	30	AMU	24	A2	23
A2	16	AMU	20	Coronary Care	20	AMU	23

The table below shows a comparison of the top five areas of agency usage compared to last month three of the areas have reduced agency usage over the last 4 week period (Green) except B3 and Coronary Care which have increased but they hold a high numbers of vacancies (Red).

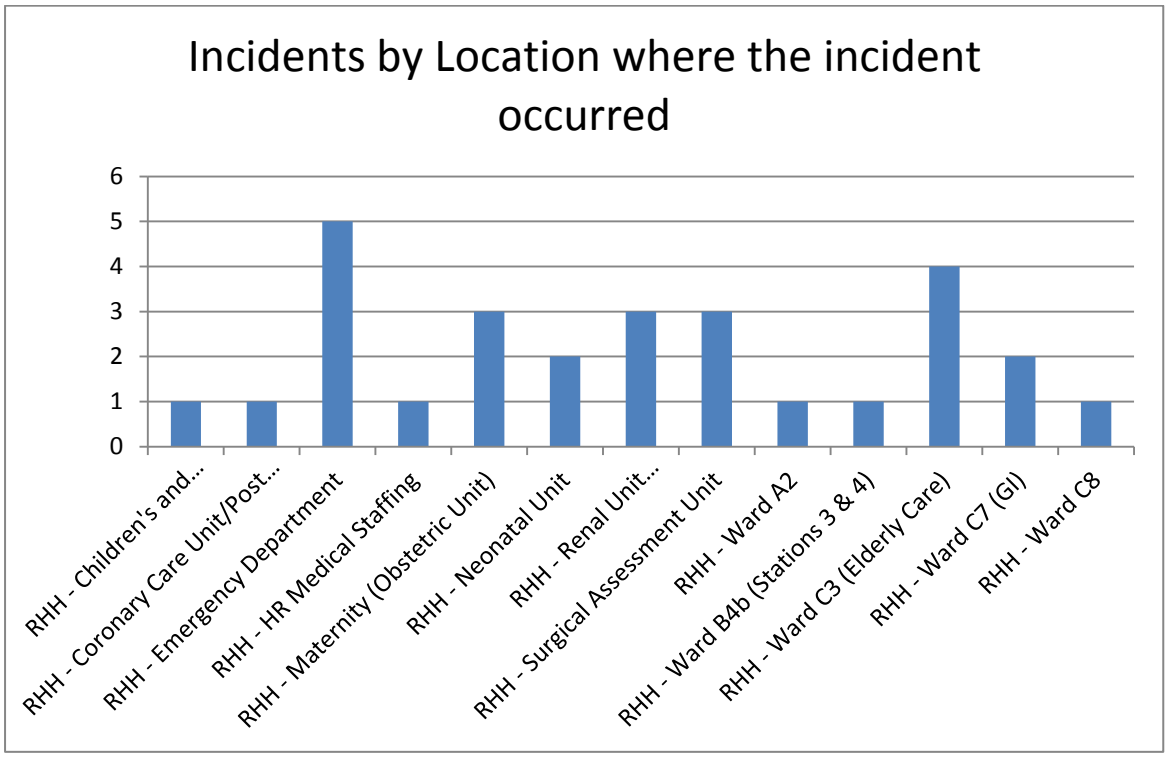
	Total shifts April 18	Total Shifts May 18
ED	356	211
Critical Care	115	91
AMU	148	100
B3	117	118
Coronary Care	51	70

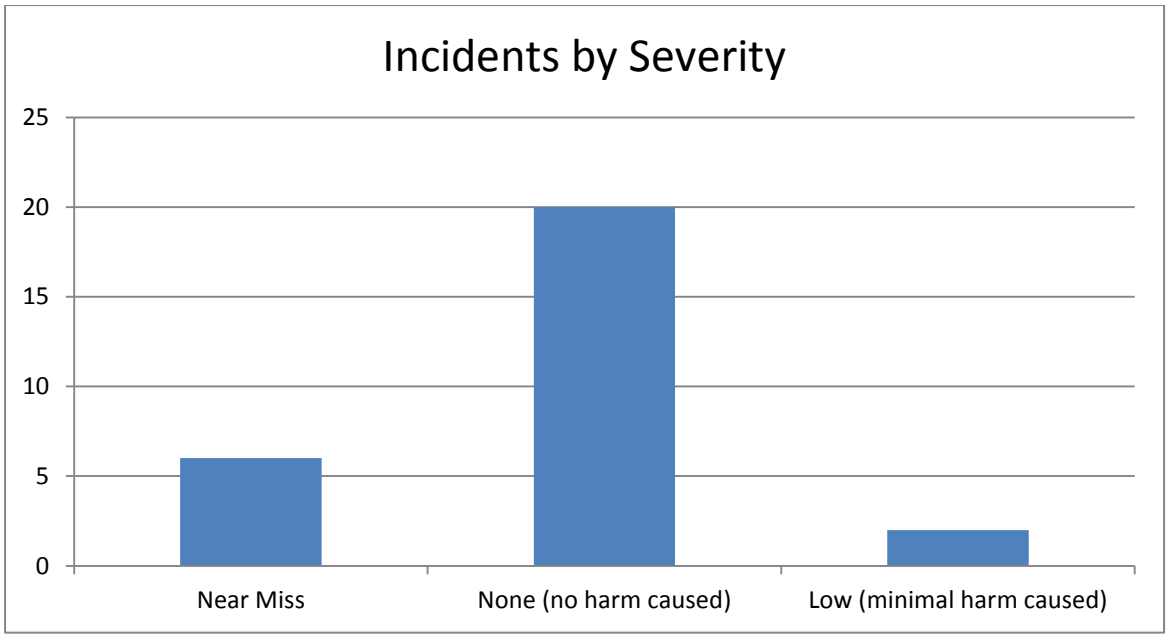
The table below shows the total number of filled agency registered nurses/CSW shifts. On average, 300 shifts per week have been filled. This is with a vacancy situation of 287.15 WTE which is an increase of 137.33 WTE above the old establishment vacancies. The controls against agency usage for CSW staff have been maintained with zero shifts during this period.

Nurse Agency Usage Figures (Registered, unregistered and total)



Staffing Incidents – April 2018





During April 2018, 28 clinical incidents were raised relating to staffing, 25 of these relate to nursing workforce whilst 3 relate to medical workforce in SAU and ED. Of the 28 incidents 26 were defined as not causing direct harm to our patients. There were two low harm incidents raised

- C7 – down CSW and a trained nurse. Noted patient became hypoglycaemic following a delay in undertaking BM sugars.
- The second low harm was as a result of reduced medical cover within ED.

This is very low numbers of incident reporting against the high number of vacancies.

Recruitment Update

The Trust has been hosting monthly recruitment events since August 2017. To date we have successfully run 10 Trust wide events and 1 area specific event. As a result, we have issued 99 conditional offer letters. On average, each event has seen 10 nurses issued with a conditional offer with 60 of the 99 being student nurses.

There are 81 student nurses due to commence within the Trust on the September preceptorship program. A keeping in touch email has been sent to all of these recruits and they have been asked to confirm their intention to commence employment with the Trust.

Of these 81, there are 43 external student nurses and 38 Dudley students. These high numbers of student nurses and relatively few experienced nurses being recruited is now cause for concern in some areas. There are certain clinical areas that are attracting high numbers of newly qualified nurses (ED, Community, Coronary Care, Theatres and Critical Care) and these specialities are finding it difficult to support this skill mix. To mitigate this, the professional development team, which provides support to newly qualified nurses, are planning to increase the peripatetic support for these staff to reduce the initial impact on the clinical staff.

Whilst these events have been successful and relatively low cost, the Trust is considering additional strategies to further increase recruitment, for instance, investing in the running of larger scale recruitment days which could be held either on-site or off-site. Advertisement of these events would be crucial to ensure a good return in terms of volume recruited. In addition, the Trust may consider running a recruitment day in another city in the UK or Ireland.

Attending job fairs can offer good value for money with a relatively short time-to-hire, which in turn can generate savings on agency nurses. Our attendance at the RCN Jobs Fair in Birmingham saw the Trust issue 12 conditional offers at a cost of approximately £5000 to attend the fair. Whilst this number is not significantly more than the average number recruited through the Trust events, these events are organised by external organisations with large scale advertising, therefore they will provide an opportunity to meet a wider nursing group.

In the coming months there are jobs fairs in Cardiff, Edinburgh, Dublin and London, at an approximate cost of £3,950. It would be worth attending one of these events as neighbouring Trusts have attended Jobs Fairs elsewhere previously and report good outcomes. The value in recruitment days/jobs fairs is the number of candidate leads that can be generated and so asking candidates to pre-register is very important. Ultimately, a percentage of those that register for the recruitment events will not turn up and therefore, having their details means we can follow up after the event to setup interviews.

The Trust was offered the opportunity to attend the British Nursing Jobs Fair in Australia in June 2018 with the objective of targeting British nurses to return to England. In addition, the events also attract secondary migrant nurses e.g. Irish and Filipino nurses and Australian nurses interested in working in the UK. At this time, the Trust has decided not to invest in this and to pursue alternative recruitment means.

The recruitment and retention lead is in the process of scoping the current substantive and bank workforce to identify how many staff the Trust currently employs to work as Clinical Support Workers, who are qualified nurses within another country and hold a live registration. She also liaising with the University of Wolverhampton who run an IELTS Preparation Course which helps candidates prepare for the IELTS Test (the first prerequisite to applying for NMC registration). The course is a 10 week course (2 hours

per week) at a cost of £100 per delegate. Work is being undertaken to explore the costs of creating a package to support suitable candidates through the IELTS, CBT and OSCE program with the aim of enabling overseas qualified nurses, who are UK resident, to work as qualified nurses. This work is in its infancy and updates will be provided in due course.

The Trust is building links with the local Army Reserves Centre with the aim of exploring employing the ex-military with the correct skill set into the NHS and will be teaming up with the Centre during Armed Forces Week and in particular 'Reserves Day'. We have been invited to attend the 'Employer Engagement' event at the Army Reserve Centre on the evening of Wednesday 27th June. It is hoped that the Trust can partner with the Armed Forces on some new initiatives in the Dudley area.

The Trust continues to support new graduates with their NMC registration fee of £120 and continues to offer a 'recommend a friend' reward of £200 to existing colleagues. To date three existing members of staff have been rewarded £200 for recommending a colleague, totalling £600 and the Trust has paid £120 NMC registration fee for 77 newly qualified nurses, totalling £9,240.

Staff Engagement and Retention

Personal Group – Hapi App

"When people are happy, they are more productive. When people feel like they make a difference, they do."

Personal Group is an employee services business, working with employers to drive productivity through better employee engagement and a healthier, more motivated workforce.

Employee Services are the things you do for your employees every day, such as discounts and rewards. These alongside a host of other engagement tools like surveys and employee communications can all be provided through Hapi – An employee services platform and app.

Let's Connect, part of Personal Group, specialises in implementing technology employee benefits. The schemes are extensively adopted across the UK in both private and public sectors.

This benefit offers employees the opportunity to access brand new technology from leading manufacturers, saving on National Insurance and spreading the cost through a salary sacrifice arrangement. A meeting has taken place with Personal Group and they have put a proposal together for the Trust and this will be presented to the Workforce committee.

If the Trust is interested in pursuing this employee engagement platform, Personal Group would happily return to the Trust to provide a demonstration and address any concerns that may be had around this tool. A presentation to the Workforce Committee is being arranged.

Exit Interviews

During the months of April-May, there have been 7 staff nurse resignations. One of these has requested an exit interview after which the case was referred to the Speak Up Guardian.

Conclusion

This report demonstrates that we are achieving nearly 100% fill rate using the historic establishments with a significant reliance on temporary staff (bank and agency). This month sees an improvement in the fill rates from the November 2017 to March 2018 period.

Benchmarking the Trust workforce data using the CHPPD will be undertaken at each stage that the Model Hospital data is updated with the caveat that comparisons need to be undertaken with caution as exact like for like comparisons cannot always be made.

The staffing review which commenced in 2017 used data from a wide variety of sources to inform and ensure the required outcome. The review included 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 also considered the outcome of the most recent Safer Nursing Tool exercise and patient acuity. The new establishments for the medical and surgical wards agreed from that review took effect from April 8th with clear rules on the use of temporary staff.

It is to be noted that there are relatively low numbers of incident reporting relating to staffing given the high vacancy numbers.

With the reviews on the medical and surgical ward areas, NNU and Critical Care completed, reports have also been produced on a number of other areas which include Main Out Patients Department (OPD), Renal Unit, Emergency Department, Emergency Assessment Unit, Elective Medical Unit and Community Nursing, a number of which have by seen by the Directors for consideration. The OPD, Renal Unit and Elective Medical Unit will be presented to the Finance and Performance Committee in June/July.

APPENDIX 1

Safer Staffing Summary	Apr			Days in Month	30											
	Day RN Day RM	Day RN Day RM	Day CSW Day MSW	Day CSW Day MSW	Night RN Night RM	Night RN Night RM	Night CSW Night MSW	Night CSW Night MSW					Actual CHPPD			
Ward	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Registered	Care staff	Total
Evergreen																
A2	240	243	210	200	150	151	183	185	101%	95%	101%	101%	1,211	3.90	3.73	7.64
A3																
A4																
B1	115	99	61	63	70	69	57	56	86%	102%	99%	97%	525	3.65	2.70	6.34
B2(H)	125	119	240	231	94	94	206	204	95%	96%	100%	99%	861	2.89	6.06	8.95
B2(T)	94	91	123	118	64	64	96	97	97%	96%	100%	101%	666	2.73	3.87	6.60
B3	210	192	200	185	184	172	165	157	91%	92%	93%	95%	987	4.33	4.06	8.39
B4	180	197	244	239	173	153	180	188	109%	98%	88%	104%	1,324	3.06	3.87	6.93
B5	191	183	144	141	153	150	93	91	96%	98%	98%	98%	969	4.03	2.87	6.90
B6																
C1	180	162	280	264	150	139	171	169	90%	94%	92%	99%	1,404	2.57	3.70	6.26
C2	204	227	62	59	165	176	30	30	111%	94%	106%	100%	668	7.05	1.37	8.42
C3	213	198	371	371	180	152	372	372	93%	100%	84%	100%	1,536	2.73	5.80	8.54
C4	150	150	60	60	90	94	90	81	100%	100%	104%	90%	645	4.31	2.62	6.93
C5	193	187	238	239	157	146	183	183	97%	101%	93%	100%	1,383	2.82	3.62	6.44
C6	90	83	64	62	60	60	63	62	92%	97%	100%	98%	443	3.78	3.36	7.14
C7	180	166	133	126	122	115	128	124	92%	94%	94%	96%	1,052	3.20	2.84	6.04
C8	205	197	231	223	183	175	232	218	96%	97%	96%	94%	1,226	3.56	4.32	7.88
CCU_PCCU	210	170	32	29	150	147	-	3	81%	91%	98%		579	6.57	0.66	7.23
Critical Care	336	336	62	60	342	341	-	-	100%	97%	100%		344	23.13	1.83	24.96
EAU	270	238	330	284	270	260	330	309	88%	86%	96%	94%	1,369	4.37	5.20	9.56
Maternity	531	534	210	200	510	499	150	147	101%	95%	98%	98%	535	18.68	7.60	26.27
MHDU	108	107	31	34	106	110	-	6	99%	110%	104%		195	13.08	2.29	15.37
NNU	144	166	-	-	136	169	-	-	115%		124%		364	10.57	0.00	10.57
TOTAL	**4,168**	**4,042**	**3,326**	**3,186**	**3,509**	**3,435**	**2,729**	**2,681**	**97%**	**96%**	**98%**	**98%**	**18,286**	**4.70**	**3.82**	**8.51**

Enclosure 7

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th June 2018

TITLE:	Mortality Report		
AUTHOR:	Dr Julian Hobbs Medical Director	**PRESENTER:**	Dr Paul Hudson Deputy Medical Director

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:

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:

- The Board is asked to receive and note the report.
- To note the reduction in sepsis mortality.
- To note the establishment of a group to audit mortality and End of Life care.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other

RECOMMENDATIONS FOR THE BOARD:

To receive and note the report.

Mortality Report

Purpose of the paper

To provide the information and assurance necessary to the board that mortality Is properly scrutinised and that the hospital continues to develop the recommendations contained in the learning from death document.

Data set

	Parameter	*Period*	*Numbers (prev in brackets)*
Mortality	Crude mortality	Apr 2017 to Mar 2018	1813 – 3.01%*(1707 – 2.81%)
	SHMI	Jan 2017 to Dec 2017	1.03 (0.98)
	HSMR	Feb 2017 to Jan 2018	109 (102.6)
Condition specific alerts	Secondary malignancies GI Haemorrhage	See below	Note – there are NO RED alerts
Rule 28 notices	Neurosurgical care VTE	Q3	N/A
National audits	Lung cancer one year adjusted survival Intensive Care Vascular surgery Bowel cancer	2016 (2017 report) 2016/2017 2017 2014/2015	See below See below See below See below
Highest 6 condition groups	Sepsis Secondary malignancy COPD Cerebrovascular disease Acute unspecified Renal Failure Pneumonia		N/A
MPR level 1	Completion	Mar 2017 to Dec 2017! Jan 2018 to Feb 2018!	90.6% (1215/1341) 71.8% (282/393)
MPR level 2	Completion	Mar 2017 to Dec 2017!	16% (08/51)

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

Latest crude mortality sits at 1813 (3.01%) and this is against a backdrop of a rise nationally. It is influenced by many factors including the provision of social care, palliative care, primary care provision and the quality of secondary and tertiary care. As such it is a useful measure as to the need for palliative care, cardiac arrest and as a baseline against which avoidability can be measured. Using PRISM 2 methodology between 0.3 and 4% of mortality in hospital care is felt to meet the 50% threshold for avoidability.

SHMI includes deaths occurring within 30 days of discharge from hospital. Our current SHMI has risen slightly but probably insignificantly and remains within the expected range.

HSMR is also increased at 109. This is at the confidence limit but almost exactly the same as February 2017 and may be associated with winter. Patients discharged are not included in this index and it may be influenced by difficulties with discharge process. Potentially the provision of community and social services and palliative and hospice care can significantly influence this measure.

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

National Audits (latest available HQIP reports):

Subject	Report time	DGFT	National	Within expected
Intensive care all mortality index	16/17	1.26	1.0	Y
Intensive care lower risk mortality index	16/17	1.30	1.0	y
Lung cancer case mix adjusted one year relative survival rate	2016	32.8%	37%	Y
National Vascular Registry post-operative in-hospital mortality rate	2017	0.4%	1.4%	Y
National Vascular Registry Risk-adjusted 30-day mortality	2017	3.3%	2.2%	Y
Bowel Cancer Risk-adjusted 90-day post-operative mortality rate	Apr15 – Mar 16	1.9%	3.2%	Y
Bowel Cancer Risk-adjusted 2-year post-operative mortality rate	Apr 14- Mar 15	13.9%	19.5%	Y

Condition specific Alerts from HED:

March 2018

No red alerts generated in **HSMR, SHMI** and **CUSUM** for the period mentioned below.

Note : *The SHMI Amber alert levels are calculated using Poisson control limits, which are narrower than the limits normally used for the "expected" range, therefore allowing earlier notification of possibly adverse changes in mortality rate.*

- HSMR Alert Period **January 2017-December 2017**
- SHMI Alert Period **December 2016-November 2017**
- CUSUM Alert Month **December 2017**

There are no current RED alerts for Mortality in HED. There are 3 amber alerts, 2 relating to Secondary Malignancies and 1 to Gastrointestinal Haemorrhage.

Hospital Standardised Mortality Ratio (HSMR) - Secondary malignancies	January 2017 - December 2017	157.97	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - Secondary malignancies	December 2016 - November 2017	149.78	
Summary Hospital-Level Mortality Indicator (Monthly SHMI) - Gastrointestinal hemorrhage	December 2016 - November 2017	144.17	

Ten Highest Condition Groups (Source HED)

Note: this table orders conditions by numbers of deaths over expected, NOT by HSMR

Diagnostic Group (CCS)	Number of discharges	Expected number of deaths	Observed	HSMR	Crude mortality rate	Obs. - Exp.
Septicemia (except in labor)	942	165.74	193	116.44	20.49%	27
Secondary malignancies	669	27.32	45	164.73	6.73%	18
Congestive heart failure; nonhypertensive	605	67.52	82	121.44	13.55%	14
Acute cerebrovascular disease	621	97	109	112.37	17.55%	12
Acute and unspecified renal failure	380	38.78	50	128.92	13.16%	11
Pneumonia (except that caused by tuberculosis or std)	2023	282.17	292	103.48	14.43%	10
Liver disease; alcohol-related	175	19.61	28	142.82	16.00%	8
Fracture of neck of femur (hip)	523	35.81	43	120.09	8.22%	7
Chronic obstructive pulmonary disease and bronchiectasis	1135	45.61	52	114	4.58%	6
Other fractures	298	11.85	18	151.9	6.04%	6

Septicaemia (Sepsis):

Mortality (over expected) has fallen since last report from 42 to 27

Modifications to review process have been made:

- Past notes are being reviewed by members of the deteriorating patient group – learning points to be reported.
- Ongoing – All deaths with that primary diagnosis will be reviewed by the Trust Sepsis Nurse Practitioner first, with any concerns going to the deteriorating patient team.
- We will therefore have going forward more specific and accurate information about this cohort

Review of deaths with primary diagnosis of secondary malignancy following high mortality indices:

A random sample of the 46 deaths contributing to this alert was reviewed:

- There were no avoidable deaths; all but one of these patients were assessed as expected to die, at the time of their first assessment on admission.
- None of the patients was undergoing active oncological treatment at the time of admission.
- Several of the patients had been prepared for discharge either to home or hospice, though there were sometimes unavoidable delays in the system.
- The notekeeping was good quality in all. All notes evidenced involvement of family and patient in their care planning. There were no concerns about general quality of care, though in four cases there had been an escalation of care which was in retrospect perhaps unnecessary.

Section 28 notices.

- Concerns in respect of record keeping and escalation triggers of deteriorating patient following head injury and NERVECENTRE communication.
- Issues of communication with the family by nursing staff, and failure to fully follow consultant recommendations re blood test**.** (Though the death was from natural causes).

Actions following previous sec 28s

Neurosurgical care

This is provided by UHB. There are a number of delays in transfers identified via Datix. The chief of medicine has written formally to the medical director at UHB. Audit data confirms significant delays at the tertiary centre regarding actioning referrals.

Actions

1. Daily update on patients awaiting transfer
2. Explore alternative referral streams
3. Clarify SLA with UHB.

Venous Thromboembolism

The Trust need to implement the NICE guidance around VTE and meet the targets around this. Not all cases of hospital associated thromboembolism are not preventable. Nationally those sites which are compliant have a forced choice implemented via an electronic solution.

Actions

1. EPR algorithm to be implemented: 2018 April.
2. Reconfigure thrombosis groups.

Deaths where there may have been a problem in care that may have affected the outcome (Q4)

This information is taken from Datix reports.

Location	Category	Putative theme	Conclusion
Death at home	Unexpected	Inappropriate discharge	Awaited
AEC	Failure of treatment	Failure to act on tests	Awaited
Ward	Unexpected	Failure to escalate	Small possibility of preventability. Pathway has been clarified
Theatre	Death in theatre	High risk ruptured AAA	No failure of care
Theatre	Death in recovery	High risk EMLAP	No failure of care

Development of reporting:

ED

There has been excellent progress on this front. ED attended the Mortality surveillance group to present their plan, which includes review of all deaths, and an engagement with us to develop the best way to escalate concerns. *(Please note that in accordance with the Trust Policy, serious concerns noted at the time will be reported on Datix; nothing below is instead of Datix)*

Following escalation of concern about availability of information from ED, we had a preliminary report in mid-April 2018:

May-December 2017: 164 deaths, 99 audited so far (reported on 13.04.2018)

- 58 'Out of ED' Cardiac arrests – 57 Out of Hospital, 1 in Mammography, brought to ED after MET call
- 21 Patients who were recognised to be dying or already being treated palliatively
- 3 Patients who died despite maximal appropriate treatment.
- 16 unable to complete at that date because of notes access.

The Care of the Dying in ED Audit was presented to the MSG. It was shown for information to the CQPSE because the CQPSE had registered concern that there had been no presented evidence that ED had engaged with our mortality review process during the previous year. Discussion was not requested at the CQPSE.

Main points do include learning issues:

Recognition of dying patients was excellent.
Review and withdrawal of unnecessary treatment was used appropriately and frequently.
Levels of pain were assessed regularly and controlled.

Learning:

- Having loved ones present if the patient wishes is an important feature of a good death but was only documented in approximately one-third of the cases.
- It is fundamental that holistic care is provided for all involved during this difficult period but there was no documentation of any spiritual or psychological support being offered.
- There was no record of discussions surrounding organ donation.

ED has taken on immediately the notion of Structured Judgement Review (SJR). They have approached the mortality review team to discuss the best way forward and we are working on the premise that their own first review can result in an immediate referral to the level 2 panel out with the tracker. (You will recall that ED deaths are not on the tracker because they are not technically inpatient deaths).

LeDeR

Of note, the National Report is available.

Actions we should take now to assist:
Bristol should be notified when a patient with LD dies. (It is not apparently a statutory requirement for the Trust to do this).

Though anyone can report a LD death, there is some logic in suggesting that the Trust should take responsibility and have a process to do this if a death occurs in hospital. It is suggested that the LD liaison nurse may be best placed to do this on behalf of the Trust.

Any information DGFT has will help inform the full LeDeR review and indeed will save it some time and effort. We should continue to carry out level 2 reviews on LD mortality and submit the conclusion to Bristol with the report when possible. We note that there is no issue with data sharing with CCG here, though engagement with primary care to complete a comprehensive review remains an issue.

We must make sure that relatives of the deceased are aware that this in-depth review will be taking place and that they may be approached by the LeDeR reviewer in due course. LD liaison nurse is of course aware of this but- **learning**- we need to strengthen this process.

Other issues arising from linking to the West Midlands Lead:
The executive team should be involved in "nominating" (more) reviewers for training and involvement; both nursing and medically qualified personnel would be welcome. This links further to "primary care involvement" below.

Involving primary care in mortality reviews:
The CCG has now nominated a GP who will hopefully engage with the Trust's mortality reviewing process. The relationship will be developed and their input assessed. Without this engagement it is not realistic to expect proper analysis of SHMI figures as they of course involve consideration of deaths within 30 days of discharge from our hospital.

Summary

The learning from deaths paper has evolved to include a more comprehensive assessment of mortality. It has identified the deteriorating patient and in particular the patient with sepsis as areas for improvement. The learning has been implemented as per the Structured Judgement Review (SJR) paper from the Royal College of Physicians (RCP) into an operational plan which is reported on to CQSPE.

Learning from Deaths Dashboard

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

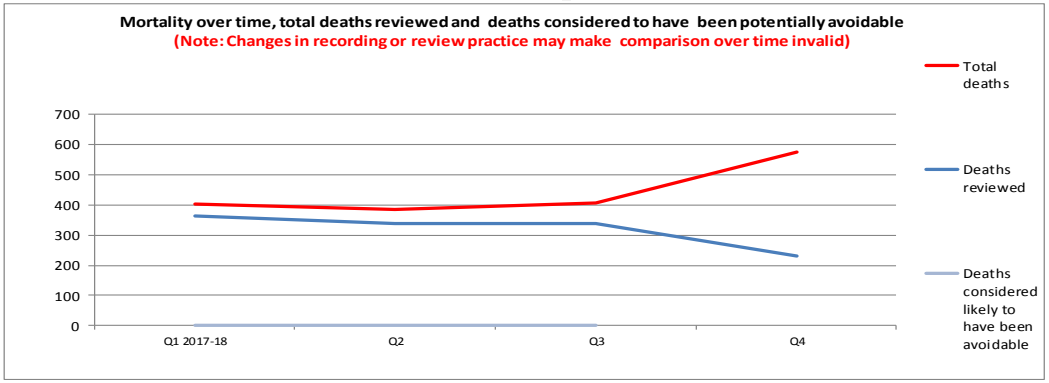
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
184	175	15	89	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
574	406	230	337	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1764	0	1267	0	2	0

Time Series: Start date 2017-18 Q1 End date 2017-18 Q4



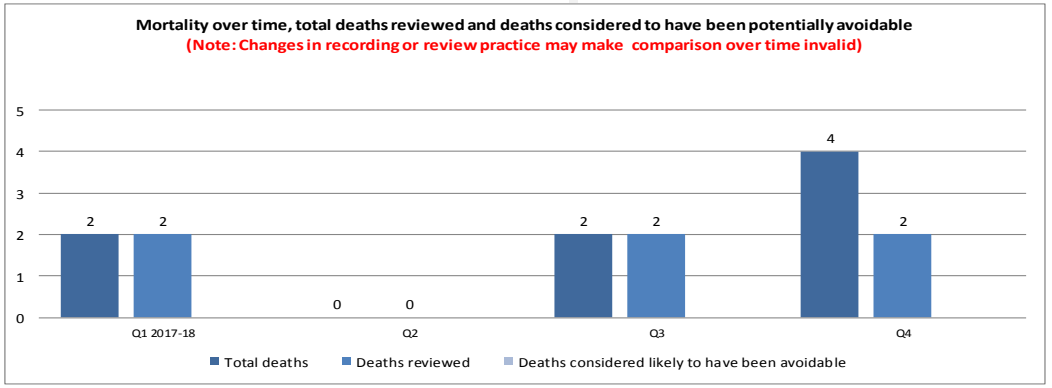
Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	15	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD	230	100.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	0.2%	This Year (YTD)	3	0.2%	This Year (YTD)	8	0.6%	This Year (YTD)	1254	99.0%

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2	0	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	2	2	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	0	6	0	0	0

Time Series: Start date 2017-18 Q1 End date 2017-18 Q4



Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to Trust Board on 7th June, 2018

TITLE:	**Annual Report and Quality Accounts 2017/18**		
AUTHOR:	**Jackie Dietrich Communications Manager**	**PRESENTER**	**Liz Abbiss Head of Communications**

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 Strategic Objectives

SUMMARY OF KEY ISSUES:

The enclosure provides the Trust Annual Report for the Trust Board. It has been developed in collaboration with relevant staff and departments. It was ratified at Audit Committee. It is being presented to the Board of Directors for information and will be laid before Parliament by Monday 25th June 2018 prior to publication.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: Annual reports and accounts** are an element of the Well Led domain of the CQC framework.
	NHSI	**Y**	**Details:** Well led
	Other	**N**	**Details:**

ACTION REQUIRED OF TRUST BOARD:

Decision	Approval	Discussion	Other
			To note

RECOMMENDATIONS FOR THE TRUST BOARD:

- To note the annual report and accounts

NHS
The Dudley Group
NHS Foundation Trust

The Dudley Group NHS Foundation Trust

Annual Report & Accounts

2017/18

The Dudley Group NHS Foundation Trust

Annual Report and Accounts 2017/18

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Section 1: Performance Report

Section 2: Accountability Report

Section 3: Annual Accounts

Section 4: Quality Report and Account

All information contained in this report was correct at the time of publication.

Throughout this document we refer to periods in the financial year as quarters:

Quarter 1 (Q1) relates to April to June
Quarter 2 (Q2) relates to July to September
Quarter 3 (Q3) relates to October to December
Quarter 4 (Q4) relates to January to March

The Dudley Group NHS Foundation Trust is referred to as 'the Trust' throughout this report.

Section 1: Performance Report

Chairman Jenni Ord

Chief Executive Diane Wake

Overview of Performance

Welcome to our Annual Report and Accounts for 2017/18. Firstly, it is important that we say thank you to everyone who has been involved in The Dudley Group over the last 12 months. It has been a year of ups and downs, which the detail in this report describes. We want you to know we are committed to the delivery of excellent care in all our services, fostering and maintaining excellence where it exists and driving substantial improvements where it is necessary.

Investing in our services

The NHS faced unprecedented demands last year, especially throughout winter. The Emergency Department at Russells Hall Hospital has seen a 9.4 per cent increase in attendances over the last five years. Within this is a 41.3 per cent increase in attendances for patients aged 85 and older. This is very significant as these patients are often seriously ill, with multiple health problems, requiring various diagnostic tests, longer stays in hospital and substantial support in the community to be discharged from hospital safely.

We continue to redesign how we see and treat emergency patients. The brand new £2.6m Emergency Treatment Centre was completed this year providing new facilities for the Urgent Treatment Centre, run by Malling Health, and our Emergency Department waiting area. Through this new build, we took the opportunity to relocate our minor injuries and ambulance triage area to help with better patient flow. We also moved the Emergency Assessment Unit (EAU) and created an Acute Medical Unit (AMU) to ensure the best care is delivered to patients.

Further investments have been made at the Guest Outpatient Centre for a new £3.5 million imaging suite, including a new MRI scanner, and refurbishment of our renal satellite centres in Tipton and Kidderminster. The new facilities at the Guest will be able to handle almost 20,000 extra scans a year and reduce waiting times for patients. All patients sent for an MRI or CT scan by their GP will no longer have to visit Russells Hall Hospital or Corbett Outpatient Centre but will, instead, go to Guest.

We perform well against many of the high profile national standards, the exception being the four-hour emergency access target which many trusts are struggling to meet.

In our planned services, we have continued to improve key performance areas and invested in services such as ophthalmology and paediatrics where additional staffing has supported plans to reduce waiting times for services.

Innovative working

We continue to work with partners on a number of joint initiatives to deliver effective patient care. The developing arrangement to support more joined up services for patients in the community should result in better, more localised, access and

greater continuity of care. We are working together with local GPs and colleagues in mental health services to deliver this.

It is pleasing to see that our innovative partnership working with social care services has dramatically reduced the number of delayed transfers of care across the borough, which helps to keep patients flowing through our Emergency Department and the whole of the hospital, and we look forward to continuing this excellent work with our partners in social care.

The Black Country Pathology work, involving The Dudley Group, Sandwell and West Birmingham NHS Trust, Walsall Healthcare NHS Trust and The Royal Wolverhampton NHS Trust, has also taken shape this year. This should enable these important services to become more sustainable, ensuring this specialist resource is shared, whilst enabling essential laboratory service requirements at each hospital site. The new service will have a central hub at New Cross Hospital and essential service laboratories at each of three other trusts, Shrewsbury and Telford Hospital NHS Trust will join the partnership in the future.

We have continued to plan the implementation of a new Electronic Patient Record (EPR). The system will transform the way we record patient information electronically, which will only need to be captured once. Eventually, we will be able to reduce our patient records releasing clinical staff to provide more direct patient care.

Financial Challenge

During 2017/18, we delivered £9.8m efficiency savings to support our financial effectiveness plan. It was particularly challenging given that the Trust has made year-on-year savings over several years. Our approach included a drive on reducing temporary staff spend. Whilst we still used considerably more of these staff than agreed, we did spend £2.4million less than in 2016/17. Further reductions for this year are also planned.

We have reinvigorated the drive to recruit local staff. A total of 167.25 whole time equivalent staff have been appointed since October 2017 and our focus remains on further recruitment and development opportunities for all staff.

Care Quality Commission (CQC) Inspection

The CQC team visited us from in December 2017 and January 2018. They inspected five core services at Russells Hall Hospital and also community adult services, including sexual health services.

We were pleased that the inspectors found our services to be caring overall, rating the care given as good. However, we are hugely disappointed that our overall Trust rating remains Requires Improvement.

We are particularly disappointed that our Emergency Department has been rated Inadequate, as staff have faced challenging demands for services, especially in the winter period.

The Emergency Department has a service improvement plan in place to deliver the safe, effective and responsive care that patients can expect and our staff aspire to. Key areas for improvement include timely triage of patients to direct them to appropriate services, consistent safeguarding practices for all patients and more effective monitoring of deteriorating patients.

Medical care, including how we care for older people, maintained a Good rating. This includes a stroke service which is one of the best in the region. Also pleasing was the recognition of improvements in maternity services, which also attracted a Good rating.

We are proud that community services were rated Good, and the CQC found examples of outstanding practice, in particular the innovative multi-disciplinary working to provide good care to patients. Compassionate care was noted and the feedback from patients confirmed this.

All staff are committed to making the improvements required, arising from our internal investigations or external assessments. Inspectors commented favourably on our incident reporting. They also received excellent feedback about how the team has tailored services to meet the needs of individuals.

Our staff

We continue to be pleased with the hard work and professionalism of our staff who have responded to the needs of very high numbers of patients, whilst striving for care excellence. Many staff took the opportunity to receive their flu jab protecting themselves, their families and their patients over the winter period. At 75 per cent, this was the highest number of staff vaccinated at the Trust.

We launched the monthly Healthcare Heroes awards this year to recognise individuals and teams who go above and beyond every day to improve patient care. We have been really impressed by the quality of all the nominations making it a tough job to choose the winners. We have hosted a variety of sporting challenges, such as 'Cycling Santas' and an 'Easter Bunny Boat Race', as well as staff cycling from London to Paris to support our charitable funds. Staff clearly enjoy supporting our charity and raising valuable funds, which are invested into patient care. You can find out more about how we engage with our staff on pages 40 and 41.

Trust volunteers continue to provide an amazing service supporting staff and patients. The team of over 450 volunteers provide a variety of roles, from Emergency Department hosts to wayfinding.

We also held a new-style Long Service Awards event which celebrated our hardworking staff who have reached the milestones of 10, 25 and 40 years' service working for the Trust. The event was a great success and many staff attended.

We received national recognition from the Secretary of State for Health Jeremy Hunt for our improvement to the proportion of cancer patients who received treatment within 62 days of referral in the period of August 2017 to October 2017, in comparison with May 2017 to July 2017.

We continued to raise awareness of dementia, a condition that affects 850,000 people in the UK every year. Staff were able to take advantage of a mobile virtual dementia tour bus and experience the fear and frustration people with dementia go through on a daily basis. Some of our staff who took the tour experienced a range of simulative distortion which robbed them of their senses to recreate the isolation and fear that people with dementia may experience every day.

Changes to the Board of Directors and Council of Governors

Several changes have occurred this year, including the post of chief executive. We welcomed Siobhan Jordan, chief nurse, in April 2017, Julian Hobbs, acting medical director, in October 2017 and Karen Kelly, chief operating officer, in January 2018. Natalie Younes joined us as director of strategy and business development in September 2017 and, finally, Tom Jackson took the vacant director of finance post in 2018.

We said goodbye to a number of serving colleagues, including Rob Johnson, lead governor, who was succeeded by Fred Allen. Looking forward, we have much to do and we do not underestimate what is expected of the Trust. We will be embracing keener and more consistent quality improvement activities in partnership with our regulators and through other facilitated support. We also know we have to deliver within our financial plan, and to also secure the best possible workforce to support patients. Thank you.

About The Dudley Group

The Dudley Group is the main provider of hospital and adult community services to the population of Dudley, parts of the Sandwell borough and smaller, but growing, communities in South Staffordshire and Wyre Forest. The only acute trust in the area to be awarded Foundation Trust status in 2008, we provide a wide range of medical, surgical and rehabilitation services. We currently serve a population of around 450,000 people from three hospital sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge. We provide the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. We also provide specialist adult community based care in patients' homes and in more than 40 centres in the Dudley Borough Council community.

A full list of our services can be found on pages 12 and 13.

The Trust has a range of policies covering social, community, anti-bribery and human rights issues and monitors these through the Workforce and Staff Engagement Committee.

Our vision is to be a healthcare provider for the Black Country and West Midlands which is trusted to provide safe, caring and effective services because people matter. Our strategic objectives can be seen below and we will continue to work to these objectives in 2018/19.

The Trust experienced a difficult 2017/18 financial year which resulted in a deficit position and a reduction in its cash balances. To mitigate the risks arising from the financial position and to give itself the best chance of financial turnaround the Trust Board has established a Financial Improvement Programme for 2018/19 with additional financial controls, targets and protocols. If achieved, the Trust will receive an additional £9m from the Provider Sustainability Fund. The Board is aware of the risk that if the financial plan is not achieved this indicates the existence of a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. This would be mitigated by the requirement of the Trust to borrow funds at some point in the next 12 months. The Board continues to monitor its monthly and future cash position and has governance arrangements in place to manage cash requirements throughout the year.

The Dudley Group NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The Code, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Signed:
Date: 22nd May 2018

Jenni Ord
Chairman

Signed:
Dated: 22nd May 2018

Diane Wake
Chief Executive

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
  - Discharge processes
- 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

- Transformation through the Digital Trust programme (Record, Share, Support)
- Increase access to 7 day services
- Transform and re-organise services to drive efficiency and improve key services:
  - Outpatient transformation
  - Theatres transformation
  - Implement Get it Right First Time recommendations for relevant specialties
  - Implement hospital pharmacy transformation plan
- Implement schemes outlined in the Clinical Strategy such as:
  Ophthalmology
  Cardiology redesign
  Paediatric services
  Therapies
  Black Country Pathology

Be the place people choose to work

- Enhance staff engagement through improved use of staff survey and best practice
- Maximise employee capability and well-being:
  - Improve sickness absence, mandatory training and appraisals
  - Workforce development

CARE
RESPECT
RESPONSIBILITY

Make the best use of what we have

- Match capacity to demand through the development of a demand/capacity management tool
- Deliver the agreed financial recovery plan through to 2019/2020:
  - Set budgets and monitor progress
  - Set a cost improvement programme of £20.8m
- 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 Multi-specialty Community Provider 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

Performance analysis

The Trust closely measures and monitors performance throughout the year with reports on both financial and operational performance for all areas of the Trust reported monthly to Finance and Performance Committee, Board of Directors and Council of Governors. In addition, an electronic performance dashboard accessible via our staff intranet allows senior staff to closely monitor performance in their specific areas and weekly performance reports are discussed by executive directors.

Financial performance

During 2017/18, the Trust encountered a difficult financial environment in keeping with the majority of acute trusts within the NHS. The Trust was set a challenging target by NHS Improvement to achieve a £2.530m surplus in 2017/18. Signing up to this control total enabled the Trust the opportunity to earn additional bonus cash in the form of a Sustainability and Transformation Fund (STF).

The STF was introduced in 2016/17 for the first time to incentivise both financial and operational performance. The Trust was successful in 2016/17 in attaining a significant amount of STF but the 2017/18 position has fallen short due to the financial outturn and the operational performance against the emergency access four-hour target.

The Trust ultimately incurred a deficit of £10.493m compared to the planned £2.530m surplus: a financial performance that was just over £13m worse than plan.

Taking the additional STF of £4.728m into account, the Trust deficit reduced to £5.765m. These figures exclude the impairment of £1.428m.

Despite the operation of an onsite Urgent Care Centre, A&E activity continued to increase throughout the year. Elective activity also improved despite periods of adverse weather and requirements to cancel some planned activity over the winter period to allow for emergency pressures. Other activity fell short of plan although the Trust did deliver more outpatients than the previous year.

Summary activity

	2017/18			2016/17	Increase
	Plan	Actual	Variance	Actual	17/18 from 16/17 (%)
A&E attendances	101,381	103,426	2,045	102,692	0.7%
Elective spells	54,385	54,510	125	51,965	4.9%
Non-elective spells (excluding maternity)	54,123	51,540	-2,583	53,220	-3.2%
Births	4,518	4,435	-83	4,496	-1.4%
Outpatient attendances/procedures	515,055	489,622	-25,433	483,995	1.2%
Community attendances	391,603	381,533	-10,070	398,739	-4.3%

* figures for non-elective spells and outpatients have been adjusted for consistency purposes following a coding change that occurred in September 2017. * Figure includes impairment of £1.428m in 17/18.

Summary financial performance

	2017/18			2016/17
	Budget £000	Actual £000	Variance £000	Actual £000
Income	£348,551	£347,548	-£1,003	£339,783
Pay	-£206,895	-£214,622	-£7,637	-£203,168
Non-pay	-£116,422	-£120,202	-£3,780	-£114,173
EBITDA	**£25,144**	**£12,724**	**-£12,420**	**£22,442**
Depreciation and finance costs	-£22,614	-£24,573	£1,959	-£22,803
Net	**£2,530**	**-£11,849**	£14,379	**-£361**
Sustainability and transformation funding	**£8,574**	**£4,728**	-£3,846	**£11,945**
Final surplus for year	**£11,104**	**-£7,121**	**-£18,225**	**£11,584**

Summary Cost Improvement Programme

In addition, we have delivered a significant level of cost savings from improved efficiencies of circa £9.8m during the year. This was less than we planned (we had planned for £12.4m) but the cost of agency staff and reduced activity hampered the ability to achieve a higher outturn.

	2017/18		
	Plan	Actual	Variance
	£000	£000	£000
Pay Efficiencies	£3,997	£3,848	-£149
Non Pay Efficiencies	£4,588	£4,275	-£313
Income Efficiencies	£3,835	£1,696	-£2,139
Total CIP	**£12,420**	**£9,819**	**-£2,601**

One of the biggest challenges the Trust continues to face is the cost of temporary staffing. Whilst the Trust extensively uses its own bank of staff to fill vacancies and shortages in rotas, it does also need to use agency staff. These staff typically cost more than substantive staff and put pressure on Trust budgets. The Trust spent over £11.7m on agency staff (in addition to staff it drew from its own bank of temporary staff). This pressure challenged the Trust both financially and operationally and is an area where concerted effort is being made in 2018/19 to further reverse this trend in spending through recruitment and retention of substantive staff.

Summary agency spends

	2015/16 £000	2016/17 £000	2017/18 £000
Medical	£2,308	£4,313	£3,847
Registered nursing and midwifery	£4,667	£6,210	£6,167
Unregistered nursing and midwifery	£162	£1,060	£213
Scientific/therapeutic	£1,444	£1,912	£1,354
Admin/manager	£1,044	£593	£128
Agency spends total	**£9,625**	**£14,088**	**£11,708**
Agency spends target			£5,772

In 2017/18, the Trust invested £17.2m on new facilities and equipment. Large building schemes included investment of £3.2m in the co-location of the Urgent Care Centre with our Emergency Department and £2.4m in the development of the new imaging suite at Guest Outpatient Centre. The Trust's Digital Trust Programme entered its second year of development with an investment of £5.4m. We also spent £3.2m on new and replacement medical equipment. All of these investments improve the efficiency of the services we provide.

Summary of capital investment

	Amount £000
Replacement Medical Equipment	£3,153
Information Technology	£1,759
Urgent Care Centre	£3,218
Guest Imaging Suite	£2,381
Digital Health Programme	£5,424
Other schemes	£507
Private Finance Initiative Lifecycle	£710
Total	£17,152

The Trust ended the year with a balance of £13.9 million, all held within the Government Banking Service, which is £4.1m less than the same time last year. This is due to the financial performance of the Trust and the lower STF earned in cash as a result. The Trust's overall liquidity position was at -7.6 days compared to the plan of 11.7 days.

During 2017/18, the Trust continued its policy of paying all local suppliers at the earliest opportunity to support the local economy during these difficult economic times. The Trust continues to perform strongly against the best practice payment policy target of 95 per cent compliance. During 2017/18, the Trust continued its strong performance again and paid 99 per cent of non-NHS invoices in value terms and 97 per cent in quantity terms.

Operational performance against targets

Performance against the majority of national standards has once again been good with the vast majority of standards being achieved – with the exception of the four-hour standard to see treat, admit or discharge patients in less than four hours of arrival at A&E. Our operational performance is summarised in the table below:

We recognise our responsibilities with regards the impact of our business activities on the social, economic and environmental wellbeing of the communities in the Dudley borough and surrounding area. In order to do this, we engage with, and seek the views of, our patients, stakeholders and the wider Dudley community through our governors and the Trust's membership scheme. Information about this, and the Trust's work to encourage more environmentally-friendly working practices, can be found on pages 44 to 45 of the Accountability Report (Section 2).

The directors consider the Annual Report and Accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Relative quote (district nursing)

"Nurses visited promptly and were amazing in looking after our mum. They all spoke to her and manager her pain relief brilliantly. Brilliant ladies and a great service."

Summary activity *prov. means provisional		2017/18	
		Target	Actual
Infection Control	Number of C. diff cases (lapses in care)	29	17 (prov.)*
Cancer Waiting Targets	Two week wait for referral to first seen	93%	94.7% (prov.)
	31 day wait from diagnosis to treatment	96%	98.7% (prov.)
	62 day wait from referral to treatment	85%	85.2% (prov.)
Emergency Department	Patients waiting four hours or less to be seen, treated, admitted or discharged in A&E	95%	86.6%
Referral to Treatment - Elective patients	% of incomplete pathways waiting less than 18 weeks	92%	94%
DM01 – access to diagnostics	% of diagnostic tests waiting less than 6 weeks	99%	97.9%

Our services

Russells Hall Hospital

Ambulatory Emergency Care
Anaesthetics, including CPET Clinic, High Risk Antenatal Clinic, Pre-operative Obstetric Clinic
Anticoagulation
Audiology
Bereavement Services
Cancer Services
Cardiology
Care Plus – private patients
Chaplaincy Service
Clinical Haematology
Critical Care Unit
Day Case Surgery Unit
Dermatology
Diabetes and Endocrinology
Dietetics
Early Pregnancy Assessment Clinic
Elective Medical Unit
Emergency Assessment Unit
Emergency Department (A&E)
Fracture clinic
Gastroenterology
Genito-urinary medicine
Head and Neck surgery including Ear,
Haematology
Nose and Throat (ENT) and Maxillofacial
Hip and knee classes
Learning disabilities support
Maternity (including pre and antenatal)
Maxillofacial prosthetics
Medical and surgical inpatient wards
Medical High Dependency Unit (MHDU)
Neurology
Obstetrics and Gynaecology
Older Persons and Stroke
Oncology
Ophthalmology
Organ donation
Orthodontics
Orthoptics
Orthotics
Outpatients
Paediatrics and Neonatology
Paediatric Assessment Unit (for GP referrals)
Pain Management Multidisciplinary Clinic
Parkinson's service
Pathology
Palliative and End of Life care
Pharmacy
Phlebotomy (blood tests)
Plastic surgery (including specialist skin cancer service)
Podiatry
Psychology
Radiology (X-ray, MRI and CT scanning)
Renal
Respiratory assessment and medicine
Rheumatology
Speech and Language Therapy
Stop Smoking Service
Surgery including breast, colorectal, upper and lower GI, and paediatric surgery
Surgical Assessment Unit (for GP referrals)
Surgical pre-operative assessment
Surgical High Dependency Unit (SHDU)
Theatres
Therapy Services (including Physiotherapy and Occupational Therapy)
Trauma and Orthopaedics
Urology (including genito-urethral reconstruction)
Vascular laboratory
Vascular surgery (Black Country Vascular Network arterial site)
Women and Children's Outpatients

Corbett Outpatient Centre

Day Case Surgery Unit
Dietetic clinic
Dudley Rehabilitation Service*
Multi-professional rehabilitation
Orthotics
Outpatient clinics including:
- Adult Genetics
- Cardiology
- Dermatology
- Gastroenterology
- Gynaecology
- Neurology
- Older Persons and Stroke
- Respiratory
- Rheumatology
- Trauma and Orthopaedics
- Urology

Pharmacy
Phlebotomy (blood tests)
Podiatry
Radiology (X-ray, ultrasound scanning, DEXA bone scanning)

Guest Outpatient Centre

Abdominal Aortic Aneurysm Screening
Dudley Rehabilitation Service*
- Multidisciplinary clinics:
- Pain Management Programme
- Renal
- Respiratory
- Rheumatology
- Urology

Outpatient clinics including:
- Bladder Dysfunction Clinic
- Dermatology
- Gastroenterology
- Heart Failure Clinic
- Immunology
- Neurology
- Older People
- Orthoptics
- Pain Management

Pharmacy
Radiology (X-ray and Ultrasound)
Respiratory Assessment

Community Services

Abdominal Aortic Aneurysm Screening
Audiology
Blood Borne Virus
Chronic Obstructive Pulmonary Disease (COPD) respiratory nurse service
Care Home Practitioner Service
Community Ear, Nose and Throat (ENT)
Community Rapid Response Team
Community general surgery
Community gynaecology service
Continence Service
Contraception and Sexual Health
Dermatology
Diabetes Specialist Team (Primary Care)
Dietetics
District nursing
Dudley Rehabilitation Service*
Heart Failure
Intermediate Care
Leg ulcer clinic
Macmillan Community Palliative Care Team
Macmillan Multidisciplinary Team
Orthoptics
Orthopaedic Assessment Service
Outpatient Parental Antibiotic Therapy (OPAT) and oncology outreach
Palliative Care Support Team (joint agency)
Paediatric community service
Physiotherapy – musculoskeletal Physiotherapy Service
Podiatric surgery
Podiatry
Tissue viability
Virtual ward

#Integrated Nursing Teams include district nurses, long-term condition nurses and assertive case managers.

**Dudley Rehabilitation Service includes: Parkinson's nurses, multiple sclerosis nurses, Integrated Living Team, stroke rehabilitation, physiotherapy, occupational therapy, speech and language therapy.*

Section 2: Accountability Report

Directors' Report

The Board of Directors was established and constituted to meet the legal minimum requirements stated in the Health and Social Care (Community Health and Standards) Act 2003 and the requirements of the NHS Foundation Trust Code of Corporate Governance published by Monitor.

The Board of Directors Nomination and Remuneration Committee works closely with the Council of Governors Appointments Committee to review the balance and appropriateness of its members' skills and competencies.

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. We have complied with this requirement since May 2015 both upon appointment and with annual re-checks.

Non-executive directors can only be removed by a 75 per cent vote of the Council of Governors following a formal investigatory process, and the taking of independent legal advice, in accordance with guidance issued by our regulators.

We are confident that our Board members do not have any interests or company directorships which could conflict with their management responsibilities. A Register of Directors' Interests is held by the Board Secretary and is available for inspection on request.

As an NHS foundation trust, no political or charitable donations have been made during 2017/18. During the year, we were not charged interest under the Late Payment of Commercial Debts (Interest) Act 1998.

As far as the directors are aware, there is no relevant audit information of which the auditor is unaware. The directors have taken all of the necessary steps to make themselves aware of any relevant audit information, through the delegated authority of the Audit committee they ensure that the auditor is aware of that information.

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that the income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. We confirm that we have met this requirement and that the income received in 2017/18 had no impact on our provision of goods and services for the purposes of the health service in England.

The Board of Directors is responsible for ensuring that we have effective governance arrangements supporting the delivery of our quality priorities. Regular reports on the Trust' progress against the established quality priorities are taken to both the Board and the Council of Governors by the chief nurse.

We have developed ward quality dashboards to support a local focus on the Trust quality metric, including the established quality priorities. These dashboards also ensure patients in each area can see at glance the quality performance of that ward. There is a plan to develop these dashboards to other non-ward clinical areas across 2018/19.

Performance against key quality priorities and such as arrangements for monitoring improvement in the quality of care and progress towards all quality standards can be found in the quality account, see page 3.

You can find more detail of how the Board of Directors has assessed itself against the well led framework through the Annual Governance Statement, see page 55.

Directors in post during the financial year

Diane Wake
Chief Executive

Paul Taylor
Director of Finance & Information (until December 2017)

Chris Walker
Acting Director of Finance & Information (during January 2018)

Tom Jackson
Director of Finance & Information (from February 2018)

Paul Bytheway
Chief Operating Officer (until September 2017)

Michael Woods
Chief Operating Officer (from October 2017 until January 2018)

Glen Palethorpe*
Director of Governance (Board Secretary)

Andrew McMenemy*
Director of HR

Jonathan Fellows
Non-executive Director (Deputy Chairman, Senior Independent Director)

Ann Becke
Non-executive Director

Dr Doug Wulff
Non-executive Director

Dr Mark Hopkin*
Associate Non-executive Director

Karen Kelly
Chief Operating Officer

Dr Paul Harrison
Medical Director/Acting Chief Executive (until October 2017)

Dr Matthew Banks
Acting Medical Director (until April 2017)

Dr Julian Hobbs
Acting Medical Director (from October 2017)

Dawn Wardell**
Chief Nurse (until May 2017)

Siobhan Jordan
Chief Nurse (from April 2018)

Anne Baines*
Director of Strategy & Performance (until June 2017)

Natalie Younes*
Director of Strategy & Business Development (from September 2017)

Mark Stanton*
Chief Information Officer

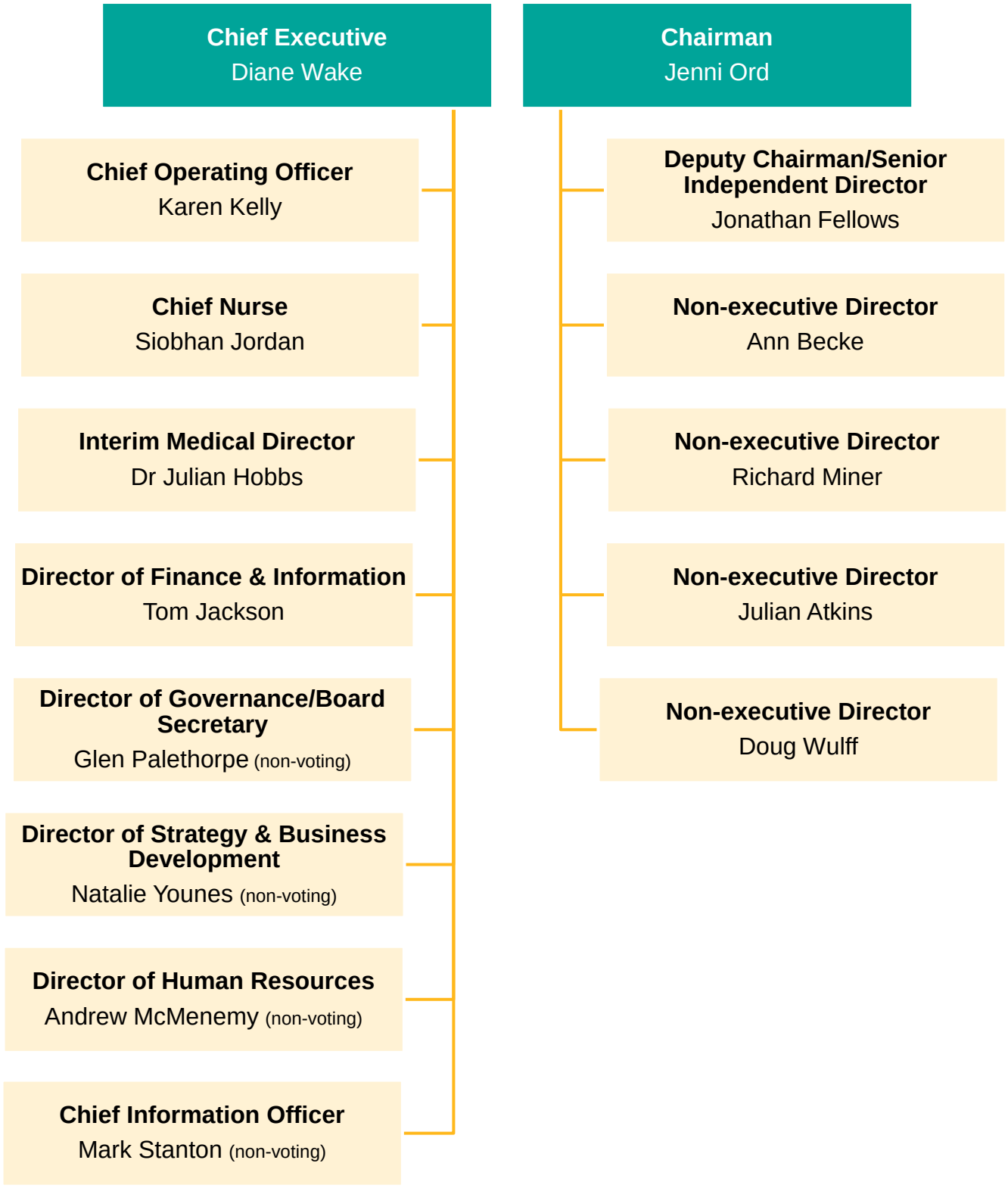
Jenni Ord
Chairman

Julian Atkins
Non-executive Director

Richard Miner
Non-executive Director

**Glen Palethorpe, Andrew McMenemy, Mark Stanton, Natalie Younes, Anne Baines and Mark Hopkin were non-voting directors and; therefore, their attendance is not listed on the attendance table on page 22. ** Dawn Wardell was seconded to NHSE from 31/03/17*

Board of Directors Structure as at 31st March 2018



Jenni Ord

Chairman

Jenni was previously the chairman of Health Education West Midlands, the regional body responsible for training investment in the NHS workforce. Her early career was in education but she went onto become a senior civil servant taking up varied director roles at The Highways Agency in Organisational Development, IT Service Management and Asset Performance and Research. Prior to that she was regional director for The Pensions Service and The Benefits Agency.

As a non-executive, she has chaired other NHS organisations including Solihull Care Trust, an integrated health and adult social care organisation, and Birmingham and Solihull PCT Cluster. Other roles have included vice chair of Birmingham Metropolitan College, which locally incorporates Stourbridge College, and work associated with the West Midlands Heritage Lottery Fund and Midland Heart Housing Association.

Jenni is passionate about developing great NHS leadership, support for staff and high quality services.

Ann Becke

Non-executive Director

Ann is the lead for safeguarding, both within the Trust and the wider health economy, and represents the Trust on the Dudley Children and Young People's Alliance. She is a member of Dudley Clinical Education Centre's Charity and takes a keen interest in the patient environment through the Arts and Environment Group. She is also the non-executive lead for complaints and chairs the IT steering group.

A graduate in World Class Service Management from Leeds University, she is a trained coach and mentor. Ann brings to the Board significant experience in the delivery of inspirational leadership, customer satisfaction and diversity.

Ann is chair of the Local Link of the charity Chernobyl Children's Lifeline and is actively involved in both the local and business community raising awareness and significant funding.

Jonathan Fellows

Non-executive Director (Deputy Chairman, Senior Independent Director)

Jonathan joined the Dudley Group as a non-executive director in October 2007, ahead of the Trust being awarded foundation trust status the following year. He is an experienced business professional, with a track record of achievement in executive and non-executive director roles in publicly listed and private companies, as well as in the NHS.

Jonathan is a Fellow of the Chartered Association of Certified Accountants and also a Fellow of the Association of Corporate Treasurers. Jonathan chairs the Trust Finance & Performance Committee, is a member of the Trust Audit Committee and is also the chair of the Black Country Pathology Service Oversight Group.

Julian Atkins

Non-executive Director

Julian joined the Trust in January 2016 as a non-executive director. He has experience in both the public and private sectors, having worked at organisations such as Alliance & Leicester, Marks & Spencer, Solihull Health Authority and the Thomas Cook Group. Prior to joining the Trust, he was part of the Executive Leadership Team and Head of Human Resources at Coventry Building Society where he worked for nearly 25 years.

Julian is a Fellow of the Institute of Financial Services and the Chartered Institute of Personnel and Development. He is a member of the board at Coventry and Warwickshire Chamber of Commerce's subsidiary training company and is also a past president of Coventry and Warwickshire Institute of Financial Services.

Julian chairs the Charitable Funds and Workforce & Staff Engagement Committees, and is a member of the Finance & Performance and Clinical Quality, Safety & Patient Experience committees. Julian is passionate about delivering excellent customer service through skilled individuals and effective teams.

Richard Miner

Non-executive Director

Richard is a chartered accountant by background and chairs the Audit Committee. Having joined the Trust in 2010, he is also a member of the Finance and Performance Committee, the Digital Trust Committee and sits on the Board of Dudley Clinical Services Limited.

A former partner in national accounting firm PKF (now part of BDO), he was also group finance director at LPC Group plc, at one time the largest independent tissue manufacturer in the UK. Richard first became involved with the NHS in 2006 as a non-executive director of Birmingham East and North PCT where he chaired the Audit Committee and World Class Commissioning working group.

He is currently a director of Enterprise FD Limited, a provider of flexible and interim finance directors to entrepreneurial and ambitious organisations. This also includes his role as finance director with Open Study College, one of the leading providers of distance learning materials.

Dr Doug Wulff

Non-executive Director

Doug is a general practitioner by profession and has worked in healthcare both in the UK and South Africa. He joined The Dudley Group after retiring from Staffordshire and Stoke on Trent Partnership NHS Trust where he was medical director.

Doug joined the Trust in February 2015 and sits on the Workforce and Staff Engagement Committee, Charitable Funds Committee and chairs the Clinical Quality, Safety and Patient Experience Committee.

A medical graduate of the University of the Witwatersrand, Johannesburg, South Africa, Doug also holds a post-graduate Diploma in Medical Administration and a Master's in Business Administration, both from the University of Pretoria. He worked in general practice and health management in South Africa until moving to the UK where he has since been a GP partner, senior clinical tutor and a member of a number of regional and national NHS committees and boards.

Mark Hopkin

Associate Non-executive Director

Mark is a general practitioner of 25 years and is a partner of Moss Grove Surgery in Kingswinford. Mark is passionate about respiratory medicine and is the clinical lead for Dudley Clinical Commissioning Group. He joined the Board in this new role of associate non-executive director in February 2017 and brings a wealth of primary care knowledge to the Board.

Quality of patient care is a clear priority for Mark and he has been fundamental in the review of respiratory pathways across Dudley and his work has shaped the respiratory work for the Multi-specialty Community Provider. His expertise is invaluable and provides another clinical expert at the Board.

Diane Wake

Chief Executive

A Registered nurse by background, Diane joined The Dudley Group NHS Foundation Trust in April 2017, from Barnsley Hospital NHS Foundation Trust where she was chief executive since 2013.

She has extensive experience in both clinical and leadership roles. Previously, she was interim CEO at Royal Liverpool and Broadgreen University Hospital NHS Trust, where she also worked as chief operating officer, director of infection prevention and executive nurse from 2007 to 2013.

Diane trained as nurse between 1984-1987 and has a comprehensive background in nursing occupying senior nurse leadership positions in surgical specialities of urology, colorectal, vascular and breast. Diane soon became a general manager, before joining Mid Yorkshire Hospitals NHS Trust as deputy director of nursing and operations and then onto Liverpool before her appointment as CEO of Barnsley Hospital NHS Foundation Trust.

Diane is chair of the Northern Burn care network. She has a passion for patient safety and high quality care and has knowledge and expertise in implementing robust governance processes. Diane lives in Shropshire.

Tom Jackson

Director of Finance

Tom joined the Trust from NHS Liverpool Clinical Commissioning Group and brought with him more than 25 years' experience in NHS finance. A Fellow of the Chartered Institute of Public Finance, Tom has fulfilled a number of financial leadership and transformation roles in the NHS. He has worked in most core NHS finance roles and has spent the last eight years at director level. In his previous role as chief finance officer, he provided strategic advice on financial management and played an active role to implementing the corporate strategy. Motivated by adding value, transformation and system working, Tom is excited about being able to support the Trust to improve services for the people of Dudley.

Siobhan Jordan

Chief Nurse

Siobhan has a wealth of senior nurse leader experience from a career spanning almost 30 years. Her NHS career has provided her with the opportunity to work in most healthcare settings, including primary care, commissioning and with the ambulance service. Most of her experience, however, has been within the acute environment where she has held three director of nursing and midwifery positions.

After completing her nurse training in 1991, Siobhan began her nursing career as a staff nurse in Accident and Emergency at The Princess Alexandra Hospital NHS Trust. Quickly moving up the ranks, Siobhan held her first chief nurse positon at Mid Essex Hospitals NHS Trust and then moved from Essex to Suffolk to take up post as director of nursing and quality for The Ipswich Hospital NHS Trust in 2010.

Siobhan embraced the opportunity to work with and learn from the Regulators, The Care Quality Commission, holding the position of head of hospital inspection, London in 2013.

Siobhan joined the Trust in 2017 as our interim chief nurse and was then appointed as our chief nurse in October 2017 she is a passionate leader and advocates for outstanding patient care, recognising that our staff are key to achieving this.

Karen Kelly

Chief Operating Officer

Karen joined us in January 2018 from Barnsley Hospital NHS Foundation Trust where she held the post of director of operations. A graduate of Keele University, Karen qualified as a nurse in 1993 and worked for more than 20 years at the University Hospital of North Staffordshire. She became part of the Transformation Team tasked with turning around Mid Staffordshire NHS Foundation Trust – becoming head of nursing there in 2010.

Following this, she held the post of medical nurse director, followed by deputy director of operations at The Royal Liverpool and Broadgreen University Hospital Trust. Karen is passionate about quality of care being delivered that ensures our patients are safe.

Dr Julian Hobbs

Interim Medical Director

Julian joined the Trust from Royal Liverpool where he has been deputy medical director and has been since 2013. Julian is also a deputy medical director and leads on mortality for Cheshire and Merseyside area team at NHS England.

Julian is a consultant cardiologist by background and has worked at Liverpool Heart and Chest Hospital alongside his current roles. Julian has had extensive experience in medical management roles for several years. He grew up in the Midlands area and is looking forward to returning, and hopes to fit in some running and cycling in Cannock Chase.

Julian said, “I am looking forward to being part of a Trust that is so well known for delivering safe and effective care and I am keen to get out and meet as many staff as possible. I am looking forward to being part of the new Electronic Patient Record project which will make systems more efficient and release more time for patient care.”

Glen Palethorpe

Director of Governance (Board Secretary)

Glen is a member of the Institute of Company Secretaries and Administrators (ICSA) and also a qualified accountant. Glen is a member of the Healthcare Finance and Management Association and is a member of the governance technical group which supports the production of various guides including the NHS Audit Committee handbook.

Glen's experience in governance, risk management, internal control and assurance was gained during his time working at KPMG, Baker Tilly, Bentley Jennison and RSM Tenon. During his career, Glen has offered insights to a number of boards on their effectiveness and the effectiveness of their reporting committees and groups.

Glen's role at the Trust is that of trust board secretary and director of governance, which sees him supporting the chair, chief executive, Board of Directors and the Council of Governors in all aspects of governance and regulatory compliance. Glen is also responsible for the corporate governance team which supports divisional and Board risk management, incidents and claims processes, along with oversight of the Trust's clinical audit team.

Natalie Younes

Director of Strategy & Performance

Natalie joined us from Lincolnshire and District Medical Services (LADMS) where she held a joint role of commercial director with the GP Federation and Mental Health Trust since 2011.

She originally started her career in Law and was called to the bar where she worked within social welfare, housing benefits, debt, employment and family law. This led onto working with the local authority focusing on deprivation and stimulating enterprise. Natalie then entered the NHS in 2010 primarily working on tendering and encouraging collaboration across providers.

Natalie said, "I am very excited to join the Trust and have the opportunity to drive business and service improvement and prepare for the NHS challenges of the future."

Mark Stanton

Chief Information Officer

Mark joined the Trust in 2014 after spending seven years as an executive director at a private healthcare organisation supplying diagnostic services to the NHS. Mark has held a number of senior IT positions internationally in large organisations including Siemens, BUPA and General Motors. During his career, Mark has been involved in large scale transformational change both within IT infrastructure and patient systems.

Mark is focused on the Digital Trust programme which includes delivering a new Electronic Patient Record (EPR) and a health economy-wide shared record system

Having brought IT services in-house in 2015, Mark is also responsible for developing the infrastructure and IT services to meet the needs of the Trust including delivering services that can be accessed directly by patients including Free WiFi and electronic patient letters.

The IT team has a commercial IT function that generates revenue for re-investment in the Trust; Mark is responsible for managing this function and growing the revenue stream.

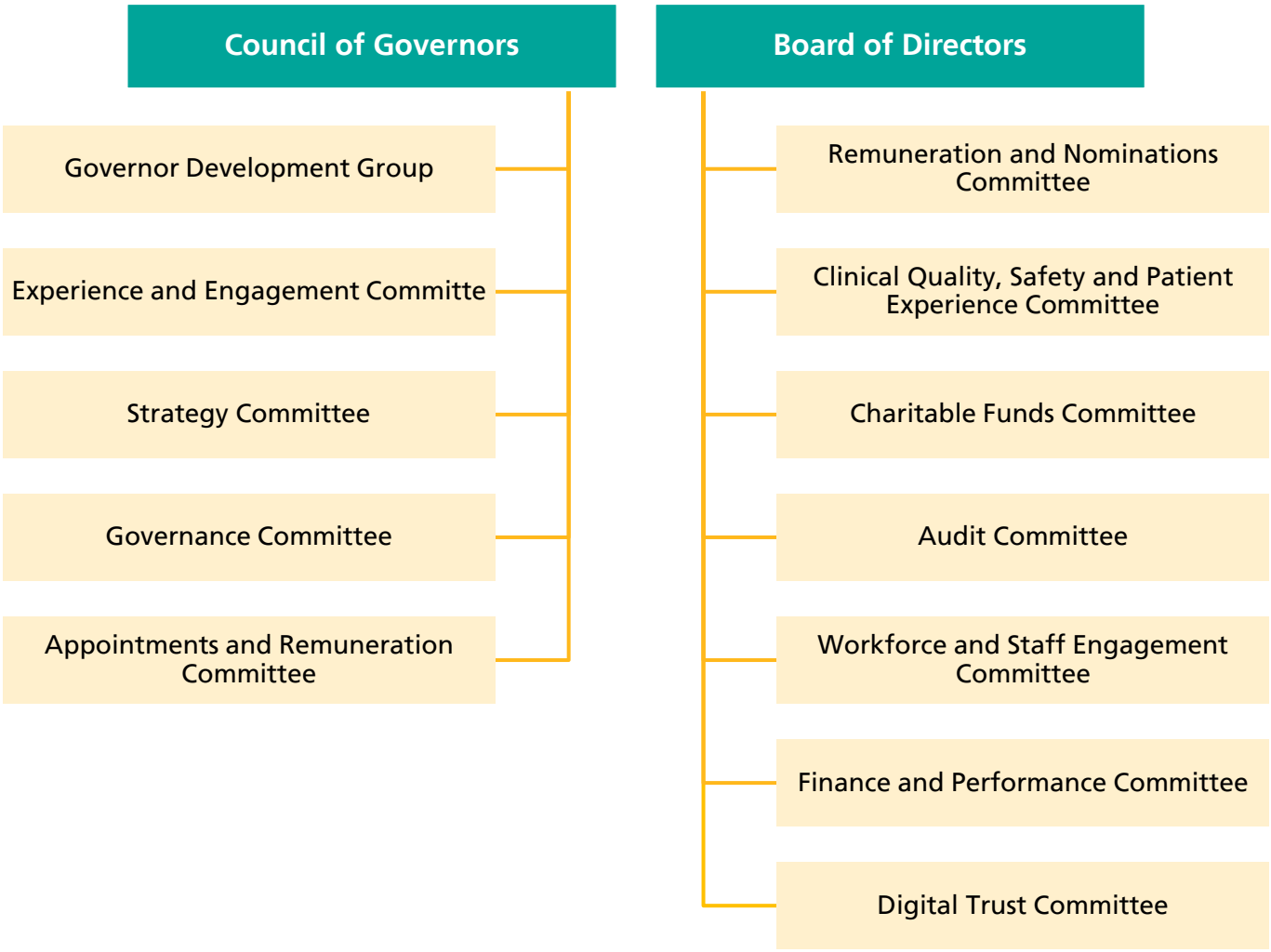
Andrew McMenemy

Director of Human Resources

Andrew has worked in the NHS for more than 20 years and has held two board-level positions in the West Midlands. He joined the Trust from Heart of England NHS Foundation Trust where he was deputy director of workforce.

He graduated from university in Glasgow with a degree in Law and also studied labour management relations in the United States. Andrew is a member of the Chartered Institute of Personnel and Development and is also a recent graduate of the NHS Nye Bevan programme for senior leaders.

Board of Directors committee structure



Board of Directors attendance

The Board of Directors meets monthly in public and carries out its business in accordance with an agreed agenda setting process and an annual cycle of business.

All voting directors, both executive and non-executive, have joint responsibility for every decision made during Board meetings.

The Board of Directors met 12 times during 2017/18:

Attendance at Board of Directors meetings 2017/18		Attendance
Diane Wake	Chief Executive	10/11
Paul Taylor	Director of Finance and Information	7/9
Paul Harrison	Medical Director	6/6
Paul Bytheway	Chief Operating Officer	4/6
Glen Palethorpe	Director of Governance	11/12
Matt Banks	Acting Medical Director	1/1
Anne Baines		2/2
Tom Jackson	Director of Finance and Information	4/4
Julian Hobbs		6/6
Siobhan Jordan		9/10
Karen Kelly	Chief Operating Officer	3/3
Natalie Younes		5/6
Mark Stanton		12/12
Andrew McMenemy		10/12
Chris Walker	Acting Director of Finance	1/1
Jenni Ord	Chairman	12/12
Mark Hopkin	Associate Non-Executive Director	10/11
Doug Wulff	Non-executive Director	11/12
Julian Atkins	Non-executive Director	12/12
Richard Miner	Non-executive Director	12/12
Jonathan Fellows	Non-executive Director	9/12
Ann Becke	Non-executive Director	9/12

Partnership working

Sustainability and transformation

The NHS and local councils are developing and implementing shared proposals to improve health and care in every part of England. Over the next few years, these represent the biggest national move to join up care in any major western country. The Black Country and West Birmingham Sustainability and Transformation Plan covers a population of 1.4 million and has several key priorities:-

- Maternal and infant health – reduce current high levels of infant mortality to bring them in line with the national average.
- GP and community services – invest an extra £25m in GP services by 2021.
- Hospital services – the new Midland Metropolitan Hospital will treat over 570,000 people when it opens and will be one of a network of hospitals serving the Black Country and offering the right care in the right place at the right time.
- NHS 111 – ringing one telephone number, the people of the Black Country will be able to book a doctor's appointment, in evenings and at weekends, get dental advice, order a repeat prescription, or get urgent advice.
- Mental health services – changes to how health and care services work together will mean those suffering early psychosis will get access to therapy within two weeks.
- Tackling deprivation – co-operate across all STP partners to tackle deprivation and other wider determinants of health such as low educational achievement, inadequate housing and unemployment
- Workforce – build a stronger, more resilient health and care workforce that is able to take advantage of expanded career opportunities across the STP footprint.

We will continue to take an active part in the STP to help us find the best solutions on a bigger scale for all the people of the Black Country.

Prior to the STP, The Dudley Group was part of the Black Country Alliance (BCA) a partnership between ourselves, Sandwell and West Birmingham Hospitals NHS Trust and Walsall Healthcare NHS Trust looking for ways to collaborate and improve hospital based services across the Black Country. The Trust benefitted from several initiatives through the BCA including the delivery of a seven day Interventional Radiology service across the region. The alliance came to an end in 2017 with the advent of the STP which will be delivering similar aims on a much larger scale.

Black Country Pathology Service

In early 2017, four trusts (ourselves, The Royal Wolverhampton NHS Trust, Sandwell and West Birmingham NHS Trust and Walsall Healthcare NHS Trust) formed a partnership to develop a single Black Country Pathology service. The service will see the creation of a hub at New Cross Hospital, Wolverhampton, with essential service laboratories at each of the other three trusts. The hub provision will require an extension to the existing facility at New Cross to accommodate the additional testing volumes and is expected to be open by June 2019.

The new system will bring together clinical expertise across the Black Country with the aims of achieving a sustainable, high quality care for patients. Among the ambitions for the service are to create a seven days services for all pathology disciplines which should lead to improved turnaround times.

Multi-specialty Community Provider (MCP)

The work to transform the way care out of hospital is provided in Dudley continues and we have worked with our partners, the GPs and Birmingham Community Healthcare, towards a final bid submission in May 2018. Given the fact that the merger of the three providers of Birmingham Community, Black Country Partnership and Dudley and Walsall Healthcare is no longer going ahead, the MCP is now looking to ensure that transaction partners have a more active role in the process.

Throughout the year, we have been working with colleagues in primary care on enacting changes in the short term including the active participation as part of the locality integrated community teams. This work sees our community staff collaborating with primary care and mental health colleagues for the benefit of patients.

Wyre Forest

We have continued to work in partnership with colleagues in the Wyre forest and have set up community ENT, gynaecology and general surgery clinics at Hume Street Medical Centre in Kidderminster. These clinics provide consultant-delivered care, locally for the people of

Kidderminster, and include access to clinical nurse specialist and audiology input, as necessary. The services have been set up in collaboration with Wyre Forest CCG.

Better Payment Code of Practice

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

	2017/18		2016/17	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	56,232	206,884	62,517	195,769
Total non-NHS trade invoices paid within target	54,349	203,852	60,742	193,278
Percentage of non-NHS trade invoices paid within target	97%	99%	97%	99%

The Trust can confirm that it has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance. This guidance discusses how public sector organisations should charge for information.

Audit Committee

The Audit Committee is a sub-committee of the Board of Directors. The committee provides the Board with an objective view of the effectiveness of internal control systems in operation within the Trust. It receives regular reports from the Trust's internal and external auditors. The committee also ensures that statutory obligations, legal requirements and codes of conduct are followed. During the financial year, the Audit Committee reviewed the Trust's accounting policies. This included a number of minor changes in 2017/18 relating to consolidation, provisions and accounting policies that have yet to be adopted. The Audit Committee considered reports relating to these changes and approved the proposed changes for the 2017/18 financial year.

The Audit Committee has discussed the key areas of focus as communicated by our external auditors in relation to risk of fraud in revenue and expenditure recognition and valuation of property, plant and equipment in relation to the financial statements. We consider we have received appropriate sources of assurance in relation to these matters.

The members were non-executive directors Richard Miner (committee chair), Jonathan Fellows and Ann Becke. The chief executive is only required to attend one meeting per year and the following also attended the meeting: Director of Finance and Information Paul Taylor, Acting Director of Finance Chris Walker, Director of Finance Tom Jackson, Director of Governance/Board Secretary Glen Palethorpe and the Trust's auditors also attend all meetings.

The Audit Committee met five times during the year:

Audit Committee membership		Attendance
Richard Miner	Non-executive Director (committee chair)	5/5
Jonathan Fellows	Non-executive Director	4/5
Ann Becke	Non-executive Director	4/5
In attendance		
Tom Jackson	Director of Finance	0/2
Glen Palethorpe	Director of Governance	5/5
Paul Taylor	Director of Finance and Information	1/3
Chris Walker	Deputy/Acting Director of Finance	5/5

The Trust has a policy in place for the approval of additional services by the external auditor to ensure that the independence of the external auditor is not compromised where work outside the audit code has been purchased.

Details of the value of both audit and non-audit services provided by Pricewaterhouse Coopers can be found on page 24 of the accounts.

Remuneration Report

Annual statement on remuneration

(Information not subject to audit)

The committee operates to review and evaluate the Board structure and expertise, as well as to agree a job description and person specification for the appointments of the chief executive and executive directors. The committee also identifies and nominates suitable candidates for such vacancies and recommends its proposed appointment for chief executive to the Council of Governors. Interview panels for executive director appointments are usually made up of existing directors, governors and external stakeholders. The committee determines the appropriate levels of remuneration for the executive directors. Remuneration levels are normally determined by reference to such factors as those applying in equivalent organisations in the NHS, changes in responsibility, performance, salary increases agreed for other NHS staff and guidance issued by the Secretary of State.

During the year, the Nomination and Remuneration committee approved the departure and replacement of the chief executive, approved the temporary acting up arrangements of the medical director to interim chief executive and approved the appointment of the substantive chief executive. The committee also received performance appraisal information for each of the executive directors and undertook an annual review to ensure the board continues to apply with the fit and proper person requirement.

For the purpose of the Annual Report and Accounts, the chief executive has agreed the definition of a "senior manager" to be voting executive and non-executive directors only.

Senior manager remuneration policy

(Information not subject to audit)

Remuneration for executive directors does not include any performance-related elements and there are no plans for this in the future. No significant financial awards or compensation have been made to past senior managers during the reporting period. There is no provision for the recovery of sums paid to directors or for withholding payments of sums to senior managers. Senior managers' service contracts do not include obligations on the Trust which could give rise to or impact on remuneration payments for loss of office.

Senior managers' individual service contracts mirror national terms and conditions of employment and include notice periods and any termination arrangements. In the event of a contract being terminated, the payment for loss of office will be determined by the Nomination and Remuneration Committee. Payment will be based on contractual obligations. Payment for loss of office will not be made in cases where the dismissal was for one of the five 'fair' reasons for dismissal.

In setting the remuneration policy for senior managers, consideration was given to the pay and conditions of employees on Agenda for Change. The Trust uses benchmarking data to ensure all salaries, including those over £142,500, are reasonable and provide value for money. In line with national pay award guidance, executive and non-executive directors received no more than a maximum salary increase of 1 per cent in 2017/18.

The Trust has not consulted with employees when determining the senior managers' remuneration.

Jenni Ord, Remuneration and Nomination Committee Chair.

Salary and Pension entitlements of Senior Managers

2017/18

A) Remuneration (Information subject to audit)

Name and Title	Note	2017-18						2016-17					
		Salary (bands of £5,000)	*Expense payments (taxable) (to the nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	# All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)	Salary (bands of £5,000)	*Expense payments (taxable) (to the nearest £100)	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	#All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
		£000	£	£000	£000	£000	£000	£000	£	£000	£000	£000	£000
Paula Clark, Chief Executive	A							90 - 95					90 - 95
Diane Wake, Chief Executive	B	180 - 185				1407.5 - 1410	1590 - 1595						0
Paul Harrison, Acting Chief Executive	C	90 - 95					90 - 95	180 - 185				67.5 - 70	250 - 255
Paul Taylor , Director of Finance & Information	F	100 - 105					100 - 105	135 - 140					135 - 140
Chris Walker, Acting Director of Finance	G	10 - 15				5 - 7.5	15 - 20						0
Tom Jackson, Director of Finance	H	25 - 30				17.5 - 20	40 - 45						0
Matthew Banks, Acting Medical Director	D	0 - 5					0 - 5	90 - 95				82.50 - 85	175 - 180
Julian Hobbs, Interim Medical Director	E	90 - 95											0
Paul Bytheway, Chief Operating Officer	I	80 - 85				52.5 - 55	140 - 145	115 - 120				2.5 - 5	120 - 125
Michael Woods, Interim Chief Operating Officer	J	35 - 40				250 - 252.5	285 - 290						0
Karen Kelly, Chief Operating Officer	K	30 - 35				7.5 - 10	40 - 45						0
Dawn Wardell, Chief Nurse	L						0	110 - 115				60 - 62.5	170 - 175
Siobhan Jordan, Chief Nurse	M	125 - 130				172.5 - 175	300 - 305						0
Jenni Ord, Chairman	N	45 - 50	1,600				45 - 50	45 - 50	2,100				50 - 55
Julian Atkins, Non Exec	O	10 - 15	300				10 - 15	10 - 15	800				10 - 15
Ann Becke, Non Exec		10 - 15	100				10 - 15	10 - 15	100				10 - 15
Jonathan Fellows, Non Exec		15 - 20					15 - 20	15 - 20					15 - 20
Richard Miner, Non Exec		15 - 20	600				15 - 20	15 - 20	800				15 - 20
Douglas Wulff, Non Exec		10 - 15	100				10 - 15	10 - 15	300				10 - 15
Aggregate Total		970 - 975	2,800	0	0	1920 - 1922.5	2835 - 2840	850 - 855	4,100	0	0	217.5 - 220	1,075 - 1,080

* Expense Payments relate to home to base travel reimbursement for non-executive directors

The all pensions related benefits disclosed arise from membership of the NHS Pensions defined benefit scheme. They are not remuneration paid (non-cash), but the increase in pension benefit net of inflation for the current year. Contributions are made by both the employer and the employee from their salary in accordance with the rules of the scheme which applies to all NHS staff in the scheme.

A Paula Clark left 31 October 2016
B Diane Wake started 3 April 2017
C Paul Harrison became acting chief executive 3 October 2016, resumed as medical director 3 April 2017 and stood down as medical director 2 October 2017. The banded remuneration of 55 - 60 (2016/17 110 - 115) relating to the clinical role is now included within the salary figure. .

D Matthew Banks became acting medical director 3 October 2016 and stood down 3 April 2017. The banded remuneration of 0 - 5 (2016/17 75 - 80) relating to the clinical role is now included within the salary figure.
E Julian Hobbs started 2 October 2017. .
F Paul Taylor left 31 December 2017.
G Chris Walker became acting director of finance 1 January 2018 until 31 January 2018.

H Tom Jackson started 1 February 2018
I Paul Bytheway started 1 May 2015 and left 24 September 2017.
J Michael Woods became chief operating officer 2 October 2017 and left 9 January
K Karen Kelly started 2 January 2018
L Dawn Wardell left 31 March 2017.
M Siobhan Jordan started 10 April 2017
N Jenni Ord started 1 January 2016
O Julian Atkins started 1 January 2016

The Trust is required to disclose the relationship between the remuneration of the highest paid Director and the median remuneration of the other Trust employees.
The banded remuneration of the highest paid Director of the Trust for 2017/18 is £185,000 - £190,000 (2016/17 £230,000 - £235,000). This was 7.1 times (2016/17 8.9 times) the median remuneration of the workforce, which was £25,000 - £30,000 (2016/17 £25,000 - £30,000).

In 2017/18, there were no (2016/17 nil) employees who received remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

B) Pension Benefits (Information subject to audit)

Name and Title	Note	Real increase in pension at age 60 (bands of £2,500)	Real increase in lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real Increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
		£000	£000	£000	£000	£000	£000	£000	£000
Diane Wake, Chief Executive	1	60 - 62.5	182.5 - 185	60 - 65	180 - 185	0	1,167	1,167	
Paul Harrison, Acting Chief Executive	2	0	0	60 - 65	190 - 195	1,252	(55)	1,197	
Paul Taylor , Director of Finance & Information	3							0	
Chris Walker, Acting Director of Finance	1	0 - 2.5	0 - 2.5	25 - 30	80 - 85	398	3	401	
Tom Jackson, Director of Finance	1	0 - 2.5	0 - 2.5	45 - 50	125 - 130	710	17	727	
Matthew Banks, Acting Medical Director	1	0	0	40 - 45	120 - 125	750	7	757	
Julian Hobbs, Interim Medical Director	1	2.5 - 5.0	5 - 7.5	45 - 50	125 - 130	779	67	846	
Paul Bytheway, Chief Operating Officer	1	2.5 - 5.0	0 - 2.5	25 - 30	70 - 75	347	47	394	
Michael Woods, Interim Chief Operating Officer	1	10 - 12.5	30 - 32.5	10 - 15	30- 35	0	176	176	
Karen Kelly, Chief Operating Officer	1	0 - 2.5	0 - 2.5	40 - 45	125 - 130	829	22	851	
Siobhan Jordan, Chief Nurse	1	7.5 - 10	17.5 - 20	30 - 35	80 - 85	360	136	496	

Note:-

1 Figures shown reflect time in office during the year.

2 Figures shown reflect time in office during the year and include accrued benefits and contributions in respect of full salary, which will include both management and medical contributions.

3 No pension benefits are received.

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 200/05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

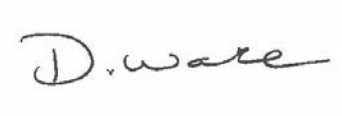
On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension Scheme are based on the previous discount rate and have not been recalculated.

The Trust is required to disclose the expenses paid to directors, non-executive directors and governors.

The band of the expenses paid for 2017/18 was £10,000 - £12,500 (2016/17 £12,500 - £15,000)

Signed Date: 22nd May 2018



Diane Wake
Chief Executive

Annual report on remuneration (Information not subject to audit)

Senior managers' service contracts

Name	Position	Commencing	End
Paul Harrison	Acting Chief Executive	03/10/16	02/04/17
Diane Wake	Chief Executive	03/04/17	
Paul Taylor	Director of Finance and Information	01/10/14	31/12/17
Chris Walker	Acting Director of Finance and Information	01/01/18	31/01/18
Tom Jackson	Director of Finance	01/02/18	
Paul Bytheway	Chief Operating Officer	01/05/15	24/09/17
Michael Woods	Chief Operating Officer	02/10/17	09/01/18
Karen Kelly	Chief Operating Officer	02/01/18	
Dr Paul Harrison	Medical Director/Acting Chief Executive	01/06/06	02/10/17
Dr Matthew Banks	Acting Medical Director	03/10/16	30/04/17
Dr Julian Hobbs	Acting Medical Director	02/10/17	
Dawn Wardell	Chief Nurse	01/06/15	25/05/18**
Siobhan Jordan	Chief Nurse	10/04/17	
Jenni Ord	Chairman	01/01/16	31/12/18
Jonathan Fellows	Non-executive Director/Deputy Chairman and Senior Independent Director	25/10/2007	30/10/18
Anne Becke	Non-executive Director	01/11/2005	30/10/18
Doug Wulff	Non-executive Director	01/02/2015	31/01/21
Julian Atkins	Non-executive Director	04/01/2016	03/01/19
Richard Miner	Non-executive Director	01/05/2012	30/09/19

*** Dawn Wardell was seconded to NHSE from 31/03/17*

Nomination and Remuneration Committee

The Nomination and Remuneration Committee is a sub-committee of the Board and holds at least one scheduled meeting per year. Ad-hoc meetings are then called by the Trust Chairman as a result of a request of at least two members of the Committee.

The committee members and their attendance during 2017/18 at meetings are as follows:

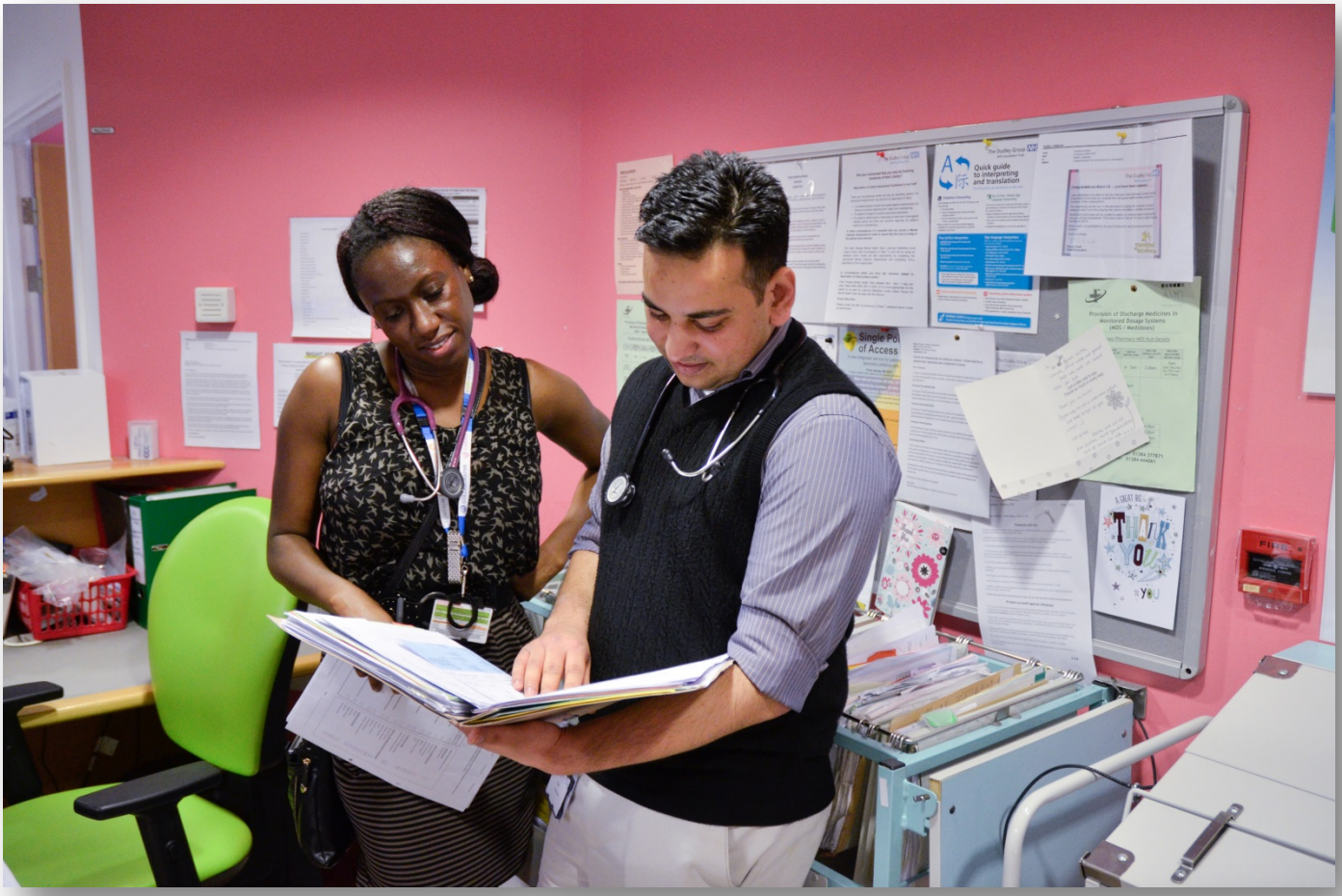
Name	Position	Commencing
Jenni Ord	Chairman (Committee Chair)	2/2
Jonathan Fellows	Non-executive Director	0/2
Ann Becke	Non-executive Director	2/2
Richard Miner	Non-executive Director	2/2
Doug Wulff	Non-executive Director	1/2
Julian Atkins	Non-executive Director	2/2

Executive directors also attend the Nomination and Remuneration Committee on occasion.

The terms and conditions for the executive directors and senior managers of the Trust are included in their individual contracts of employment which includes notice periods and any termination arrangements.

Governor and director expenses

During 2017/18, 17 individuals (2016/17 15) were executive or non-executive directors for the Trust. Of these, 11 (2016/17 9) received expenses in the reporting period and the aggregate sum of expenses paid was £11,518.77 (2016/17 £13,799.16). In addition, 25 individuals (2016/17 27) individuals were governors for the Trust. Of these, 2 (2016/18 5) received expenses in the reporting period and the aggregate sum of expenses paid was £174.56 (2016/17 £156.06).



Staff Report

Workforce overview

The Trust is a major employer in the Dudley borough, with 4,964 members of staff.

Staff in post at 31st March 2018

	Total	WTE*
Additional Professional Scientific and Technical	197	178.99
Additional Clinical Services	1132	960.69
Administrative and Clerical	995	871.63
Allied Health Professionals	367	307.85
Healthcare Scientists	125	111.79
Medical and Dental	503	479.68
Nursing & Midwifery Registered	1616	1432.01
Students	29	29.00
Total	**4,964**	**4,371.65**

* WTE is whole time equivalent

Equality and Diversity

During 2017/18, the Trust was a member of the NHS Employers Diversity Partners programme which provided support to further develop activities around equality and diversity. This, alongside the appointment of an equality coordinator, has supported progress on our equality delivery work.

The Trust reinstated the Diversity Management Group to provide further oversight and coordination of activities to improve access and experience for both patients and staff who are protected by at least one of the nine characteristics.

The Workforce and Staff Engagement Committee continued to monitor the Trust's activities in promoting equality and diversity and received a number of updates about our equality delivery work, which aims to support the Trust in agreeing key equality objectives and developing additional work to promote equality and diversity. This includes how we are meeting the duties outlined in the Equality Delivery System (EDS2) and Workforce Race Equality Standard (WRES). This includes gender pay reporting which, from April 2017, requires employers with 250 or more employees to publish statutory calculations each year showing the pay gap between male and female employees. You can read our report under About Us / Equality and Diversity on our website: www.dudleygroup.nhs.uk

During the year, the Board of Directors received a report on WRES, which included the Trust's employment statistics for 2016/17 against the equality and diversity characteristics. This is an annual process to ensure that the Trust is a providing fair opportunities for black and minority ethnic (BME) employees in relation to recruitment, training and development, and promotion. Access to training and the likelihood of BME staff being investigated were areas identified for action. The National NHS Leadership Academy 'Stepping Up' programme was accessed by nine Trust staff in 2018. This is a specific programme for BME staff in leadership roles. Work is underway to evaluate and provide further groups for the programme. Further work is underway to address other areas highlighted through this annual process.

Mandatory training, which includes a module on equality and diversity, was completed by more than 90 per cent of all Trust staff in 2017/18. All new employees also complete this mandatory module during their induction. For 2017/18, this now includes more information on autism and on supporting patients with disabilities.

We are subscribed to the 'Disability Confident' scheme which is a national standard that recognises that the Trust is positive about employing disabled people and have reviewed our recruitment practices. In order to progress through the levels in the scheme, the recruitment team will be developing a range of actions in 2018/19 which includes internships supporting applicants with disabilities, adapting recruitment processes to make it easier for people with disabilities to take part and providing guaranteed interviews for those with disabilities who meet the job criteria.

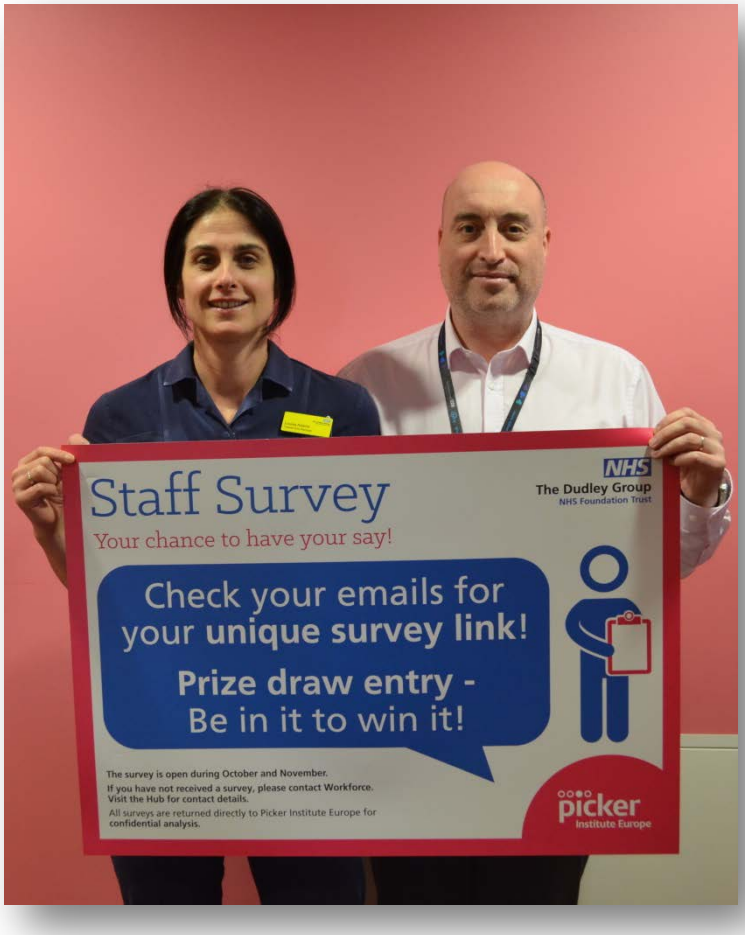
A range of other activities have been undertaken during 2017/18 to support people with characteristics protected by the Equality Act. For example, we have implemented and promoted the Accessible Information Standard to make sure we meet the needs of people with information and/or communication needs. This also includes the use of Recite-Me on the Trust website which enables the content to be adapted for a range of users. Braille language signs have been installed in toilets and a sensory garden has been created for children with disabilities.

Annually, we publish workforce data to support us in reviewing how well we are representing the local area and ensuring we promote employment and development opportunities to all.

	% of all applications received	% of all applicants shortlisted	% of applicants appointed
Disabled	4.50%	4.10%	3.90%
Non-disabled	93.90%	94.40%	94.80%
Undisclosed	1.60%	1.50%	1.30%

At 31st March 2018, the Board of Directors composed six non-executive directors and nine executive directors. Of the total, six were female and nine were male. Of the total number of staff employed by the Trust, 3,982 were female and 850 male.

The Sickness Absence Policy includes details on continuing the employment of, and making reasonable adjustments for, disabled individuals.



Detailed workforce statistics

NHS workforce statistics 2017/18

An analysis of the Trust's workforce statistics indicates they are comparable with the local Dudley population. Historically, the Trust has seen a higher proportion of female workers than males, and this is typically reflected across other combined acute and community NHS trusts.

		1st April 2017 to 31st March 2018	1st April 2016 to 31st March 2017	
Age	Under 18	0.12%	0.19%	
	18-19	0.62%	0.54%	
	20-24	7.01%	7.21%	
	25-29	12.39%	13.14%	
	30-34	13.54%	12.78%	
	35-39	11.50%	11.25%	
	40-44	11.20%	11.81%	
	45-49	13.60%	13.78%	
	50-54	14.26%	14.34%	
	55-59	9.95%	9.12%	
	60-64	4.23%	4.29%	
	65+	1.57%	1.55%	
Gende	Male	17.83%	17.57%	
	Female	82.17%	82.43%	
Ethnicity	White	68.29%	White	69.80%
	BME	16.10%	Mixed	1.12%
	Not stated	15.61%	Asian or Asian British	9.06%
			Black or Black British	3.48%
			Other	1.35%
			Not stated	15.17%

Average number of employees (WTE) (Information subject to audit)	2017/18			2016/17		
	Total number	Permanent number	Other number	Total number	Permanent number	Other number
Medical and dental	531	487	44	526	471	55
Ambulance staff	0	0	0	0	0	0
Administration and estates	876	852	24	852	808	44
Healthcare assistants and other support staff	1,371	1,286	85	1,340	1,177	163
Nursing, midwifery and health visiting staff	1,597	1,469	128	1,581	1,404	177
Nursing, midwifery and health visiting learners	33	33	0	34	34	0
Scientific, therapeutic and technical staff	308	285	23	303	276	27
Healthcare science staff	0	0	0	0	0	0
Social care staff	0	0	0	0	0	0
Agency and contract staff	0			0		
Bank staff	0			0		
Other	0	0	0	0	0	0
Total average numbers	4,716	4,412	304	4,636	4,170	466
Of which:						
Number of employees (WTE) engaged on capital projects	0	0	0	3	1	2

Staff costs (Information subject to audit)

	Year ended 31 March 2018			Year ended 31 March 2017		
	Total £'000	Permanent £'000	Other £'000	Total £'000	Permanent £'000	Other £'000
Salaries and wages	167,506	165,311	2,195	156,523	154,526	1,997
Social security costs	15,855	15,855	0	14,689	14,689	0
Apprenticeship levy	812	812	0	0	0	0
Employer's contributions to NHS Pensions	18,721	18,721	0	17,808	17,808	0
Pension Cost - other *	20	20	0	15	15	0
Termination Benefits	0	0	0	0	0	0
Temporary Staff (including agency)	11,708	0	11,708	14,088	0	14,088
NHS Charitable fund staff	44	44	0	44	44	0
Total	214,666	200,763	13,903		203,167	187,082

Staff Health and Wellbeing

Supporting our staff to be healthy at work is an important role undertaken. This year we have developed a range of activities to further support staff, alongside the core Health and Wellbeing Service which undertakes:

Pre-Employment checks – these make sure that our staff have the right immunisation to protect themselves and our patients and we are informed of any conditions we may need to support them with.

Support to staff who are unwell – this part of the service links with individuals, managers and the human resource team to provide support and advice to those who are unwell. They might be members of staff currently in work and who need specific advice and support or it may be for staff who are on short or long term sickness absence. This includes access to a consultant physician, referrals to other services and fast-tracking of appointments to support staff to stay in work or to return to work more quickly.

Mental Health Support – a range of support is in place for staff experiencing mental health issues which includes access to a counsellor at the Trust. During 2017/18, the Trust has begun a partnership with Remploy to offer a wider range of support to people experiencing mental health issues.

Physiotherapy Service for Staff – this dedicated service provides access to fast-track physiotherapy to support staff who have identified a musculoskeletal problem. It provides appointments and ongoing support for staff who have a MSK issue that requires ongoing support. A drop in service is also available to allow rapid access to staff for acute issues.

During 2017/18, the staff physiotherapy service continued to work well and both drop in services and appointments are well utilised. Further activities to support staff are in development including pain management and back care to support those with ongoing conditions.

The Staff Health and Wellbeing Group promotes additional activities and has developed a range of new schemes this year. This has included developing a staff choir, mindfulness sessions to enable staff time and space to relax and de-stress, promoting healthy workplaces through staff health fairs and developing a range of physical activity initiatives. In addition, they have developed a support group for staff diagnosed with cancer.

A fruit stall is in place at the entrance to the building promoting healthy eating and further initiatives have been undertaken to improve access to healthy food choices in the Trust premises. This includes increasing the health eating options by limiting snacks with high sugar, fat and salt content; removing promotions on unhealthy foods and snacks and removing foods and drinks high in sugar, salt or fat from till-points.

Access to physical activity has improved through extended opening hours at the Action Heart gym. A number of physical challenges were undertaken during the year including a Santa Cycle race and Easter Bunny Boat Race to promote being active and raise money for the Trust Charity. Work will be continuing during 2018/19 to develop more opportunities to support staff to become healthier including the move towards a smoke free Trust.

The annual flu vaccine campaign was delivered between October 2017 and February 2018 to all staff, with a particular focus on clinical staff. The Trust significantly improved its vaccine uptake performance by patient-facing staff – increasing from 49.8 pre cent in 2016 to 75.85 pre cent in 2017/18 and meeting the expected performance of 70 per cent for the year.

	Staff sickness rate
Quarter 1 (Apr-Jun 2017)	3.72%
Quarter 2 (Jul-Sep 2017)	4.19%
Quarter 3 (Oct-Dec 2017)	4.83%
Quarter 4 (Jan-Mar 2018)	4.83%
Total for 2016/17	4.40%

Figures Converted by Department of Health and Social Care to Best Estimates of Required Data Items			**Statistics Published by NHS Digital from Electronic Staff Record Data Warehouse**	
Average FTE 2017	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absense
4,273	40,906	9.6	1,559,526	66,359

Health and Safety

The Trust continues to provide a safe and secure environment for the provision of the highest standards of clinical care to patients. In order to do this, the Trust's Health and Safety Department consistently reviews its policies and procedures to ensure compliance with statutory duties.

The Health and Safety Department continued to be instrumental in overcoming health and safety issues throughout the year ensuring safe standards are in place for staff, patients, visitors and other persons attending the site.

During 2017/18, the Trust implemented a new hand hygiene process for all staff to work towards eliminating occupational dermatitis. This was a collaborative project with infection prevention and control, staff health and wellbeing and health and safety working together to ensure protective measures are in place for the teams whilst not affecting the clinical practices within the areas.

In 2018/19, the Health and Safety Department will continue to focus on health related issues arising from the work activities undertaken and the working environment. The health and safety team will continue to work closely with other teams within the Trust to ensure that measures are in place to reduce the risk factors.

Countering fraud and corruption

The Trust takes its responsibility towards countering fraud and corruption in the NHS very seriously. The Trust's Fraud and Corruption Policy lays down its absolute commitment to maintaining an honest, open and well-intended atmosphere within the Trust.

This commitment is the cornerstone of an anti-fraud culture, championing the deterrence and prevention of fraud and the rigorous investigation of any cases of fraud or corruption. Where fraud is proven, the Board will apply all available sanctions e.g. disciplinary/criminal action and use of the civil law to recover funds.

Trust Volunteer Service

More than 450 volunteers from the local community give their time on a regular basis to make a real difference to patients, visitors and staff at the Trust.

Individuals volunteer for a variety of reasons including: the satisfaction of knowing they are doing something for others, the chance to make new friends, to gain experience of a busy healthcare environment and to gain confidence and strengthen interpersonal skills.

Volunteers are asked to pledge a minimum of 100 hours per year. Our volunteers range in age from 16 to 81.

Some of the tasks volunteers undertake include:

- Nutrition and hydration support
- Wayfinding and escorting
- Reception enquiries
- Undertaking patient surveys
- Clerical support
- Assisting at events
- Music library
- Patient friends
- Outpatient hosts
- Emergency Department hosts
- Chaplaincy support
- Fundraising activities
- Library trolley
- Patient experience

The dedicated work of all the volunteers is highly valued by the Trust, and it is pleasing to know that volunteers also get satisfaction from their role. We are always keen to recruit new volunteers. Individuals can find further information and apply online via our website: www.dudleygroup.nhs.uk/volunteering Alternatively, contact our Volunteers' Coordinator on (01384) 456111 extension 1887 or dgft.volunteering@nhs.net

NHS Staff Survey

The 2017 annual staff survey was conducted between October and December and all Trust staff were asked to participate.

Overall, 4,712 staff were invited to participate in 2017 with 1,702 staff returning completed surveys.

Response rate

	2017	2016
Trust Response rate	36.1%	44%
National Average response rate	43%	40%

*for combined acute and community trusts

Responses to questions are converted into 32 key findings and are displayed either as a percentage or as a scale summary score – with 5 being the maximum score and 1 being the minimum score.

Of the 32 key findings, this year 21 are on a par with or better than average for combined acute and community trusts.

The Trust's overall staff engagement score continues to be better than average with a score of **3.79 out of 5** for 2017. The average was **3.78.**

In comparison to performance in 2016, the Trust has improved in the percentage of staff appraisals having been completed within the last 12 months moving from 88 per cent to 90 per cent. There were five areas were scores declined since the previous survey. These included staff feeling unwell due to work related stress, recognition of staff and staff satisfaction with their level of responsibility and involvement. However, in relation to staff engagement, staff motivation at work increased over the same period of time.

Plans for 2018/19

After initial analysis of results, an engagement plan has been developed to share results will all staff. We will continue to develop our staff engagement plans through focus groups, ward walks and team meetings. Posters and summaries are being distributed to teams for local action. The key findings have identified broad themes for action, and the plans for 2018/19 are to identify a number of strategic aims and align actions alongside. The focus will be to identify a more strategic approach to organisation-wide improvements for staff and wellbeing and then to use the survey responses (alongside other measures throughout the year) as a benchmark. This gives the opportunity to focus on the bigger issues and in making improvements in areas already identified as important to staff – recognition, engagement, communication and staffing infrastructure.

Top and bottom key findings

Top five ranking Key Findings (KF) overall	Trust 2016	Trust 2017	Average 2017	Comparison
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months (lower score better)	20%	21%	24%	**+3%** on average **+1%** on last year
KF31 Staff confidence and security in reporting unsafe clinical practices (higher score better)	3.74	3.74	3.67	**+0.07** on average **Same** as last year
KF11 Percentage of staff appraised in last 12 months (higher score better)	88%	90%	86%	**+ 4%** on average **+2%** on last year
KF23 Percentage of staff experiencing physical violence from staff in last 12 months (lower score better)	1%	1%	2%	**-1%** on average **Same** as last year
KF12 Quality of appraisals (higher score better)	3.18	3.19	3.11	**+0.08** on average **+0.01** on last year

Bottom five ranking Key Findings (KF) overall	Trust 2016	Trust 2017	Average 2016	Comparison
KF16 Percentage of staff working extra hours (lower score better)	74%	75%	71%	**+4%** on average **+1%** on last year
KF22 Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months (lower score better)	14%	16%	14%	**+2%** on average **+2%** on last year
KF18 Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves(lower score better)	53%	55%	53%	**+2%** on average **+2%** on last year
KF2 Staff satisfaction with the quality of work and care they are able to deliver (higher score better)	3.92%	3.83%	3.90%	**-0.07** on average **-0.09** on last year
KF17 Percentage of staff feeling unwell due to work related stress in the last 12 months (lower score better)	35%	41%	38%	**+3%** on average **+6%** on last year

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

Staff Friends and Family Test

To help support the NHS Staff Survey, we also conduct the Staff Friends and Family Test (FFT) throughout the year. The Staff FFT allows us to collect feedback from staff on a quarterly basis which means we can analyse and share results with our staff. As the survey runs throughout the year, we are able to map staff morale over time, allowing the Trust to identify trends, contributing factors and improvements. The staff FFT is reported through to the workforce and staff engagement committee and forms a valuable source of information for our engagement plan.

The staff Friends and Family Test asks staff:

1. **How likely are you to recommend your Trust to friends and family if they needed care or treatment?**

2. **How likely are you to recommend your Trust to friends and family as a place to work?**

During 2017/18, the Staff Friends and Family Test received a total of 1,066 responses. On average for the year, 78 per cent of our staff would recommend us to friends and family if they needed care or treatment. The percentage of staff who would recommend us as a place to work averages at 60 per cent in 2017/18.

Patient quote (intermediate care team – occupational therapy)

"Service has been excellent. From the minute I arrived I had all the help I needed. Food first class, staff lovely."

Engaging with our staff

Good communication and engagement across all our sites is a priority to ensure staff, patients and the public know what is happening in the Trust. We have a number of ways to communicate with staff depending on the message and who needs to act on it. One way is the front page of our Trust intranet – The Hub – where staff based in hospital or out in the community can read about Trust news including health campaigns, finance information, staffing and recruitment updates etc. Other ways we engage with our staff include:

Team Brief

The chief executive continues to maintain a monthly Team Brief to keep staff up to date on the Trust's strategic direction, new policies and other timely staff news. A paper handout accompanies Team Brief for those staff who cannot attend the session in person.

Healthcare Heroes

New to the Trust is our monthly Healthcare Heroes Awards which recognise the achievements of a team and an individual. Staff, patients and visitors can nominate anyone they feel has gone above and beyond the call of duty. The awards have proved extremely popular and attract in excess of 50 nominations a month. The chief executive personally chooses the winners and takes great delight in surprising them with a Healthcare Hero framed certificate. The awards are captured on video and these are uploaded to the Trust's Facebook page.

Patient Safety and Patient Experience Bulletins

We produce a weekly Patient Safety and Experience Bulletin which is emailed to every member of staff in the Trust. Each week, the electronic bulletin focuses on a key patient safety or experience topic chosen by a different guest editor around their area of expertise. The bulletin is sponsored by our chief nurse Siobhan Jordan and our medical director Julian Hobbs. Topics covered so far include: sepsis, nasogastric tube placement and cauda equina syndrome.

Committed to Excellence

We hold our main annual staff awards, Committed to Excellence, to recognise the achievements of both clinical and non-clinical staff. Staff and patients have been enthusiastic supporters of the awards nominating staff in one of five categories: Excellence in Patient Care; Excellence in Service Improvement, Unsung Hero – Clinical; Unsung Hero – Non-clinical and Team Excellence. For 2018, the awards are being revamped to include a special award for volunteers and a Healthcare Hero Award category to select the best of the award recipients from the previous 12 months.

Long Service Awards

We continued to celebrate the dedication and commitment of our longest serving members of staff at our Long Service Awards ceremonies hosted by the chief executive and chairman. Events are held throughout the year and celebrate thousands of years of continuous service for The Dudley Group. Staff receive a long service certificate along with a commemorative badge when they reach milestone lengths of service.

Chief Executive's Strategic Objectives Roadshows

Staff from all areas and all levels of the organisation were encouraged to attend strategic objective roadshows to find out what the Trust's objectives meant for them and how they can help to deliver them. The sessions explained the Trust's strategic direction for the coming year and how it will affect their work, specifically how they set appraisal targets.

Quality and Safety Reviews

Staff can also get involved via Quality and Safety Reviews – an ongoing rota of visits to clinical areas where a non-executive and executive director, accompanied by a member of the governance team, talk to staff about current issues. Governors also take part in the walkrounds to talk to patients about their experiences. An action plan is then developed and followed up at the next walkround. More on Quality and Safety Reviews can be found in the Quality Report on page 63.

Staff Development

A range of learning opportunities are in place for staff to access, including a quarterly leadership forum for our middle and top leaders – they hear from guest speakers and have the opportunity to network. Our Developing Leaders programme has been launched upskilling our staff to lead teams and services. Further opportunities for development are offered through a range of apprenticeship qualifications, both for new and existing staff.

Additional support for learning and development is being put in place for 2018/19 to ensure our staff can grow and learn in our Trust.

Off-payroll engagements

There were no off-payroll engagements during 2017/18. It is our policy not to use off-payroll enagements.

Patient quote

"The staff were amazing!!!! So friendly, caring, helpful, understandable and professional. NHS saw me quicker than privately. The service was first class too. Feel very proud to have such a brilliant health system."

Exit packages (Information subject to audit)

Staff exit packages 2017/18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000s	Number	£000s	Number	£000	Number	£000s
<£10,000	0	0	12	22	12	22	0	0
£10,000 - £25,000	0	0	2	37	2	37	0	0
£25,001 - 50,000	0	0	1	30	1	30	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**15**	**89**	**15**	**89**	**0**	**0**

Staff exit packages 2016/17

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£000s	Number	£000s	Number	£000s	Number	£000s
<£10,000	0	0	12	21	12	21	0	0
£10,001 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	**0**	**0**	**12**	**21**	**12**	**21**	**0**	**0**

Staff exit packages: other (non-compulsory) departure payments

	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000s	Number	£000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	15	89	12	21
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval (special severence payments)*	0	0	0	0
Total**	**15**	**89**	**12**	**21**
of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Expenditure on consultancy

Details of expenditure on consultancy can be found on page 19 of the accounts.

Patient quote (clinical oncology)

"They took time to explain everything and didn't rush me at all. They were very friendly and caring . Made me feel like Ii mattered as a person, and I wasn't just another patient. THANK YOU X"

Sustainability and environment

The Trust is a significant employer, buyer and provider of services within the region and we recognise our activities have a detrimental effect on the environment. We have a responsibility to our staff, patients and wider community to act in a responsible manner. Our Sustainable Development Management Plan provides an opportunity for us to take significant strides towards lessening our impact through consuming less, emitting less from our buildings, providing sustainable travel opportunities and greener procurement, which will together minimise our impact on the environment.

NHS England has set a target of a 34 per cent reduction in carbon footprint by 2020 and an 80 per cent reduction by 2050 (based on 1990 levels). These targets are for reductions in absolute emissions, so will be even more challenging in the context of growth. Achieving the Climate Change Act 2008 target of 34 per cent reduction in Carbon Dioxide will present a significant challenge to the Trust and will require changes to the way we manage and operate our infrastructure, how we procure goods and services, how we dispose of our waste and how our staff, patients, suppliers and contractors travel to the Trust. The Trust's estates is owned and managed by our PFI partners. The Trust is now working closely with its PFI partners to identify carbon reduction projects and we expect these programmes of work to have a real impact on our carbon footprint in future years. The Trust will continue to use internal and external performance benchmarking to improve sustainability.
Our strategy is aimed at minimising the impact that our activities have on the environment by reducing the unnecessary and wasteful consumption of energy, by using energy derived from greener or more energy efficient sources and by improving the efficiency of our buildings and the equipment that is used within those buildings. We continue to work to reduce our use of energy and meet the 34 per cent reduction in carbon emissions target by working closely with Interserve, our PFI partner.

Our PFI partners are in the process of implementing two major changes:

- A new larger CHP system will replace the existing CHP system in 2018 in order to achieve greater fuel efficiencies; and
- There is anticipated to be a site-wide replacement of all light bulbs with LED lighting, which will reduce electricity consumption.

The Trust is committed to improving local air quality and improving the health of our community by promoting active travel to our staff, patients and the public who use our services. Our travel carbon footprint has increased for patient and visitor travel, which can be explained by the significant rise in patient contacts the Trust has experienced in recent years. However, our local initiatives have helped to achieve a net reduction in business travel and staff commuting. The table below outlines our travel statistics, including carbon footprint:

Category		2013/14	2014/15	2015/16	2016/17
Patient and visitor travel	Miles	305,259,251	312,303,717	338,745,305	356,117,915
	tCO_2e	112,785	114,750	122,502	128,705
Business travel and fleet	Miles	1,173,112	1,181,223	1,108,677	901,797
	tCO_2e	433	434	401	326
Staff commute	Miles	4,213,287	3,976,765	3,918,465	4,081,491
	tCO_2e	1,557	1,461	1,417	1,475

We support a culture of active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise caused by cars all cause health problems for our local population, patients, staff and visitors. There are a number of initiatives in place to promote active travel, for example:

- Staff car parking permits are only allocated to members of staff who meet specific eligibility criteria. Members of staff who live close to their place of work and could reasonably use public transport are encouraged to do so, and, in most circumstances, would not be given a parking permit. Instead, staff are encouraged to use public transport, cycle, walk or car share.
- The Trust also participates in a cycle to work scheme which allows staff to take advantage of salary sacrifice savings on income tax and national insurance against the cost of a new bicycle and associated equipment up to a total cost of £1,000.
- We also maintain a good relationship with local transport providers who regularly visit the Trust's sites to provide free information to staff, patients and visitors about transport routes, service times and special offers on fares.

Our PFI partner, Interserve, also has a number of initiatives in place to reduce the travel carbon footprint. Interserve has 12 vans and a hybrid Toyota Prius for transporting products around Trust sites and to patients. This includes taking medical gasses to surgeries, delivering drugs out to cancer patients' homes and transporting medical equipment to community centres and GP surgeries.

The Trust is taking a new approach to procurement by implementing a shared services function with Walsall Healthcare NHS Trust and Sandwell and West Birmingham Hospitals NHS Trust. This will involve implementing a new inventory management system to optimise efficiency across the three trusts. The new inventory system will help the Trust realise financial savings by achieving economies of scale across all three trusts. This will lead to efficiency savings and reduce the carbon footprint as only one transaction and delivery method will be required. Further, the automation of processes through procure-to-pay and the data capabilities of the new system will lead to a vastly improved procurement function. The Trust will be able to benchmark performance against comparator trusts and aims to have the most efficient procurement function across the West Midlands.

The Sustainable Development Management Plan has a number of actions which will be delivered during 2018/19. The Trust will work with our PFI partners, staff and local community to deliver these actions. In addition the Trust will play a key role in delivering new models of care and implementing major change initiatives through the Black Country Sustainability and Transformation Plan (STP) and the Dudley Multispecialty Community Provider (MCP). Both of these initiatives will help drive sustainability within the Dudley Health Economy.

Foundation Trust membership

The membership of the Trust comprises local people and staff who are directly employed by us or our partner organisations. Our minimum age for membership is 14 years; there is no upper age limit. Full details of who is eligible to register as a member of the Trust are in the Trust Constitution which is available on our website www.dudleygroup.nhs.uk. Any public members wishing to come forward as a governor when vacancies arise or vote in governor elections must reside in one of the Trust's constituencies. Staff are automatically included as members within staff group constituencies unless they choose to opt out.

During 2017/18, we continued to promote membership to local communities and the importance of having a voice. We continue to maintain a public membership of more than 13,000. As at the 31st March 2018 the Trust had a total of 13,888 public members.

Membership growth

Membership	31 March 2015	31 March 2016	31 March 2017	31 March 2018
Public	13,770	13,981	13,875	13,888

The membership strategy continued to focus on developing opportunities to maintain a public membership target of no less than 13,000, and refine recruitment activity to target any identified areas of shortfall. This is important to ensure that our membership continues to reflect the diversity of the communities we serve and the protected characteristics as set out in the Equality Act 2010. The Trust's strategy also included developing more opportunities for engaging with members to gain feedback that we can use to improve patient experience.

Our 'Meet your Experts' health fair events create a unique opportunity to learn about the services provided by the Trust and visit areas not normally seen by the public. Some of the events' younger guests who may be considering a career in healthcare say the tours are inspiring. Members continue to engage well with these events.

During 2017/18, we hosted one behind the scenes event at Russells Hall Hospital (in July) and more than 100 members and their guests attended and had a chance to meet staff from some of our specialties including day case, paediatric, learning disability, pharmacy, therapies and interventional radiology. There was also an opportunity to meet with the Trusts' governors and learn more about their role and the elections process.

More information about the Trust and the latest news can be found on our website at www.dudleygroup.nhs.uk. The members' area of the website also contains information about being a member and the contribution members make to the ongoing success of the organisation. Members can:

- be involved in shaping the future of healthcare in Dudley by sharing their views*
- vote in governor elections*
- stand for election to represent their constituency**
- attend behind the scenes tours and member events
- participate in public meetings, public and patient involvement panels and focus groups
- fundraise for The Dudley Group NHS Charity

**excluding those living Outside of the West Midlands*

***candidates must be minimum 16 years old*

Patient quote (community physiotherapy)

"Fantastic, professional, helpful advice. I feel that I am very lucky to have such an excellent service"

Membership report at 31 March 2018

Public Constituencies	Number of Members
Brierley Hill	1,774
Central Dudley	2,422
Halesowen	1,151
North Dudley	1,382
Outside of the West Midlands	365
Rest of the West Midlands	1,771
South Staffordshire and Wyre Forest	1,185
Stourbridge	1,712
Tipton and Rowley Regis	2,126
Staff Constituencies	**Number of Members**
Allied Health Professionals and Healthcare Scientists	689
Medical and Dental	503
Nursing and Midwifery	2,748
Non Clinical	995
Partner Organisations	649

Public membership breakdown by age, gender and ethnicity		Number of Members
Age	0-16 years	14
	17-21 years	761
	22+ years	12,665
	Not stated	448
Gender	Male	4,622
	Female	9,173
	Unspecified	93
Ethnicity	White	11,348
	Mixed	401
	Asian or Asian British	1,238
	Black or Black British	426
	Other	71
	Not stated	404

Council of Governors

The Council of Governors was formed on 1st October 2008 and is responsible for holding the non-executive directors to account for the performance of the Board of Directors. The majority of the Trust's governors are elected through the public membership to make up the Council of Governors which consists of 25 governors in total:

Public elected – 13 governors
Staff elected – 8 governors
Appointed from key stakeholders – 4 governors

Tables summarising the Council of Governors and the constituencies they represent can be found on page 50.

The Board of Directors continues to work closely with the Council of Governors through regular attendance at both full Council of Governor meetings and the committees of the council. Both non-executive and executive directors are assigned as nominated attendees at the Council of Governors sub-committees. This provides opportunities for detailed discussion and debate on strategy, performance, quality and patient experience and enables governors to see non-executive directors function. Governors regularly attend public Board of Directors meetings.

The Board of Directors is accountable to the Council of Governors ensuring it meets its Terms of Authorisation. A Register of Interests confirming individual declarations for each governor is maintained by the Trust and is available on request by calling (01384) 321124 or emailing foundationmembers@dgh.nhs.uk.

All the Trust's governors comply with the 'fit and proper' persons test as described in the Trust's provider licence. The conditions are incorporated into the Foundation Trust Constitution.

The Council of Governors has the following key responsibilities:

- appointing and/or removing the chair, including appraisal and performance management
- appointing and/or removing the non-executive directors
- appointing the external auditors
- advising the Board of Directors on the views of members and the wider community
- ensuring the Board of Directors complies with its Terms of Authorisation and operates within that licence
- recruiting and engaging with members
- advising on strategic direction
- receiving the Annual Accounts, any report of the auditor on them, and the Annual Report at the Annual Members' Meeting
- approving significant transactions which exceed 25 per cent by value of Trust assets, Trust income or increase/reduction to capital value
- approving any structural change to the organisation worth more than 10 per cent of the organisation's assets, revenue or capital by way of merger, acquisition, separation or dissolution
- deciding whether the level of private patient income would significantly interfere with the Trust's principal purpose of providing NHS services
- approving amendments to the Trust's Constitution

Where an item is reserved for both Council of Governors and Board of Directors approval, for example a change to the Trust's Constitution, then this change would not be made if either party did not approve the recommendation put before them. In practice, a constructive and close working arrangement is maintained between the Council of Governors and Board through the Chair and Lead Governor and; therefore, disagreements have not occurred during the year.

The Trust continues to work closely with the Council of Governors to further develop the governor role to reflect the requirements of the Health and Social Care Act and other best practice and guidance.

Ongoing training and development is provided by the Trust allowing experts from within and outside the Trust to work with the Council of Governors to identify key aspects of their role. This includes how they influence strategy within the Trust, how they undertake their secondary governance duties and how they will engage with members and the wider community so that their views and opinions can be heard.

Patient quote (ENT)

"My ENT consultant was brilliant. I felt like he cared and really listened to me and has really tried his best to do everything within his powers to help with my illness."

Council of Governor committees

The Council of Governors has established the following committees:

- Governor Development Group (chair Rob Johnson April - December 2017. Fred Allen January to March 2018)
- Appointments & Remuneration Committee (chair Rob Johnson April - December 2017. Fred Allen January to March 2018)
- Experience and Engagement Committee (chair Karen Phillips)
- Strategy Committee (chair Rob Johnson April - December 2017. Lydia Ellis January to March 2018)
- Governance Committee (chair Fred Allen April - December 2017. Nicola Piggott January to March 2018)

Council of Governors membership and meetings 2017/18

The Council of Governors meet a minimum of four times per year. Meeting papers are published on our website at www.dudleygroup.nhs.uk and Trust members and the wider public are welcome to attend and observe.

In 2017/18, the full Council of Governors met on five occasions including the Annual Members' Meeting held in July 2017.

Attendance at full Council of Governors meetings 2017/18

Public Elected Governors	Public Constituency	Attendance
Mr Darren Adams (end of term Dec '17)	Stourbridge	3/3
Mr Fred Allen	Central Dudley	4/5
Mr Terry Brearley (elected Dec '17)	Brierley Hill	2/5
Mr Richard Brookes (end of term Dec '17)	Brierley Hill	3/3
Nr Arthur Brown (elected Dec '17)	Stourbridge	2/2
Mrs Lydia Ellis	Stourbridge	3/5
Ms Sandra Harris (elected Dec '17)	Central Dudley	2/2
Mr Rob Johnson (end of term Dec '17)	Halesowen	2/3
Mrs Diane Jones (end of term Dec '17)	South Staffordshire & Wyre Forest	0/5
Mrs Viv Kerry	Halesowen	4/5
Mrs Joan Morgan (end of term Dec '17)	Central Dudley	3/3
Mrs Natalie Neale (elected Dec '17)	Brierley Hill	1/2
Mr Rex Parmley (elected Dec '17)	Halesowen	2/2
Mr James Pearson-Jenkins (resigned Sept 17)	Tipton & Rowley Regis	0/2
Mrs Yvonne Peers (re-elected Dec '17)	North Dudley	3/5
Mrs Nicola Piggott	North Dudley	2/5
Mrs Pat Price	Rest of the West Midlands	3/5
Mr Peter Siviter (elected Dec '17)	South Staffordshire & Wyre Forest	2/2
Mrs Farzana Zaidi (elected Dec '17)	Tipton & Rowley Regis	1/2
Staff Elected Governors	**Staff Constituency**	
Mr Sohail Butt (resigned Dec '17)	Medical & Dental	2/4
Mr Bill Dainty	Nursing & Midwifery	4/5
Miss Jenny Glynn (resigned June '17)	Allied Health Professionals & Healthcare Scientists	1/1
Mrs Michelle Lawrence	Nursing & Midwifery	3/5
Mrs Ann Marsh (elected Mar '18)	Allied Health Professionals & Healthcare Scientists	1/1
Mrs Margaret Parker (elected Mar '18)	Nursing & Midwifery	1/1
Mrs Karen Phillips	Non-clinical	4/5
Mrs Edith Rollinson (elected Mar '18)	Allied Health Professionals & Healthcare Scientists	1/1
Mrs Jacky Snowdon (end of term Dec '17)	Nursing & Midwifery	1/4
Mr Alan Walker (re-elected Mar '18)	Partner Organisations	4/5
Appointed Governors	**Appointed Constituency**	
Cllr Adam Aston	Dudley Metropolitan Borough Council	2/5
Mr Ricky Bhogal (resigned June '17)	University of Birmingham Medical School	0/1
Dr Richard Gee (re-appointed Dec '17)	Dudley CCG	4/5
Dr Anthea Gregory (appointed Dec '17)	University of Wolverhampton	1/2
Mrs Mary Turner	Dudley CVS and Trust Volunteers	5/5

Figures show number of meetings attended that were held during the term of office. The Council of Governors monitors attendance at full council meetings and committee meetings as agreed under the governors' code of conduct. In all instances above where governors have maintained less than the required attendance, the Council of Governors is satisfied that there was reasonable cause for non-attendance.

Full Council of Governor meetings are regularly attended by key clinicians and senior staff from across the Trust providing presentations and question and answer sessions to help governors understand how the organisation works.

In 2017/18, members of the Board of Directors attended the following full Council of Governors meetings.

Executive and non-executive director attendance at full Council of Governors meetings 2017/18*

Director and title	Attendance
Julian Atkins Non-executive Director	4/5
Ann Becke Non-executive Director	1/5
Paul Bytheway Chief Operating Officer	2/3
Jonathan Fellows Non-executive Director	2/5
Paul Harrison Medical Director (until Sept '17)	1/3
Julian Hobbs Medical Director (joined Oct '17)	0/2
Tom Jackson Director of Finance	1/1
Siobhan Jordan Chief Nurse	5/5
Karen Kelly Chief Operating Officer	1/1
Andrew McMenemy Director of Human Resources	4/5
Richard Miner Non-executive Director	1/5
Jenni Ord Chairman	5/5
Glen Palethorpe Director of Governance/Board Secretary	5/5
Mark Stanton Chief Information Officer	2/5
Paul Taylor Director of Finance (interim)	2/3
Diane Wake Chief Executive	4/5
Michael Woods Chief Operating Officer (Interim)	1/1
Doug Wulff Non-executive Director	1/5

**Board members are not required to attend all full Council of Governors meetings unless invited to do so to present on a specific topic. Non-executive and executive directors also attended sub-committees of the Council of Governors.*

During the year, the Council has not exercised its right under paragraph 10C of schedule 7 of the NHS Act 2006 to require a director to attend a full Council of Governors meeting.

Governor resignations, elections and re-appointments

During 2017/18, elections were held for vacancies in the following constituencies:

- **Public** Brierley Hill, North Dudley, Central Dudley, Halesowen, South Staffs & Wyre Forest, Stourbridge and Tipton & Rowley Regis
- **Staff** Nursing and Midwifery, Allied Health Professionals & Healthcare Scientists. Medical & Dental and Partner Organisations

In accordance with the Trust's Constitution, we use the method of single transferable voting for all elections. This system allows voters to rank candidates in order of preference and, after candidates have either been elected or eliminated; unused votes are transferred according to the voter's next stated preference.

During the year, a total of seventeen members put themselves forward as nominees for the twelve vacancies arising with more than 11 per cent returning votes in contested elections. Electoral Reform Services was appointed to oversee the election process which returned the following governors for a three-year term:

Governors elected or appointed during 2017/18

December 2017 Governor and constituency
Arthur Brown Public: Stourbridge
Richard Gee Appointed: Dudley CCG
Anthea Gregory Appointed: University of Wolverhampton
Sandra Harris Public: Central Dudley
Natalie Neale Public: Brierley Hill
Rex Parmley Public: Halesowen
Yvonne Peers Public: North Dudley
Peter Siviter Public: South Staff & Wyre Forest
Farzana Zaidi Public: Tipton & Rowley Regis

March 2017 Governor and constituency
Ann Marsh Staff: Allied Health Professional and Healthcare Scientists
Margaret Parker Staff: Nursing & Midwifery
Edith Rollinson Staff: Allied Health Professional and Healthcare Scientists
Alan Walker Staff: Partner Organisations

Governors reaching end of term of office or resigning during 2017/18

Governor and constituency	Date end of term/ resigned
Darren Adams Public: Stourbridge	Dec 2017
Ricky Bhogal Appointed: University of Birmingham	Jun 2017
Richard Brookes Public: Brierley Hill	Dec 2017
Sohail Butt Staff: Medical & Dental	Dec 2017
Richard Gee Appointed: Dudley Clinical Commissioning Group	Dec 2017
Jenny Glynn Staff: Allied Health Professional and Healthcare Scientists	Jun 2017
Rob Johnson Public: Halesowen	Dec 2017
Diane Jones Public: South Staffs & Wyre Forest	Dec 2017
Joan Morgan Public: Central Dudley	Dec 2017
James Pearson Jenkins Public: Tipton & Rowley Regis	Sept 2017
Yvonne Peers Public: North Dudley	Dec 2017
Jackie Snowden Staff: Nursing & Midwifery	Dec 2017
Alan Walker Staff: Partner Organisations	

Council of Governors review 2017/18

Since authorisation, our Council of Governors has regularly conducted a review of its effectiveness in discharging its statutory and other duties. Throughout the year, governors have continued to participate in Trust activities that seek to assure and improve standards of quality and patient experience. Governors have joined senior Trust staff to complete Quality and Safety Reviews conducted across clinical and treatment areas of the Trust. Two governors are members of the Trust's Patient Experience Group and the Quality and Safety Group – both of which report to the Clinical Quality, Safety and Patient Experience Committee of the Board of Directors. Governors also attend the Drugs and Therapeutic Group which reports to the Trust's Medicines Management Group. Governors are active members of the Clinical Education Charity.

During the year Governors have participated in the newly established mini-PLACE audits and also join the national PLACE audit as Patient Assessors.

Governor engagement with Trust members and local communities

The Trust supports governors in raising public and staff awareness of the work of the Trust and their role within their constituencies. The 'Out There' initiative continues to support governors to undertake their role in finding out what people think about the Trust and feedback their views to the Board of Directors.

During 2017/18, governors continued to reach out into their constituencies and have attended a number of community and support groups such as GP patient panels and participation groups. Examples are given below:

Events attended in 2017/18	
April 2017	Dudley College – Careers & Volunteering Fair
May '17	Community event - How to Stay Happy in in Brierley Hill
July '17	Annual Members Meeting & health fair
Sept '17	Patient Participation Group (PPG) - Share, Learn & Network Event
Oct' 17	Meadowbrook Surgery PPG
Nov'17	People's Network – Let's talk about Dementia

Many of the our governors also actively participate in Trust-led events such as the behind the scenes events which provide Trust members and members of the wider community an opportunity to learn more about areas of the Trust.

Lead Governor

The Lead Governor role is designed to assist the Council of Governors where it may be considered inappropriate for the Chairman, or her deputy, to deal with a particular matter. The Lead Governor will also provide an independent link between the Council of Governors and the Board of Directors.

In July, the Council elected a new Lead Governor to serve alongside the existing Lead Governor who would stand down in December 2017. Fred Allen, Public Elected Governor for Brierley Hill was selected in March by the Council as successor to Rob Johnson, Public Elected Governor for Halesowen and enabled Fred Allen the opportunity to work alongside as an associate Lead Governor until formally taking up the role in December 2017.

How to contact a governor or director

There are several ways Trust members or members of the public can contact either their governor or a member of the Board of Directors:

- at Council of Governors meetings in public
- at Board of Directors meetings in public
- at the Annual Members' Meeting
- at members events
- via the Foundation Trust office on email or by phone

For dates and times of these meetings and other members events, please visit the members section on the Trust website at www.dudleygroup.nhs.uk or contact the Foundation Trust office:

Email dgft.foundationmembers@nhs.net

Telephone (01384) 321124

Write Freepost RSEH-CUZB-SJEG, 2nd Floor South Block, Russells Hall Hospital, Pensnett Road, Dudley, DY1 2HQ

Several governors are also happy to be contacted directly and their details can be obtained using the details above.

Patient quote (outpatients)

"Staff very friendly reassuring polite let you know what's happening explaining everything to you every step of the way brilliant. Thank you"

Code of Governance disclosures

For disclosures relating to the Trust's Council of Governors, please see pages 47 to 52 of this report.

For disclosures relating to the Trust's Board of Directors, please see pages 14 to 23 of this report.

For disclosures relating to the Nomination and Remuneration Committee, please see pages 26 to 31 of this report.

For disclosures relating to the Audit Committee, please see pages 25 of this report.

For disclosures relating to the Foundation Trust membership, please see pages 45 to 47 of this report.

Single oversight framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.
The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's Risk Assessment Framework (RAF) was in place. Information for the prior year and first two quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

The latest reported segmentation from NHS Improvement puts The Dudley Group NHS Foundation Trust within segment 2, where segmentation of 3 or 4 would indicate a trust is or is likely to be breach of its licence. There were no issues within the Trust's annual review of its governance, risk management and systems of internal control that are recorded within the Trust's Annual Governance Statement (page 43 onwards) that would indicate a change in segmentation is likely.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017/18 Scores				2016/17 Scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	4	4	3	3	2	3
	Liquidity	2	1	1	1	1	1
Financial efficiency	Income & Expenditure margin	4	3	1	1	1	1
Financial controls	Distance from financial plan	4	4	1	1	1	2
	Agency spend	4	4	4	4	4	4
Overall scoring		**4**	**3**	**3**	**3**	**3**	**3**

*If any of the five measures scores '4' then the overall score can only be a maximum of '3'.

The Trust did not achieve its agency spend target set by NHSI of £5.772m. This resulted in the Trust scoring a '4' in the agency spend metric.

Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of The Dudley Group NHS Foundation Trust.

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Dudley Group NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Dudley Group NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

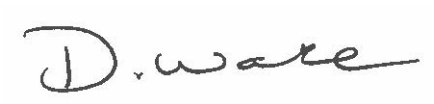
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed Date: 22nd May 2018



Diane Wake

Chief Executive

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Dudley Group NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Dudley Group NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The director of governance and board secretary has board level responsibility for the oversight of the Trust's risk management policies and processes. The Board of Directors has established a Risk and Assurance Group, which met quarterly for the first three quarters of the year and then moved to monthly from February 2018. The group reviews corporate and directorate specific risks and associated assurances and mitigation plans and oversees the effective operation of the Trust's risk register. It is in place to challenge the levels of assurance throughout the organisation and to ensure the effective management and mitigation of risks and to support learning. Additionally, each division of the Trust, through their divisional governance framework, reports to the Risk and Assurance Group on their management of risks at an operational level.

The Trust has a comprehensive induction and training programme, supplemented by elearning training packages and ad hoc learning opportunities for staff. Collectively, these cover a wide range of governance and risk management topics for both clinical and non-clinical staff in all disciplines and at all levels in the organisation.

Additionally, training is available from the corporate governance team on aspects of the wider risk management and governance agenda.

The risk and control framework

The Board of Directors provides leadership on the management of risks, determining the risk appetite for the organisation and ensuring that the approach to risk management is consistently applied. Through the Board Assurance Framework, the Board determines the total risk appetite the Trust is prepared to accept in the delivery of its strategic objectives. The board takes assurance from the Risk and Assurance Group which reports into the Audit Committee as to the controls in place to manage the identified risks to their determined target score and the monitoring of any required actions where the risk exceeds the board's appetite for risk in that area.

The Trust's Risk Management Strategy and Policy provides guidance on the identification and assessment of risk and on the development and implementation of action plans. The divisions undertake continuous risk assessments to maintain their risk registers and to implement agreed action plans. Risks are assessed by using a 5x5 risk matrix where the total score is an indicator as to seriousness of the risk. Action plans to address or manage risks are recorded in the risk register and managed at divisional and/or board level. Regular reports to the Risk and Assurance Group confirm the progress made in managing these identified risks.

Each level of management, including the board, reviews the risks and controls for which it is responsible. The board and board committees monitor the progress against actions to minimise or mitigate risks in accordance with the Risk Management Strategy. In 2017/18, each board committee undertook to review in more detail a sample of risks where it is the allocated oversight committee. Each committee confirmed the outcome of its reviews within the report to the board.

This information flow complimented the reviews undertaken by the Audit Committee on the board corporate risk and assurance frameworks. Papers received at the board and at board committees identify the risks to the achievement of Trust objectives and their link to the risk register. The Trust uses a dedicated monitoring system to record and monitor all risks across the organisation including the current and targeted mitigated risk scores and progress against the identified action plans where the risk is above its target score. Active risk management forms part of the divisional governance framework with the operational risk registers being a standing item on the Risk and Assurance Group's agenda. Positive assurance to date confirms the effectiveness of the management and control of these identified risks. Action plans are in place to address any perceived gaps in control or assurance that arise during the year.

The reporting framework requires risks to be identified on board and committee front summary sheets providing an ongoing record of emerging issues which allow the link back to the Board Assurance Framework.

The Trust has also a number of arrangements to monitor quality governance and improvements in quality. These include the use of performance dashboards, a clinical audit programme, the review and monitoring of Nursing Care Indicators and the robust monitoring against local and national targets for quality measures including healthcare associated infections (HCAI), pressure ulcers and falls, all of these linking to the Trust's own quality priorities.

The Trust developed its integrated performance report during 2017/18 which sees a consistent base set of data being used to report to each of the workforce, finance and performance and clinical quality, safety and patient experience committees as well as operationally to the divisions and the executive team. Complementing this reporting has been the development of quality dashboards for each ward which provides visual feedback on quality metric delivery for staff and patients.

Nursing Care Indicator audits along with the undertaking of matron observation audits, measure the quality of care given to patients and the monthly audits of key nursing interventions and associated documentation are published, monitored and reported to the Board of Directors by the chief nurse. This is supported by the implementation of real-time surveys, capturing the views of patients and using these to make improvements. The Trust also continues to monitor the hospital standardised mortality ratio (HSMR) to ensure it is consistent with national levels.

Regular reports on the progress against key quality priorities provide assurance that these are actively managed and progressed at an operational level. Additionally, matrons and divisional leaders attend the board on rotation to discuss quality issues and the operational risks to the achievement of their objectives. Internal audit also provides an independent opinion on the adequacy of the arrangements for ensuring compliance with the care quality standards.

Information risks are managed and controlled through the Trust's established risk management process. The Trust has a Caldicott and Information Governance Group (CIGG) which reports to the Audit Committee and whose remit is to review and monitor all risks and incidents relating to data security and governance. The Trust complies with the NHS Information Governance Toolkit and is currently achieving the minimum of Level 2 performance for all areas, which is deemed satisfactory performance by the Department of Health. The Trust has achieved over the minimum level by securing a Level 3 in eight of the 45 applicable requirements, and has an action plan in place to progress to Level 3 in those areas which are cost effective and support our commitment to high quality patient care. The Trust's Caldicott Guardian works with the director of governance and board secretary who has board level responsibility for information governance and is the Trust's Senior Information Risk Owner (SIRO).

The Board Assurance Framework identifies the key risks to the achievement of the Trust's objectives and the independent assurance mechanisms that report on the effectiveness of the Trust's system of internal control in those areas. It supports this Corporate Governance Statement and is informed by partnership working across the Black County Sustainability and Transformation Plan footprint, the local health economy via the Black Country Alliance and through working with the Dudley Clinical Commissioning Group (CCG) especially in respect of the Dudley New Care Models project, Council of Governors, community wide safeguarding boards and other stakeholders. The Board Assurance Framework focuses on those key risks to achievement of the Trust's objectives, below are the significant issues that have been tracked and reported to the board and the degree of risk remaining at the end of the year:

Failure to meet the key emergency access performance target

At the beginning of 2017/18, the Trust saw good performance in respect of the emergency access target to see, treat, admit or discharge 95 per cent of patients within four hours of arrival at our Emergency Department. However, for the last two quarters of the year, the Trust, in line with the whole NHS, has seen increased pressure on emergency services the organisation did not achieve this target.

The Trust has reviewed the emergency access pathway and worked with Dudley CCG to co-locate the Urgent Treatment Centre with our Accident and Emergency Department with building works completed at the end of February 2018. The new facility is designed to offer improved assessment space for patients arriving by ambulance which should improve their experience of the service.

New models of care pathways within our emergency services were implemented in March to rapidly see and treat acute medical illness and stream these patients to the Acute Medical Unit away from the Emergency Department.

Failure to reduce the number of delayed transfers of care

The Board recognised the financial pressure the Dudley local authority has been under to manage this rising demand for social care, and the Trust has continued this year to actively engage with the local authority to address this risk. However, the Trust has seen an increase in the number of delayed transfer of care patients remaining in hospital beds. The work undertaken by the local authority and the strong partnership working in place the Trust has seen a reduction in local patients remaining in hospital longer than is needed but this has not been replicated with patients out of the Dudley area. Out of area delays are complex and, therefore, this risk has remained high across the year and it is anticipated that it will remain so into 2018/19.

Failure of the PFI provider to maintain the building in line with statutory requirements and to ensure a resilient estate

The Board has held a series of formal meetings with the PFI provider across the year recognising the significant performance issues identified by the Trust's own management checks of the PFIs contractual performance. Enhanced reporting of the qualitative aspects of the PFI provider's performance has been provided to Clinical Quality, Safety and Patient Experience Committee and through specific reports to the board itself. The PFI partner has made changes to its local senior team which should see the provider's performance improve in 2018/19.

Reduced capacity within safeguarding adults/children team due to infrastructure vulnerabilities

The Board recognised that the Trust needed to invest in its safeguarding team and has appointed a new head of safeguarding along with further specialist staff. The Trust has also worked with The Black Country Partnership NHS Foundation Trust who provides the specialist paediatric liaison nurse to better co-ordinate their work and to co-locate them with the Trust's safeguarding team which allows more efficient workflow. These changes, especially the recruitment of staff, will strengthen safeguarding processes and capacity. This will see this risk being mitigated in 2018/19.

Competing demands on clinicians' time may lead to a lack of quality clinical input across key Trust projects

The Board has recognised the level of clinical input required across a number of key developments within the Trust this year, and into next, as a risk. The medical director has, through the job planning process, sought to assist in mitigating this risk. The time allocated and spent at a divisional level and the range of demands on clinician's time has been reviewed and will assist in mitigating this risk. The Trust has invested in more clinical information officers and appointed to the post of a newly created clinical safety officer to support the desired level of clinical engagement with the Trusts' Digital Trust project. This risk will remain into 2018/19 given the level of Sustainability and Transformation Partnership projects coupled with the ongoing development of the Multi-speciality Community Provider revised clinical pathways.

Safer staffing levels

The Board has received assurance through regular updates provided by the chief nurse on the staffing levels at a clinical delivery (ward) level for each shift, as measured against the NICE guidance issued in this area. The Trust has utilised its investment in the technology to assist in ensuring that safe staffing levels are maintained through the use of an electronic rostering system which supports the internal Nurse Bank function to efficiently fill shifts. The reporting to the board has identified that the Trust has remained safely staffed throughout the year. However, in recognition of the continued pressure within the area of staffing, especially with the higher than planned reliance on agency staff, the board has approved a programme of investment for the recruitment of more substantive nurses across the Trust.

High dependency on agency staff

The Trust has seen a reduction in the use of agency staff in 2017/18; this is in part due to the need to ensure safe staffing levels are maintained during the sustained period of increased demand on Trust services and, in part, to fill natural gaps in staff rotas as staff retire or leave the Trust. The Trust has undertaken a number of initiatives to improve both the recruitment and retention of staff to reduce the Trust's reliance on agency staff. The Trust has proactively sought advice from NHS Improvement in this area, which has been used to check that the Trust's strategies in this area are robust. Their advice has enabled the Trust to gain confidence in its developed processes as NHS Improvement was able to benchmark the Trust's processes against exemplar peers.

The Trust has made improvements in this area but, with the continued pressure on services and the national challenges in respect of the recruitment within all categories of medical, nursing and health care professionals, the board anticipates this risk will remain a key risk for the Trust across 2017/18.

Failure to deliver the 2017/18 Trust's Cost Improvement (Transformation) Programme

During the year, the Finance and Performance Committee has provided oversight of the Trust's delivery of its established Cost Improvement Programme. Whilst the Trust has broadly delivered the same magnitude of cost improvement this year (2017/18) as it did last year (2016/17), the Trust has under delivered on its established 2017/18 plan. The under delivery of the plan was significantly impacted by the Trust's inability to achieve the reduction in agency staff that was within the 2017/18 approved plan.

Trust plans assume a significant level of income at risk from commissioners

In setting the 2017/18 annual plan, the Board recognised the system risk in respect of the inability of the system to stem demand for no-elective care. This risk has been discussed regularly with the commissioners and was mitigated as part of the contract performance meetings across the year. It is recognised that a similar risk will be prevalent in 2018/19.

Failure to remain financially sustainable in 2017/18 and beyond

The Board recognised the level of risk within its developed financial plan especially in respect of the set control total and its link to Sustainability and Transformation Partnership funding. The board has through the Finance and Performance Committee received regular reports on the Trust's financial position, and has continued to assess the risk for both the current year and future years. The board, in approving its outline 2018/19 financial plan, has recognised there remains a high degree of financial risk associated with the delivery of its objectives.

Lack of paediatric medical workforce capacity to meet service demands, standards and recommendations resulting in overdue follow up appointments

During the year, the Surgery, Women's and Children's Division identified a back log in meeting the demand for their paediatric outpatient service. The Division formulated an improvement plan which is being delivered. During the period of the backlog the risk was monitored by the Clinical Quality, Safety and Patient Experience Committee and there was increased reporting to Dudley Clinical Commissioning Group. As a result of the work delivered then this risk has been reduced.

The delivery of a safe and effective Emergency Care service

During the recent CQC inspection, the CQC raised a number of concerns. As a result of these concerns, the Board agreed to the placing of a specific risk on the Trust's Board Assurance Framework. The Trust has established a comprehensive improvement plan which not only address the CQC concerns, many of which

were addressed immediately as they were raised, but also planned service improvements, some linked to the planned building works to co-locate the Urgent Treatment Centre within the Emergency Department. The tracking of these actions is overseen by the Clinical Quality, Safety and Patient Experience Committee as well as through the divisional and directorate governance meetings. Further work is required within the Emergency Department to increase the space in the resuscitation area.

New models of care

The Board has recognised that its support and contribution to the development of MCP new models of care across Dudley is not without risks for the Trust. The Board see these risks falling across two main areas, the financial impact of the development of the new care model and the workforce capacity impact associated with the development of the new care model along with the establishment of a separate organisational form for the MCP which is a requirement of the Dudley CCG contract. The Trust is working with all relevant system partners and with the regulators to manage this risk.

During 2016/17, the work of the internal auditors and the Board review of the Assurance Framework and supporting governance processes identified some gaps in control which resulted in specific action plans being drawn up with their progress reported to and monitored by the Audit Committee. These identified weaknesses are considered to be operational in nature and through the robust monitoring of the delivery of the actions have not impacted on the final delivery of the Trust's stated objectives.

In 2017/18, the Board commissioned an external independent assessment of the board's effectiveness against the Monitor Well Led Framework. The outcome of this work was reported back to the board along with a developed action plan. The CQC also undertook its annual Well Led assessment this year. The outcome of the CQC assessment resulted in the Trust receiving a rating of "requires improvement" for well led.

The Trust had developed an action plan to improve the effectiveness of both the board and the divisional management structure based on the external board effectiveness review. This also includes a structured clinical leadership development programme linked to the development of the Trust's clinical strategy and drive to become a more clinically led organisation. The subsequent CQC conclusion corroborated the actions identified reported to the board. 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 coming year.

In accordance with Schedule 7 of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) only directors may be members of the Board committees. All committees of the board are chaired by non-executive directors. The board has established seven committees, each with clear terms of reference which are reviewed annually to ensure they remain appropriate to support the board. The review within 2017/18 did not require any significant changes to any of the individual committee terms of reference. Each committee chair provides a formal summary of key issues arising from the committee to the full Board of Directors. This summary report provides information on the assurance received at the committee which supports the Trust's assurance framework and performance reporting ultimately received by the board.

The Trust informs and engages with its key stakeholders in relation to risk through a number of forums which include a regular joint contract/clinical quality review meeting with the Trust's host commissioners and the sharing of performance reports including key risks with the Trust's Council of Governors. Key stakeholders include Dudley CCG, our PFI partner Summit Healthcare (Dudley) Ltd, the Council of Governors, the FT members, patient groups, patients, the local community and the Local Authority Select Committee on Health and Adult Social Care. Where major service re-design is initiated patients and their views are taken into account, to understand how changes may affect them, an example of this, was in respect of the Trust's day case transformation programme where improvements, including the extending of the opening times of the unit, were based on the views of our patients and their feedback to these changes have been positive.

Whilst during this year the CQC has served two Section 31 notices, neither placed any restrictions on Trust's licence and, therefore, the Foundation Trust is compliant with the registration requirements of the Care Quality Commission (CQC).

The CQC issued its report on the Trust as a result of its recent inspection in 2017/18. This report rated the Trust overall as 'requires improvement'. In arriving at this overall assessment, the CQC assessed 44 elements within five areas. Of the 44 elements, 27 were rated as 'good' which meant that in the service rating for medical care, maternity and community services, the Trust was in fact rated as 'good'. The CQC also reconfirmed the 'good' ratings for surgery, outpatients and end of life although these were not subject to a detailed inspection between December 2017 and January 2018. For the service areas where the Trust was rated as 'inadequate' or 'requires improvement', a detailed action plan was put in place.

The monitoring of the delivery of this improvement plan will be reported to the Board and the Clinical Quality, Safety and Patient Experience Committee as well as providing formal feedback to the CQC themselves. 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.

Never Event

The Trust experienced three never events in 2017/18, each was reported and investigated through the Trust's incident reporting systems. The Trust made immediate changes to practice on the identification of these incidents and, upon the conclusion of each of the investigation, made further enhancements to the system of internal control operated by the clinical area. The learning from these incidents has been shared widely within the Trust. Our commissioners have been engaged during our investigation process and are satisfied that we have enhanced our processes as a result of this incident and that we acted swiftly and appropriately, engaging with the affected patient during our investigation, including making a swift and full apology through the application of the Trust's Duty of Candour processes.

As an employer with staff entitled to be members of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all of the organisation's obligations under equality and diversity and human rights legislation are complied with.

In partnership with its PFI provider, the Foundation Trust has undertaken a number of risk assessments and Carbon Reduction Delivery Plans are in place. Amongst these, risk assessments have been undertaken in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust produces a detailed Annual Plan incorporating both service and quality initiatives and reflecting service, operational requirements and financial targets in respect of income and expenditure and capital investments. These include the Trust's plan for improving productivity and efficiency in order to minimise income losses, meet the national efficiency targets applied to all NHS providers and fund local investment proposals. The plan incorporates projections for the next two years which facilitates forward planning in the Trust. Financial plans are approved by the Board of Directors, supported by the Finance and Performance Committee, prior to submission to NHS Improvement.

The in-year resource utilisation is monitored by the board and its committees via a series of detailed reports covering finance, activity, capacity, human resource management and risk. Clinical risk assessments are conducted on individual savings proposals that may impact on the provision or delivery of clinical services. The Trust has continued to face a challenging year financially in 2017/18 this has materialised in the Trust not achieving its original control total surplus. The Trust recognises that this financial risk will continue into 2018/19. The Trust continues with its transformation programme to ensure that it remains financially sustainable going forward and underpins the Trust's longer term financial strategy.

Performance review meetings assess each division's performance across a full range of financial, operational and quality matrices which, in turn, forms the basis of the monthly integrate performance report to the Finance and Performance Committee. Monthly reports are submitted to NHS Improvement from which the Trust's risk rating is calculated and a relevant NHS Improvement Single Oversight Framework segmentation is assigned. The Trust has been assigned a segmentation rating of 2, where segmentation of 3 or 4 would indicate a Trust is or is likely to be breach of its licence.

The key processes embedded within the Trust to ensure that resources are used economically, efficiently and effectively, centre around a robust budget setting and control system which includes activity related budgets and periodic reviews during the year which are considered by executive directors and the Board of Directors. The budgetary control system is complemented by Standing Financial Instructions, a Scheme of Delegation and Financial Approval Limits. This process enables regular review of financial performance by highlighting areas of concern via variance analysis. The Finance and Performance Committee also receives a monthly report showing the Trust's performance against CQUIN, NHS Improvement and CQC targets.

As Accounting Officer, I have overall accountability for delivery of the Annual Plan and I am supported by the executive directors with delegated accountability and responsibility for delivery of specific targets and performance objectives. These are formally reviewed and monitored monthly by the Board of Directors and its committees. Independent assurance on the use of resources is provided through the Trust's internal audit programme, Audit Committee and external agencies such as NHS Improvement, External Audit and the CQC.

Information governance

As described previously, the Trust takes information governance very seriously and its associated risks are managed in the same way as other corporate risks. The Trust has, through the completion and submission of its Information Governance Toolkit, scored a "satisfactory" rating against all 45 applicable mandatory elements being judged to meet at least level 2 (the minimum standard required). The Board has received assurance via a review of this submission by Internal Audit at the year-end which confirmed that for the sampled requirements the evidence supported the Trust's own assessment. The Trust has maintained its ISO 27001 accreditation in respect of its IT Security processes; this accreditation was maintained after a successful external validation of the Trust's processes which provided further assurance in respect of the Trust's information governance processes.

The Trust has reported two incidents to the Information Commissioner (ICO) where breaches to the confidentiality of data occurred. For each incident, a full investigation was undertaken in accordance with the Trust's incident management policy and procedures. The learning from these incidents has been shared widely within the Trust. Both the ICO and our commissioners have been engaged during our investigation process, as appropriate, and are satisfied that we acted swiftly and appropriately engaging with the affected patients where necessary throughout the investigation.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Board of Directors has taken the following measures to ensure the Quality Report presents a balanced view and has appropriate controls to ensure the accuracy of data.

Governance and leadership

The executive and non-executive directors have a collective responsibility as a board to ensure that the governance arrangements supporting the Quality Accounts and Report provide adequate and appropriate information and assurances relating to the Trust's quality objectives. Board sponsors are nominated for all quality priorities providing visible board leadership of specific quality initiatives.

Whilst the chief executive has overall responsibility for the quality of care provided to patients, the implementation and co-ordination of the quality framework is delegated to both the chief nurse and medical director. They have joint responsibility for reporting to the Board of Directors on the development and progress of the quality framework and for ensuring that the Quality Strategy is implemented and evaluated effectively.

Policies

High quality organisational documentation is an essential tool of effective governance, which will help the Trust achieve its strategic objectives, operational requirements and bring consistency to day to day practice. A common format and approved structure for such documents helps reinforce corporate identity, helps to ensure that policies and procedures in use are current, and reflects an organisational approach. A standard approach ensures that agreed practice is followed throughout the organisation. With regard to the development of approved documentation, all procedural documents are accessible to all relevant staff supporting the delivery of safe and effective patient care.

Systems and processes

The systems and processes which support the development of the quality accounts focus on engagement activities with public, patients and staff and utilising the many media/data capture opportunities available.

The topics were agreed by the Board of Directors and the Council of Governors on the basis of their importance both from a local perspective (e.g. based on complaints, results of Nursing Care Indicators) and a national perspective (e.g. reports from national bodies e.g. Age Concern, CQC findings etc).

The Trust reviews its quality priorities annually engaging with governors, staff, members of the public and partner organisations. This year has seen the Trust continue with many of the priorities from the last year including nutrition and infection control. The Trust's 2016/17 quality priorities are discussed further in the Trust's Quality Account.

People and skills

In addition to the leadership provided by the Board of Directors, clinical divisional management teams, led by clinical directors and co-ordinated by general managers, are accountable for, and ensure that a quality service is provided within, their respective divisions and areas of authority. They are required to implement the Quality Strategy, providing safe, effective and personal care and ensure that patients have a positive experience and are treated with courtesy, respect and kindness.

Training opportunities are available for clinical and non-clinical staff and competency is monitored as part of the Trust's appraisal system. External reviewers provide independent opinions on the appropriateness and adequacy of training.

The Board of Directors ensures that quality improvement is central to all activities. This is achieved by routine monitoring, participation in national improvement campaigns, celebrating success with our staff awards and proactively seeking patient views on our services.

Data use and reporting

Data Quality Assurance over the various elements of quality, finance and performance is of key importance to management and the board and reviews of the Trust's system of internal control in respect of data quality are undertaken in each year through the approved Internal Audit work plan.

The Trust has robustly utilised existing data collection and reporting arrangements to monitor progress against the quality priorities and identify trends. Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made.

Internal Audit specifically devotes an element of their annual work plan to providing assurance over the Trust's data quality processes. They have a rolling programme of areas for review ensuring that over time the Trust's data quality systems are subject to review. In 2017/18 this work included a review of the data quality systems underpinning the Trust's Referral to Treatment (RTT) waiting time reporting which considered and concluded positively on the work and controls in place within the access team for validating the data.

However, the work of the Trust's external auditors identified a national issue with the data quality relating to the RTT data. This being once the reported data is centrally fixed and cannot then be changed by any subsequent validation activity undertaken by the Trust. The external auditors also identified that the period close date used by the Trust was the last Sunday of the month rather than the actual month end date which again could impact on the completeness of the data reported.

In addition to the internal audit review, since the introduction of the Referral to Treatment (RTT) waiting times in 2007, the Trust has developed a comprehensive set of in-house RTT monitoring reports that are used both within the organisation to manage the RTT waits, in conjunction with information held on the Trust's OASIS Patient Administration System (PAS), and for the external reporting of performance.

The reports have been produced by the Information Department who have worked closely with the divisions to generate reports that match the patient pathways, primarily using data sourced from the Trust's Patient Administration System (PAS) system.
Internal, management audits, of the RTT pathways are done on an ad-hoc basis by both operational and information staff periodically throughout the year.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and the Clinical Quality, Safety and Patient Experience Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board Assurance Framework and the Trust's risk management arrangements provide me with evidence that the controls to manage the risks to the Trust achieving its principal objectives have been reviewed and are effective. My review is also informed by the work of external and independent assessors and advisors including the Care Quality Commission.

During 2017/18, the work of the internal auditors and the board's review of the Board Assurance Framework and supporting risk management and governance processes identified some internal control weaknesses and perceived gaps in control which have been reported as part of the Trust's routine and ongoing monitoring arrangements. These identified weaknesses are considered to be operational in nature and have had their actions robustly monitored to ensure improvement is made to the systems in place across the Trust.

The Head of Internal Audit opinion stated that "The organisation has an adequate and effective framework for risk management, governance and internal control".

Internal Audit identified "further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

However, none of the identified weaknesses were deemed to be significant in terms of the overall systems of internal control of the Trust.

Conclusion

My review of the effectiveness of the risk management and internal control has confirmed that:

The Trust has a generally sound system of internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

The systems of internal control in relation to the Quality Report are consistent with the Trust's overall system of internal control and the board has been assured that the Quality Report presents a balanced view and that the data is accurate.

Based on the work undertaken by a range of assurance providers, there were no significant control issues identified during 2017/18.

Where improvements have been recommended, then robust mechanisms have been established to track the delivery of these improvements. These include for those made by the CQC within their two Section 31 notices we established a comprehensive service improvement plan and have been tracking their implementation at both management and Board / Committee levels. Management proactively sought to enhance its oversight of the Trust's cost improvement delivery, the delivery of which is key to the Trust's continuing to be a going concern, through the establishment of a Financial Improvement Group which reports to the Finance and Performance Committee.

I, therefore, believe that the Annual Governance Statement is a balanced reflection of the actual control position in place within the year.

Signed Date: 22nd May 2018

Diane Wake
Chief Executive

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

- make judgements and estimates which are reasonable and prudent;

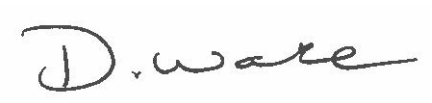
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

Signed Date: 22nd May 2018



Diane Wake
Chief Executive

Signed Date: 22nd May 2018

Tom Jackson
Director of Finance

Independent Auditors' Report to the Council of Governors of The Dudley Group NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, The Dudley Group NHS Foundation Trust's Group and Trust financial statements:

- give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2018 and of the Group and Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Accounts (the "Annual Report"), which comprise: the Consolidated and Foundation Trust Statement of Financial Position as at 31 March 2018; the Consolidated and Foundation Trust Statements of Comprehensive Income for the year then ended; the Consolidated and Foundation Trust Statement of Cashflows for the year then ended; the Consolidated and Foundation Trust Statements of Changes in Taxpayer's and Others' Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the Group financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1 to the financial statements concerning the Group's and the Trust's ability to continue as a going concern.

The Trust recorded a financial deficit in 2017/18, and whilst the Trust is forecasting a financial surplus for 2018/19, this is dependent on a significant improvement in financial performance, and on receiving the Trust's allocated share of the Provider Sustainability Fund (PSF) from NHS Improvement. To receive its share of the PSF in full, the Trust must achieve its financial plan and its Accident and Emergency (A&E) waiting times target regarding the percentage of patients who are admitted, transferred or discharged within 4 hours of their arrival at an A&E department.

The Trust's cash forecasts indicate that, should the necessary improvements in financial performance not be achieved, the Trust will be reliant on external cash support from the Department of Health within the 2018/19 financial year.

These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Group's and the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Group or the Trust were unable to continue as a going concern.

Explanation of material uncertainty

The financial performance of the Trust during 2017/18, with a deficit position and deterioration in the cash balance, requires us to consider whether there are material uncertainties that should be disclosed in the accounts.

The Trust has produced a financial plan for 2018/19 which includes a cashflow forecast. We noted a number of financial dependencies which the Trust will need to achieve in order to meet its plan, including:

- a significant improvement in performance in achieving cost savings;
- a 47% reduction in annual agency spend so that it is below the agency ceiling which has been set by NHS Improvement for 2018/19; and
- achievement of the conditions set by NHS Improvement for the Trust to receive its share of the Provider Sustainability Fund, including meeting the Trust's target for A&E waiting times in 2018/19.

What audit procedures we performed

In considering whether it is appropriate for the financial statements to be prepared on a going concern basis we:

- obtained the Trust's financial plan for 2018/19, and understood the uncertainties within the plan and the risks in delivering the plan; and
- considered the Trust's cashflow forecasts for the period to 31 May 2018, including the Trust's assessment of the downside risks.

The Trust's cash flow forecast for 2018/19 shows a downside position where the Trust would require external cash funding in order to be able to meet its obligations as they fall due. The nature of any financial support is not yet confirmed, and so it is not clear at present how the continuity of the Trust's services would be achieved, should cash support be required. As a result there is a material uncertainty, which may cast significant doubt over the Trust's ability to continue as a going concern.

Our audit approach

Context

The Trust is the main provider of acute emergency and scheduled healthcare in Dudley, operating from three sites, the main site at Russells Hall Hospital, the Corbett Outpatient Centre and the Guest Outpatient Centre. It also provides community services in Dudley from a number of different locations. It has an annual income of £354 million, which is funded predominantly by local Clinical Commissioning Groups and NHS England.

Our audit for the year ended 31 March 2018 was planned and executed having regard to the fact that the Group and Trust's operations were largely unchanged in nature from the previous year. Whilst the Group and Trust's overall financial stability were impacted by a deterioration in financial performance, our approach to the audit in terms of scoping and areas of focus was largely unchanged.

Overview

- Overall materiality: £6,962,000 which represents 2% of total revenue.

- The consolidated financial statements comprise the parent, The Dudley Group NHS Foundation Trust, and its subsidiaries (The Dudley Group NHS Foundation Trust Charity and Dudley Clinical Services Limited).
- All work was performed by a single audit team who assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement and determined the extent of testing we needed to do over each balance in the financial statements.

Our key audit matters were:

- Risk of fraud in revenue and expenditure recognition;
- Valuation of Property, Plant and Equipment; and
- Going concern.

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to going concern, described in the *Material uncertainty relating to going concern* section above, we determined

the matters described below to be the key audit matters to be communicated in our report. This is not a complete list of all risks identified by our audit.

Key audit matter	*How our audit addressed the Key audit matter*
Key audit matter 1 – Group and Trust *Risk of fraud in revenue and expenditure recognition* *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure and notes 3 to 5 for further information.* There is a risk that, due to the financial position of the Trust, management has adopted accounting policies or treated income or expenditure transactions in such a way as to lead to an understatement of the reported deficit position. This, combined with the nature of a number of the Trust's contracts, the 'Sustainability and Transformation Fund' money, and the timing of the intra-NHS balance agreement process, led us to focus on it. We considered revenue recognition to be a risk, in particular revenue streams from the Clinical Commissioning Groups ("CCGs") and NHS England, which together comprise £317 million of the Trust's £354 million of income. The service level agreements with the CCGs are renegotiated annually and are paid in standard monthly instalments. A year-end adjustment is then negotiated with the CCGs to reflect actual levels of activity where contracts follow Payment by Results. The value and recoverability of the adjustment is subject to management judgement. Due to the incentive for the Trust to achieve its financial Control Total, in order to receive Sustainability and Transformation Fund money, we considered the risk to be focused on the existence of income from material CCG contracts, in particular the year-end adjustments. We also considered expenditure recognition to be a risk. Given the incentive described above we focussed on the completeness of expenditure in the Statement of Comprehensive Income and of liabilities recorded in the Statement of Financial Position. We focused our work on the elements of income and expenditure that are most susceptible to manipulation: • non-standard journal transactions; • income recognition for material contracts with CCGs, specifically the year adjustment; and • unrecorded liabilities.	*Journals* We tested a sample of journal transactions that had been recognised in both income and expenditure, focussing in particular on those that had been transacted near the end of the year. We agreed the journal entries to supporting documentation, for example invoices and cash transactions. Our testing found that they were supported by appropriate documentation and that the income and expenditure was recognised in the appropriate accounting period for the correct value. *Revenue* For a sample of transactions recognised during the year and around the year-end (both before and after), we confirmed that income and expenditure had been recognised in line with the Group's accounting policies and in the correct accounting period by agreeing transactions to the supporting invoice and cash receipts/payments where appropriate. For a sample of CCG income, we obtained the signed contract and agreed its value to the income recognised during the year. For a sample of income from over and under performance against the contract we agreed the income to supporting evidence. This included inspecting information from the year-end intra-NHS balance agreement process to identify any significant differences between the income and debtors reported with NHS organisations. No material issues were identified from the work performed. *Expenditure* We performed testing to identify whether there were any unrecorded liabilities. We: • tested a sample of large payments made and invoices received after 31 March 2018 to supporting documentation, to check that, where they related to the 2017/18 financial year, an accrual was recognised appropriately; and • compared accrued expenses recognised as at 31 March 2018 with that recognised in the prior year to identify differences in the accruals recognised year on year. We also inspected the information from the year-end intra-NHS balance agreement process to identify any significant differences between the expenditure and creditors reported with NHS organisations. No material issues were identified from the work performed.

Key audit matter 2 – Group and Trust

Valuation of property, plant and equipment

See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating the valuation of property, plant and equipment and note 13 for further information.

We focussed on this area because property, plant and equipment ("PPE") represents the largest balance in the Trust's Statement of Financial Position and the valuation of land and buildings requires significant levels of judgement and technical expertise in choosing appropriate assumptions. Therefore our work has focused on whether the methodology, assumptions and underlying data used to determine the value of Property, Plant and Equipment were appropriate and correctly applied. PPE amounts to £236.373 million of which £220.551 million is land and buildings.

All PPE is measured initially at cost, with land and buildings subsequently measured at fair value. A professionally accredited expert prepares valuations following Royal Institution of Chartered Surveyors (RICS) requirements. Valuations have to be prepared sufficiently regularly so that carrying values are not materially different from fair value at the reporting date.

A valuation carried out in 2017/18 and was undertaken by the Trust's valuation experts. Changes included updating the value of assets using industry-standard indices and continuation of revaluing PFI assets net of VAT. This resulted in an increase in the fair value of Trust buildings of £22.543 million.

We considered the key areas of focus to be:

- the key inputs to the valuation, in particular the floor areas on which the valuation is based; and
- the methodology, assumptions and underlying data used by the valuation expert.

We obtained the valuation and assessed the competence and objectivity of the Trust's Valuer by using the work of an auditor's expert in the valuation of PPE to help us look at their assumptions and approach and compare it with industry requirements.

We assessed the methodology, assumptions and estimates used in the valuation including the consistency of these with our own expectations based on our experience of similar valuations and wider industry trends.

We tested a sample of the material assets, checking that the input data used by the valuer as the basis for the valuation, in particular the floor areas, was consistent with the underlying estates information.

We checked that the valuation information had been correctly input into the Fixed Asset Register and the accounting treatment recorded in the Trust's financial statements was appropriate.

Our work did not identify any material issues.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Group, the accounting processes and controls, and the environment in which the Group operates.

The Trust is the Corporate Trustee of The Dudley Group NHS Foundation Trust Charity. The Charity is consolidated into the Group financial statements. Dudley Clinical Services Limited is wholly owned by The Dudley Group NHS Foundation Trust and is also consolidated into the Group financial statements. We conducted the audit on the Consolidated Group financial statements at the Trust's headquarters in Dudley, which is where the Trust's finance function is based.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	*Trust financial statements*
Overall materiality	£6,962,000 (2017: £6,518,500)	£6,614,100 (2017: £6,192,575)
How we determined it	2% of revenue (2017: 2% of revenue)	2% of revenue (2017: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

For each component in the scope of our group audit, we allocated a materiality that is less than our overall group materiality. The range of materiality allocated across components was £40,925 and £6,614,100. The Trust is the only significant component of the Group. Certain components were audited to a local statutory audit materiality that was less than our overall group materiality.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £250,000 (Group audit) (2017: £250,000) and £250,000 (Trust audit) (2017: £250,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out in the Statement of accounting officer's responsibilities, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

As part of an audit in accordance with ISAs (UK), we exercise professional judgement and maintain professional scepticism.

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of The Dudley Group NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

During the year ended 31 March 2018 the Care Quality Commission (CQC) carried out an inspection at the Trust and issued its report on 18 April 2018. The Trust's overall rating is 'Requires Improvement' but Urgent and Emergency Services was rated as 'Inadequate' in the following areas: 'are services safe?' and 'are services well-led?'.

We have concluded that, except for the matter above, the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2018.

Other matters on which we report by exception

We are required to report to you if:

- The statement given by the directors in the Performance Report, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for members to assess the Group and Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- The section of the Annual report in the Accountability Report, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- The Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

- We have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- We have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- We have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Alison Breadon (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Cornwall Court
19 Cornwall Street
Birmingham
B3 2DT

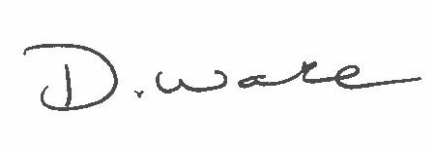
25 May 2018

Section 3: Annual Accounts

Foreword to the Accounts

These accounts for the period 1st April 2017 to 31st March 2018 have been prepared by The Dudley Group NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed Date 22nd May 2018



Diane Wake
Chief Executive

Consolidated and Foundation Trust Statements of Comprehensive Income
For the Year Ended 31 March 2018

	Note	Group		Foundation Trust	
		Year Ended 31 March 2018 £'000	Year Ended 31 March 2017 £'000	Year Ended 31 March 2018 £'000	Year Ended 31 March 2017 £'000
Operating Income from patient care activities	3	323,187	315,280	323,187	315,280
Other Operating Income	4	29,652	36,862	29,554	36,796
Total Operating Income from continuing operations		**352,839**	**352,142**	**352,741**	**352,076**
Operating Expenses of continuing operations	5	(346,316)	(326,788)	(345,972)	(326,634)
Operating Surplus / (Deficit)		**6,523**	**25,354**	**6,769**	**25,442**
Finance Costs					
Finance income	9	117	122	66	72
Finance expense - financial liabilities	10	(11,039)	(11,089)	(11,039)	(11,089)
PDC Dividends payable		(3,129)	(2,976)	(3,129)	(2,976)
Net Finance Costs		**(14,051)**	**(13,943)**	**(14,102)**	**(13,993)**
Gain/(loss) of disposal of assets	13	56	0	56	0
Corporation tax expense	11	(37)	(34)	0	0
Surplus/(Deficit) for the year from continuing operations		**(7,509)**	**11,377**	**(7,277)**	**11,449**
SURPLUS/(DEFICIT) FOR THE YEAR		**(7,509)**	**11,377**	**(7,277)**	**11,449**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	13	(505)	(23,294)	(505)	(23,294)
Revaluations	13	22,543	0	22,543	0
May be reclassified to income and expenditure where certain conditions are met:					
Fair Value gains/(losses) on Available-for-sale financial instruments	14	5	175	0	0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**14,534**	**(11,742)**	**14,761**	**(11,845)**

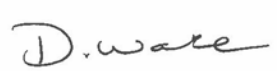
The notes on pages 5 to 39 form part of these accounts.
All income and expenditure is derived from continuing operations.

There are no Non-Controlling Interests in the Group, therefore the deficit for the year of £7,509,000 (2016/17 surplus of £11,377,000) and the Total Comprehensive Income of £14,534,000 (2016/17 Total Comprehensive Expense of £11,742,000) is wholly attributable to the Trust.

Consolidated and Foundation Trust Statements of Financial Position
As at 31 March 2018

	Note	Group		Foundation Trust	
		31 March 2018	31 March 2017	31 March 2018	31 March 2017
Non-current assets		£'000	£'000	£'000	£'000
Intangible assets	12	3,292	2,677	3,292	2,677
Property, plant and equipment	13	236,373	208,482	236,373	208,482
Other Investments	14	1,316	1,311	0	0
Trade and other receivables	17	12,026	10,338	12,026	10,338
Total non-current assets		253,007	222,808	251,691	221,497
Current assets					
Inventories	16	2,991	2,897	2,847	2,730
Trade and other receivables	17	12,926	21,802	12,754	21,982
Other financial assets	15	500	1,028	0	0
Cash and cash equivalents	24	14,113	18,026	13,496	17,367
Total current assets		30,530	43,753	29,097	42,079
Current liabilities					
Trade and other payables	18	(23,567)	(18,144)	(23,345)	(17,913)
Borrowings	23	(6,255)	(5,156)	(6,255)	(5,156)
Provisions	21	(147)	(140)	(147)	(140)
Other financial liabilities	19	(1,639)	(1,788)	(1,639)	(1,788)
Total current liabilities		(31,608)	(25,228)	(31,386)	(24,997)
Total assets less current liabilities		**251,929**	**241,333**	**249,402**	**238,579**
Non-current liabilities					
Trade and other payables	18	(40)	(80)	(40)	(80)
Borrowings	23	(122,236)	(127,432)	(122,236)	(127,432)
Total non-current liabilities		(122,276)	(127,512)	(122,276)	(127,512)
Total assets employed		**129,653**	**113,821**	**127,126**	**111,067**
Financed by					
Taxpayers' equity					
Public Dividend Capital		25,951	24,653	25,951	24,653
Revaluation reserve		81,286	59,249	81,286	59,249
Income and expenditure reserve		20,411	27,531	19,889	27,165
Others' equity					
Charitable Fund reserves		2,005	2,388	0	0
Total Taxpayers' and Others equity		**129,653**	**113,821**	**127,126**	**111,067**

The financial statements were approved by the Board of Directors and authorised for issue on their behalf by:



Signed .....

Date: 22nd May 2018

Diane Wake
Chief Executive

Consolidated and Foundation Trust Statements of Changes in Taxpayers' and Others' Equity
for the Year Ended 31 March 2018

	Group					Foundation Trust			
	..... Taxpayers' Equity					..... Taxpayers' Equity			
	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	** Charitable Fund Reserves	Total Taxpayers' and Others' Equity	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve	Total Taxpayers' Equity
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Taxpayers' and Others' Equity at 1 April 2016	**24,653**	**82,547**	**15,943**	**2,420**	**125,563**	**24,653**	**82,547**	**15,712**	**122,912**
Prior period adjustment	0	0	0	0	0	0	0	0	0
Taxpayers' and Others' Equity at 1 April 2016 - restated	**24,653**	**82,547**	**15,943**	**2,420**	**125,563**	**24,653**	**82,547**	**15,712**	**122,912**
Surplus / (Deficit) for the year	0	0	11,551	(174)	11,377	0	0	11,449	11,449
Transfers between reserves	0	(4)	4	0	0	0	(4)	4	0
Impairments	0	(23,294)	0	0	(23,294)	0	(23,294)	0	(23,294)
Revaluations - property, plant and equipment	0	0	0	0	0	0	0	0	0
Fair Value gains/(losses) on available -for-sale financial investments	0	0	0	175	175	0	0	0	0
Public Dividend Capital Received	0	0	0	0	0	0	0	0	0
Other reserve movements	0	0	0	0	0	0	0	0	0
Consolidation adjustment	0	0	33	(33)	0	0	0	0	0
Taxpayers' and Others' Equity at 31 March 2017	**24,653**	**59,249**	**27,531**	**2,388**	**113,821**	**24,653**	**59,249**	**27,165**	**111,067**
Taxpayers' and Others' Equity at 1 April 2017	**24,653**	**59,249**	**27,531**	**2,388**	**113,821**	**24,653**	**59,249**	**27,165**	**111,067**
Surplus / (Deficit) for the year	0	0	(7,121)	(388)	(7,509)	0	0	(7,277)	(7,277)
Transfers between reserves	0	0	0	0	0	0	0		0
Impairments	0	(505)	0	0	(505)	0	(505)	0	(505)
Revaluations - property, plant and equipment	0	22,543	0	0	22,543	0	22,543	0	22543
Fair Value gains/(losses) on available -for-sale financial investments	0	0	0	5	5	0	0	0	0
Public Dividend Capital Received	1,298	0	0	0	1,298	1,298	0	0	1298
Other reserve movements	0	(1)	1	0	0	0	(1)	1	0
Consolidation adjustment	0	0	0	0	0	0	0	0	0
Taxpayers' and Others' Equity at 31 March 2018	**25,951**	**81,286**	**20,411**	**2,005**	**129,653**	**25,951**	**81,286**	**19,889**	**127,126**

** Charitable Fund Reserves comprise Unrestricted Funds £1,979,000 (2016/17 £2,371,000) of which £1,839,000 (2016/17 £2,157,000) have been designated for specific purposes, Restricted Funds £26,000 (2016/17 £17,000) and Endowment Funds £nil (2016/17 £nil). Unrestricted Funds comprise those funds that the Trustee is free to use for any purpose in furtherance of the Charity objectives, Restricted Funds are specific appeals for funds or donations where legal restrictions have been imposed by the Donor, and Endowment Funds are held as capital by the Charity to generate income for charitable purposes but cannot themselves be spent.

Consolidated and Foundation Trust Statements of Cash Flows
for the Year Ended 31 March 2018

	Group		Foundation Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
Cash flows from operating activities	£'000	£'000	£'000	£'000
Operating surplus/(deficit) from continuing operations	6,523	25,354	6,769	25,442
Operating surplus/(deficit)	**6,523**	**25,354**	**6,769**	**25,442**
Non-cash income and expense:				
Depreciation and amortisation	9,251	8,856	9,251	8,856
Impairments and Reversals	1,428	0	1,428	0
Income recognised in respect of capital donations (cash and non-cash)	(187)	(77)	(187)	(77)
(Increase)/Decrease in trade and other receivables	7,191	(13,681)	7,545	(13,734)
Increase/(Decrease) in other assets	0	0	0	0
(Increase)/Decrease in inventories	(94)	131	(117)	96
Increase/(Decrease) in trade and other payables	3,900	(1,842)	3,916	(1,988)
Increase/(Decrease) in other liabilities	(149)	(707)	(149)	(707)
Increase/(Decrease) in provisions	7	(139)	7	(139)
Tax (paid) / received	(34)	0	0	0
Movements in charitable fund working capital	533	223	0	0
NET CASH GENERATED FROM/(USED IN) OPERATIONS	28,369	18,118	28,463	17,749
Cash flows from investing activities				
Interest received	63	73	60	71
Purchase of financial assets	0	(212,000)	0	0
Sales of financial assets	0	212,000	0	0
Purchase of intangible assets	(1,470)	(1,720)	(1,470)	(1,720)
Sales of intangible assets	0	0	0	0
Purchase of Property, Plant and Equipment	(13,347)	(2,988)	(13,347)	(2,988)
Sales of Property, Plant and Equipment	63	0	63	0
NHS Charitable funds - net cash flows from investing activities	49	48	0	0
Net cash generated from/(used in) investing activities	(14,642)	(4,587)	(14,694)	(4,637)
Cash flows from financing activities				
Public dividend capital received	1,298	0	1,298	0
Capital element of PFI Obligations	(5,199)	(5,343)	(5,199)	(5,343)
Interest paid	0	(7)	0	(7)
Interest element of PFI Obligations	(11,039)	(11,082)	(11,039)	(11,082)
PDC Dividend paid	(2,700)	(2,696)	(2,700)	(2,696)
Net cash generated from/(used in) financing activities	(17,640)	(19,128)	(17,640)	(19,128)
Increase/(decrease) in cash and cash equivalents	**(3,913)**	**(5,597)**	**(3,871)**	**(6,016)**
Cash and Cash equivalents at 1 April	18,026	23,623	17,367	23,383
Cash and Cash equivalents at 31 March	**14,113**	**18,026**	**13,496**	**17,367**

1. Accounting Policies and Other Information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Accounting Manual 2017-18, issued by the Department of Health. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DH Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Going Concern

The Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The Trust experienced a difficult 2017/18 financial year which resulted in a deficit position and a reduction in its cash balances. To mitigate the risks arising from the financial position, and to give itself the best chance of financial turnaround, the Trust Board has established a Financial Improvement Programme for 2018/19 with additional financial controls, targets and protocols. If achieved, the Trust will receive an additional £9m from the Provider Sustainability Fund. The Board is aware of the risk that if the financial plan is not achieved this indicates the existence of a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. This would be mitigated by the requirement of the Trust to borrow funds at some point in the next 12 months. The Board continues to monitor its monthly and future cash position and has governance arrangements in place to manage cash requirements throughout the year.

Accounting Convention

The annual report and accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.1 Consolidation

The group annual report and accounts consolidate the annual report and accounts of the Trust and all of its subsidiary undertakings made up to 31st March 2018. The income, expenses, assets, liabilities, equity and reserves of the subsidiaries have been consolidated into the Trust's annual report and accounts and group annual report and accounts have been prepared.

Subsidiaries

Subsidiary entities are those which the Foundation Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate annual report and accounts lines. The amounts consolidated are drawn from the published annual report and accounts of the subsidiaries for the year. Where subsidiaries' accounting policies are not aligned with those of the Foundation Trust then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

NHS Charitable Fund

The NHS Foundation Trust is the corporate trustee to Dudley Group NHS Charity. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

Prior to 2013/14, the FT ARM permitted the NHS Foundation Trust not to consolidate the charitable fund. From 2013/14, the Foundation Trust has consolidated the charitable fund and has applied this as a change in accounting policy.

The charitable fund's statutory annual report and accounts are prepared to 31st March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- eliminate intra-group transactions, balances gains and losses.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Income is recognised in the period in which services are provided, for patients whose treatment straddles the year end this means income is apportioned across financial years on the basis of length of stay. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the

NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actual (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.4 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably and;
    - has an individual cost of at least £5,000; or
    - the items form a group of assets which collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under the same managerial control; or
    - form part of the initial equipping and setting up cost of a new building or refurbishment of a ward or unit, and the items collectively have a cost of at least £5,000.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All Property, Plant and Equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

For property assets the frequency of revaluations will be at least every five years, in line with Monitor's view.

The fair value of land and buildings are determined by valuations carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out primarily on the basis of modern equivalent cost for specialised operational property and existing use value for non-specialised operational property. For the Trust's PFI buildings the valuation does not include any VAT liability as VAT is recoverable on the unitary payments made by the Trust and any re-provision of the buildings would be carried out via a further PFI agreement. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Assets under construction are valued at cost and are subsequently revalued by professional valuers when they are brought into use if factors indicate that the value of the asset differs materially from its carrying value. Otherwise, the asset should only be revalued on the next occasion when all assets of that class are revalued.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure
Expenditure incurred after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the income statement in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits expected to be obtained from use of an item of property, plant and equipment and where the cost of the item can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement.

Depreciation
Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

The Trust depreciates its non-current assets on a straight line basis over the expected life of the assets after allowing for the residual value. Useful lives are determined on a case by case basis. The typical lives for the following assets are:

Asset Category	Useful Life (years)
Buildings	As per valuer's estimate
Engineering Plant & Equipment	5 - 15
Medical Equipment	5 - 15
Transport Equipment	7
Information Technology	5 - 7
Furniture & Fittings	5 - 10

Freehold land is considered to have an infinite life and is not depreciated.
Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon reclassification.
Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of other impairments are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:
- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met. Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, Government Grant and other grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in the HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a lifecycle element, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

The lifecycle element is established on the lifecycle plan contained within the financial model. Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value. The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively. Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is

treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

The Trust will review any prepayment balance annually and compare the total of the prepayment balance and remaining lifecycle contributions to the original agreed plan of lifecycle spend. An impairment will be recognised when the total of the prepayment balance compared to the expected prepayment balance exceeds by more than 10% the total remaining lifecycle spend as per the original plan. If the Trust is provided with an updated plan of future spend then this will be used as the basis of the impairment review.

1.6 Intangible Assets

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the license and their useful lives.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at current value in existing use. Where no market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.6 Intangible Assets

Amortisation and impairment

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The carrying value of intangible assets is

reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Asset Category	Useful Life (years)
Software Licences	2 - 10

1.7 Government Grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups or NHS Trusts for the provision of services. Grants from the Department of Health, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is credited to income at the same time, unless the grant has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the grant, in which case, the grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First In, First Out (FIFO) method.

1.9 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours.

1.10 Financial Instruments and Financial Liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. Regular way purchases or sales are recognised and de-recognised, as applicable, using the settlement date. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure' or Loans and Receivables. Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial Liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent

movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and 'other receivables'. Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available for sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available for sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in ' Finance Costs' in the Statement of Comprehensive Income.

Other Financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset. For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.11 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability. The asset and liability are recognised at the inception of the lease, and are de-recognised

when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.12 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's long term discount rate of -0.8 per cent (2016/17 0.8 per cent) in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 0.24 per cent (2016/17 0.24 per cent) in real terms.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 17, but is not recognised in the Trust annual report and accounts.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 26, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services and National Loans Fund deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual report and accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual report and accounts.

1.15 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Foreign Exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;

- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and

- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expenditure in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.17 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the annual report and accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in note 30 to the annual report and accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.18 Corporation Tax

The Trust is a Health Service Body within the meaning of S519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to remove the exemption in relation to specified activities of a Foundation trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the future scope of income tax in respect of activities where income is received from a non-public sector source.

The tax expense on the Statement of Comprehensive Income comprises current and deferred tax due to the Trust's trading commercial subsidiaries. Current tax is the expected tax payable for the year, using tax rates enacted or substantively enacted at the Statement of Financial Position date, and any adjustment to tax payable in respect of previous years.

Deferred tax is provided using the Statement of Financial Position liability method, providing for temporary differences between the carrying amounts of the assets and liabilities for financial reporting purposes and the amounts used for taxation purposes. Deferred tax is not recognised on taxable temporary differences arising on the initial recognition of goodwill or for temporary differences arising from the initial recognition of assets and liabilities in a transaction that is not a business combination and that affects neither accounting nor taxable profit.

Deferred taxation is calculated using rates that are expected to apply when the related deferred asset is realised or the deferred taxation liability is settled. Deferred tax assets are recognised only to the extent that it is probable that future taxable profits will be available against which the assets can be utilised.

1.19 Critical accounting judgements and key sources of estimation and uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the annual report and accounts.

- Accounting for PFI

- Application of IFRIC 4 Determining whether an Arrangement contains a Lease

- Application of IFRIC12 Service Concession Arrangements

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year

- Valuation of Non- Current Assets

- Provisions

- Settlement of Over Performance with Healthcare Purchasers

1.20 Accounting Standards that have been issued but have not yet been adopted

The Accounting Standards Board (IASB) has issued a number of standards which will impact on the Trusts accounts. However, these have yet to be applied to the Department of Health Group Accounting Manual. Those standards are:

IFRS 9 Financial Instruments
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM, early adoption is not therefore permitted. Changes to the standard will amend the methodology and amount of bad debt provision recognised by the Trust when the standard is adopted within the NHS. The standard requires that Trusts make an impairment assessment of all debt at the point that it is due for payment based on evidence available for the likely payment of debt by debtors of that nature. This may result in a larger bad debt provision as the Trust recognises a provision for current debt raised in addition to the analysis currently carried out on aged debt.

IFRS 14 Regulatory Deferral Accounts
Not yet EU-endorsed. The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries. It applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

IFRS 15 Revenue from Contracts with Customers
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM, early adoption is not therefore permitted. The standard deals with the valuation and timing of income recognition. The new standard requires that income is recognised based on the satisfaction of promises within the contract for supply or service. This is expected to have a minimal impact to the Trust, however may alter the timing of recognition for some income types such as private patient income for ongoing treatments.

IFRS 16 Leases
Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM, early adoption is not therefore permitted. The new leasing standard will see almost all of the Trust leases moving onto the balance sheet. The standard requires that the right to use an asset is put onto the Trust's balance sheet along with the obligation to repay the lessor over the term of the lease (much the same as the current accounting for finance leases). The only exception to this would be leases where the term is less than 12 months. The Trust has begun work to establish the scope and value of contracts containing a lease which would be captured within this standard.

IFRS 17 Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM, early adoption is not therefore permitted. This is not expected to have a material impact on the Trust's Accounts.

IFRS 22
Application required for accounting periods beginning on or after 1 January 2018. This is not expected to have a material impact on the Trust's Accounts.

IFRS 23 Uncertainty over Income Tax Treatments
Application required for accounting periods beginning or after 1 January 2019. This is not expected to have a material impact on the Trust's Accounts.

1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

1.22 Transfers of functions to/from other NHS/Local Government Bodies

For functions that have been transferred to the Trust from another NHS Body, the assets and liabilities transferred are recognised in the annual report and accounts as at the date of transfer. The assets and liabilities are not adjusted to their fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the Cost and Accumulated Depreciation/Amortisation balances from the transferring entity's annual report and accounts are preserved on recognition in the Trust's annual report and accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector annual reports and accounts.

For functions that the Trust has transferred to another NHS/Local Government Body, the assets and liabilities are de-recognised from the annual report and accounts as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. Adjustments to align the acquired function to the Foundation Trust's policies are applied after initial recognition and are adjusted directly in taxpayers' equity. There have not been any transfers during 2017/18.

1.23 Sustainability and Transformation Fund

The Trust has received £4.728m of the Sustainability and Transformation Fund (STF) in 2017-18. £2.487 M of this amount related to a core element of the fund which the Trust received for achieving both its financial and performance targets in quarter 1 and quarter 2 of the year. In addition the Trust received £2.241m incentive general distribution STF based on the balance of unearned STF after the core, incentive and bonus scheme payments, to all providers that signed up to a control total in 2017/18. This was on a sliding scale based on distance from the control total weighted by initial STF allocations set by NHSI.

The £4.728m is recognised in other operating income within the statement of comprehensive income. The Trust was paid £2.487 during 2017/18 with the remaining £2.241m stated as accrued income within trade and other receivables on the statement of financial position.

2 Segmental Analysis

The analysis by business segment is presented in accordance with IFRS 8 Operating Segments, on the basis of those segments whose operating results are regularly reviewed by the Board (the Chief Operating Decision Maker as defined by IFRS 8) as follows:

Healthcare Services

The Board as 'Chief Operating Decision Maker' has determined that Healthcare Services operate in a single operating segment, which is the provision of healthcare services. The segmental reporting format reflects the Trust's management and internal reporting structure.

The Trust has identified segments in line with the thresholds in IFRS 8, applying the requirement of the DH GAM to consider expenditure instead of income as income is not analysed between segments in our monthly finance report to the Trust Board. Following a significance test of the expenditure segments the Trust found that there were four significant operating segments subject to the external reporting requirements of IFRS 8. Applying the aggregation criteria to the Trust's four significant operating segments found that in all cases the segments had similar economic characteristics, the nature of the services are similar, the nature of the production process are similar, the type or class of customer for the services are similar, the methods used to provide the services are similar and the nature of the regulatory environment is similar.

The Trust's significant operating segments satisfy all of the criteria listed for an aggregation to be deemed appropriate. The four significant operating segments of the Trust are all active in the same

business – the provision of healthcare, and all operate within the same economic environment – the United Kingdom. Given that the purpose of disclosing segmental information is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments, reporting a single segment of "Healthcare" would be consistent with the core principle of IFRS 8, as it would show the singular nature of both the business activity and the economic environment of the Trust.

Income from activities (medical treatment of patients) is analysed by customer type in note 3 to the accounts on page 17. Other operating income is analysed in note 4 to the accounts on page 18 and materially consists of revenues from healthcare, research and development, medical education, and the provision of services to other NHS bodies. Total income by individual customers within the whole of HM Government and considered material, is disclosed in the related parties transactions note 27 to the accounts on page 34.

Dudley Clinical Services Limited
The company is a wholly owned subsidiary of the Trust and provides an Outpatient Dispensing service. As a trading company, subject to an additional legal and regulatory regime (over and above that of the Trust), this activity is considered to be a separate business segment whose individual operating results are reviewed by the Trust Board (the Chief Operating Decision Maker).

A significant proportion of the company's revenue is inter segment trading with the Trust which is eliminated upon the consolidation of these group financial statements. The quarterly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table on page 16.

Dudley Group NHS Charity
The Trust Board are corporate trustees for Dudley Group NHS Charity. Following Treasury's agreement to apply IAS 27 to NHS Charities from 1st April 2013, the Trust has established that as the Trust is the corporate trustee of the linked NHS Charity, it effectively has the power to exercise control so as to obtain economic benefits. The Charity is therefore treated as a group entity and is consolidated. The consolidation is for reporting purposes only and does not affect the charities' legal and regulatory independence and day to day operations. Some of the charity's expenditure is inter segment trading with the Trust which is eliminated upon the consolidation of these group financial statements. The quarterly performance report to the Chief Operating Decision Maker reports financial summary information in the format of the table on page 16.

Year ended 31 March 2018	Healthcare Services £000	Dudley Clinical Services Limited £000	Dudley Group NHS Charity £000	Inter Group Eliminations £000	Total £000
Total segment revenue	352,741	5,407	409	(5,718)	352,839
Total segment expenditure	(345,972)	(5,216)	(846)	5,718	(346,316)
Operating Surplus/(Deficit)	6,769	191	(437)	0	6,523
Net Financing	(10,973)	2	49	0	(10,922)
PDC Dividends Payable	(3,129)	0	0	0	(3,129)
Taxation	0	(37)	0	0	(37)
Retained surplus/(deficit) - before non-recurring items	(7,333)	156	(388)	0	(7,565)
Non-recurring items	56	0	0	0	56
Retained surplus/(deficit)	(7,277)	156	(388)	0	(7,509)
Reportable Segment assets	280,788	791	2,046	0	283,625
Eliminations	0	0	0	(88)	(88)
Total assets	280,788	791	2,046	(88)	283,537
Reportable Segment liabilities	(153,662)	(269)	(41)	0	(153,972)
Eliminations	0	0	0	88	88
Total liabilities	(153,662)	(269)	(41)	88	(153,884)
Net assets/liabilities	127,126	522	2,005	0	129,653

Year ended 31 March 2017	Healthcare Services £000	Dudley Clinical Services Limited £000	Dudley Group NHS Charity £000	Inter Group Eliminations £000	Total £000
Total segment revenue	352,076	5,414	370	(5,718)	352,142
Total segment expenditure	(326,634)	(5,247)	(625)	5,718	(326,788)
Operating Surplus/(Deficit)	25,442	167	(255)	0	25,354
Net Financing	(11,017)	2	48	0	(10,967)
PDC Dividends Payable	(2,976)	0	0	0	(2,976)
Taxation	0	(34)	0	0	(34)
Retained surplus/(deficit) - before non-recurring items	11,449	135	(207)	0	11,377
Non-recurring items	0	0	0	0	0
Retained surplus/(deficit)	11,449	135	(207)	0	11,377
Reportable Segment assets	263,576	931	2,426	0	266,933
Eliminations	0	0	0	(372)	(372)
Total assets	263,576	931	2,426	(372)	266,561
Reportable Segment liabilities	(152,509)	(565)	(38)	0	(153,112)
Eliminations	0	0	0	372	372
Total liabilities	(152,509)	(565)	(38)	372	(152,740)
Net assets/liabilities	111,067	366	2,388	0	113,821

3 Revenue from Activities

3.1 By Commissioner	Year Ended 31 March 2018 £'000	* Restated Year Ended 31 March 2017 £'000
NHS England	43,821	42,850
Clinical Commissioning Groups	272,775	265,303
NHS Foundation Trusts	17	6
NHS Trusts	3,448	2,960
Local Authorities	1,885	2,434
NHS Other	212	146
Non NHS: Private patients	35	61
Non-NHS: Overseas patients (chargeable to patient)	196	211
NHS injury scheme (was RTA)	686	1,237
Non NHS: Other	112	72
Total income from activities	**323,187**	**315,280**

* Restated to show NHS England and Clinical Commissioning Groups separately.

3.2 By Nature	Year Ended 31 March 2018 £'000	** Restated Year Ended 31 March 2017 £'000
Acute Services		
Elective income	48,443	46,744
Non-Elective income	91,141	104,718
First Outpatient income	25,948	19,611
Follow-up outpatient income	23,679	26,541
A&E income	13,634	12,526
High cost drugs income from Commissioners	28,077	24,202
Other NHS Clinical Income	64,349	51,205
Community Services		
Income from CCG's and NHS England	19,307	21,361
Income from other sources (e.g. local authorities)	642	721
Income at Tariff	**315,220**	**307,629**
Private Patients	35	61
Other clinical income	7,932	7,590
Total income from activities	**323,187**	**315,280**

** Restated to show further analysis.

3.3 Income from Commissioner Requested Services and Non-Commissioner Requested Services

Under the terms of its Provider Licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Year Ended 31 March 2018 £'000	* Restated Year Ended 31 March 2017 £'000
Income from Commissioner Requested Services	295,271	285,547
Income from Non Commissioner Requested Services	19,949	22,082
Income from Activities	315,220	307,629
Other Clinical Income	7,967	7,651
Total Income	**323,187**	**315,280**

Other NHS Clinical Income comprises the following services pathology; rehabilitation; community support services; radiology; renal services; patient transport services; and appliances.

* Restated following the change of analysis in note 3.2

3.4 Private Patient Income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The annual report and accounts disclosures that were provided previously are now no longer required.

3.5 Overseas Visitors

	Year Ended 31 March 2018	Year Ended 31 March 2017
	£'000	£'000
Income recognised this year	196	211
Cash payments received in-year	44	47
Amounts added to provision for impairment of receivables	190	205
Amounts written off in-year	38	54

4 Other Operating Income

	Year ended 31 March 2018	Year ended 31 March 2017
	£'000	£'000
Research and development	1,341	1,301
Education and training	11,347	11,161
Education and training - apprenticeship fund	27	0
Charitable asset donations	187	77
Charitable contributions to expenditure	0	0
Non-patient care services to other bodies	5,405	5,534
Sustainability and Transformation Fund Income	4,728	11,945
Rental revenue from Operating Leases - contingent rent	306	292
Income in respect of Staff Costs	2,687	2,897
NHS Charitable Funds incoming resources excluding investment income	409	370
Other	3,215	3,285
Total other operating income	**29,652**	**36,862**

Other income is derived from Staff Recharges £2,687,000 (2016/17 £2,897,000); Pharmacy Drugs £755,000 (2016/17 £965,000); and numerous other small amounts.

5 Operating Expenditure

5.1 Operating Expenses

	Year ended 31 March 2018	*Restated Year ended 31 March 2017
	£'000	£'000
Purchase of healthcare from NHS and DHSC bodies	2,606	2,113
Purchase of healthcare from non-NHS and non-DHSC bodies	1,519	1,310
Staff and executive directors costs	213,300	201,732
Non-executive directors	139	128
Supplies and services - clinical (excluding drug costs)	27,716	27,792
Supplies and services - general	1,438	1,155
Drug costs (inventory consumed and purchase of non-inventory drugs)	32,699	31,792
Drugs Inventories written down	0	0
Consultancy costs	1,011	476
Establishment	1,932	1,617
Premises - Business Rates	1,407	1,442
Premises - Other	3,773	1,953
Transport - Business Travel	661	671
Transport - Other	102	153
Depreciation on property, plant and equipment	8,396	8,289
Amortisation on intangible assets	855	567
Impairments net of (reversals)	1,428	0
Increase / (decrease) in impairment of receivables	140	(327)
Audit fees payable to the external auditor		
Audit services	69	59
Other Auditor Remuneration	4	13
NHS Charitable Fund Accounts	6	6
Internal audit - non staff costs	148	134
Clinical negligence	14,996	13,805
Legal Fees	155	(14)
Insurance	165	22
Research and development - staff costs	1,366	1,352
Research and development - non staff	82	0
Education and training - staff costs	0	0
Education and training - non staff	517	674
Education and training - apprenticeship fund	27	0
Operating lease expenditure	2,672	2,475
Redundancy	0	0
Charges to operating expenditure for on-SOFP IFRIC 12 schemes e.g. PFI	22,552	23,567
Car Parking and security	0	114
Hospitality	0	39
Other losses and special payments	16	3
Other NHS Charitable funds resources expended	796	542
Other	3,623	3,134
TOTAL	**346,316**	**326,788**

Other expenditure includes numerous small amounts.

* Restated to reflect amended analysis

5.2 The Late Payment of Commercial Debts (interest) Act 1998

During the year 2017/18 (2016/17 £ nil) the Trust was not charged interest for the late payment of commercial debts.

6 Operating Leases

6.1 Payments and future commitments

	Year ended 31 March 2018	Year ended 31 March 2017
	£'000	£'000
Minimum lease payments	2,672	2,475
	2,672	2,475
Total future minimum lease payments Payable:		
Not more than one year	2,607	2,471
Between one and five years	242	35
After 5 years	0	0
Total	2,849	2,506

6.2 Income and future receipts

	Year ended 31 March 2018	Year ended 31 March 2017
	£'000	£'000
Contingent rent	306	292
	306	292
Total future minimum lease income Receivable:		
Not more than one year	297	0
Between one and five years	34	0
After 5 years	46	0
Total	377	0

7 Directors' Remuneration and other benefits

	Year ended 31 March 2018	Year ended 31 March 2017
	£'000	£'000
Salary	973	858
Taxable Benefits	3	4
Performance Related Bonuses	0	0
Employer contributions to a pension scheme	98	69
	1,074	931

Further details of directors' remuneration can be found in the remuneration report.

8 Employee Expenses and Numbers

8.1 Employee Benefits

	Year Ended 31 March 2018			Year Ended 31 March 2017		
	Total	Permanent	Other	Total	Permanent	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	167,506	165,311	2,195	156,523	154,526	1,997
Social security costs	15,855	15,855	0	14,689	14,689	0
Apprenticeship Levy	812	812	0	0	0	0
Employer's contributions to NHS Pensions	18,721	18,721	0	17,808	17,808	0
Pension Cost - other	20	20	0	15	15	0
Termination Benefits	0	0	0	0	0	0
Temporary Staff (including agency)	11,708	0	11,708	14,088	0	14,088
NHS Charitable funds staff	44	44	0	44	44	0
Total	214,666	200,763	13,903	203,167	187,082	16,085

8.2 Average Number of Persons Employed

This information can now be found in the staff report section of the annual report and accounts.

8.3 Employee Benefits

Employees benefits include payment of salaries/wages and pension contributions. There were no other employee benefits paid in 2017/18 (2016/17 £ nil).

8.4 Retirements due to Ill-health

During the year 2017/18 there were 0 (in 2016/17 there were 0) early retirements from the Trust on the grounds of ill-health.

The estimated additional pension liabilities of these ill-health retirements will be £nil (2016/17 £nil).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division, and therefore there is no liability or provision in the Trust annual report and accounts.

8.5 Sickness Absence

The detail of staff sickness / absence from work for the year are:

	For the Year 2017	For the year 2016
Total Days Lost	40,906	38,202
Total Staff Years	4,273	4,118
Average Working Days Lost Per WTE	10	9

This sickness absence data represents the calendar year ended 31 December not the financial year.

8.6 Other Compensation Schemes and Exit Packages

This information can now be found in the staff report section of the annual report and accounts.

9 Finance Income

	Year ended 31 March 2018	Year ended 31 March 2017
	£'000	£'000
Interest on bank accounts	68	74
NHS Charitable funds: investment income	49	48
	117	122

10 Finance Expense - Financial Liabilities

	Year ended 31 March 2018	Year ended 31 March 2017
Interest Expense:	£'000	£'000
Other	0	7
Finance Costs in PFI obligations		
Main Finance Costs	5,174	5,365
Contingent Finance Costs	5,865	5,717
	11,039	11,089

11 Taxation recognised in Statement of Comprehensive Income

The activities of the subsidiary company Dudley Clinical Services Limited have given rise to a corporation tax liability recognised in the Statement of Comprehensive Income of £37,000 (2016/17 £34,000). The activities of the Trust and the Charity do not incur corporation tax.

UK Corporation Tax Expense	Year ended 31 March 2018	Year ended 31 March 2017
Current tax expense	£'000	£'000
Current year	37	34
Adjustments in respect of prior years	0	0
Total income tax expense in Statement of Comprehensive Income	37	34

Reconciliation of effective tax rate	Year ended 31 March 2018	Year ended 31 March 2017
	£'000	£'000
Effective tax charge percentage	19.00%	20.00%
Tax if effective tax rate charged on surpluses before tax	(1,430)	2,282
Effect of:		
Surpluses not subject to tax	1,467	(2,248)
Total income tax charge for the year	37	34

The subsidiary company falls under the 'small profits' rate for corporation tax and tax rates are not planned to change from 19% for future financial years.

12 Intangible Assets

2017/18	Group Computer Software	Group Asset Under Construction	Total	2016/17 Restated *	Group Computer Software	Group Asset Under Construction	Total
	£'000	£'000	£'000		£'000	£'000	£'000
Gross Cost as at 1 April 2017	6,646	78	6,724	Gross Cost as at 1 April 2016	4,917	0	4,917
Prior period Adjustments	0	0	0	Prior period Adjustments	0	0	0
Gross Cost as at 1 April 2017 restated	6,646	78	6,724	Gross Cost as at 1 April 2016 restated	4,917	0	4,917
Additions Purchased	1,470	0	1,470	Additions Purchased	1,720	78	1,798
Additions Donated	0	0	0	Additions Donated	25	0	25
Reclassification	78	(78)	0	Reclassification	0	0	0
Impairments	0	0	0	Impairments	0	0	0
Disposals	0	0	0	Disposals	(16)	0	(16)
Gross Cost as at 31 March 2018	8,194	0	8,194	Gross Cost as at 31 March 2017	6,646	78	6,724
Amortisation as at 1 April 2017	4,047	0	4,047	Amortisation as at 1 April 2016	3,496	0	3,496
Prior period Adjustments	0	0	0	Prior period Adjustments	0	0	0
Amortisation as at 1 April 2017 restated	4,047	0	4,047	Amortisation as at 1 April 2016 restated	3,496	0	3,496
Provided during the Year	855	0	855	Provided during the Year	567	0	567
Disposals	0	0	0	Disposals	(16)	0	(16)
Amortisation as at 31 March 2018	4,902	0	4,902	Amortisation as at 31 March 2017	4,047	0	4,047
Net Book Value				Net Book Value			
Purchased at 1 April 2017	2,560	78	2,638	Purchased at 1 April 2016	1,393	0	1,393
Donated at 1 April 2017	39	0	39	Donated at 1 April 2016	28	0	28
Total at 1 April 2017	2,599	78	2,677	Total at 1 April 2016	1,421	0	1,421
Net Book Value				Net Book Value			
Purchased at 31 March 2018	3,270	0	3,270	Purchased at 31 March 2017	2,560	78	2,638
Donated at 31 March 2018	22	0	22	Donated at 31 March 2017	39	0	39
Total at 31 March 2018	3,292	0	3,292	Total at 31 March 2017	2,599	78	2,677

* Restated 2016/17 to show the items reclassified as intangible assets under construction.

A separate schedule for the Trust intangible assets has not been produced as the NHS Charity intangible assets represent just £nil (31 March 2017 £nil) of the net book value held by the Group and the subsidiary does not have any intangible assets.

13 Property, Plant and Equipment

13.1 2017/18

	Group								
	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost at 1 April 2017	241,308	25,150	173,028	0	985	32,650	118	8,671	706
Additions - purchased	14,394	0	6,618	0	3,700	1,808	35	2,005	228
Additions - leased	1,101	0	0	0	0	1,101	0	0	0
Additions - donated	187	0	0	0	0	137	0	50	0
Impairments charged to operating expenses	(1,428)	0	(1,428)	0	0	0	0	0	0
Impairments charged to the revaluation reserve	(555)	0	(555)	0	0	0	0	0	0
Reclassifications	0	0	5	0	(110)	0	0	103	2
Revaluations	17,733	0	17,733	0	0	0	0	0	0
Disposals	(1,025)	0	0	0	0	(989)	(8)	(7)	(21)
Cost at 31 March 2018	271,715	25,150	195,401	0	4,575	34,707	145	10,822	915
Accumulated depreciation at 1 April 2017	32,826	0	0	0	0	25,674	103	6,442	607
Provided during the year	8,396	0	4,860	0	0	2,474	23	977	62
Impairments charged to the revaluation reserve	(50)	0	(50)	0	0	0	0	0	0
Revaluations	(4,810)	0	(4,810)	0	0	0	0	0	0
Disposals	(1,020)	0	0	0	0	(988)	(8)	(7)	(17)
Accumulated depreciation at 31 March 2018	35,342	0	0	0	0	27,160	118	7,412	652
Net book value									
NBV - Owned at 1 April 2017	50,490	25,150	17,746	0	985	4,270	15	2,227	97
NBV - PFI at 1 April 2017	157,817	0	155,282	0	0	2,535	0	0	0
NBV - Donated at 1 April 2017	175	0	0	0	0	171	0	2	2
NBV total at 1 April 2017	208,482	25,150	173,028	0	985	6,976	15	2,229	99
NBV - Owned at 31 March 2018	57,879	25,150	20,062	0	4,575	4,437	27	3,365	263
NBV - PFI at 31 March 2018	178,227	0	175,339	0	0	2,888	0	0	0
NBV - Donated at 31 March 2018	267	0	0	0	0	222	0	45	0
NBV total at 31 March 2018	236,373	25,150	195,401	0	4,575	7,547	27	3,410	263

A separate schedule for the Trust tangible assets has not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any tangible assets.

13.2 2016/17 * Restated

	Group								
	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Cost at 1 April 2016	267,027	25,150	199,821	0	280	32,459	118	8,499	700
Additions - purchased	3,847	0	1,213	0	738	1,262	0	628	6
Additions - leased	0	0	0	0	0	0	0	0	0
Additions - donated	52	0	10	0	0	42	0	0	0
Impairments charged to the revaluation reserve	(28,016)	0	(28,016)	0	0	0	0	0	0
Reclassifications	0	0	0	0	(33)	0	0	33	0
Revaluations	0	0	0	0	0	0	0	0	0
Disposals	(1,602)	0	0	0	0	(1,113)	0	(489)	0
Cost at 31 March 2017	241,308	25,150	173,028	0	985	32,650	118	8,671	706
Accumulated depreciation at 1 April 2016	30,861	0	0	0	0	24,315	87	5,906	553
Provided during the year	8,289	0	4,722	0	0	2,472	16	1,025	54
Impairments charged to the revaluation reserve	(4,722)	0	(4,722)	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0	0	0	0
Disposals	(1,602)	0	0	0	0	(1,113)	0	(489)	0
Accumulated depreciation at 31 March 2017	32,826	0	0	0	0	25,674	103	6,442	607
Net book value									
NBV - Owned at 1 April 2016	51,605	25,150	18,728	0	280	4,683	31	2,590	143
NBV - PFI at 1 April 2016	184,342	0	181,093	0	0	3,249	0	0	0
NBV - Donated at 1 April 2016 ** Restated	219	0	0	0	0	212	0	3	4
NBV total at 1 April 2016	236,166	25,150	199,821	0	280	8,144	31	2,593	147
NBV - Owned at 31 March 2017	50,490	25,150	17,746	0	985	4,270	15	2,227	97
NBV - PFI at 31 March 2017	157,817	0	155,282	0	0	2,535	0	0	0
NBV - Donated at 31 March 2017	175	0	0	0	0	171	0	2	2
NBV total at 31 March 2017	208,482	25,150	173,028	0	985	6,976	15	2,229	99

* Restated 2016/17 to show the items reclassified as intangible assets under construction. ** Restated to reflect reclassification to PFI.

A separate schedule for the Trust tangible assets has not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any tangible assets.

13.3 Financing of Property, Plant and Equipment

	Total	Land	Buildings excluding dwellings	Dwellings	Group Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
Net Book Value	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
At 31 March 2018									
Owned	57,879	25,150	20,062	0	4,575	4,437	27	3,365	263
On Statement of Financial Position PFI contracts and other service concession arrangements	178,227	0	175,339	0	0	2,888	0	0	0
Donated	267	0	0	0	0	222	0	45	0
	236,373	25,150	195,401	0	4,575	7,547	27	3,410	263
At 31 March 2017									
Owned	50,490	25,150	17,746	0	985	4,270	15	2,227	97
On Statement of Financial Position PFI contracts and other service concession arrangements	157,817	0	155,282	0	0	2,535	0	0	0
Donated	175	0	0	0	0	171	0	2	2
	208,482	25,150	173,028	0	985	6,976	15	2,229	99

A separate schedule for the Trust tangible assets has not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any tangible assets.

13.4 Analysis of Property, Plant and Equipment

	Total	Land	Buildings excluding dwellings	Dwellings	Group Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
Net Book Value									
at 31 March 2018	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Commissioner Requested Assets	210,968	25,150	185,818	0	0	0	0	0	0
Non Commissioner Requested Assets	25,405	0	9,583	0	4,575	7,547	27	3,410	263
	236,373	25,150	195,401	0	4,575	7,547	27	3,410	263
Net Book Value									
at 31 March 2017									
Commissioner Requested Assets	189,743	25,150	164,593	0	0	0	0	0	0
Non Commissioner Requested Assets	18,739	0	8,435	0	985	6,976	15	2,229	99
	208,482	25,150	173,028	0	985	6,976	15	2,229	99

Commissioner Requested assets are land and buildings owned or leased by the Foundation Trust, the disposal of which may affect the Trust's ability to provide these requested goods and services.

Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	7
Furniture & Fittings	5	10

Land does not depreciate.

13.6 Impairment Losses

The Trust carried out an impairment review of its non-current assets in March 2018 . For land and buildings the Trust received a valuation report from the District Valuer prepared on a Modern Equivalent Asset (MEA) basis. The valuation report was prepared in accordance with the terms of the Royal Institution of Chartered Surveyors' Valuation Standards, 6th Edition, insofar as the terms are consistent with the requirements of HM Treasury, the National Health Service and NHSI. On application there was no movement in the value of land and a general increase in value of buildings (£22.374m) compared to the carrying value following the March 2017 valuation.

In line with IFRS the Trust took the increase in value of the buildings directly to the revaluation reserve.

The valuation for the Guest Ambulatory Centre resulted in an impairment of £1.428m.

In addition the Trust undertook an impairment review of equipment and intangible assets. The carrying value of equipment and intangible assets was deemed to fairly reflect the value of the assets.

Impairment of Assets	31 March 2018 £'000	31 March 2017 £'000
Changes in market price	1,428	0
Unforeseen Obsolescence	0	0
Net impairments charged to the revaluation reserve	505	23,294
TOTAL IMPAIRMENTS	1,933	23,294

13.7 Asset

Valuations

The Trust received a MEA valuation from the District Valuer in March 2018. The updated valuations of the Trust's land, buildings and dwellings were applied to the Trust annual report and accounts and enable the Trust to disclose an up to date position with regard to asset valuations. No significant assumptions were made as part of the valuation process as minimum capital expenditure had been applied to the land and buildings since the previous full revaluation exercise. If the Trust had not received this updated valuation the carrying values of land, buildings and dwellings would have been £25,150,000; £174,796,000 and £nil respectively.

13.8 Non Current Assets Held For Sale

During the year 2017/18 there were no Non Current Assets held for sale (2016/17 £ nil).

13.9 Capital Commitments

Commitments under capital expenditure contracts at the end of the year, not otherwise included in the annual report and accounts were £8,847,000 (2016/17 £5,133,000). The amount relating to property, plant and equipment is £6,603,000 (2016/17 £5,133,000) and intangible assets £2,244,000 (2016/17 £nil).

13.10 Gains/losses on disposal /derecognition of assets

	31 March 2018 £'000	31 March 2017 £'000
Gains on disposal/derecognition of other property, plant and equipment	63	0
Losses on disposal/derecognition of other property, plant and equipment	(7)	0
	56	0

14 Other Investments

14.1 Investments

	Group	
	2017/18	2016/17
	£'000	£'000
Carrying Value at 1 April	1,311	1,136
Prior period adjustment	0	0
Carrying Value at 1 April restated	1,311	1,136
Movement in fair value of Available-for-sale financial assets recognised in Other Comprehensive Income	5	175
Disposals	0	0
Carrying Value at 31 March	1,316	1,311

The investments are stocks and shares which are only held by Dudley Group NHS Charity.

A separate schedule for the Trust investments has not been produced as the Trust does not have any investments (2016/17 £nil).

14.2 Subsidiaries

The Trust wholly owns the subsidiary company Dudley Clinical Services Limited with a share of £1. Dudley Clinical Services Limited, was registered in the UK company number 8245934 ,and commenced trading on 9 October 2012.

15 Other Financial Assets

	Group	
	2017/18	2016/17
Non Current	£'000	£'000
NHS Charitable funds: Other financial assets	0	0
Current		
NHS Charitable funds: Other financial assets	500	1,028
	500	1,028

A separate schedule for the Trust other financial assets has not been produced as the Trust does not have any other financial assets (2016/17 £nil).

16 Inventories

	Group		Foundation Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£'000	£'000	£'000	£'000
Drugs	1,760	1,765	1,616	1,598
Consumables	1,178	1,072	1,178	1,072
Energy	15	20	15	20
Other	38	40	38	40
TOTAL Inventories	2,991	2,897	2,847	2,730

The Trust expensed £31,541,000 of inventories during the year (2016/17 £26,834,000).

The Trust charged £nil to operating expenses in the year due to write-downs of obsolete inventories (2016/17 £nil)

17 Trade and Other Receivables

17.1 Trade and Other Receivables

	Group		Foundation Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
Current	£'000	£'000	£'000	£'000
Trade receivables	6,896	14,151	6,896	14,151
Accrued income	2,492	4,603	2,492	4,632
Provision for impaired receivables	(854)	(794)	(854)	(794)
Prepayments (non PFI)	2,047	1,358	2,042	1,697
PFI Prepayments				
Prepayments - Capital contributions	0	0	0	0
Prepayments - Lifecycle replacements	0	0	0	0
Interest Receivable	9	4	9	4
Corporation tax receivable	0	0	0	0
PDC dividend receivable	0	0	0	0
VAT Receivable	1,253	1,138	1,102	968
Other receivables	1,067	1,324	1,067	1,324
NHS Charitable funds Trade and other receivables	16	18	0	0
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	12,926	21,802	12,754	21,982

	31 March 2018	31 March 2017	31 March 2018	31 March 2017
Non Current	£'000	£'000	£'000	£'000
Prepayments (non PFI)	1,915	2,003	1,915	2,003
PFI Prepayments				
Prepayments - Capital contributions	0	0	0	0
Prepayments - Lifecycle replacements	8,565	6,789	8,565	6,789
Other Receivables	1,546	1,546	1,546	1,546
NHS Charitable funds Trade and other receivables	0	0	0	0
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	12,026	10,338	12,026	10,338

NHS receivables consist of balances owed by NHS bodies in England, receivables with other related parties consist of balances owed by other HM Government organisations.

Other current and non current receivables include the NHS Injury Scheme (was RTA).

Included within trade and other receivables of both Group and Trust are balances with a carrying amount of £3,066,000 (31 March 2017 £2,630,000) which are past due at the reporting date but for which no specific provision has been made as they are considered to be recoverable based on previous trading history.

17.2 Provision for impairment of receivables

	Group	
	31 March 2018	31 March 2017
	£'000	£'000
At 1 April	794	1,282
Increase in provision	662	657
Amounts utilised	(80)	(161)
Unused amounts reversed	(522)	(984)
At 31 March	854	794

17.3 Analysis of impaired receivables

	Group			
	31 March 2018		31 March 2017	
	Trade and other receivables	Investments and other financial assets	Trade and other receivables	Investments and other financial assets
Ageing of impaired receivables	£'000	£'000	£'000	£'000
0 - 30 Days	48	0	26	0
30 - 60 Days	45	0	21	0
60 - 90 Days	22	0	43	0
90 - 180 Days	67	0	130	0
over 180 Days (over 6 months)	673	0	574	0
Total	855	0	794	0

A separate schedule for the impairment of receivables have not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any impaired receivables.

17.4 Analysis of non-impaired receivables

	Group			
	31 March 2018		31 March 2017	
	Trade and other receivables	Investments and other financial assets	Trade and other receivables	Investments and other financial assets
Ageing of non-impaired receivables past their due date	£'000	£'000	£'000	£'000
0 - 30 Days	2,631	0	6,282	0
30 - 60 Days	392	0	209	0
60 - 90 Days	96	0	478	0
90 - 180 Days	251	0	481	0
over 180 Days (over 6 months)	2,327	0	1,462	0
Total	5,697	0	8,912	0

A separate schedule for the Trust non-impairment of receivables has not been produced as the NHS Charity non impaired receivables represent just £16,000 (31 March 2017 £18,000) of the value shown by the Group in the 0-30 days category and the subsidiary did not have any receivables outstanding .

18 Trade and Other Payables

	Group		Foundation Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
Current	£'000	£'000	£'000	£'000
Trade payables	2,641	4,323	2,491	4,323
Trade payables - capital	2,268	1,221	2,268	1,221
Taxes payable	7,116	4,059	7,077	4,023
Other payables	7,582	6,171	7,582	6,051
Accruals	3,214	2,056	3,222	2,019
PDC dividend payable	705	276	705	276
NHS Charitable Funds trade and other payables	41	38	0	0
TOTAL CURRENT TRADE & OTHER PAYABLES	23,567	18,144	23,345	17,913
Non Current				
Trade payables	40	80	40	80
TOTAL NON CURRENT TRADE & OTHER PAYABLES	40	80	40	80

Taxes payable consists of employment taxation only (Pay As You Earn and National Insurance contributions), owed to HM Revenue and Customs at the year end, and Corporation Tax payable by the subsidiary Dudley Clinical Services Limited.

19 Other Financial Liabilities

	Group		Foundation Trust	
Current	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£'000	£'000	£'000	£'000
Deferred Income	1,639	1,788	1,639	1,788
TOTAL OTHER CURRENT LIABILITIES	1,639	1,788	1,639	1,788

Non-current liabilities are £nil (31 March 2017 £nil).

Where income has been received for a specific activity which is to be delivered in the following financial year, that income is deferred.

20 Deferred Tax

Liability for corporation tax only arises from the activity of the commercial subsidiary, the activities of the Trust do not incur corporation tax, see accounting policy note 1.18 for detailed explanation.

The subsidiary did not have any deferred tax in 2017/18 (2016/17 £nil).

21 Provisions

	Group Current		Group Non Current	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£'000	£'000	£'000	£'000
Other legal claims	147	140	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Other	0	0	0	0
Total	147	140	0	0

	Total	Other legal claims	Restructuring	Redundancy	Other
	£'000	£'000	£'000	£'000	£'000
At 1 April 2017	140	140	0	0	0
Arising during the year	111	111	0	0	0
Utilised during the year - cash	(25)	(25)	0	0	0
Utilised during the year - accruals	0	0	0	0	0
Reversed unused	(79)	(79)	0	0	0
At 31 March 2018	147	147	0	0	0
Expected timing of cashflows:					
- not later than one year;	147	147	0	0	0
- later than one year and not later than five years;	0	0	0	0	0
- later than five years.	0	0	0	0	0
TOTAL	147	147	0	0	0

A separate schedule for the Trust provision for liabilities and charges has not been produced as neither the NHS Charity or the subsidiary have any provisions.

Other Legal Claims include claims under Employers' and Public Liability.

The NHS Litigation Authority has included in its provisions at 31 March 2018 £207,047,000 (2016/17 £182,846,000) in respect of clinical negligence liabilities for the Trust.

22 Prudential Borrowing Limit

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been repealed with effect from 1 April 2013 by the Health and Social Care Act 2012. The disclosures provided previously are no longer required.

23 Borrowings

	Group	
	As at 31 March 2018	As at 31 March 2017
Current	£'000	£'000
Obligations under Private Finance Initiative contracts (excl lifecycle)	6,255	5,156
Total Current borrowings	6,255	5,156
Non Current		
Obligations under Private Finance Initiative contracts	122,236	127,432
Total Other non Current Liabilities	122,236	127,432

A separate schedule for the Trust borrowings has not been produced as neither the NHS Charity or the subsidiary Dudley Clinical Services Limited have any borrowings.

24 Cash and Cash Equivalents

	Group		Foundation Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£'000	£'000	£'000	£'000
At 1 April	18,026	23,623	17,367	23,383
Transfers By Absorption	0	0	0	0
Net change in year	(3,913)	(5,597)	(3,871)	(6,016)
At 31 March	14,113	18,026	13,496	17,367
Analysed as follows:				
Cash at commercial banks and in hand	619	592	2	2
Cash with the Government Banking Service	13,494	17,434	13,494	17,365
Other current investments	0	0	0	0
Cash and cash equivalents as in Statement of Financial Position	14,113	18,026	13,496	17,367
Bank overdraft	0	0	0	0
Cash and cash equivalents as in Statement of Cash Flows	14,113	18,026	13,496	17,367

25 Events after the reporting year

The Group nor the Trust have any events after the reporting year.

26 Contingencies

27 Related Party Transactions

The Dudley Group NHS Foundation Trust is a public benefit corporation which was established under the granting of authority by Monitor, the Independent regulator for Foundation Trusts. The Trust has taken advantage of the partial exemption provided by IAS 24 'Related Party Disclosures', where the Government of the United Kingdom is considered to have ultimate control over the Trust and all other related party entities in the public sector.

The Trust considers other NHS Foundation Trusts to be related parties, as they and the Trust are under the common performance management of NHS Improvement - part of the NHS in England. During the year the Trust contracted with certain other Foundation Trusts for the provision of clinical and non clinical support services. The Department of Health is also regarded as a related party. During the year the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent organisation.

The Trust has had a number of material transactions with other Government Departments and Local Government Bodies. These related parties are summarised on the following table by Government Department, with disclosure of the total balances owed and owing as at the reporting date and the total transactions for the reporting year with the Trust.

27 Related Party Transactions

	Year ended 31 March 2018				Year ended 31 March 2017			
Group	Income	Expenditure	Receivable	Payable	Income	Expenditure	Receivable	Payable
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Birmingham Women's and Children's Foundation Trust	16	879	7	379	0	0	0	0
Black Country Partnership Foundation Trust	193	514	27	24	257	508	0	0
Dudley & Walsall Mental Health Trust	2,370	8	39	0	2,437	0	134	0
The Royal Wolverhampton Trust	2,676	2,198	447	376	2,656	1,790	463	291
Sandwell & West Birmingham Trust	2,228	868	512	290	1,820	784	605	149
Worcestershire Acute Hospitals Trust	361	1,164	54	301	282	975	55	284
Birmingham Cross City CCG	898	0	9	0	810	0	0	0
Birmingham South & Central CCG	605	0	0	8	490	0	0	0
Cannock Chase CCG	420	0	0	205	662	0	161	0
Dudley CCG	211,774	11	2,383	1,437	205,558	73	4,943	1,654
Redditch & Bromsgrove CCG	650	0	114	1	635	0	77	0
Sandwell & West Birmingham CCG	36,258	0	12	49	35,903	0	1,417	0
Shropshire CCG	604	0	34	0	555	0	0	0
South East Staffs & Seisdon Peninsular CCG	10,410	0	550	36	10,385	0	1,127	0
Walsall CCG	2,368	0	56	0	2,421	0	0	0
Wolverhampton CCG	5,073	0	152	0	4,682	0	72	0
Wyre Forest CCG	5,078	0	474	8	4,044	0	796	0
NHS England	49,515	4	2,765	0	55,659	0	6,556	0
Health Education England	10,719	5	56	0	10,414	0	835	0
NHS Improvement	0	15,141	60	60	0	0	0	0
Other related parties - Whole of Government Accounts								
Dudley Metropolitan Borough Council	2,354	73	155	0	2,735	0	171	0
HMRC	0	16,704	1,253	7,116	0	14,723	1,138	4,059
NHS Pensions	0	18,721	0	0	0	17,808	0	2,301
NHS Blood & Transplant	15	1,599	0	26	0	1,522	0	0

27 Related Party Transactions (continued)

Key management personnel, namely the Trust Board Directors, are those persons having authority and responsibility for planning, directing and controlling the activities of the Trust. During the year none of the key management personnel have parties related to them that have undertaken any material transactions with The Dudley Group NHS Foundation Trust.

The table below details, on an aggregate basis, key management personnel compensation:

	31 March 2018	31 March 2017
Compensation	£'000	£'000
Salaries and short-term benefits	915	800
Post-employment benefits	230	385
	1,145	1,185

The annual report and accounts of the parent (the Trust) are presented together with the consolidated annual report and accounts and any transactions or balances between group entities have been eliminated on consolidation. Dudley Group NHS Charity has a Corporate Trustee who are the Board members of the Trust. The Board members of Dudley Clinical Services Limited include the following Non Executive Directors from the Trust: Richard Miner as Chairman and Douglas Wulff as a Director.

Dudley Clinical Services Limited does not have any transactions with any NHS or Government entity except those with its parent, the Trust and HMRC. The Group receivables includes £156,000 owed to the subsidiary (£174,000 2016/17) and £16,000 owed to Dudley Group NHS Charity (£18,000 2016/17), and the Group payables includes £191,000 (£156,000 2016/17) owed by the subsidiary and £41,000 (£38,000 2016/17) owed by Dudley Group NHS Charity.

28 Private Finance Initiatives

28.1 PFI schemes on the Statement of Financial Position

The Dudley PFI project provided for the refurbishment and new building of major inpatient facilities at Russells Hall Hospital, the building of new facilities at Guest Hospital and Corbett Hospital. The Capital value of the scheme was £160,200,000. The Project agreement runs for 40 years from May 2001. The Dudley PFI is a combination of buildings (including hard Facilities Managed (FM) services) and a significant range of allied and clinical support services.

The standard Unitary Payment changes periodically as a consequence of:

- Inflation (based on RPI and reviewed annually)
- Deductions for poor performance (Deficiency points and financial penalties for poor performance or non-compliant incidents).
- Variations to the Project Agreement (PA) (agreed under Variations procedure in the PA)
- 50% of market testing or refinancing impact
- Energy tariff adjuster (the difference between actual energy tariff changes and the uplift that comes through RPI)
- Volume adjuster (computed by comparing actual in patient days against that in the schedule, with a tolerance of plus or minus 3%)

The Trust has the rights to use the specified assets for the length of the Project Agreement and has the rights to expect provision of the range of allied and clinical support services. At the end of the Project Agreement the assets will transfer back to the Trust's ownership.

The PFI transaction meets the IFRIC 12 definition of a service concession, as interpreted in the Annual Reporting Manual (ARM) issued by Monitor, and therefore the Trust is required to account for the PFI scheme 'on-balance sheet' and this means that the Trust treats the asset as if it were an asset of the Trust and the substance of the contract is that the Trust has a finance lease and payments comprise two elements, an imputed finance lease charge and service charges.

28 Private Finance Initiatives (continued)

	As at 31 March 2018	As at 31 March 2017
	£'000	£'000
Gross PFI Liabilities	140,309	143,610
of which liabilities are due		
- not later than one year;	18,073	16,178
- later than one year and not later than five years;	25,020	20,624
- later than five years.	97,216	106,808
Finance charges allocated to future periods	(11,818)	(11,022)
Net PFI liabilities	**128,491**	**132,588**
- not later than one year;	6,255	5,156
- later than one year and not later than five years;	25,020	20,624
- later than five years.	97,216	106,808

The Trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31 March 2018	31 March 2017
	£'000	£'000
Within one year	29,913	27,971
2nd to 5th years (inclusive)	119,653	111,884
Later than 5 Years	523,064	540,293
Total	**672,630**	**680,148**

Analysis of amounts payable to the service concession operator:

*Restated

	31 March 2018	31 March 2017
	£'000	£'000
Unitary payment payable to the concession operator	**38,246**	**37,551**
Consisting of:		
- Interest charge	5,174	5,365
- Repayment of finance lease liability	4,901	5,112
- Service element	19,768	19,409
- Capital lifecycle maintenance	710	754
- Contingent rent	5,865	5,717
- Addition to lifecycle prepayment	1,828	1,194
Total amount paid to concession operator	**38,246**	**37,551**

Other amounts paid to the service concession operator but not part of the unitary payment

Amounts charges to revenue	2,784	4,158
Amounts capitalised	5,873	443
Total amount paid to the service concession operator	**46,903**	**42,152**

Total length of the project (years)	40
Number of years to the end of the project	23

* Restated to reflect change of classification.

28.2 PFI schemes off the Statement of Financial Position

The Trust does not have any PFI schemes which are deemed to be off-statement of financial position.

29 Financial Instruments and Related Disclosures

A financial instrument is a contract that gives rise to a financial asset in one entity and a financial liability or equity instrument in another entity. The nature of the Trust's activities means that exposure to risk, although not eliminated, is substantially reduced.

The key risks that the Trust has identified are as follows:

29.1 Financial Risk

Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups (CCG's) and the way those CCG's are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Finance and Performance Committee.

29.2 Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

29.3 Market (Interest Rate) Risk

All of the Trust financial assets and all of its financial liabilities carry nil or fixed rates of interest. The Trust is not therefore, exposed to significant interest rate risk.

29.4 Credit Risk

The majority of the Trust's income comes from contracts with other public sector bodies, resulting in low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in note 17 to the annual report and accounts. The Trust mitigates its exposure to credit risk through regular review of debtor balances and by calculating a bad debt provision at the end of the year.

29.5 Liquidity Risk

The Trust's net operating costs are incurred under annual service agreements with Clinical Commissioning Groups and NHS England, which are financed from resources voted annually by Parliament. The Trust ensures that it has sufficient cash to meet all its commitments when they fall due. This is regulated by the Trust's compliance with the 'Financial Sustainability Risk Rating' system created by Monitor, the Independent Regulator of NHS Foundation Trusts. In addition should the Trust identify a shortfall on cash it has the ability to borrow from the FT financing facility. The Board continues to monitor its monthly and future cash position and has governance arrangements in place to manage cash requirements throughout the year. The Trust is not, therefore, exposed to significant liquidity risks.

29.6 Fair Values

All of the financial assets and all of the financial liabilities of the Trust are measured at fair value on recognition and subsequently amortised cost.

29 Financial Instruments and Related Disclosures (continued)

29.7 Financial Assets and Liabilities By Category

The following tables show by category the financial assets and financial liabilities at 31 March 2018 and 31 March 2017. The values are shown at fair value which is representative of the carrying value.

Financial Assets	Group				Foundation Trust			
	As at 31 March 2018		As at 31 March 2017		As at 31 March 2018		As at 31 March 2017	
	Total	Loans and Receivables	Total	Loans and Receivables	Total	Loans and Receivables	Total	Loans and Receivables
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Trade and other receivables (excluding non financial assets) with NHS and DH bodies	8,374	8,374	16,258	16,258	8,374	8,374	16,258	16,258
Trade and other receivables (excluding non financial assets) with other bodies	482	482	445	445	326	326	271	271
Cash and cash equivalents	13,899	13,899	17,957	17,957	13,496	13,496	17,783	17,783
Consolidated NHS Charitable fund financial assets	2,046	2,046	2,426	2,426	0	0	0	0
	24,801	24,801	37,086	37,086	22,196	22,196	34,312	34,312

*Other Financial Assets are fixed term cash investments with UK Bank Institutions

Financial Liabilities	Group				Foundation Trust			
	As at 31 March 2018		As at 31 March 2017		As at 31 March 2018		As at 31 March 2017	
	Total	Other Financial Liabilities	Total	Other Financial Liabilities	Total	Other Financial Liabilities	Total	Other Financial Liabilities
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Obligations under Private Finance Initiative contracts	128,491	128,491	132,588	132,588	128,491	128,491	132,588	132,588
Trade and other payables (excluding non financial liabilities) with NHS and DH bodies	2,444	2,444	2,273	2,273	2,444	2,444	2,273	2,273
Trade and other payables (excluding non financial liabilities) with other bodies	10,752	10,752	11,803	11,803	10,483	10,483	11,610	11,610
Provisions under contract	147	147	140	140	147	147	140	140
Consolidated NHS Charitable Fund financial liabilities	41	41	38	38	0	0	0	0
	141,875	141,875	146,842	146,842	141,565	141,565	146,611	146,611

29.8 Maturity of Financial Liabilities

	Group		Foundation Trust	
	As at 31 March 2018	As at 31 March 2017	As at 31 March 2018	As at 31 March 2017
	£'000	£'000	£'000	£'000
In One Year or Less	19,599	19,330	19,289	19,099
In more than one year but not more than two years	6,295	5,196	6,295	5,196
In more than two years but not more than five years	18,765	15,508	18,765	15,508
In more than five years	97,216	106,808	97,216	106,808
Total	141,875	146,842	141,565	146,611

30 Third Party Assets

The Trust held £33,000 as cash at bank or in hand at 31 March 2018 (31 March 2017 £33,000) which related to monies held by the Trust on behalf of patients. These balances are excluded from cash at bank and in hand figures reported in the annual report and accounts.

31 Losses and Special Payments

NHS Foundation Trusts are required to record payments and other adjustments that arise as a result of losses and special payments on an accruals basis, excluding provisions for future losses.

	2017/18		2016/17	
	Number	Value	Number	Value
		£000		£000
Loss of Cash	1	0	0	0
Fruitless payments	2	2	2	1
Bad debts and claims abandoned	104	49	110	66
Damage to Buildings, property etc. due to:				
Theft	5	2	0	0
Stores losses	9	15	2	15
Total Losses	121	68	114	82
Ex gratia payments	17	40	18	43
Total Special Payments	17	40	18	43
Total Losses and Special Payments	**138**	**108**	**132**	**125**

There were no (2016/17 £nil) clinical negligence, fraud, personal injury, compensation under legal obligations or fruitless payment cases where the net payment for the individual case exceeded £300,000

32 Auditors' Liability

In accordance with the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, the liability of the Trust Auditor, Pricewaterhouse Coopers LLP is restricted to £1,000,000 in respect of liability to pay damages for losses arising as a direct result of breach of contract or negligence in respect of services provided in connection with or arising from their letter of engagement dated 6th April 2018.

Section 4: Quality Report and Account

Part 1: Introduction - Chief Executive's Statement

Throughout this document, there are a number of quotes taken from reviews that patients themselves have posted online on NHS Choices and Patient Opinion, as well as a number of examples of learning from complaints and incidents.

Part 1: Introduction - Chief Executive's statement

The Trust continued to focus on providing high quality care and treatment across our hospital, outpatient centres and adult community services during 2017/18. Despite unprecedented demands on our services that have continued beyond the usual winter period, our aim and vision is to be a healthcare provider for the Black Country and West Midlands which is trusted to provide safe, caring and effective services because people matter.

Our responsibility is to provide high quality treatment and care for all our patients. By this, we strive to provide:

- a good patient experience
- safe care and treatment
- a good and effective standard of care

This report uses these three elements to describe the quality of care delivered at the Trust over the year, providing an overall account of where we are performing well and where we can make improvements.

Following on from this introduction, in Part 2 we have outlined our priority quality measures and charted their progress throughout the year. A summary of current and previous priorities can be seen in the table in Section 2.1.1, as can more details on each priority on the page numbers listed in that table. These details include progress made to date, as well as our new priority targets for 2018/19. This part of the report also includes mandated sections on such topics as clinical audit, research and development and data quality.

In Part 3 we have included other key quality initiatives and measures, and specific examples of good practice on all of the above three elements of quality, which provide a useful picture of what is occurring across the Trust as a whole.

Independent reviews of the quality of care at the Trust are undertaken throughout the year by a variety of organisations (see Section 2.2.1) and, as this report indicates, we are constantly monitoring ourselves in many ways on the quality of our care. This allows us to assure both patients and ourselves of what we are doing well and what we learn when we need to change practice and improve our services. In terms of outside assessments, the significant review of our services was undertaken by our regulators the Care Quality Commission (CQC) (see Section 2.2.5) over the winter period in December 2017 and January 2018, and the report became available in the middle of April 2018. While we were pleased at the overall 'Good' ratings given to our medical care and care of the elderly, maternity and community Health services, we were disappointed by the ratings given to the other three areas assessed, urgent/emergency care, critical care and Services for children/young People. With regards to the latter, the Trust took immediate action and continues to do so to improve its services and achieve its ambition of being an outstanding CQC rated Trust.

Throughout the report, we have included quotes from patients about their experience here at the Trust, together with examples of lessons learned from patient feedback and from those occasions when care did not reach the high standards that we set for ourselves. These give an indication that the Trust does not stand still but is always pursuing a path of improvement.

Our quality priorities

You will see in Part 2 that we have made progress with some but not all of our 2017/18 priorities. I can report that from our patients who partake in the national Friends and Family Test (FFT) the Trust has received good feedback in some of our services (all aspects of maternity care and the community) although some areas (Emergency Department and outpatients) are below the national average. In addition, it is reassuring to see that our results compare favourably with our neighbours (details in Section 3.2.2). With regards to infection control, we have had no MRSA bacteraemia cases and we are under the national target for C. Difficile cases arising due to lapses in care. We have achieved our target of the number of avoidable Stage 3 pressure ulcers in the hospital although that is not the case in the community and across both areas for Stage 4 avoidable ulcers. One of our three nutrition measures has also been met.

We recognise that we need to make a number of improvements with other priorities related to pain management and medication administration and as a consequence we have rolled them over to next year (2018/19). We will make further efforts to achieve them. In addition, due to their importance, two further topics have been added as priorities: discharge management and incident reporting.

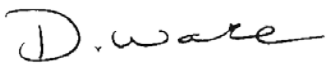
Measuring quality

This report includes many objective indicators of quality, and we have also included a number of specific examples of the many quality initiatives from around the Trust and what patients have said about the care they have received from us. We could not include them all but, hopefully, these examples, together with the innovation and initiatives that Trust staff have achieved and implemented in the year, give a sense of our quality of care. I would like to make a special mention to all of the staff and departments that have either been nominated, or progressed and gone on to win, both local and national awards (see Section 3.4.2). I am also pleased to see in the report how we are harnessing the power of technology in a number of ways, for example, to enhance care to patients with such developments as using new digital reminiscence therapy software to assist patients with dementia, developing apps to ensure effective care to patients with Parkinsons disease, using new innovative biologic drugs and remotely assessing pregnant patients with diabetes blood glucose levels.

The Trust and its Board of Directors have sought to take all reasonable steps and have exercised appropriate due diligence to ensure the accuracy of the data reported. Following these steps, to the best of my knowledge, the information in this document is accurate.

Finally, 2018/19 will be another challenging year for the Trust as we focus on providing high quality care as well as achieving access targets and other national requirements in the light of tighter financial constraints. We will continue to work with patients, commissioners, our Black Country Alliance partners and other stakeholders to deliver further improvements to quality in the context of growing demand for services and developments in healthcare provision generally.

Signed:
Date: 22nd May 2018



Diane Wake
Chief Executive

Part 2: Priorities for improvement and statements of assurance from the Board of Directors

2.1 Quality improvement priorities

2.1.1 Summary

The table below provides a summary of the history of our quality priorities over the past five years and outlines the new priorities for 2018/19.

Quality Priority	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	Notes
Patient experience Ensure that the percentage of patients who report positively on their experience is better than the national average. Ensure pain control measures improve.	Hospital: Partially achieved Community: Not achieved	Hospital: Partially achieved Community: Partially achieved	Hospital: Partially achieved Community: Partially achieved	Hospital: Partially achieved Community: Partially achieved	Hospital: Partially achieved Community: Partially achieved	Priority 1	See page 7 for more information
Pressure ulcers Reduce the occurrence of avoidable pressure ulcers.	Hospital: Partially achieved Community: Achieved	Hospital: Partially achieved Community: Partially achieved	Hospital: Achieved Community: Not achieved	Hospital: Partially achieved Community: Partially achieved	Hospital: Partially achieved Community: Not achieved	Priority 2	See page 10 for more information
Infection control Reduce our MRSA rate in line with national and local priorities.	Not achieved	Achieved	Not achieved	Achieved	Achieved	Priority 3	See page 13 for more information
Reduce our Clostridium difficile rate in line with local and national priorities.	Not achieved	Achieved	Achieved	Achieved	Achieved		
Nutrition Ensure there are effective processes in place for nutrition care	Partially achieved	Partially achieved	Partially achieved	Partially achieved	Partially achieved	Priority 4	See page 15 for more information
Hydration Ensure there are effective processes in place for hydration care	Achieved	Achieved					
Medications Ensure effective processes are in place for the medicine administration	N/A	N/A	N/A	Not achieved	Not achieved	Priority 5	See page 18 for more information
Discharge Management						Priority 6	See page 20 for more information
Incident Management						Priority 7	See page 21 for more information

2.1.2 Choosing our priorities for 2018/19

The Quality Priorities for 2017/18 covered the following five topics:

1. Patient experience
2. Infection control
3. Pressure ulcers
4. Nutrition/hydration
5. Medication

These key topics were agreed by the Board of Directors due to their importance both from a local perspective (e.g. based on key issues from patient feedback, both positive and negative) and from a national perspective (e.g. reports from national bodies such as the Health Ombudsman, CQC etc.). The first four topics were agreed five years ago by a collaborative event on the Quality Report, hosted by the chief executive and chief nurse who were in post at the time, attended by staff, governors, Foundation Trust members and others from key outside organisations. These topics have been endorsed in discussions with the Dudley MBC Health and Social Care Scrutiny Committee and Dudley Clinical Commissioning Group. The fifth topic, medication, was added in 2016/17 following a review of patient feedback on their care and treatment.

Following further year on year consultation internally and with governors, those who attended the Annual Members Meeting, the public generally via an online questionnaire and discussions with our main commissioner, it has been agreed that these topics should be retained with two further topics added.

The retained topics continue to be fundamental when considering the provision of high quality patient care. Positive patient experience of our services is a core purpose of the Trust. We are committed to minimising healthcare associated infection rates, which is a key patient and commissioner expectation. There are national campaigns of zero tolerance of avoidable pressure ulcers and the need to focus on the assessment and enhancement of patients' nutritional status.

For 2018/19, it has been agreed to increase our priorities to include two new important areas. Firstly, we consider safe and effective discharge to be of central importance in the pathway of care for our patients. Effective planning of discharge will result in fewer delays in this process and patients being able to return back out into the community to the most appropriate place of residence. Secondly, the safety of our patients is paramount. It is widely recognised that an organisation with a positive safety culture has a high incident reporting rate with a reducing number of serious incidents, the latter resulting from learning and changing practice.

All of our priorities have named leads with responsibility for coordinating the actions aimed at achieving the targets. Every quarter, our progress in all the targets is reported to the Clinical Quality, Safety and Patient Experience Committee, the Board of Directors and the Council of Governors. In addition, a summary of the progress is placed on the Trust website.

The Quality Priorities for 2018/19 will cover the following seven topics:

1. Patient experience
2. Infection control
3. Pressure ulcers
4. Nutrition/hydration
5. Medication
6. Discharge management
7. Incident management

2.1.3 Our priorities

Priority 1 for 2017/18: Patient experience

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

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

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

Rationale for inclusion and how we measure and record this priority

a) The NHS Friends and Family Test (FFT) is firmly embedded within the Trust with all patients given the opportunity to complete the survey after each episode of care and treatment in all areas of the organisation. The FFT survey remains a national focus and provides valuable data to support local actions to improve the patient experience. We also use this information to benchmark our performance against other trusts (see Section 3.2.2).

b) Having assessed the outcome of the National Patient Survey, it was decided to include as a new target a topic where we did not perform as well as other questions. To monitor this throughout the year, rather than waiting for the results of the yearly national survey, we have been using the results of our continual real-time survey which has an equivalent question. We measure this by inviting inpatients, who have been given an estimated discharge date and who are expecting to be discharged within 48 hours, to answer this question. An average of 120 patients are surveyed each month.

c) From patient feedback, the Trust has also included a measure related to pain management. As part of their caring role, nursing staff assess patients' needs in terms of pain prevention and relief. Patients are asked to score their level of pain and nurses will take appropriate action ensuring that patients are positioned correctly and receiving appropriate analgesia. Nurses document those pain level scores on an at least a four-hourly basis unless this is recorded as not necessary, for example, for a short stay pain free patient admitted for non-invasive tests. Pain scores are audited as part of the Quality Indicator monitoring, which is a monthly check of 10 sets of nursing notes undertaken at random on every ward (see Section 3.3.5).

Developments during 2017/18

- Expanded the Friends and Family Test SMS survey solution to more areas of the Trust
- Continued to improve the way FFT feedback is shared with areas to support local and Trust-wide improvement actions
- Introduced competition and prizes for increased engagement with patients and their families
- Rolled out the new patient observation chart (National Early Warning Score system), which includes a section for recording pain scores
- Ensured that the training for the new chart includes emphasising the need to record the pain score of patients (or where not relevant, to record this in the exceptions box)
- Established a fortnightly Patient Experience Improvement Group chaired by the chief nurse to develop improvement initiatives and monitor progress on action plans

Current status

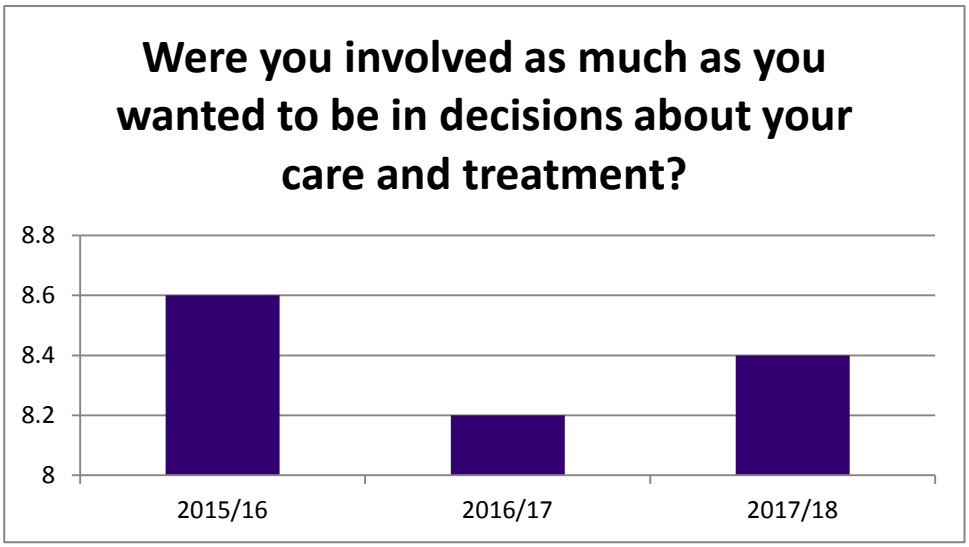
Family and Friends Test

a) The results are provided on the table and of the 11 months where national figures are available (84) we are achieving the target on 51 occasions. Both maternity and maternity post natal ward achieved the target every month with postnatal ward missing the target only once. Missing the target were: inpatients in May and September to February; A&E for eleven months from April to February; outpatients in June and August to February; maternity antenatal in June, January and February; community in April, November and December.

% FFT Scores	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Inpatient	**96.4**	**95.6**	**96.5**	**96.4**	**96.3**	**95.9**	**95.1**	**95.3**	**95.1**	**94.1**	**94.1**	**93.7**
National	96	96	96	96	96	96	96	96	96	96	96	96
A and E	**75**	**76.6**	**78.7**	**77.4**	**72.5**	**75.9**	**83.6**	**80.3**	**77.4**	**74.4**	**74.4**	**74.5**
National	87	87	88	86	87	87	87	87	85	86	85	84
Maternity Antenatal	**100**	**98.5**	**95.8**	**98.9**	**99.5**	**97.2**	**99.3**	**89.1**	**97.3**	**90.9**	**90.9**	**97.7**
National	97	96	97	96	96	97	96	n/a*	97	97	97	97
Maternity Birth	**99.1**	**98.8**	**98.3**	**98.9**	**98.5**	**98**	**98.5**	**96.9**	**98.9**	**97.8**	**97.8**	**97.0**
National	96	97	97	96	96	96	96	n/a*	97	97	97	97
Maternity Postnatal Ward	**97.5**	**95.2**	**98.8**	**97.8**	**95.5**	**97.9**	**97.7**	**96.3**	**97.8**	**100**	**100**	**98.5**
National	95	95	95	94	94	94	94	n/a*	94	95	95	95
Maternity Postnatal Community	**100**	**100**	**100**	**100**	**96.6**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
National	98	98	100	98	98	98	98	n/a*	98	98	98	98
Community	**94**	**96**	**97.4**	**98**	**98.2**	**97.1**	**95.1**	**95.9**	**95.7**	**96.3**	**96.3**	**97.4**
National	96	96	96	96	96	95	95	96	96	95	96	95
Outpatients	**95.3**	**95.2**	**91.6**	**95.3**	**93.4**	**92.3**	**90.8**	**89.8**	**92.8**	**91.7**	**91.7**	**91.6**
National	94	94	94	94	94	94	94	94	94	94	94	94

Items marked n/a Please note that NHS England has not supplied the national results for Maternity services in November 2017. Advice given is that every effort is being made to produce this as soon as possible, subject to data quality considerations.*

b) The score at the end of 2017/18 for the local survey question 'Were you involved as much as you wanted to be in decisions about your care?' was 8.4 compared to the 2016/17 full year score of 8.2. This priority is achieved.



This is a weighted score also known as a partial credit score consistent with the NHS Survey programme.

c) Pain management

With regards to the target on recording the pain score of patients, although it was achieved for four individual months, it can be seen that it has not been achieved consistently throughout the year, and so this target has been retained for 2018/19.

General Inpatients	2016/2017	Quarter 1 2017/2018	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	2017/18
Pain score	90%	95%	88%	94%	93%	93%

New priority 1 for 2018/19: Patient experience

a) Achieve monthly response rates in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average.
b) Achieve monthly scores in Friends and Family Test (FFT) for all areas (inpatients, outpatients, maternity, Emergency Department and community) that are equal to or better than the national average.
c) 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?
d) Ensure that in 95 per cent or more cases, a patient's pain score is recorded at least every four hours (unless otherwise indicated in the exception box)

Rationale for inclusion and how we measure and record this priority

- The FFT target will be retained as it remains a national focus and provides excellent benchmarking information and drives improvement to the patient experience. It is measured and recorded as described above.
- It is important for the Trust to encourage as many patients as possible to respond to the FFT. A new target relating to the numbers responding is also now included.
- Although we have achieved this target from the continual real-time survey in 2017/18, the provisional results of the national survey suggest it would be useful to continue monitoring this issue.
- The target to ensure that a patient's pain score is recorded at least every four hours will also be retained. It is measured as described above.

Developments planned for 2018/19

- Hold 'Feedback Fridays' weekly to encourage responses to the survey
- Ensure that all areas have a champion for FFT.
- Ensure that all areas where participation is low have action plans in place.
- Roll out SMS to the rest of the Trust.
- Ensure delivery of improvement actions identified using FFT feedback to support an improved percentage recommended score.
- Ensure study days occur in May so that all staff are re-educated on the importance of pain management and its correct documentation.
- Clarify the audit question so that it covers all documents where pain relief may be recorded.

FFT and real-time survey Board sponsor: Chief Nurse Siobhan Jordan, **operational lead**: Head of Patient Experience Jill Faulkner.
Pain Management Board sponsor: Chief Nurse Siobhan Jordan, **operational leads:** Julie Pain and Jenny Bree, associate chief nurses and Matron Sara Davies.

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

Rationale for inclusion

- 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 realises there is still much to do and moving to a zero tolerance approach is the aim.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

How we measure and record this priority

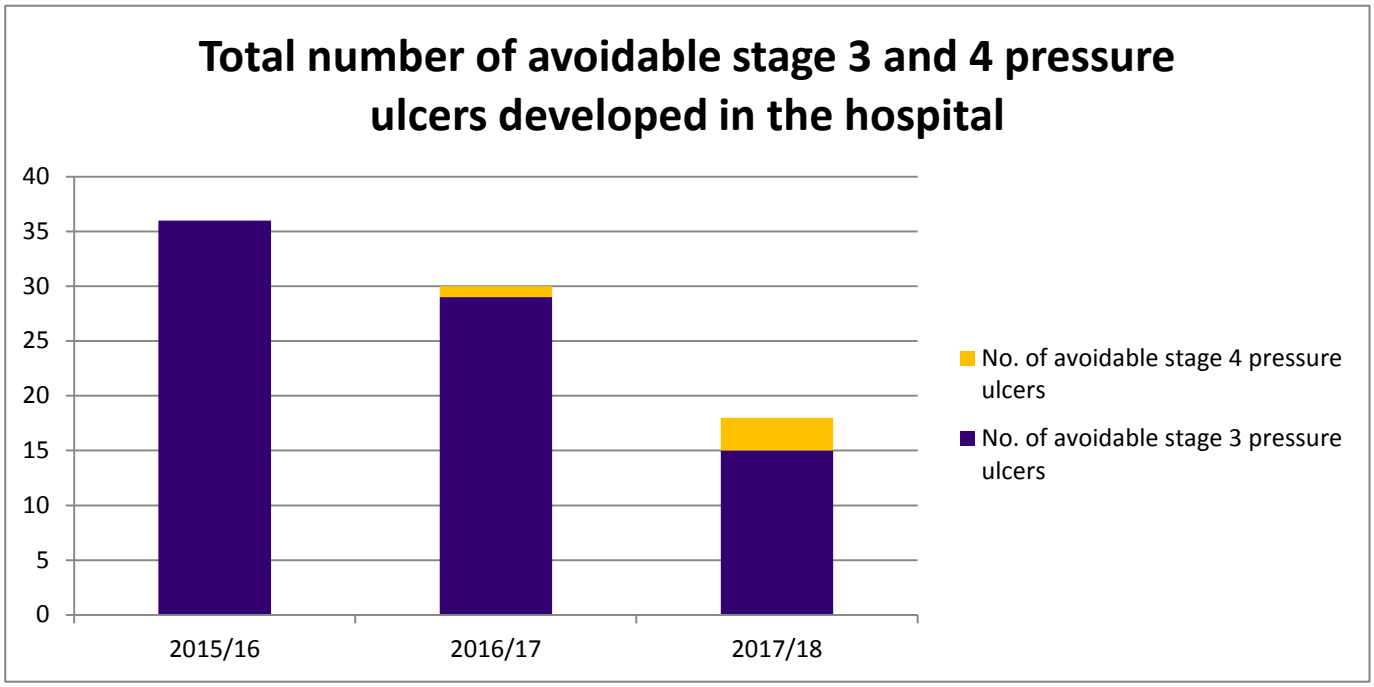
- A pressure ulcer is defined as 'a localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear'. There are six classes of pressure ulcer, stages 1, 2 3 & 4, Unclassified Stage 3 (UC3) and Suspected Deep Tissue Injury (SDTI).
- When a patient is identified as having a pressure ulcer, the details are entered into the Trust's incident reporting system to be reviewed by the tissue viability Team prior to reporting externally.
- If pressure damage is noted within 72 hours of admission to the hospital, providing that the Trust staff have taken all reasonable steps to prevent tissue damage and the patient has not been under the care of our community teams or on the district nurse caseload, this is not considered to have developed whilst under the care of the Trust. This time frame is agreed regionally as it is recognised that pressure damage can occur but not be visible immediately.

Developments that occurred in 2017/18

- The Trust-wide pressure ulcer prevention and management documentation (SKIN bundle) was reviewed to ensure accuracy of recording and the ability to provide evidence of care delivered. This work was undertaken as part of the NHS England Collaborative Pressure Ulcer Improvement Program, which is an initiative involving 24 trusts across England.
- The current RCA investigation process was reviewed to ensure that it is completed in agreed timeframes and the RCA documentation is more robust with action plans developed that are monitored to ensure shared learning is undertaken.
- The supply and use of pressure relieving devices was audited to ensure they are effective and appropriate so that patients receive the right device for their need.
- The number of device related pressure ulcers due to an oxygen mask and nasal cannula has been addressed with the use of an alternative device. There have been no further incidents since the change occurred but monitoring will continue.
- Photographic images are now made to support the verification process.

Current status: Hospital

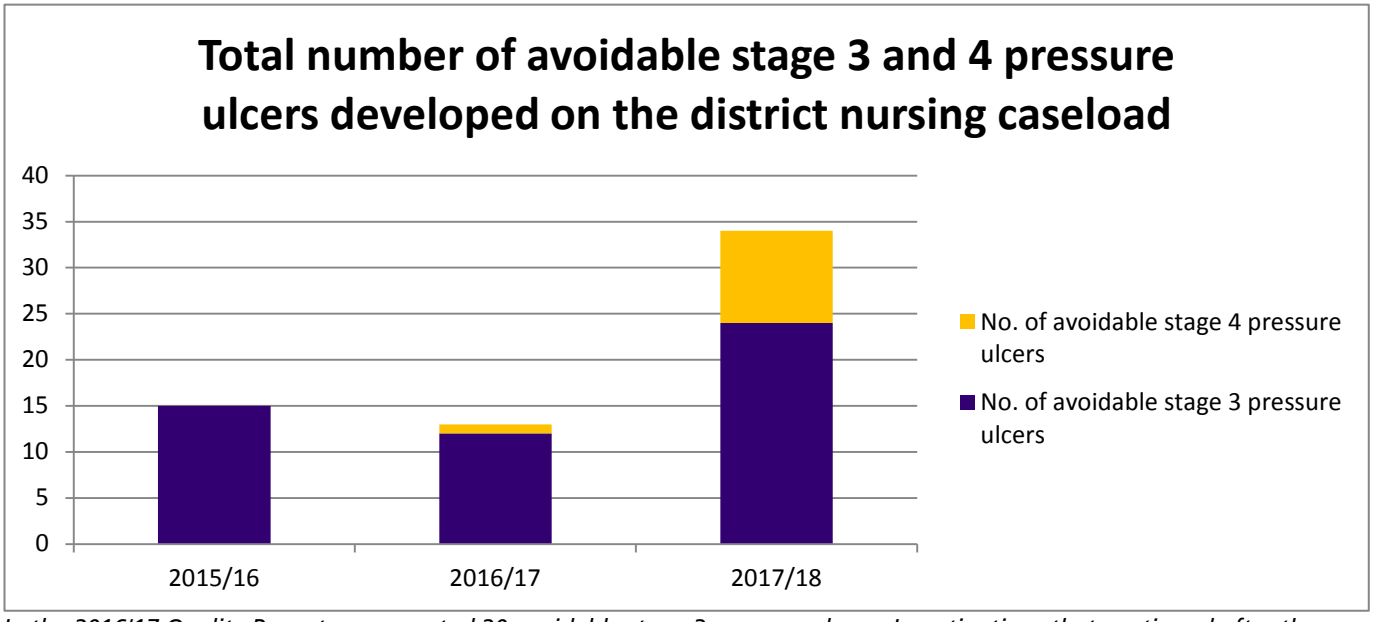
The graph below shows the total number of avoidable stage 3 and 4 pressure ulcers that have developed in the hospital from 2015/16 to the present. It gives an indication of the fall in numbers due to the hard work of all staff involved. While there were 30 stage 3 and 4 ulcers in 2016/17, these have been reduced to 18 this year (see note under graph).



In the 2016/17 Quality Report, we reported 20 avoidable stage 3 pressure ulcers. Investigations that continued after the year end later found a further nine avoidable stage 3 ulcers. The 2017/18 figures may be incomplete as a number of pressure ulcers are still being investigated to ascertain whether they were avoidable or not.

Current status: Community

The target of there being no avoidable stage 4 pressure ulcers acquired throughout the year on the district nurse caseload has not been achieved as there have been 10 cases this year. The target to reduce the number of avoidable stage 3 acquired from 2016/17 to 2017/18 has not been achieved with there being 24 cases compared to 12 the year before (see graph below).



In the 2016/17 Quality Report, we reported 20 avoidable stage 3 pressure ulcers. Investigations that continued after the year end later found a further nine avoidable stage 3 ulcers. The 2017/18 figures may be incomplete as a number of pressure ulcers are still being investigated to ascertain whether they were avoidable or not.

New priority 2 for 2018/19: Pressure ulcers	
Hospital	**Community**
a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year. b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2018/19 reduces from the number in 2017/18 by at least 10 per cent.	a) Ensure that there are no avoidable stage 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable stage 3 pressure ulcers acquired on the district nurse caseload in 2018/19 reduces from the number in 2017/18 by at least 10%.

Rationale for inclusion

- We did not achieve all of the pressure ulcer targets we set ourselves in 2017/18 with a particular rise in avoidable stage 3 pressure ulcers in the community.
- Pressure ulcers remain a significant healthcare problem despite the knowledge that pressure ulcers are largely preventable.
- Avoidable pressure ulcers are a key indicator of the quality and experience of patient care.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

How we measure and record this priority

In order to reduce the incidence of pressure ulcer development, it is important that we measure the incidence and identify the contributing trends and themes.

- When potential pressure damage is identified, the details are entered into the Trust's incident reporting system. Depending on the stage of damage, the incidents are reviewed by the lead nurse, matron or the tissue viability team to confirm stage and provide advice and support to the patients care provider.
- Root Cause Analysis (RCA) investigation is performed for all acquired pressure ulcers of stage 3 and above including Suspected Deep Tissue Injury to allow for a systematic evaluation of the contributing factors.
- The duty of candour process ensures that we inform patients and relatives if there have been mistakes in their care that have led to significant harm.

Developments planned for 2018/19

- Develop robust education and training programmes for staff.
- Plan and deliver three educational study days to address key priority topics, pressure ulceration, lower limb ulceration and complex wound management.
- Work with the patient safety team to develop robust reporting processes to ensure data collected is accurate.
- Explore the 'Risk Assessment' tool for the Emergency Department to ensure it is specific to the clinical area for patient assessment.
- Deliver the 'React to Risk' and '50 day pressure ulcer challenge' with an aim to reduce the incidence of avoidable stage2, 3 and 4 pressure ulceration.
- Deliver the International 'Stop the Pressure' campaign to the Trust.

Board Sponsor: Chief Nurse Siobhan Jordan
Operational Lead: Deputy Chief Nurse Carol Love-Mecrow, Julie Pain and Jenny Bree, associate chief nurses and Tissue Viability Lead Nurse Gill Hiskett

Priority 3 for 2017/18: Infection control

Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.

MRSA	Clostridium difficile
Have 0 post 48 hour cases of MRSA bacteraemia (blood-stream infections).	Have no more than 29 post 48 hour cases of Clostridium difficile with a lapse in care identified.

Rationale for inclusion

- The Trust and Council of Governors have indicated that the prevention and control of infections remains a Trust priority.
- NHS England has a zero tolerance of MRSA bacteraemia.
- The Trust had a challenging nationally-set target of 29 C. diff cases for the coming year.

How we measure and record this priority

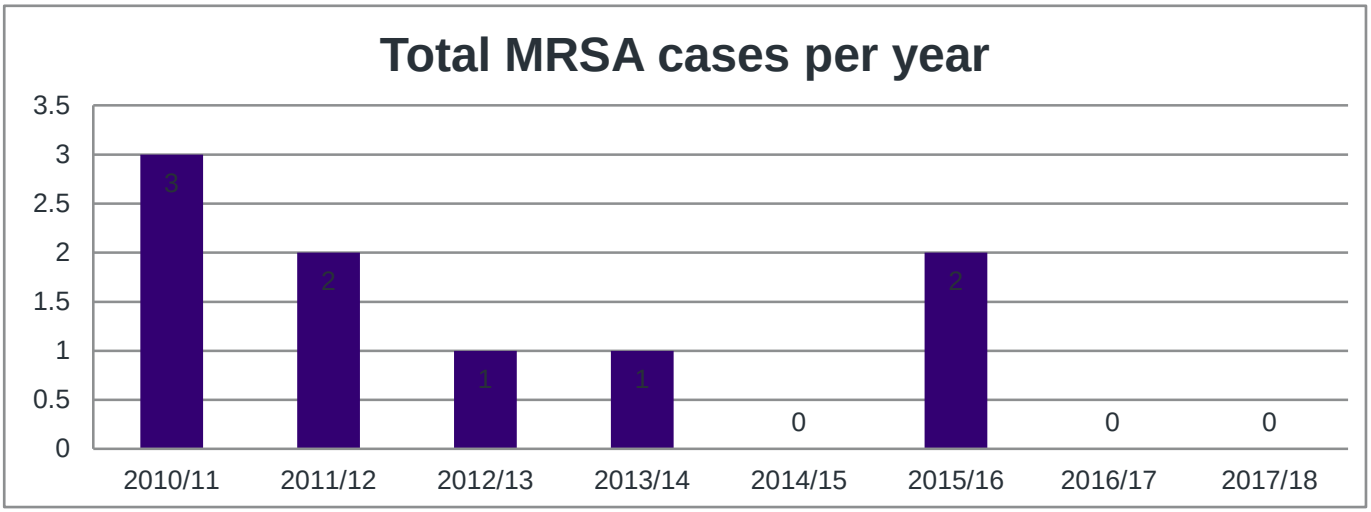
Infections are monitored internally, along with other key quality indicators, on the Trust's electronic dashboard (see Section 3.1). In addition, these infections are monitored by our commissioners at quality review meetings. Positive MRSA bacteraemia and C. diff results are also reported onto the national Healthcare Associated Infections data capture system.

Developments that occurred in 2017/18

- Developed current ward dashboard to include saving lives audit data.
- Held a cannula awareness day.
- Implemented new Clostridium difficile RCA investigation tool and assessment form.
- Developed a Glycopeptide Resistant Enterococcus (GRE) patient information leaflet.
- Undertook Infection Prevention and Control Awareness sessions in the main reception at Russells Hall Hospital.
- Participated in the annual World Antibiotic Awareness Week and European Antibiotic Awareness day in order to raise awareness of appropriate antibiotic use amongst staff, patients and visitors.

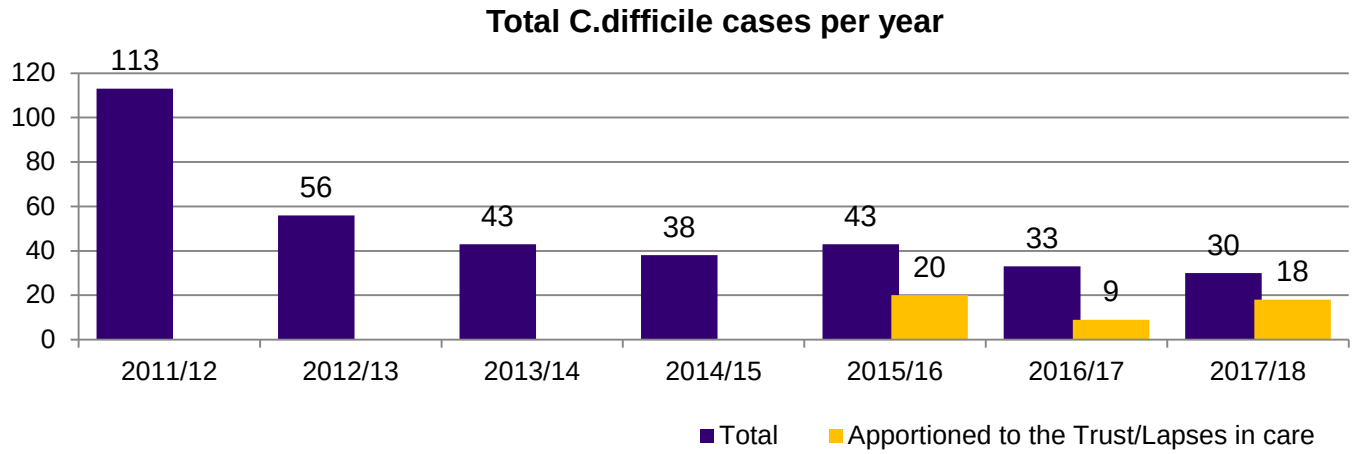
Current status: MRSA

NHS England has set a zero tolerance approach to MRSA bacteraemia. There have been zero post-48 hour cases reported in the year and so the target has been achieved.



Current status: Clostridium difficile

In the year, we have reported a total of 30 cases of C. difficile of which 18 have been recognised as being due to a lapse of care and attributed to the Trust. The other cases are related to external factors. Both NHS Improvement and NHS England are assessing the Trust's performance against a target of 29 cases due to a lapse in care.



New priority 3 for 2018/19: Infection control

Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.

MRSA	Clostridium difficile
Have 0 post 48 hour cases of MRSA bacteraemia (blood stream infections).	Have no more than 28 post 48 hour cases of Clostridium difficile with a lapse in care identified.

Rationale for inclusion and how we measure and record this priority

- The Trust and Council of Governors have indicated that the prevention and control of infections remains a Trust priority.
- NHS England has a zero tolerance of MRSA bacteraemia.
- The Trust has a challenging nationally-set target of 28 C. diff cases for the coming year.

The indicators are measured and recorded as described above.

Developments planned for 2018/19

- Trust-wide mattress audit in conjunction with Tissue Viability.
- Participate in National Infection Prevention and Control week.
- Participate in W.H.O campaign – Clean Your Hands Campaign.
- Review process for Gram negative surveillance.
- Antimicrobial Stewardship awareness week.
- Review Antimicrobial prescribing and referrals from wards.
- Recruitment of governors as 'infection control secret shoppers'.
- Review MRSA Screening Policies and data collection.
- Continue ongoing work with the wider health economy through the HCAI Partnership Group.
- Implement the revised mandatory training programme for infection control.
- Adopt the catheter 'passport' to improve catheter care across the health economy after final ratification

Board sponsor: Chief Nurse Siobhan Jordan, **operational leads:** Director of Infection Prevention and Control Dr. E.N. Rees, Matron, Infection Prevention and Control Angela Murray.

Priority 4 for 2017/18: Nutrition and hydration

Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items):

a) is 95% or above in each of the first three quarters for the Trust as a whole
b) has a 'Green' rating (95% or above) in the final quarter for every ward in the hospital

Nutrition assessments – hospital	Nutrition assessments – community
At least 95% of acute patients will receive a nutritional assessment using the nationally recognised MUST (Malnutrition Universal Screening Tool).	At least 95% of patients will receive a nutritional assessment on initial contact with the community health nursing team using the nationally recognised MUST (Malnutrition Universal Screening Tool).

Rationale for inclusion

- Poor nutrition and hydration leads to poor health, increased and prolonged hospital admissions and increased costs to the NHS. The consequences of poor nutrition and hydration are well documented and include increased risk of infection, poor skin integrity and delayed wound healing, decreased muscle strength, depression and, sadly, premature death. Put simply, poor nutrition and hydration causes harm.
- A target on the completion of the MUST when patients first come into contact with the hospital or community nursing service was included in the Quality Account a number of years ago; however, present results show this needs some focus to improve. The MUST has been designed to help identify adults who are underweight and at risk of malnutrition, as well as those who are obese. The tool has been in use at the Trust for a number of years.
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

How we measure and record these priorities

As part of the monitoring of care relating to nutrition and hydration, a comprehensive audit tool was introduced in 2014. This follows the Nursing Care Indicator model (see Section 3.3.5) and involves auditors checking what is recorded in the nursing notes and asking patients about their experience of being offered drinks and a choice of food. It also includes observations of the environment, for instance, whether patients have drinks within reach and whether patients are placed in an optimal position for eating. In total, there are 24 elements to the audit and it is undertaken on 10 patients on every ward each month. The MUST score is audited as part of the NCI monitoring, which is a monthly check of 10 sets of nursing notes undertaken at random on every ward (see Section 3.3.5).

Developments that occurred in 2017/18

- Evaluated progress of weekly patient weighing.
- Implemented updated fluid balance charts, underpinned with clear instructions on their use.
- Updated teaching package and placed on intranet.
- Reviewed dietetic team referral criteria guidance which includes an amended nutrition bundle.
- Ensured patients' nutritional needs were met by appropriate ordering of meals. Nutrition group worked with catering assistants.
- Had active publicity campaign as part of the National Nutrition week.
- Re-launched Nutrition Steering Group.
- Joined National Nutritional Collaborative working with other trusts on this topic.
- Nursing representation now in place at the Combined Services Group.
- Started Nutritional Observation Audit.

Current status: Nutrition/hydration

With regards to the nutrition audit, while the target was met in the first two quarters (and in eight of the 12 months), it was narrowly missed in the second two quarters (see chart below).

For the second part of the target (every ward achieving 95 per cent or above in the last quarter), this has not been achieved. 14 of the 20 areas had scores 95 per cent or above, with six wards not achieving the target.

Nutrition audit Hospital					
2016/2017	Qtr 1 2017/2018	Qtr 2 2017/2018	Qtr 3 2017/2018	Qtr 4 2017/2018	2017/18
96%	95%	95%	94%	93%	94%

Wards: Qtr 4	
95% and above	14
94 to 85%	4
84% and less	2

The MUST target for the hospital has not been met, although improvements were made throughout the year. It has been agreed to retain this target next year and make an extra effort to achieve this in the future.

MUST assessment Hospital					
2016/2017	Qtr 1 2017/2018	Qtr 2 2017/2018	Qtr 3 2017/2018	Qtr 4 2017/2018	2017/2018
85%	91%	92%	93%	94%	93%

The MUST target for the community services has been met as the quarterly figures below indicate.

MUST assessment Community					
2016/2017	Qtr 1 2017/2018	Qtr 2 2017/2018	Qtr 3 2017/2018	Qtr 4 2017/2018	2017/18
96%	97%	96%	93%	98%	96%

Relative Quote (Day Surgery Unit)

"My health and wellbeing were paramount and I felt that I received a first class service. The nurses on the ward, the theatre nurse, the anaesthetists, the physiotherapists all helped to make my short stay as comfortable as possible."

New priority 4 for 2018/19: Nutrition and hydration	
Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items): a) is 95% or above in each of the first three quarters for the Trust as a whole b) has a 'Green' rating (95% or above) in the final quarter for every ward in the hospital	
Nutrition assessments – hospital	**Nutrition assessments – community**
At least 95% of acute patients will receive a nutritional assessment within 24 hours of admission using the nationally recognised MUST (Malnutrition Universal Screening Tool).	At least 95% of patients will receive a nutritional assessment on initial contact with the community health nursing team using the nationally recognised MUST (Malnutrition Universal Screening Tool).

Rationale for inclusion and how we measure and record this priority

- Due to non-achievement of three of the four targets in 2017/18 decided to retain them for 2018/19.
- Retain the emphasis on nutrition and hydration due to not meeting some of the targets for last year.
- Trust is taking part in National Collaborative project on this topic
- Feedback from our patients, staff, community groups and governors indicates this should remain a target.

The indicators are measured and recorded as described above.

Developments planned for 2018/19

- Continue nutritional collaborative work by implementation of a more systematic approach to supported mealtimes
- Revise protected meal policy as supported mealtime policy.
- Ensure nutrition link nurse group meets on a monthly basis and nutrition steering group on a three monthly basis.
- When new Electronic Patient Record is implemented, MUST assessment will be mandatory.
- Review the menus available in the Trust.
- Review food supplier.
- Implement a screensaver which will stress the importance of good nutrition.
- Organise a structured training programme on MUST for all staff across the Trust.
- Implement food hygiene training for all nursing staff that handle food (mandatory requirement).

Board sponsor: Chief Nurse Siobhan Jordan**, operational leads:** Jenny Bree and Julie Pain, associate chief nurses, Matron Lesley Leddington and Deputy Matron Debra Vasey.

Priority 5 for 2017/18: Medications

Ensure that in 95% or more cases, all prescribed medications will either be: a) signed and dated as administered or b) have an omission code recorded.

Rationale for inclusion

The importance of patients receiving their prescribed medication appropriately and on time cannot be overestimated. It contributes to patient wellbeing and recovery and is an indicator of the overall quality of patient care. On occasion, this does not happen, for instance, if the patient is nil by mouth in preparation for a particular test, declines the medication, is having an X-ray or is in the theatre suite having a procedure undertaken. It is essential that nurses administering medications record the date and time on the prescription chart. In the few cases when it is not given, this should also be recorded, along with the reason why (a standard set of codes are used for this which include some of the examples stated above). Feedback from our patients, staff, community groups and governors indicates this issue should remain a target.

How we measure and record this priority

The recording of medications administered and omitted are audited as part of the Nursing Care Indicators (NCI) monitoring, which is a monthly check of 10 sets of nursing notes undertaken at random on every ward (see Section 3.3.5).

Developments that occurred in 2017/18

- Refocus of priorities for link workers for 2017/18 and shared action plan with senior team.
- Posters relating to missed dosage and efficacy of analgesia displayed in all medication trolleys and treatment rooms and kept up to date by link workers.
- Trust intranet for medicines management developed to become more user friendly for nursing/medical staff.
- Matron and pharmacy lead nominated.

Current status: Medications

It can be seen from the chart below that even though there was an improvement later in the year the target for the whole 12 months has not been met and so this is retained for 2018/19.

Medications signed and dated/omission code recorded					
End of year results 2016/2017	**Qtr 1 2017/2018**	**Qtr 2 2017/2018**	**Qtr 3 2017/2018**	**Qtr 4 2017/2018**	**2017/18**
88-92%	**94%**	**92%**	**93%**	**96%**	**93%**

New priority 5 for 2018/19: Medications

a) Ensure that in 95% or more cases, all prescribed medications will either be: a) signed and dated as administered or b) have an omission code recorded.

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

Rationale for inclusion

As explained previously, the importance of patients receiving their prescribed medication appropriately and on time cannot be overestimated. Due to the non-achievement of the target in 2017/18, this topic has been retained.

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

How we measure and record this priority

The correct recording of medications administered and omitted is measured as explained above. The appropriate wearing of red identification bands for patients with allergies is measured as part of the spot wristband audit undertaken by matrons on all inpatients on a random day every quarter. Once the Electronic Patient Record is implemented this year, it will be possible to produce a report of all inpatients with allergies against which a check can be made that all of them are wearing a red identification band.

Learning Lessons

A Near Miss in pharmacy occurred relating to cyclophosphamide 50mg and cyclizine 50 mg, where the two drugs were confused and labelled (not dispensed). This prompted pharmacy to introduce a new caddy system and this clearly separates the products on the shelves in the pharmacy.

Developments planned for 2018/19

- Collaborative work to be undertaken with the West Midland Medicines Safety Officer Group to benchmark trusts with omitted doses. Regular audit and action plans for the region will also commence.
- Electronic EPMA system to be launched in June 2018 which will alert nursing staff to doses due, reducing the risk of omitted doses. Following implementation monitoring and audit of omitted doses will become easier.
- Include missed doses in September 2017 Medicines Link Newsletter to re-educate all staff.
- Datix trends to be reviewed by Safer Medicines Group (SMP).
- Red wrist band policy to be written and agreed
- Red wrist band policy to be launched Trust-wide via the intranet
- Weekly audits will commence initially by medicines matron to ensure compliance and then will revert to monthly audits once embedded to be completed by Lead nurses.

Board sponsor: Chief Nurse Siobhan Jordan, **operational leads:** Julie Pain and Jenny Bree, associate chief nurses, Matron Sara Davies and Governance Pharmacist Suzanne Cooper.

New priority 6 for 2018/19: Discharge Management

a) All patients will have an Expected Discharge Date (EDD) determined by assuming ideal recovery and assuming no unnecessary waiting.
b) Early discharge. All medical and surgical wards will discharge the following number of patients before midday: In Q1, at least one patient. In Q2 at least two patients, which will be maintained in Q3 and Q4.
c) Delays in discharge. The total number of days that patients due for discharge are delayed will reduce by the following compared to the same quarter in 2017/18: Q1 by 10%, Q2 by 15%, which will be maintained in Q3 and Q4.

Rationale for inclusion and how we measure and record this priority

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

We measure and record this priority with the estimated discharge date and time of discharge recorded on the electronic patient administration system, which links with the Trust's discharge database. On the database, delays in discharge and the reasons for delays are recorded. These systems make it possible to monitor the above targets.

Developments planned for 2018/19

- Ensure that daily ward rounds occur moving to twice daily ward rounds by the end of the year.
- Ensure that daily/twice daily ward rounds are included in consultant job planning.
- Implement the 'Red 2 Green' process.
- Reinstate 'stranded patient'/length of stay meetings.
- Ensure that the Estimated Discharge Date is a mandatory field on the patient administration system and the Estimated Discharge date is retained in the system.

Relative Quote (Critical Care)

"They treated my Grandad with respect and dignity in his last hours. They showed great compassion to us as a family, making sure we and my Grandad were all as comfortable as could be. I would like to thank the whole team for their hard work and dedication"

Board sponsor: Chief Operating Officer Karen Kelly, o**perational leads:** Discharge Facilitator Gregg Marson, Divisional Manager Karen Hanson, Chief of Surgery Matt Weller, Chief of Medicine and Integrated Care Matt Banks and Clinical Director of the Urgent Care Directorate Hassan Paraiso.

New priority 7 for 2018/19: Incident Management

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

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

Rationale for inclusion and how we measure and record this priority

- The safety of our patients is paramount.
- It is widely recognised that an organisation with a positive safety culture has a high incident reporting rate with a reducing number of serious incidents, the latter resulting from learning and changing practice.
- With regards to the overall reporting rate, latest published six monthly comparative figures the Trust reporting rate was 79th of 136 organisations. This comparative position shows that there is room for further improvement.

Measurement and reporting

All incidents are recorded within the Trust's incident management system, Datix. Data is extracted from this system monthly and is reported at both an operational level through the respective divisional governance meetings and at a Board level through the reporting to the Clinical Quality, Safety and Patient Experience Committee and the Board itself. Reported incidents are also recorded within the Trust's integrated performance report and developed ward quality dashboards.

Developments planned for 2018/19

In order to support the organisational change, the following key developments / actions are planned:

- Expand the corporate incident management team to provide enhanced divisional support through a dedicated incident business partner.
- Enhance reporting on learning from past incidents to encourage future reporting.
- Development of the reporting of positive practice to encourage best practice.

Board sponsor: Director of Governance Glen Palethorpe, o**perational leads:** Patient Safety Manager Justine Edwards, Helen Hudson, Claire Evans and Sushma Tiwari, divisional patient safety advisors.

New father quote (Maternity)

"I thank God for your team and pray that you will continue the outstanding work you do day in day out. Thanks again from an extremely proud father."

2.2 Statements of assurance from the Board of Directors

2.2.1 Review of services

During 2017/18, The Dudley Group NHS Foundation Trust* provided and/or sub-contracted 59 relevant health services. The Trust has reviewed all the data available to them on the quality of care in 59 of these relevant health services. The income generated by the relevant health services reviewed in 2017/18 represents 98.3 per cent of the total income generated from the provision of relevant health services by the Trust for 2017/18. **Henceforth referred to as 'the Trust'*

The above reviews were undertaken in a number of ways. With regards to patient experience and safety, the Trust executive and non-executive directors, governors and other senior staff, together with representation from Dudley Clinical Commissioning Group, undertake Quality and Safety Reviews of clinical areas (see section 3.3.2). The Trust has a Mortality Surveillance Group, chaired by the medical director, which reviews all matters relating to mortality including the Trust's mortality tracking system. Dudley Clinical Commissioning Group is invited to join the mortality review process. Every month, each of the two clinical divisions at the Trust have a performance review undertaken when they are assessed by directors on a variety of quality indicators.

We also monitor safety, clinical effectiveness and patient experience through a variety of other methods:

- Quality Indicators - monthly audits of key nursing interventions and their documentation. These are being expanded to cover all professional groups with each area having a Quality Dashboard that all staff and patients can view so that the performance in terms of quality care is clear to everyone associated with that service. The key quality indicators are published, monitored and reported to the Board of Directors every quarter (see section 3.3.5).
- Ongoing patient surveys that give a 'feel' for our patients' experiences in real time allow us to quickly identify any problems and correct them (see section 3.2.2).
- A variety of senior clinical staff attend the monthly three key sub-committees of the Board to report and present on performance and quality issues within their area of responsibility: Clinical Quality, Safety and Patient Experience Committee, Finance and Performance Committee and Workforce and Staff Performance Committee.
- The Trust has an electronic dashboard of indicators for directors, senior managers and clinicians to monitor performance. The dashboard is essentially an online centre of vital information for staff.
- The Trust works with its local commissioners, scrutinising the Trust's quality of care at joint monthly Clinical Quality Review Meetings.

- External assessments of the Trust services, which included the following key ones this year:

    - The Quality Surveillance Team (QST) lead an Integrated Quality Assurance Programme for the NHS and is part of the National Specialised Commissioning Directorates, Quality Assurance and Improvement Framework (QAIF). The role of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance framework for all cancer services and specialised commissioned services within NHS England. For cancer services, the Trust was required to submit its annual assessments in 2017 against the QST measures in collaboration with each relevant Quality Lead/Services Specialist. Services have received initial feedback and action plans are in place to mitigate against any risks identified.

- The following pathology departments were assessed:
  All pathology departments have continued to perform well in their accreditation inspections, the United Kingdom Accreditation Service (UKAS) Assessment Manager and Peer Assessors being complimentary about each area's verification of tests and overall laboratory compliance to the standards. At every visit they have complimented all the departments on their openness and positive approach to inspection, which is reflected in the following outcomes:

  a) Assessed against CPA (Clinical Pathology Accreditation) standards and in transition to accreditation by UKAS against ISO 15189:2012 Medical laboratories – Requirements for quality and competence:

  Microbiology – CPA accreditation maintained with findings to action following an assessment visit by UKAS on 16th to 18th May 2017. All findings cleared by Assessment Manager, awaiting final decision from UKAS Decision Makers.

  Immunology – CPA accreditation maintained with findings to action following an assessment visit by UKAS on 12th and 14th June 2017. All findings cleared by Assessment Manager, awaiting final decision from UKAS Decision Makers.

  b) Assessed against ISO 15189:2012 standards

  Cellular Pathology and the mortuary have maintained accreditation against ISO 15189:2012 as assessed by UKAS. They underwent their Surveillance 2 on 16th January 2018, evidence for findings to be submitted by 17/02/2018.

  Biochemistry has achieved accreditation against ISO 15189:2012 assessed by UKAS against the tests witnessed. However, with the introduction of the new analysers and the majority of biochemistry tests changing platforms, the department will need to apply for extension/change of scope once new analysers and pre-analytics are verified. Their Surveillance 1 will be in 29th March 2018, they will submit their verifications for an extension to their accredited scope before the end of February 2018.

  Haematology has achieved accreditation against ISO 15189:2012 assessed by UKAS against the tests witnessed. Their Surveillance 1 will be on 17th to 18 April 2018. They too will be applying for minor extension to scope.

  In addition, Microbiology had a visit from the Health and Safety Executive (HSE) on 17th January 2018. The HSE inspected the Containment Level 3 Facility within the laboratory which is used when processing high risk samples. Microbiology did extremely well with no improvement notices issued as all findings were satisfactory.

- With regards to education and training, the Trust had a number of educational visits during the year. In June 2017, the training of the doctors in the two Foundation Years was assessed. The trainees described an enjoyable training experience and overall, they were positive about their learning environment. It was highlighted that all trainees would recommend their post to a colleague and would all recommend the Trust to a friend or family. A number of issues were raised which were impacting on the educational experience and these have been rectified. In November 2017, General Surgery was assessed and trainees were positive in their overall feedback about working and training in the Trust. An action plan was drawn up based on the comments of the juniors. A Defence Deanery Review also took place in November 2017

and trainees described the learning experience at Russells Hall Vascular Unit as the premiere placement in the region. In January 2018, a visit took place to the Obstetric and Gynaecology areas. The good points from this review were that trainees were positive about working and supervision in the gynaecology ward and clinics, antenatal clinics and theatres. GP trainees gave positive feedback about their training experience and the new college tutor has received very good feedback. Actions were required with labour ward leadership and handover in that area.

- In April 2017, a DoH GIRFT (Get it Right First Time) visit occurred in **Orthopaedics.** One of the key recommendations made was the streamlining of prostheses used; for elective hip prostheses we now have one supplier; phase 2 is to review our trauma prostheses. Four further GIRFT visits occurred in June 2017 in **Obstetrics and Gynaecology, Ophthalmology, Spinal Services and Urology** with two further visits in July 2017: **Maxillo-Facial Surgery and ENT.** When recommendations were made, action plans were drawn up. The British Orthopaedic Association undertook a **Hip Fracture Review** in June 2017. The final report was received in February 2018 and appropriate actions are taking place. Peer reviews were undertaken on the **Critical Care (July 2017) and Neonatal Care (2018).** No report has been produced so far but for the latter, review actions have already commenced. The Trust's **GI** services were assessed in the year and received accreditation from the Joint Advisory Group (JAG) on GI Endoscopy. In November 2017, NHS Improvement undertook a review of **Infection Prevention and Control** and actions have commenced based on a detailed action plan that has been compiled.

- Early in 2016, NHS England alerted Dudley CCG that the Trust had reported a higher number of serious incidents in maternity compared to comparable trusts in the West Midlands during April 2014 to December 2015.
  A review of all investigation (RCA) reports related to these incidents was carried out by an independent reviewer at the request of the CCG. A Quality Improvement Board (QIB) was established involving six organisations including the Trust, Dudley CCG, the Care Quality Commission (CQC), NHS England, NHS Improvement and Healthwatch Dudley. The objectives of the QIB were to work together to enhance maternity services, ensuring that families were included in the process and gaining assurance that maternity services were safe and effective with robust risk management processes. An action plan was developed which included all issues identified and the completion of all actions was actively monitored within the Trust and via the Quality Improvement Board. In October 2017, a report was published to inform all stakeholders of the outcome of the QIB and to provide assurances of the improvements made within the maternity services. The maternity services are able to demonstrate the improvements in care and safety for all women and babies. Systems and processes have been strengthened to improve governance overall. Partnerships with other maternity units have been forged which allows for sharing of good practice and lessons learned between all organisations. We are pleased that this has been evidenced and the CQC have rated our maternity services as good overall at their recent inspection.

2.2.2 Participation in national clinical audits and confidential enquiries

During 2017/18, 45 national clinical audits and three national confidential enquiries covered relevant NHS services that the Trust provides. During that period the Trust participated in 100 per cent of the national clinical audits and 100 per cent of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. The national clinical audits and national confidential enquiries that the Trust was eligible to participate in, actually participated in, and for which data collection was completed during 2017/18 are listed below. Tables 1 and 2 show the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. There was no data collection nationally for four national audits.

Table 1

National Clinical Audits	Participation	% submitted
Women		
Maternal, Newborn and Infant Clinical Outcome Review Programme – MBRRACE	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
Paediatrics and Neonates		
Diabetes (Paediatric) (NPDA)	Yes	100%
National Intensive and Special Care (NNAP)	Yes	100%
National Audit of Seizures and Epilepsies in children and young people (Epilepsy 12)	Yes	Not started nationally
Acute Care		
BAUS - Urology Audits - Nephrectomy	Yes	100%
BAUS - Urology Audits - Percutaneous Nephrolithotomy	Yes	100%
Case Mix Programme (CMP)	Yes	100%
National Cardiac Arrest Audit (NCAA)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
Fracture Neck of Femur (Care in Emergency Department)	Yes	100%
Pain in Children (Care in Emergency Department)	Yes	100%
VTE in Lower Limb Immobilisation (Care in Emergency Department)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	Not started nationally
UK Parkinson's Audit	Yes	100%

Long Term Conditions		
Inflammatory Bowel Disease IBD Registry, Biological Therapies Audit	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Pulmonary rehabilitation	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary care	Yes	100%
Learning Disability Mortality Review Programme (LeDeR)	Yes	100%
National Vascular Registry	Yes	100%
National Audit of Dementia	Yes	Not started nationally
National Ophthalmology Audit	Yes	100%
National clinical audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Yes	Not started nationally
National Diabetes Programme		
National Inpatient Audit Diabetes (Adult)	Yes	100%
National Foot Care Audit	Yes	100%
National Pregnancy in diabetes	Yes	100%
Cardiovascular Disease		
Cardiac Rhythm Management (CRM)	Yes	100%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	100%
National Heart Failure Audit	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Cancer		
Bowel Cancer (NBOCAP)	Yes	100%
Lung Cancer (NLCA)	Yes	100%
National Prostate Cancer Audit	Yes	. 100%
National Audit of Breast Cancer in Older People (NABCOP)	Yes	100%
Head and Neck Cancer Audit	Yes	100%
Oesophago- Gastric Cancer (NAOGC)	Yes	100%
Trauma		
Major Trauma - The Trauma & Audit Research Network (TARN)	Yes	100%
National Joint Registry (NJR)	Yes	100%
Falls and Fragility Fractures Audit Programme (FFFAP)		
Inpatient Falls	Yes	100%
National Hip Fracture database	Yes	100%

Blood Transfusion		
National Comparative Audit of Blood Transfusion Programme - Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	Yes	100%
National Comparative Audit of Blood Transfusion Programme -2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	Yes	100%
National Comparative Audit of Blood Transfusion Programme - Audit of Patient Blood Management in Scheduled Surgery - Re-audit September 2016	Yes	100%
Serious Hazards of Transfusion (SHOT)	Yes	100%

Table 2

National Confidential Enquiries				
Name of Study	**No. of Cases included**	**No. and percentage of clinical questionnaires submitted**	**No. of case notes submitted**	**No. of organisation questionnaires submitted**
Chronic Neurodisability	7	5 (71%)	3	2
Young People's Mental Health	7	3 (43%)	3	2
Cancer in children, teens and young adults	1	1 (100%)	1	1

The reports of 13 national clinical audits were reviewed in 2017/18 (Table 3) and the Trust has taken or intends to take the following actions to improve the quality of healthcare provided (Table 4)

Table 3

Audits
NHFD – National Hip fracture Database
NNAP – National Neonatal Audit Programme: 2017 Annual Report on 2016 data
National Clinical Audit of Rheumatoid and Early Arthritis
7 Day Review Services – NHS England
NADIA (Inpatient Diabetes Audit)
NPDA – National Audit Paediatric Diabetes
The National Maternity and Perinatal Audit (NMPA)
UK renal registry report for Russells Hall Hospital (IBD)
SSNAP – Sentinel Stroke Audit
ICNARC (Intensive Care National Audit and Research Centre) CMP
National Audit of Dementia
National Diabetes Foot Care Audit 2014-2016
Pulmonary Rehabilitation: Steps to breathe better

Table 4

National Audit Title	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
NHFD – National Hip Fracture database	Theatre efficiency has improved mainly in obstetrics and trauma theatres. The Trust's case mix adjusted mortality has significantly dropped to 5.4%. This reduction is credited to the extensive work undertaken within the department including: an anaesthetic review of all mortalities, the introduction of a 15 minute spinal rule and 20 minute surgical rule and a re-focus on admission to theatre time.
NNAP (Neonatal Annual Audit programme)	Total compliance was achieved for the standard for babies screened for retinopathy, with 54% receiving documented clinical follow up at two years; however, this was in line with national average. 46% achieved the standard of babies with temperature measured. The Trust is investing in new thermometers to provide the best possible equipment and this should improve compliance.
National Clinical Audit of Rheumatoid and Early Arthritis	All new patient referrals are triaged to ensure inflammatory arthritis patients are seen within three weeks as per standard. For a new diagnosis of arthritis, all patients will receive Arthritis Research UK patient leaflet. Communication with patients will improve by discussing treatment targets at follow up clinics.
7 Day Review Services	The Trust is working towards twice daily ward rounds on all wards. The ward round checklist will have as mandatory a patient discussion. There is a need to document clearly those patients who are fit for discharge or medically optimised that do not need daily consultant review. Future audits will define which level of care criteria the patient meets before determining if they need daily/twice daily review.
NADIA (Inpatient Diabetes Audit)	The Trust is in the lowest quartile for diabetes-related incidents. 100% of patients receive the diabetic foot assessment within 24 hours of admission.
NPDA – National Audit Paediatric Diabetes	To improve the Trust's compliance rate, a dedicated person will be employed to input all the data into the 'Twinkle' database, and a psychologist will form part of the team.
The National Maternity and Perinatal Audit (NMPA)	There are nine key standards that are measured for this audit and the Trust is non-compliant with two; however, the Trust is aware and is taking the necessary action.
SSNAP – Sentinel Stroke Audit	The compliance rate in the audit is one of the best in the country. The targets were achieved and exceeded on the following standards: 1. Proportion of patients scanned within one hour of clock start, 4. Proportion of patients reported as requiring occupational therapy, 9.2 Proportion of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation. There was a demonstrated improvement in mood and continence recording in the audit.
ICNARC (Intensive Care National Audit and Research Centre) CMP	All discharges are now reviewed by a consultant after leaving ICU.

National Audit Title	Details of actions taken or being taken to improve the quality of local services and the outcomes of care.
National Audit of Dementia	A local action plan is being developed to address the low compliance areas
National Diabetes Foot Care Audit 2014-2016	The Trust is planning to create patient pathways and work closely with the commissioners to improve foot care services
Pulmonary Rehabilitation: Steps to breathe better	An individualised exercise plan for post-rehabilitation patients has been implemented and care bundles are to be re-introduced

Local clinical audit

The reports of 24 completed local clinical audits were reviewed in 2017/18 and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Speciality/Audit Title	Actions Trust has taken or intends to take
Anaesthetics: Utilisation of Obstetric HDU Review Stickers	HDU admission stickers have improved anaesthetic documentation. Trainee obstetric induction package now includes the importance of review and documentation of HDU admissions. Posters displayed in HDU rooms prompting midwives to ask for review of appropriate patients.
Obstetrics: Induction of Labour NICE Guidance Audit	Management of induction labour includes maternal and fetal monitoring, along with adequate pain relief being given in more than 75% of cases.
Paediatrics: Management of Paediatric Head Injury NICE Guidance Audit	All children requiring head CTs or a period of observation after head injury were identified correctly and the sedation policy was updated to avoid failed sedation for those needing sedation for CT head.
Paediatrics: Regional Early Onset Neonatal Sepsis Audit	All babies had screening bloods taken and received the appropriate antibiotics at the correct dose. Continued teaching sessions at the beginning of each rotation into paediatrics to explain the EONS guideline and the importance of antibiotics within the first hour. GP trainees/ new ST1s are encouraged to attend clinical skills session for insertion of cannulas in neonates
Renal Medicine: Acute Kidney Injury NICE Guidance Audit	Improvement in urinalysis rates. All AKI cases requiring USS scanning had a timely request in place. AKI is taught regularly on FY1/FY2 and new starters program.
Pathology: Familial Hypercholesterolemia NICE Guidance Audit	All patients included in this audit were receiving high-intensity statins as recommended by NICE
Elderly Care: Bed Rails Audit	Patients are being assessed for bed rails in all areas across the Trust. Education around the bed types available for the patients has been incorporated into the falls training and policy.

Gastroenterology: Management of Acute Upper Gastrointestinal Bleeding NICE Guidance Audit	Endoscopic management was demonstrated as good. All patients were communicated with regarding their care, a quarter of relatives were also involved in discussions. Education has been provided for junior doctors to record Blatchford and Rockall scores, appropriate medical management of variceal and non-variceal upper gastrointestinal bleeding. The Introduction of new EAU clerking booklet to ensure better communication with relatives of patients admitted with UGIB and that written information is provided and documented.
Palliative Care: Audit of AMBER Implementation	A review into the use of the AMBER Care Bundle was undertaken, informed by the results of the audit with an initial recommendation that the process for identifying and managing uncertainty in the Trust is undertaken by the Trust End of Life Action Plan Group. Following further discussions with executive team and the Deteriorating Patient Group, the importance of identifying and managing uncertainty was acknowledged and in the future this will be addressed by the Deteriorating Patient Working Group.
Anaesthetics: Epidural response times	The audit showed an improvement in performance compared to the previous audit completed in April 2016. Results were disseminated at the governance audit meeting and teaching for the junior doctors around this guidance took place, the information was also distributed in the obstetric staff newsletter
Obstetrics: Audit of Vaginal Deliveries	All patients received a CTG to monitor fetal wellbeing prior to the siting of the regional epidural anaesthesia. Where a paediatrician was required 100% requested the correct grade to review the patient The audit has continued as an on-going audit with the random selection of one case per month from the birth register, to be reviewed by the multidisciplinary team at the maternity SIRS meeting and reported to the Maternity Quality Governance meeting provided annually.
Paediatrics: Audit of Readmissions to the Children's Ward of Babies up to 28 days of age	All babies admitted with poor feeding or weight loss were given a clinical feeding plan by the medical team Training sessions for Children's ward staff led by the Specialist Midwife for Infant Feeding (SPMW). Current guidelines revised to comply with BFI standards.
Pharmacy: Audit on the Quantity and Quality of Outpatient Medication Referral / Prescriptions Forms 2016	to improve awareness amongst patients and healthcare professionals about the about the legal requirement to show identification when certain types of medication are collected and encourage their engagement with this process; Further education required for pharmacy staff regarding the issuing of controlled drugs for outpatients. Improved quality of patient experience by raising awareness and setting expectations about the need for pharmacy staff to complete identification checks for certain medication.
General Medicine: Bed Rails Audit	The audit results have shown that compliance with assessing patients need for bed rails is positively being undertaken in all areas across the Trust and is reviewed and adopted as per Trust standard in policy. A re-audit of the use of bed rails is planned to determine if compliance continues to the high standard observed during this audit.

Theatres: Efficiency Of Tissue Sampling Following Diabetic Toe Amputations	New protocols released amongst theatres and checklists as reminders for surgeons to send off samples. Compliance was re-audited following implementation of these local protocol/ tools, with an increase to > 95 % shown. Results disseminated at the governance audit meeting, highlighting the vital aspect of effective treatment of diabetic amputees (service improvement and awareness). Further discussions are taking place within the department for implementation of a either stickers or electronically authorised tabs for samples sent (quantity and quality). Re-audit using same tool to ensure continued compliance to the standard.
Diabetes: Medical Team (Out Of Hours) Workload Audit	Nurse rounds should take place before 4pm so the day team can sort out jobs before they leave at 5pm. Use of other staff to minimize jobs e.g. ANP and up-skilling of current staff to do basic tasks e.g. bloods/IV cannula/blood gas. Assess appropriateness of out-of-hour jobs e.g. warfarin dosing/drug chart rewrites etc.
Acute Medicine: Improving the prescribing of Alcohol Withdrawal Regimen in AMU	Alcohol Withdrawal Prescribing Chart has been added to the clinical guideline.
Acute Medicine: Clinical Handover Audit	To ensure that there has been improvement in the handover process, an audit is scheduled during 2018/19.
Stroke Medicine: Prevention of Venous Thromboembolism in Patients who have had a Stroke.	All staff encouraged to fill out the form in its entirety and repeat form when needed. Liaise with VTE team regarding findings and discuss changes to VTE form and protocol, including alternative methods of assessment to improve compliance. Liaise with VTE team regarding changing VTE assessment form to include IPCSs as a recommendation. Re- audit on Forward Plan 2018/19.
Acute/General Medicine: Management of Deep Vein Thrombosis (DVT) In Ambulatory Emergency Care AEC	Radiology provide a fixed number of slots /day for DVT scans to ensure Doppler scans are performed within 24hrs of suspected diagnosis. Electronic GP notification form with scan outcome. Wells' score in electronic Doppler request forms. Re-audit on Forward Plan 2018/19
Obstetrics: Review of elective Caesarean sections Higher than expected rate of caesarean section CQC Alert	A review of case notes has been undertaken by a consultant to confirm that there are no concerns and patient safety has not been compromised. Although the Trust has a higher rate than the national average, there are no issues.
Obstetrics: Oxytocin Audit	Clinical Guideline for Syntocinon has been updated. A separate audit of observations during labour has been undertaken. Training on intrapartum care guidelines for midwifery staff has been introduced. There is a registrar review of all patients being induced, in person, on transfer to DS with documented plan. Re-audit on Plan 2018/19.

Acute Medicine: Adequacy of lumbar puncture documentation	Proforma has been introduced and a re-audit to measure improvement will be undertaken during 2018/19.
Pharmacy: An audit of clinical antibiotic reviews for sepsis patients	Trust using PIP Paediatric guidelines for antibiotics. Electronic alerts on the laboratory system flagging culture results as available. Addition of a sticker to add to culture documentation to prompt antibiotic review, adherence to guidelines and duration defined. Embed the new sepsis scoring tool into clinical practice. Re-audit including patients with no blood cultures.

2.2.3 Research and development (R & D)

The number of patients receiving health services provided or sub-contracted by the Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1,726.

Clinical specialties

Dudley opened its own locally designed and sponsored National Institute for Health Research (NIHR) portfolio study in July 2017, the culmination of two years' hard work led by Dr Julian Sonksen and his team. 'Recovery after Emergency Laparotomy (REmLap): a prospective, observational, feasibility study', is an intensive questionnaire study that follows patients from 48 hours after a major abdominal surgery for up to one year. A number of newly opened interventional trials are also running in anaesthetics/critical care; it has become departmental practice to offer eligible participants involvement in an interventional study and the REmLap study. Since opening, the study has already been audited once by the R&D Department.

The Clinical Research Unit's biomedical scientists continue to recruit to observational studies. During 2017, a second Dudley patient was identified as a carrier of Pompe disease, a rare enzyme disorder. A further two arms of the same umbrella study have now open to recruitment, seeking to identify Gaucher's and Fabry's diseases amongst patients with abnormal blood test results. Identification of individuals will allow them to receive an explanation for their symptoms; carriers will receive genetic counselling.

A current NIHR malignant haematology pilot study is seeking to identify whether giving blood transfusions to keep haemoglobin levels higher in adults with acute myeloid leukaemia receiving intensive chemotherapy will improve patients' overall quality of life. Dudley has already recruited its target of three participants; a larger study is expected to follow.

Training and infrastructure

Dr Gail Parson's appointment as deputy R&D director in 2017 has provided impetus for research initiated by allied health professionals, nurses and midwives. R&D has established Trust-wide, multidisciplinary research support forums. Drs Liz Hale and Gail Parsons co-chair bi-monthly meetings, providing advice, guidance and opportunities for discussion and direction in terms of clinical studies and approaches to changing practice.

Specialist nurses Trust-wide are gaining improved awareness of studies carried out in their own clinical areas. They assist with recruitment to specific studies and are forming closer working relationships with research nurses and clinical staff.

Research is now included on the Trust-wide patient experience meeting agenda, chaired by the chief nurse. The focus is on awareness of research activity, with regular updates on studies to enhance practice.

The drug secukinumab was licensed for use in a number of dermatological conditions during 2017. Dudley dermatology research nurses have acquired considerable experience of the drug during clinical trials since 2011 and were, therefore, recognised as the local experts. They now provide patient education for all dermatology patients starting treatment on the drug.

Good Clinical Practice workshops continue to be provided for staff involved in research studies. A shorter training module, Good Clinical Practice Fundamentals, aimed at staff administering study drugs and surgical/diagnostic interventions, commenced in August 2017. These are short, one-hour training sessions which can then be delivered by an appropriate person in the ward/ department. Generic sessions are tailored for clinical staff and for laboratory staff, depending on their role in a study. Experience indicates that workshops are best received when elements of training for current and upcoming studies are incorporated into the generic training. The Neonatal Unit is the first location to provide such training to staff.

The R&D administration team continue to exploit the functionality of the national EDGE database to track the progress of research studies set up and record recruitment to studies. The admin team train new researchers in the use of EDGE as a recruitment tool. It also serves a repository for research training records and delegation logs. Two members of Trust staff, one from the Finance Department, shared attendance at the two-day 2018 EDGE conference in Birmingham to take full advantage of the workshops and networking opportunities on offer. The Trust also exhibited a poster at the conference, explaining how we use the database for reporting purposes.

An audit programme of research studies is now running to improve all aspects of research quality.

A bulletin of clinical research learning points is now being published and disseminated amongst all the Trust's research nurses. This monthly communication helps to spread good practice and can be produced by individual support departments as well as R&D leads.

Research is now incorporated into the student nurse placement programme as a means of introducing research into the nurse training programme. Students now spend a week in the department, shadowing the research nurses and receiving introductory information from administration staff regarding project site set up and maintenance. The scheme is coordinated by two Band 6 research nurses.

Public engagement

R&D is now actively involving The Dudley Group's NIHR research ambassador in feasibility assessment for new research projects. This provides us with valuable feedback on studies from the patient's perspective. A second research ambassador has now stepped forward and we look forward to her input once training is completed.

Research into practice

The improved control of the symptoms of psoriasis by the drug secukinumab observed during commercial clinical trials means that Dudley dermatologists were among the first to prescribe secukinumab for their patients when the drug received its marketing authorisation in 2017.

The vascular team opted to recruit to the Midlands acute kidney injury observational study (MARI AKI) as a means of promoting improved clinical care.

Following the success of the CONCEPTT trial, which looked at the suitability of continuous glucose monitoring (CGM) for pregnant women living with Type 1 diabetes, the Diabetes Centre has now purchased its own devices. The wearers download data weekly and a small 'technology MDT group' monitors the women remotely. Additionally, the CGM service is now offered to women with T1DM as pre-conception care.

Research conducted in the rheumatology department has also contributed to (inter)national guidelines: both 2017 EULAR recommendations for cardiovascular disease management in rheumatic diseases and the NRAS 'Love your Heart' interactive website incorporate recommendations on lifestyle modification based on research conducted solely in Dudley. Work co-led by Dudley investigators also informs the latest specialist recommendations on the use of cardiac magnetic resonance imaging in the diagnosis and management of people with rheumatic disease.

Publications

Trust publications for the calendar year 2017, including conference posters, stand at 116.

2.2.4 Commissioning for Quality and Innovation (CQUIN) payment framework

What are CQUINs and what do they mean for the Trust?

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 Clinical Commissioning Group and NHS England).

A proportion of the Trust's income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. Further details of the agreed goals for 2017/18 and for the following twelve month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/

The value of CQUINs is based on 2.5% of our activity outturn which equates to a potential income of £6,463,083. A total of twelve CQUIN schemes were agreed with a combination of locally and nationally agreed goals with associated milestones. At the end of the financial year, it is forecast that we will achieve the majority of the indicators. For example, we have:

- achieved the national target set for vaccinating frontline staff against flu
- removed unhealthy drinks and snacks from our restaurants and retail outlets
- met targets for screening patients for serious infections and reviewing their antibiotics
- implemented advice and guidance for GPs to ensure patients receive the right care in the right setting
- met the target of 100% of our services being available for electronic referral
- reviewed and improved our discharge pathways for patients aged over 65 years
- provided advice to patients who would benefit from advice on lifestyle changes (for example, patients that smoke)
- reviewed patients who access our dental services and treated patients as outpatients (rather than day case patients) where appropriate
- raised awareness of aortic aneurysm screening for males to improve the number of patients accessing screening services
- reduced the amount of medicines wasted across the Trust

However, the indicators where we have not achieved our targets are listed below. Mitigating actions have been put in place for 2018/19. These include:

- improving the health and wellbeing services available for staff to address concerns relating to work-related stress and musculoskeletal problems raised through the staff survey
- improving the initial administration of antibiotics for patients where an infection is identified and ensuring an overall reduction in patient antibiotic consumption. Therefore, we will receive part payment of this CQUIN and will continue to develop and implement our improvement plan for this in 2018/19
- ensuring that patients with mental health issues are identified and their care plans are reviewed to prevent attendance at A&E. New processes will be put in place in 2018/19
- monitoring the number of patients that are waiting for appointments to reduce the numbers of people waiting and the length of time they wait. We have plans to ensure all specialties are compliant with this CQUIN in 2018/19
- reviewing our use of a national database for reporting administration of cancer drugs

The final CQUIN settlement figure for 2017/18 has not yet been agreed. However, for the purpose of the year-end accounts, the Trust is assuming this will equate to an estimated 88% which is approximately £5.9m. In 2016/17, the final figure received was £5.5m.

CQUINs 2017/18

The achievement to date of CQUINs for 2017/18 have been rated on a RAG (red/amber/green) as detailed in the tables below:

Acute and community 2017/18

Goal No.	CQUIN targets and topics	Quality domains	RAG
1	NHS staff health and well-being	Effectiveness	
2	Timely identification and treatment of Sepsis, and Antimicrobial Resistance	Safety Effectiveness	
4	Improving services for people with mental health needs who present to A&E	Safety Effectiveness	
6	Advice and guidance	Effectiveness	
7	E-referral consultant review process	Effectiveness	
8	Supporting proactive and safe discharge	Effectiveness	
9	Preventing ill health by risky behaviours – alcohol and tobacco screening, advice, and referral	Effectiveness	

NHS England Specialised services, Public Health & Dental 2017/18

Goal No.	CQUIN targets and topics	Quality domains	RAG
1	AAA screening – improving access and uptake	Effectiveness	
2	Secondary care clinical attachment in oral surgery	Effectiveness	
GE3	Hospital medicines optimisation	Effectiveness	
WC5	Neonatal community outreach	Safety Effectiveness	

Achieved

Partially achieved

Not Achieved

CQUINs 2018/19

The estimated value of CQUINs for 2018/19 is approximately £6.9m. £4.1m of our CQUIN value for 2018/19 will be apportioned to achieving the eleven indicators listed below. The remainder is focused on our engagement with the local Sustainability and Transformation Plan (STP) and delivery of financial balance across local health economies.

Acute and community 2018/19

Goal No.	CQUIN targets and topics	Quality domains
1	NHS staff health and well-being	Effectiveness
2	Timely identification and treatment of Sepsis, and Antimicrobial Resistance	Safety Effectiveness
4	Improving services for people with mental health needs who present to A&E	Safety Effectiveness
6	Advice and guidance	Effectiveness
7	E-referral consultant review process	Effectiveness
8	Supporting proactive and safe discharge	Effectiveness
9	Preventing ill health by risky behaviours – alcohol and tobacco screening, advice, and referral	Effectiveness

NHS England Specialised services, Public Health & Dental 2018/19

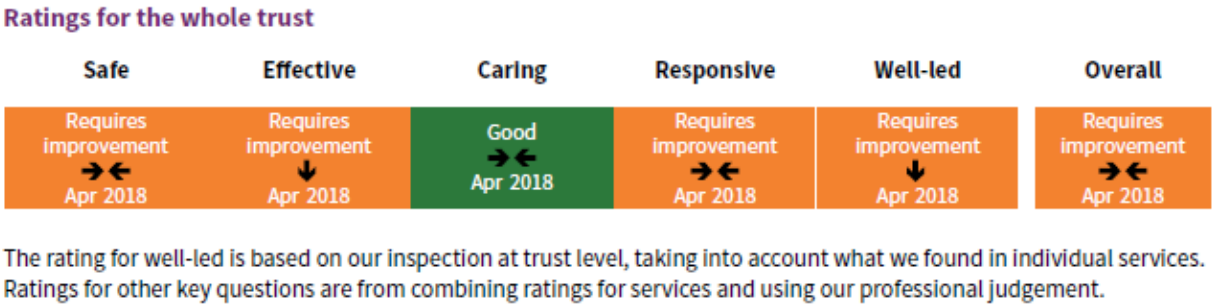
Goal No.	CQUIN targets and topics	Quality domains
1	AAA screening – improving access and uptake	Effectiveness
2	Secondary care clinical attachment in oral surgery	Effectiveness
GE3	Hospital medicines optimisation	Effectiveness
WC5	Neonatal community outreach	Safety Effectiveness

2.2.5 Care Quality Commission (CQC) registration and reviews

The Dudley Group NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions. The CQC has taken enforcement action against the Trust during 2017/18. This took the form of serving two Section 31 notices but neither placed any restrictions on the Trust's licence. It required the Trust to send enhanced assurance over aspects of urgent and services which the Trust has done on a weekly basis and therefore the Trust is compliant with the registration requirements of the CQC. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

The Trust was inspected by the CQC in December 2017/January 2018. The CQC issued its report on this inspection in April 2018. This report rated the Trust overall as 'Requires Improvement'. In arriving at this overall assessment the CQC assessed 44 elements within five areas (see charts below and over the page). Of the 44 elements, 27 were rated as 'Good' which meant that in the service rating for medical care, maternity and community services the Trust was in fact rated as 'Good'. The CQC also reconfirmed the 'Good' ratings for surgery, outpatients and end of life although these were not subject to a detailed inspection between December 2017 and January 2018. For the service areas where the Trust was rated as 'Inadequate' or 'Requires improvement', a detailed action plan was put in place. The monitoring of the delivery of this improvement plan will be reported to the Board and the Clinical Quality, Safety and Patient Experience Committee as well as providing formal feedback to the CQC itself. In order to support the Board's continued review of the Trust's compliance with the CQC's requirements, the Trust has continued with its regular internal quality and safety reviews (see Section 3.3.2). 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 policies 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 disseminated 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.

Both a summary and full report of that inspection has been published and is available at www.cqc.org.uk/provider/RNA



Ratings for Russells Hall Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓↓ Apr 2018	Requires improvement Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement →← Apr 2018	Inadequate ↓ Apr 2018	Inadequate ↓ Apr 2018
Medical care (including older people's care)	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018	Good →← Apr 2018
Surgery	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Critical care	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement →← Apr 2018
Maternity	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018	Good Apr 2018
Services for children and young people	Requires improvement ↓ Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement ↓ Apr 2018	Requires improvement ↓ Apr 2018
End of life care	Requires improvement Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014	Good Mar 2014
Outpatients	Good Mar 2014	N/A	Good Mar 2014	Requires improvement Mar 2014	Good Mar 2014	Good Mar 2014
Overall*	Requires improvement →← Apr 2018	Requires improvement ↓ Apr 2018	Good →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018	Requires improvement →← Apr 2018

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018
Overall*	Good Apr 2018	Good Apr 2018	Good Apr 2018	Requires improvement Apr 2018	Good Apr 2018	Good Apr 2018

2.2.6 Quality of data

The Trust submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics (HES) which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number

	The Dudley Group	National average
Admitted patient care	99.9%	99.4%
Outpatient care	99.9%	99.5%
Accident and emergency care	99.4%	97.3%

The percentage of records in the published data which included the patient's valid General Medical Practice Code

	The Dudley Group	National average
Admitted patient care	100%	99.9%
Outpatient care	100%	99.8%
Accident and emergency care	100%	99.3%

All above figures are for April 2017 to Jan 2018.

The Trust's Information Governance Assessment Report, version 14.1, overall score for 2017/18 was 72% and was graded 'Green', 'Satisfactory' and Level 2 compliant.

The Trust was not subject to the Payment by Results clinical coding audit during 2017/18.

This year, two data protection incidents were reported to the Information Commissioner (ICO). One incident involved inappropriate access to patient information by one individual; the other involved the theft of a container of mixed paper waste. For each incident, a full investigation was undertaken in accordance with the Trust's incident management policy and procedures. The learning from these incidents has been shared widely within the Trust and its PFI partners. Both the ICO and our commissioners have been engaged during our investigation process and are satisfied that we acted swiftly and appropriately, including disciplining staff involved, engaging with the affected patients during our investigation and including making swift and full apologies through the application of the Trust's Duty of Candour processes. These incidents have now been closed by the Information Commissioner's Office.

The Trust will be taking the following actions to improve data quality:

- The Trust continually monitors data quality externally via Secondary Uses Service (SUS) reporting, and University Hospitals Birmingham Hospital Evaluation Data tool (HED).

Learning lessons:

All cupboards containing Adrenaline 1:1000 are now clearly labelled and confirmation has been received of where in the Trust this dose of adrenaline is placed. Teaching on anaphylaxis has been revisited to ensure that primary treatment and secondary treatment is a key indicator in all lesson plans when delivering medical sessions.

2.2.7 Learning from deaths

1. During 2017/18, 1,801 of the Trust's patients died. This comprised the following number of deaths that occurred in each quarter of that reporting period: 408 in the first quarter; 387 in the second quarter; 427 in the third quarter; 579 in the fourth quarter.

2. By the 31st March 2018, 1,425 case record reviews and 62 investigations have been carried out in relation to 1,801 of deaths included above.

In 62 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 364 in the first quarter; 322 in the second quarter; 426 in the third quarter; 313 in the fourth quarter.

3. Fifteen, representing 0.83% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of: 2 representing 0.49% for the first quarter; 2 representing 0.51% for the second quarter; 3 representing 0.74% for the third quarter; 8 representing 1.55% for the fourth quarter.

These numbers have been estimated using a) The Trust's mortality review process which includes an initial (Level 1) peer review of all deaths by the department concerned using a standard questionnaire which may lead to a Level 2 review performed by a mortality panel using a structured case note review data collection as recommended by the National Mortality Case Record Review Programme b) Coroner Rule 28 cases when making recommendations about future care and c) root cause analysis reports following investigations if a death is reported as a serious incident if that is clinically appropriate (e.g. death potentially avoidable).

4. A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified above.

The Trust has identified the following learning:

- For patients with head injuries, the need for more effective two-way communication with and from the tertiary specialist centre, and to ensure that all appropriate users have access to the system.
- Following a septicaemia case, the need for more timely identification and treatment.
- After an surgical delay, a review of the pathway was undertaken.
- With an incomplete risk assessment for VTE, an improvement in the recording of the assessment was identified.
- For palliative care patients, the need to review the investigations undertaken

5. A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period.

From the cases reviewed, the Trust has taken a number of actions. It has introduced the NORSe (Network of on-call referral service) pathway for neurosurgery. The Trust has also highlighted and suggested optimisation of the process with the tertiary specialist centre.

Following a septicaemia case, it has introduced into the Emergency Department an electronic system of alerting staff to the deteriorating patient, further training for staff and increased audit. The processes involved are also being reviewed and optimised as part of a Trust-wide plan for the management of the deteriorating patient.

It has also strengthened the Emlap pathway, introducing an additional surgical senior registrar on call.

Plans to introduce an electronic VTE assessment process have been undertaken and are well developed as part of the Trust implementation of an electronic patient record. A formal ward round checklist document with specific reference to the VTE has been instigated to further augment existing checks pending the roll out of the EPR.

Considerable work has been undertaken to support earlier identification of patients in the last year of life and to look at the processes involved in optimising care. The aim of identifying palliative and end of life care needs at an earlier stage offers the opportunity to advance care plan and provide an individual plan of care. Work has also been undertaken through education of medical and nursing staff to establish awareness of potentially unnecessary investigations/ interventions at the end of life.

6. An assessment of the impact of the actions described above which were taken by the provider during the reporting period.

At present, as assessment of the impact hasn't been undertaken.

(All of these items (1-9) are new statutory statements to be included for the first time this year. As items 7-9 refer to the 'previous reporting period' (i.e. 2016/17) and 'the relevant document for that previous reporting period' when this reporting was not required these items cannot be completed this year. We will commence to have available data in next year's (2018/19) report.)

7. [Number] case record reviews and [number] investigations completed after [date] which related to deaths which took place before the start of the reporting period.

8. [Number] representing [number as percentage of number in item 1 of the relevant document for the previous reporting period]% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the [name, and brief explanation of the methods used in the case record review or investigation].

9. [Number] representing [number as percentage of number in item 27.1 of the relevant document for the previous reporting period]% of the patient deaths during [the previous reporting period] are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.2.8 Core set of mandatory indicators

All trusts are required to include comparative information and data on a core set of nationally-used indicators. The tables include the two most recent sets of nationally-published comparative data as well as, where available, more up-to-date Trust figures. It should be appreciated that some of the 'Highest' and 'Lowest' performing trusts may not be directly comparable to an acute general hospital, for example, specialist eye or orthopaedic hospitals have very specific patient groups and so generally do not include emergency patients or those with multiple long-term conditions.

Mortality					
Topic and detailed indicators	**Immediate reporting period: Oct 2016 – Sep 2017**		**Previous reporting period: Jul 2016 – Jun 2017**		**Statements**
	Value		**Value**		The Trust considers that this data is as described for the following reasons: • The Trust is pleased to note that the Trust's SHMI values are within the expected range
	Trust	0.9975	Trust	1.0027	
	National average	1	National average	1	
Summary Hospital-level Mortality Indicator (SHMI) value and banding	Highest	1.2473	Highest	1.2277	
	Lowest	0.7270	Lowest	0.7261	
	Banding		**Banding**		The Trust has taken the following action to improve this indicator and so the quality of its services by: • Continuing to improve case note reviews of deaths in hospital
	Trust	2	Trust	2	
	National average	2	National average	2	
	Highest	1	Highest	1	
	Lowest	3	Lowest	3	
Percentage of patient deaths with palliative care coded at either diagnosis or specialty level (Context indicator)	Trust	27.6%	Trust	28.5%	The Trust considers that this data is as described for the following reasons: • There is a very robust system in place to check accuracy of palliative care coding
	National average	31.5%	National Average	31.1%	
	Highest	59.8%	Highest	58.6%	The Trust has taken the following actions to improve this percentage, and so the quality of its services by: • Ensuring this percentage will always be accurate and reflect actual palliative care.
	Lowest	11.5%	Lowest	11.2%	

Patient Reported Outcome Measures (PROMS)					
Topic and detailed indicators	**Immediate reporting period: 2016/17 Provisional***		**Previous reporting period: 2015/16 Final**		**Statements**
Groin Hernia Surgery	Trust	0.04	Trust	0.07	The Trust considers that this data is as described for the following reasons: • Using feedback data (from NHS Digital) we are very pleased with the outcomes that patient report. Patients who said that their problems are better now when compared to before their operation: • Hip replacement: 97% *(national = 95%),* • Patients that described the results of their operation as good, very good or excellent: • Groin hernia: 93% *(national = 93%),* • Knee replacement: 82% *(national = 86%),* • Varicose veins: 90% *(national = 85%).* The Trust has taken the following actions to improve these scores, and so the quality of its services by: • Ensuring the Trust regularly monitors and audits the pre and postoperative healthcare of all patients. Surgical operative outcomes are consistently of high quality and safety, with excellent patient satisfaction for these procedures.
	National average	0.09	National average	0.09	
	Highest	0.14	Highest	0.16	
	Lowest	0.01	Lowest	0.02	
Varicose Vein Surgery	Trust	0.13	Trust	0.04	
	National average	0.09	National average	0.10	
	Highest	0.15	Highest	0.15	
	Lowest	0.01	Lowest	0.00	
Hip Replacement Surgery	Trust	0.45	Trust	0.44	
	National average	0.44	National average	0.44	
	Highest	0.54	Highest	0.52	
	Lowest	0.31	Lowest	0.32	
Knee Replacement Surgery	Trust	0.32	Trust	0.32	
	National average	0.32	National average	0.32	
	Highest	0.40	Highest	0.40	
	Lowest	0.24	Lowest	0.19	

Groin Hernia and Varicose Vein Data is Final

Patient Quote:

"I spent several days in the Coronary and Post-coronary Care Units. I really cannot praise the staff enough-nothing is too much trouble. They are such a dedicated team and Russells Hall Hospital should be so proud of them."

Readmissions					
Topic and detailed indicators	**Immediate reporting period: 2011/12**		**Previous reporting period: 2010/11**		**Statements**
% readmitted within 28 days **Aged 0-15**	Trust	9.09	Trust	9.34	The Trust considers that this data is as described for the following reasons: • since the only national published figures (see across) are historical, we have looked at our latest locally available (pre-published) data. (Aged 16 and over: 2012/13 10.2%, 2013/14 9.9%, 2014/15 7.69%, 2015/16 8.02%, 2016/17 8.43%, 2017/18 ytd. 7.35%**); (Age 0-15: 2012/13 10.3%, 2013/14 9.7% 2014/15 10.05%, 2015/16 10.21%, 2016/17 10.85%, 2017/18 ytd. 9.02%**) The Trust intends to take the following actions to improve these percentages, and so the quality of its services: • Adults: continue to review and develop our ambulatory care facilities in medicine and surgery and review clinical pathways and outpatient rapid access. • Children: review our assessment processes for those that require a specialist paediatric assessment and work with commissioners to develop services for those patients requiring on going CAMHS support and embed a community paediatric service
	National average	10.15	National average	10.15	
	Highest	NA*	Highest	NA*	
	Lowest	NA*	Lowest	NA*	
% readmitted within 28 days **Aged 16 and over**	Trust	11.62	Trust	11.55	
	National average	11.45	National average	11.42	
	Highest	NA*	Highest	NA*	
	Lowest	NA*	Lowest	NA*	

**comparative figures not available. **2017/18ytd. = April 2017 to November 2017*

Responsiveness to inpatients' personal needs					
Topic and detailed indicators	**Immediate reporting period: 2016/17**		**Previous reporting period: 2015/16**		**Statements**
Average score from a selection of questions from the National Inpatient Survey measuring patient experience **(Score out of 100)**	Trust	61.8	Trust	67.4	The Trust considers that this data is as described for the following reasons: • the Trust is disappointed that this indicator remains lower than the national average. The Trust intends to take the following actions to improve this score, and so the quality of its services: • appointed a dedicated Head of Patient Experience to focus on the development and monitoring of trust- wide actions
	National Average	67.79	National average	69.6	
	Highest	86.2	Highest	86.2	
	Lowest	54.4	Lowest	58.9	

Staff views					
Topic and detailed indicators	**Immediate reporting period: 2017**		**Previous reporting period: 2016**		**Statements**
Percentage of staff who would recommend the Trust to friends or family needing care (Comparison is with all combined Acute and Community trusts)	Trust	70%	Trust	72%	The Trust considers that this data is as described for the following reasons: ● the Trust is disappointed there has been a decrease in the percentage of staff who would recommend the Trust as a place to receive treatment. The Trust intends to take/has taken the following actions to improve this percentage, and so the quality of its services by: ● multidisciplinary groups focusing on action planning for improvements. ● communicating with and supporting managers to understand their data broken down by division and area and take actions where necessary. ● involving and communicating with staff though adopting the Listening in Action programme.
	National average	69%	National average	68%	
	Highest	Not yet available	Highest	Not known	
	Lowest	Not yet available	Lowest	Not known	

For a full review of the results of the latest NHS Staff Survey, in particular, those related to the Workforce Race Equality Standard, please see the Annual Report.

Venous Thromboembolism (VTE)					
Topic and detailed indicators	**Immediate reporting period: Q3 Oct – Dec 2017**		**Previous reporting period: Q2 Jul – Sep 2017**		**Statements**
Percentage of admitted patients risk-assessed for Venous Thromboembolism	Trust	93.78%	Trust	94.40%	The Trust considers that this data is as described for the following reasons: ● the Trust is pleased to note that it is near the national average in undertaking these risk assessments. The Trust intends to take the following actions to improve this percentage, and so the quality of its services by: ● continuing the educational sessions with each junior doctor intake ● continuing with a variety of promotional activities to staff and patients
	National average	95.30%	National average	95.21%	
	Highest	100%	Highest	100%	
	Lowest	76.08%	Lowest	71.88%	

Infection Control					
Topic and detailed indicators	**Immediate reporting period: 2016/17**		**Previous reporting period: 2015/16**		**Statements**
Rate of Clostridium difficile per 100,000 bed days amongst patients aged 2 or over	Trust	13.5	Trust	18.5	The Trust considers that this data is as described for the following reasons: • The data included is for the total number of trust apportioned C. difficile cases identified within any acute Trust. This number does not take into account avoidability assessments. The rate has improved since last year, approaching the national average in the context of many trusts with worsening figures (note highest rate nationally has increased from 67.2 to 82.7 per 100,000 bed days in patients over 2 years of age). The Trust intends to take/has taken the following actions to improve this rate, and so the quality of its services: • the process for reviewing individual C. diff cases is continuing using the new avoidability tool introduced in 2017. • The well-functioning antimicrobial guidelines have continued to be updated to reflect national objectives including reductions in carbapenem and piperacillin tazobactam useage, which the Trust is achieving. • Treatment protocols for C. diff continue to be updated to ensure they reflect current evidence-based practice.
	National average	13.2	National average	14.9	
	Highest	82.7	Highest	67.2	
	Lowest	0	Lowest	0	

Clinical incidents					
Topic and detailed indicators	**Immediate reporting period: Apr 2017 – Sept 2017**		**Previous reporting period: Oct 2016 – Mar 2017**		**Statements**
Rate of patient safety incidents	Trust	37.02 (number 4344)	Trust	38.4 (number 4820)	The Trust considers that this data is as described for the following reasons: ● As organisations that report more incidents usually have a better and more effective safety culture, the Trust notes it has maintained average reporting rate and its severe incidents are in line with the national average.
(incidents reported per 1000 bed days)	Average	42.84	Average	41.10	
	Highest	111.69	Highest	68.97	
(Comparison is with 136 acute trusts)	Lowest	23.47	Lowest	23.13	
Percentage of patient safety incidents resulting in severe harm or death	Trust	0% (number 0)	Trust	0.1% (number 4)	The Trust has taken the following actions to improve this rate and the numbers and percentages, and so the quality of its services: ● Continued focus on the dissemination of learning from incidents especially serious incidents to seek to reduce the likelihood of similar incidents occurring elsewhere in the Trust. ● Investment has continued across the year on training staff on incident investigations to enable them to focus on the root cause of the incident and, therefore, develop better actions plans.
	National average	0.1%	National average	0.1%	

In addition to the above indicators, NHS England has requested that the Trust includes the latest results of the two following questions that are asked as part of the National Staff Survey:

Staff Survey Results					
2017					
Percentage of staff experiencing harassment, bullying or abuse from staff in the last twelve months	Trust	21%	**Percentage of staff believing that Trust provides equal opportunities for career progression or promotion**	Trust	85%
	National average	24%		National Average	85%

2.2.9 Seven day hospital services

The Trust has taken a number of actions to ensure it is working towards providing services in line with this national initiative. In particular, it has increased the number of consultant ward rounds in a number of specialities so patients are seen by senior decision makers at weekends. There has been increased senior medical cover at weekends in the acute medical admission area of the Trust. Vascular interventional radiology is now available 24 hours, seven days a week. The Trust has also been working with local partners at Wolverhampton, Walsall and Sandwell and Birmingham so that all other non-invasive interventional radiology will shortly be available on a similar basis.

Patient Quote:

"Their compassion and willingness to go the extra mile and a little more is a credit to your service." (Ward C4)

Part 3: Other quality information

3.1 Introduction

The Trust has a number Key Performance Indicator (KPI) reports which are used by a variety of staff groups to monitor quality on a day-to-day basis. The main repository for the reporting of the Trust's key performance measures is a web based dashboard, which is available to all senior managers and clinicians, and currently contains over 130 measures, grouped under the headings of Quality, Performance, Workforce and Finance.

In addition, continual monitoring of a variety of aspects of quality of care includes weekly reports sent to senior managers and clinicians which include the Emergency Department, Referral to Treatment and stroke and cancer targets. Monthly reports which include a breakdown of performance by ward based on Nursing Care Indicators, ward utilisation, adverse incidents, governance and workforce indicators, and patient experience scores, are also sent to all wards. In becoming more transparent, each ward now displays its quality comparative data on a large information board (see section 3.3.5) for staff, patients and their visitors.

To compare ourselves against other trusts, we use Healthcare Evaluation Data (HED) – a leading UK provider of comparative healthcare information – as a business intelligence monitoring tool.
To ensure quality improvement, the Trust has multiple organisation-wide frameworks from which it shares learning from patient feedback, clinical reviews and incidents. These include:

- **Quarterly Learning Report:**
  A quarterly learning report is produced outlining learning that has occurred across the organisation from all sources; incidents, complaints and reviews. This is presented to the directors and uploaded to the Trust intranet for all staff and shared with Dudley Clinical Commissioning Group.
- **Incident Reporting Database:**
  Every incident that occurs is reported in a central database which is designed to capture changes in practice, learning and good practice to share across the organisation. This data is included in the quarterly learning report and cascaded through divisional meetings.
- **Intranet Learning Page:**
  The Trust has a designated intranet page to which all staff have access.
- **Patient Safety and Experience Bulletin:**
  This commenced in 2017 and consists of a weekly email sent to all staff on a wide range of topical subjects that have arisen from local incidents and national initiatives. Examples of issues covered include diabetes care, malnutrition in hospital and correct usage of oxygen cylinders.

The following three sections of this report provide an overview, with both statistics and examples, of the quality of care at the Trust, using the three elements of quality as outlined in the initial Chief Executive's statement:

Patient Experience
Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?

Patient Safety
Are patients safe in our hands?

Clinical Effectiveness
Do patients receive a good standard of clinical care?

The final section includes indicators and performance thresholds set out by NHS Improvement, the Trust regulator, in its Risk Assessment Framework.

Patient Experience

3.2 Does the Trust provide a clean, friendly environment in which patients are satisfied with the personal care and treatment they receive?

3.2.1 Introduction

The Trust values and welcomes all feedback to help us ensure we meet the needs and expectations of our patients, their families and carers, our staff and our stakeholders. As a foundation trust we are also legally obliged to take into consideration the views of our members as expressed through our Council of Governors.

3.2.2 Trust-wide initiatives

How do patients share feedback?

Online

Mobile phone

Over the phone

On paper

Face to face

National surveys

We gather feedback in a number of ways, some of which are described in other parts of this report (e.g. complaints, concerns, compliments, quality and safety reviews) and some in more detail below:

- Real-time surveys (face-to-face surveys)
- Patient stories
- The Friends and Family Test (FFT)
- NHS Choices and Patient Opinion online reviews
- National surveys including the National Inpatient Survey

Real-time surveys

During the year, 1,618 inpatients participated in our real-time surveys. These surveys complement the Friends and Family Test and the results are reported in a combined report to wards and specialties, allowing them to use valuable feedback from patients in a timely manner. The data from these surveys also allows us to react quickly to any issues and to use patient views in our service improvement planning.

Patient stories

The continued use of patient and staff stories at the Board of Directors meetings during the year enables the patient voice to be heard at the highest level. These stories are circulated to senior managers and shared with frontline staff and used for service development planning and training purposes.

During the year, **social media** usage has expanded to a point where the Trust now has 3,061 Twitter followers and Facebook has accumulated 4,579 'likes' to date. Many more patients and their families are taking to social media to provide. feedback.

As at 12 March 2018

Below are some examples of the quantity of feedback we received during the year and more detailed information about some of the methods. These methods alone highlight more than 64,500 opportunities for us to listen to our patients' views.

Method	Total
FFT – Inpatient (inc. daycase)	**24,500**
FFT – Emergency department	**9,174**
FFT – Maternity	**5,899**
FFT – Community	**4,801**
FFT – Outpatients	**15,232**
Community patient experience survey	**586**
Real-time surveys (inpatient 1,478, AMU 87, maternity 53)	**1,618**

Method	Total
NHS Choices/Patient Opinion	**215**
National surveys Maternity 2017	**100**
National surveys Adult Inpatient 2017	**448**
National survey Emergency Department 2016*	**307**
National survey Childrens and Young peoples 2016*	**250**
Inpatient food surveys	**1,394**
Discharge surveys	**85**
Bereavement surveys	**238**

**Data not available for inclusion in 2016/17 annual report*

Friends and Family Test (FFT)

The test asks patients to answer a simple question 'How likely are you to recommend (the particular service or department) to friends and family if they needed similar care or treatment?' with answers ranging from extremely likely to extremely unlikely. This is followed up with a question asking 'Please tell us why you gave that response'. The results are published on the national NHS England website. The scores, which are updated monthly, are displayed on our website and prominently in our wards/departments for all patients, staff and visitors to view them.

We also monitor our performance compared to that of our neighbours. This table shows our FFT scores for the period April 2017 to February 2018 (11 months) which indicates our performance compared to our neighbours. Where organisations have collected fewer than five responses, the figures are not published (these are N/A in table).

Inpatients FFT	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Sandwell & West Birmingham	95%	92%	79%	83%	83%	83%	82%	85%	89%	88%	86%	89%
Dudley Group	96%	96%	97%	96%	96%	96%	95%	95%	95%	94%	95%	94%
Royal Wolverhampton	94%	92%	92%	92%	90%	93%	93%	91%	92%	92%	91%	90%
Walsall	96%	94%	96%	95%	97%	94%	95%	92%	91%	93%	97%	94%
Worcester Acute	97%	97%	97%	97%	95%	95%	95%	97%	94%	95%	95%	94%
National average	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
A&E FFT	**Apr 17**	**May 17**	**Jun 17**	**Jul 17**	**Aug 17**	**Sep 17**	**Oct 17**	**Nov 17**	**Dec 17**	**Jan 18**	**Feb 18**	**Mar 18**
Sandwell & West Birmingham	75%	71%	73%	72%	75%	72%	73%	73%	73%	75%	86%	75%
Dudley Group	75%	76%	79%	77%	73%	76%	84%	80%	77%	74%	76%	75%
Royal Wolverhampton	87%	84%	82%	83%	85%	84%	83%	81%	82%	82%	91%	82%
Walsall	74%	73%	77%	76%	77%	75%	73%	76%	77%	75%	97%	76%
Worcester Acute	88%	93%	91%	88%	85%	88%	91%	92%	86%	79%	95%	74%
National average	87%	87%	88%	86%	87%	87%	87%	87%	85%	86%	85%	84%

Maternity Antenatal FFT	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Sandwell & West Birmingham	88%	90%	N/A	90%	50%	90%	93%		75%	N/A	N/A	100%
Dudley Group	100%	99%	96%	99%	100%	97%	99%	89%	97%	91%	96%	98%
Royal Wolverhampton	100%	100%	88%	N/A	N/A	N/A	n/a		N/A	N/A	N/A	N/A
Walsall	67%	71%	93%	82%	88%	88%	73%		80%	97%	N/A	81%
Worcester Acute	98%	100%	98%	96%	99%	96%	90%		100%	96%	99%	99%
National average	97%	96%	97%	96%	96%	97%	96%		97%	97%	97%	97%

Maternity Birth FFT	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Sandwell & West Birmingham	82%	83%	69%	76%	58%	48%	83%		N/A	94%	97%	100%
Dudley Group	99%	99%	98%	99%	99%	98%	99%	97%	99%	98%	99%	97%
Royal Wolverhampton	100%	100%	100%	90%	100%	86%	92%		95%	92%	99%	95%
Walsall	95%	95%	100%	95%	100%	88%	89%		83%	100%	100%	100%
Worcester Acute	100%	100%	100%	100%	100%	100%	100%		100%	96%	96%	98%
National average	96%	97%	97%	96%	96%	96%	96%		97%	97%	97%	97%

Maternity Postnatal FFT	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Sandwell & West Birmingham	91%	91%	73%	73%	81%	84%	89%		74%	N/A	97%	100%
Dudley Group	98%	91%	99%	98%	96%	98%	98%	96%	98%	100%	100%	99%
Royal Wolverhampton	90%	86%	76%	84%	85%	N/A	96%		100%	94%	98%	94%
Walsall	63%	95%	92%	65%	83%	92%	100%		85%	97%	100%	96%
Worcester Acute	95%	98%	98%	96%	99%	98%	98%		95%	97%	96%	100%
National average	95%	95%	95%	94%	94%	94%	94%		94%	95%	95%	95%

Maternity Postnatal Community FFT	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Sandwell & West Birmingham	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	N/A	N/A	N/A
Dudley Group	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	100%	100%
Royal Wolverhampton	100%	95%	100%	100%	N/A	N/A	N/A		N/A	N/A	N/A	N/A
Walsall	70%	100%	N/A	89%	71%	100%	87		100%	99%	100%	98%
Worcester Acute	100%	100%	94%	100%	100%	100%	100%		100%	100%	100%	97%
National average	98%	98%	100%	98%	98%	98%	98%		98%	98%	98%	98%

Please note that NHS England have not supplied the datasets for Maternity services in November 2017. Awaiting March results.

Community	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Sandwell & West Birmingham	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dudley Group	94%	96%	97%	98%	98%	97%	95%	96%	96%	96%	97%	97%
Royal Wolverhampton	90%	86%	89%	90%	86%	89%	89%	91%	91%	87%	91%	91%
Walsall	99%	98%	97%	97%	98%	97%	97%	99%	99%	97%	99%	97%
Worcester Acute	98%	97%	97%	97%	95%	95%	96%	96%	96%	96%	97%	97%
National average	96%	96%	96%	96%	96%	95%	95%	96%	96%	95%	96%	95%

Outpatients	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Sandwell & West Birmingham	90%	98%	88%	91%	89%	89%	91%	92%	90%	92%	88%	91%
Dudley Group	95%	95%	92%	95%	93%	92%	91%	90%	93%	92%	89%	92%
Royal Wolverhampton	93%	93%	94%	94%	93%	93%	93%	93%	94%	94%	94%	93%
Walsall	91%	90%	91%	91%	90%	91%	91%	90%	91%	91%	91%	92%
Worcester Acute	95%	94%	94%	94%	94%	94%	95%	95%	91%	92%	92%	92%
National average	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%

Awaiting March results

NHS Choices and Patient Opinion

Patients can give feedback about their experience of any of our services on the NHS Choices and Care Opinion (formerly Patient Opinion) websites. Patients can post comments anonymously or choose to give their name. All comments are responded to online.

In the year 2017/18, the Trust received 215 pieces of feedback via NHS Choices and Patient Opinion. We actively encourage patients to engage in this way and consistently attract more comments than neighbouring trusts.

NHS Choices operates a star rating system where patients can also rate their experience from one to five stars. Not everyone chooses to award a star rating. The average star rating for each of the Trust sites was 4.0 stars or better. More than 58 per cent all comments received have been positive.

Overall star ratings as per NHS Choices website as at 05 February 2018		
Location	***Overall star rating***	
Russells Hall Hospital		4 stars based on 281 ratings (unchanged)
Corbett Outpatient Centre		4 stars based on 29 ratings (4.5 stars in Q2)
Guest Outpatient Centre		4 stars based on 9 ratings (4.5 stars in Q2)
The Dudley Group (no location specified)		4 stars based on 13 ratings (unchanged)

Patient Quote:

"We attended the new Emergency Department and just wanted to give you a positive feedback especially due to all the negatives around. Our score would be 10 out of 10…brilliant!"

3.2.3 National survey results

In 2017/18, the results of the following national patient surveys were published:

Participants for all national surveys are selected against the sampling guidance issued by the Care Quality Commission (CQC) for the months indicated in the table below:

Survey name	Survey sample month	Trust response rate	National average response rate
2016 Children and Young People's Survey	Sept - Oct 2016	20%	26%
2016 Emergency Department Survey	October 2016	25%	26%
2016 Cancer Patient Experience Survey	April – June 2016	67%	67%
2017 Women's Experiences of Maternity Services	February 2017	34%	37%

What the results of the surveys told us

Children's and Young People's Survey 2016

The national results were published in November 2017 which highlighted where improvement was needed. We were identified in the Care Quality Commission outliers report as performing 'worse than expected' for the 0-7 age group and 'as expected' for the 8-15 age group compared to other trusts within the survey. The Trust's core service rating was 'Good'. An action plan has been developed and is being monitored.

Emergency Department Survey 2016

The national results were published in October 2017 by the CQC reporting that we had scored 'about the same' as most other trusts for 27 out of 29 questions asked in the survey. Analysis of the results has been completed and actions taken for improvement.

The Trust's overall Patient Experience Score for this survey was 75 compared to the national average of 78.2. We rank 106 out of 137 trusts where the highest score was 83.6 and the lowest score was 71.1. The outliers report has also been published to which we do not feature as we are 'about the same' as other trusts.

Cancer Patient Experience Survey 2016

This National Cancer Patient Experience Survey 2016 was commissioned and managed by NHS England and is the sixth iteration of the survey. The Trust received a 67 per cent response rate which was the same as the national response rate of 67 per cent.

Scores were provided for 52 questions that relate directly to patient experience. The Trust's performance was comparable to national results.

Women's Experiences of Maternity Services 2017

The CQC published the results of the 2017 Women's Experiences of Maternity Services survey in January 2018 which sampled women who had given birth during January 2017. The Trust response rate was 34.1 per cent based on 100 women completing the survey. The national response rate was 37.4 per cent.

The total number of questions requiring subjective responses totalled 51. The Trust scores had improved when compared to 2015 results on 27 questions, were worse for 15 and were the same for 3. Four of the questions were new to 2017.

Overall we were rated as 'about the same' as other trusts for the questions relating to labour and birth, staff during labour and birth and care in hospital after birth.

Acting on feedback received

We continue to use the feedback from national and local surveys to improve patient experience. Below are some examples of actions taken as a result of patient feedback in the year.

You said	We have
It would be good to have free parking when attending for a chemotherapy appointment	Increased number of parking passes to enable patients undergoing chemotherapy to park for free
It would be helpful to receive a reminder of when my next appointment is due	Implemented an appointment reminder service with a reply option if patients need to tell us that they are no longer able to attend
We want to spend more time with our partner after the birth of our baby	Extended the maternity ward visiting hours from 9pm to 10pm
There should be more options of where MRI and CT scans can be completed	Expanded the imaging facilities at the Guest Outpatient Centre to include CT and MRI scanning
Performance information needed to be clearly displayed on each ward area for both staff and patients to see	Installed new information boards in prominent locations on each ward displaying quality performance information
Wheelchairs are more easily available when visiting the hospital	Raised funds as part of the fundraising campaign 'The Big Push' in conjunction with the local Dudley News and have provided 50 new wheelchairs for the Russells Hall Hospital site
Those with a hearing impairment cannot always hear when they are being called to come through for their appointment	Expanded the provision of vibrating pagers/bleeps to more outpatient and Emergency Department areas
It would be good to have an on line community to support new mums	Established a closed Facebook user group which provides information and networking/support opportunities
PALS information leaflets should be available in languages other than English	Translated the PALS and complaints leaflet into the top five languages used by our patients and published on the Trust website and intranet
Patients waiting to be seen in ED should be offered refreshments	Introduced a supply of refreshments that are available to patients and their families whilst waiting in ED. This included those waiting in the temporary waiting areas provided as an interim facility whilst building works were underway to create the new Emergency Treatment Centre.

Learning Lessons:

Delays in the availability of pressure relieving devices in community due to district nurses having to collect the equipment from the main hospital were resolved by storing repose cushions and heel protectors at the district nurses bases rather than the hospital.

3.2.4 Examples of specific patient experience initiatives

Children's Secret Garden

In November 2017, the Mayor of Dudley unveiled a secret garden that was built for children with additional needs who attend Russells Hall Hospital for outpatient appointments. A bare piece of land next to the children's outpatient department was transformed and now features a slide, swings and sensory toys to provide children with a relaxing outdoor environment. The secret garden was an idea suggested by parents at a listening event to improve the experience for children with additional needs. This idea also formed part of an award entry shortlisted for the Nursing Times Awards 2017.

Fruit and Vegetable Stall

A brand new fresh fruit and vegetable stall outside Russells Hall Hospital is proving a massive hit with staff and patients who are keen to eat more healthily. Brierley Hill's Young's Fresh Fruit stall opened for business outside the hospital's main entrance and gives staff and patients the chance to buy fresh fruit and vegetables. Chief Executive Diane Wake said, "We want to make it as easy as possible for the people of Dudley to lead healthy lives and make good choices, whether they visit the stall for a tasty treat or as part of their weekly shop." Visitor Jinaid Younis said, "It's a very good idea and is very convenient for members of the public and for staff." The stall is open from 8am until 4pm, Monday to Saturday and sells everything from bananas to blueberries and peaches to potatoes.

Virtual Dementia Tour Bus

A mobile virtual dementia tour bus that takes away people's primary senses visited Russells Hall Hospital to give staff a realistic glimpse into the condition that affects 850,000 people in the UK.

The Mobile Virtual Dementia Tour allows people to experience the fear and frustration people with dementia go through on a daily basis. Staff who took the tour experienced a range of simulative distortion which robbed them of their senses to recreate the isolation and fear that people with dementia may experience every day. Staff wore goggles to replicate impaired vision, gloves to restrict movement and shoe inserts to create peripheral neuropathy (weakness, numbness and pain in the feet) associated with dementia. As participants tried to perform daily activities, amplified sounds, flashing lights and restricted movement trapped them into a simulated world of fear and frustration.

Lead nurse for mental health Emma Hammond said, "The tour was extremely thought provoking and a great experience to develop an understanding of what people living with dementia might experience. I believe this will enable me to improve patient care." Communications Apprentice Lauryn Edwards, whose auntie Elsie was diagnosed with the condition at the age of 93, boarded the virtual dementia tour bus. "The tour was scary; I was unable to move properly or think clearly. It took me out of my comfort zone," said Lauryn, who was one of her aunt's carers. "I now understand that people with dementia are not aggressive and complicated, but scared, confused and isolated. It also explains why they shuffle when they're walking. "I wish I'd taken part in the tour before my auntie Elsie died in 2012. I would have understood her behaviour and looked after her better."

3.2.5 Complaints, concerns and compliments

Total number of complaints, PALS concerns and compliments

Complaints
In the year, the Trust received a total of 412 new complaints compared to 298 for 2016/17.

Percentage of complaints against activity
The table below shows the percentage of complaints against total patient contact activity in each quarter of 2017/18 and full year figures as at end of 2017/18. The percentage of complaints against activity has remained low.

ACTIVITY	TOTAL Year ending 16/17	Total Q1 ending 30/6/17	Total Q2 ending 30/9/17	Total Q3 ending 31/12/17	Total Q4 Ending 31/3/18	TOTAL Year ending 17/18
Total patient activity	769626	266874	286785	265324	303743	1122726
% Complaints against activity	0.03%	0.02%	0.04%	0.04%	0.04%	0.04%

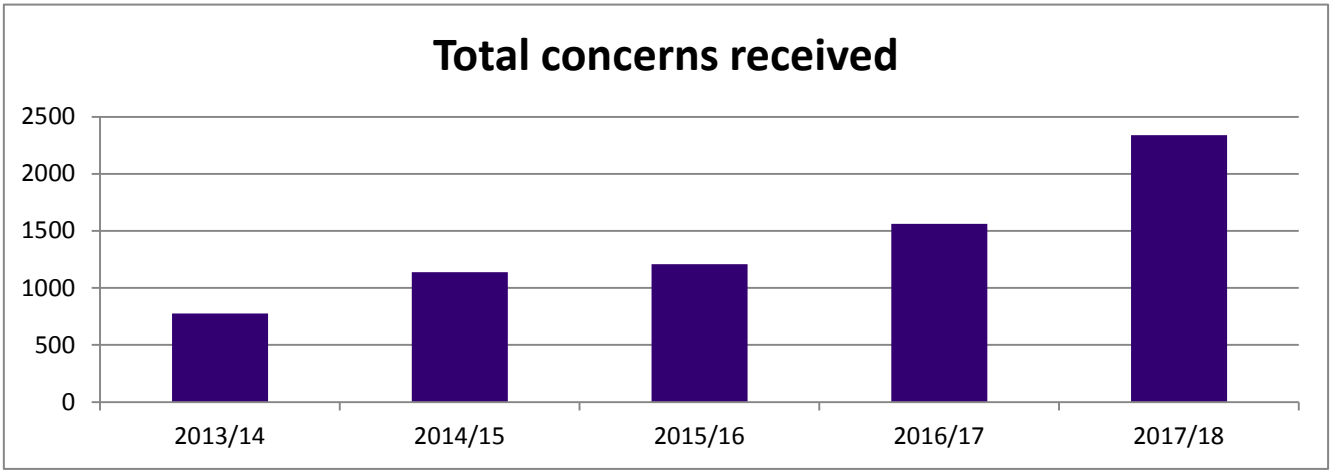
Complaints to the Parliamentary and Health Service Ombudsman (PHSO)
During the year, the PHSO received five complaints about the Trust. Four of the five complaints have been accepted by the PHSO for investigation.

Complaints by Type
The chart below show the top five types of complaints received in each quarter during the year. The themes of complaints we receive remain similar to last year, reflecting the importance that patients place on effective treatment, timely appointments, discharge and transfers.

Quarter 1, 2017/18	Quarter 2, 2017/18	Quarter 3, 2017/18	Quarter 4, 2017/18
Communications	Clinical Treatment – Surgical	Values and Behaviours (Staff)	Values and Behaviours (Staff)
Clinical treatment – Surgical	Communications	Communications	Communications
Patient Care including Nutrition/Hydration	Clinical Treatment – General Medicine	Clinical Treatment – Accident and Emergency	Clinical Treatment – Accident and Emergency
Admissions/Discharges & Transfers	Admissions/discharges & transfers	Admissions/discharges & transfers	Clinical treatment – Surgical
Clinical treatment – General Medicine	Appointments including delays and cancellations	Clinical Treatment - Obstetrics and Gynaecology	Appointments including delays and cancellations

Patient Advice and Liaison Service

The table below details the total number of concerns raised over the last five years with the Patient Advice and Liaison Service (PALS). The Trust has worked hard to raise awareness of the PALS services to our patients, carers and their families and have seen a year on year increase in the number of those contacting and using the service.

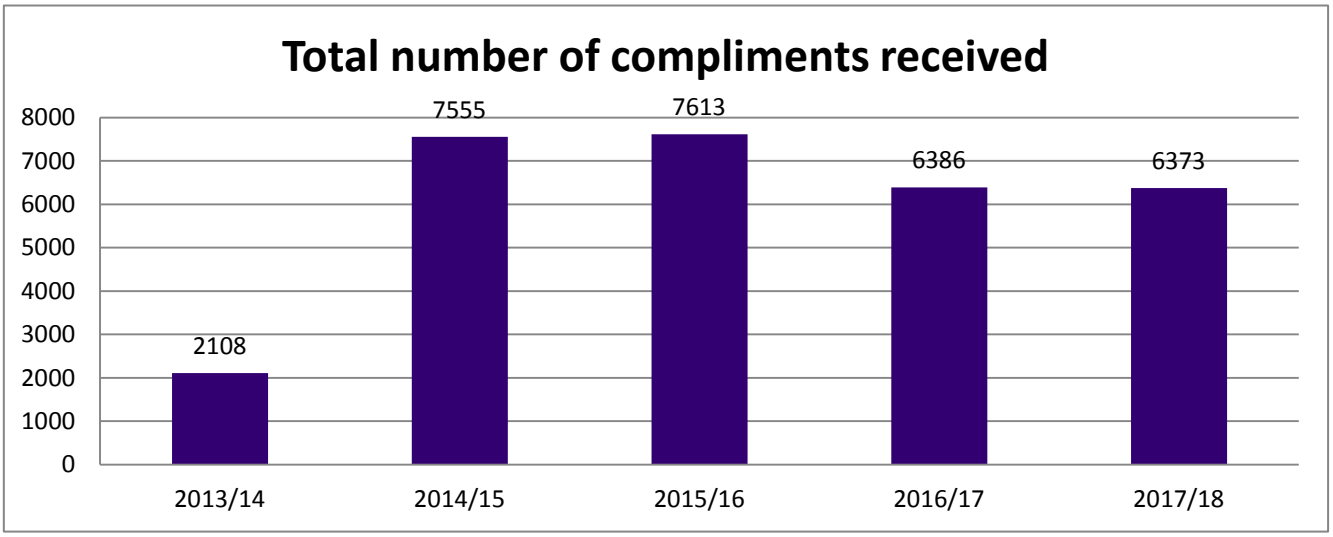


Concerns by Type

During the year, the types of concerns received were about communication, appointments including delays and cancellations and about the processes of admission/discharge and transfer. Like the types of complaints received, the themes of concerns reflect the importance that patients place on timely appointments and effective treatment.

Compliments

The table below details the total number of compliments received during the year compared with previous years. It is very pleasing to see how many patients take the time to tell us of their good experiences, with 6,373 compliments received. All compliments received are shared with staff so they can hear first-hand what our patients say about their particular area/ward or department.



Examples of actions taken and changes in practice made in response to complaints and concerns

Issue raised by patient/carer	Actions taken/changes made
Heavy demand on the two extension numbers provided for the clerical/booking team in the Imaging Department.	Switchboard operators have been instructed to put calls through to the imaging secretaries' office if the booking lines are busy. Two additional members of clerical staff have also recently been appointed to work in the Imaging Department (including weekends) to address this
Members of staff entered the consultation room uninvited during consultation with patient.	Lead nurse ensured that every staff member working in the clinic are re-educated in the chaperone and privacy, dignity policies and general clinic etiquette. Staff also shared this anonymised complaint with staff in other clinics so that they can hear from a patient's perspective the effect of not considering and adhering to basic standards of privacy and dignity.
Inadequate medication management and observations undertaken by nursing staff on a ward	All nursing staff and junior doctors have been reminded of the importance of giving regular antibiotics/fluids as early as possible if infections are suspected. In addition, mandatory training is given to staff at induction. Staff have also been advised of the importance of appropriately recording within the clinical record if medications have been omitted and the reason why. Staff to patient ratios have been reviewed on the ward. Education has been provided to staff with regards administering nasal drops and this was discussed during daily team meetings.
Family experienced difficulties in obtaining a death certificate from the bereavement office	Staff have been spoken to with regards to providing a good patient service and reminded of the process for issuing a death certificate. In addition, the complaint was shared and discussed with all matrons and lead nurses who cascaded the learning to all ward based staff at their daily meetings. Additional training has been undertaken on the bereavement process, which included the process for dealing with a patient's property.
Staff within the Emergency Department failed to identify that the patient had a piece of glass remaining in the wound	Case was discussed with staff involved and feedback given. Senior clinical staff also communicated with all colleagues within the department to ensure that all wounds that have been the potential to contain glass are X-rayed in the future.
Patient injured hand when staff were lowering the chair for the scan to commence within the outpatients ophthalmology clinic	The outpatients ophthalmology clinic now use different seats to ensure that there is not a reoccurrence.
Process for informing Healthy Pregnancy Support Workers of pregnancies which end in miscarriage has been inadequate.	Guideline 'Notification of pregnancy loss' has been re-written. Process has been changed to ensure early pregnancy assessment unit inform community messages of women who miscarry and are eligible for Healthy Pregnancy Support Worker engagement.

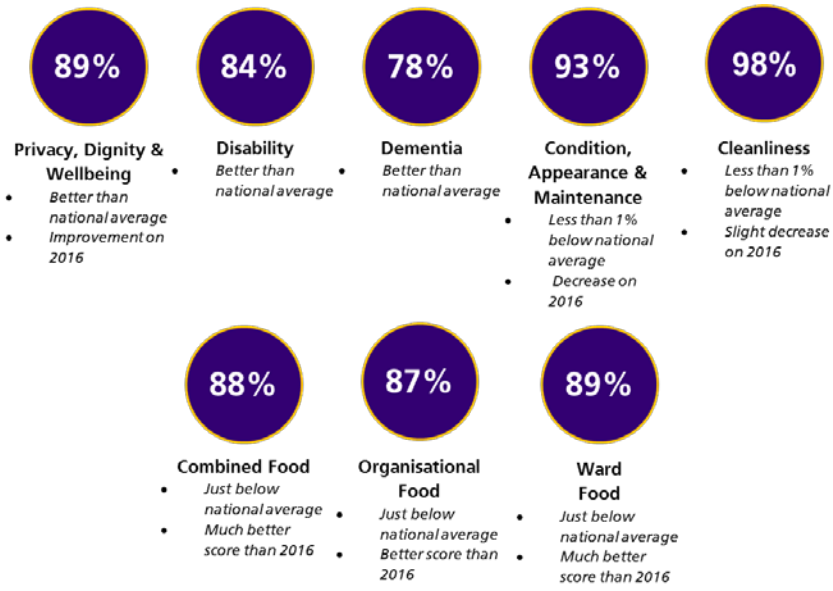
3.2.6 Patient-led Assessments of the Care Environment (PLACE)

Patient-led Assessments of the Care Environment (PLACE) is the national system for assessing the quality of the hospital inpatient environment but does not include the provision of patient clinical care. All trusts are required to undertake these inspections annually to a prescribed timescale. In 2017, the assessment took place on 26 April 2017 with the results being nationally published on 15 August 2017. The 2018 assessment is scheduled to take place before the end of May 2018.

The PLACE team is led by patient assessors who make up at least 50 per cent of the assessment team. In 2017, 12 patient assessors took part, nominated via the Trust's patients and governor engagement lead, with the remainder being staff assessors from the Trust and Summit Healthcare. The inspection covers wards, outpatient areas, communal areas and external areas to assess:

- Cleanliness
- The condition, appearance and maintenance of the buildings and fixtures (inside and out)
- How well the building meets the needs of those who use it, e.g. signage
- The quality and availability of food and drinks
- How well the environment protects people's privacy, dignity and wellbeing
- How the premises are equipped to meet the needs of patients with disability and dementia

The scores to the right show that in 2017 the Trust scored above the national average in the categories of a) Privacy, Dignity and Wellbeing b) Disability and c) Dementia. Areas where scores were below the national average were in the categories of a) Cleanliness b) Condition, Appearance and Maintenance of the building and c) Food. Although the food scores were below the national average, there was a significant increase in the food scores compared to 2016 and since commencement in 2013.



Following PLACE, a Trust action plan was agreed and actions assigned to individuals. These have been monitored by the Patient Experience Improvement Group. Actions have been completed in the main, although actions relating to the need to rectify areas of wear and tear, especially in inpatient areas, have provided a challenge due to the Trust's clinical activity.

The Trust Cleaning Operations and Monitoring Group meets monthly to review the cleanliness audits carried out across the Trust and to monitor against recognised cleaning standards. There has been a 'refresh' emphasis on cleanliness throughout the Trust and action plans have been developed which will be monitored via this group.

A Catering Review Group meets regularly to monitor inpatient food provision and also oversees the food survey activity, providing feedback on patient views and comments to the group. The Trust's PLACE food scores have significantly increased since 2016 and it is thought that since the 'chosen by patient' menu has been further embedded, this has worked well and demonstrated by the positive impact on the Trust's food scores. This group is committed to continual review of its food provision to patients.

3.2.7 Single-sex accommodation

We are compliant with the government's requirement to eliminate mixed-sex accommodation. Sharing with members of the opposite sex only occurs when clinically necessary (for example, where patients need specialist care such as in the Critical Care Unit), or when patients actively choose to share (for instance in the Renal Dialysis Unit). During the year, the Trust has reported 51 breaches of same-sex accommodation. All of these patients were those who were cared for in a specialised unit, such as the Intensive Care Unit or High Dependency Unit. Following improvement in their condition, the patients were assessed as being able to be moved to a general ward but had to stay in the specialised unit longer than necessary due to there being no general ward beds immediately available. All of these occurred when capacity issues were a major problem both at the Trust and in the NHS generally.

As part of our real-time survey programme, patient perception is also measured by asking patients whether they shared a room or bay with members of the opposite sex when they were admitted to hospital. In the year of the 1,132 patients who responded to this question, 82 (less than 7.25 per cent) had the perception that they shared a room/bay with members of the opposite sex. This excludes emergency and specialist areas.

3.2.8 Patient experience measures

	Actual 2013/14	Actual 2014/15	Actual 2015/16	Actual 2016/17	Actual 2017/18	Comparison with other Trusts 17/18
Patients who agreed that the hospital room or ward was clean	**9.0**	**8.9**	**9.0**	**8.8**	**8.8**	8.2 lowest – 9.7 highest
Rating of overall experience of care (on a scale of 1-10)**	**7.7**	**7.8**	**8.0**	**7.8**	**7.8**	7.4 lowest – 9.2 highest
Patients who felt they were treated with dignity and respect	**8.6**	**8.7**	**8.9**	**8.9**	**8.9**	8.5 lowest – 9.8 highest

The above data is from national inpatient surveys conducted for CQC.
*** National range lowest to highest score.*

3.3 Are patients safe in our hands?

3.3.1 Introduction

The Trust ensures the safety of its patients is a main priority in a number of ways, from the quality of the training staff receive, to the standard of equipment purchased. This section includes some examples of the preventative action the Trust takes to help keep patients safe, and what is done on those occasions when things do not go to plan.

3.3.2 Quality and safety reviews

The Trust is committed to the delivery of high quality patient care and has established a system of quality and safety reviews which assess if it is 'Safe', 'Effective', 'Caring', 'Responsive' and 'Well-led' (CQC Fundamental Standards). The reviews provide assurance of these areas to the Board. They utilise a set of tools that enable a full review of a clinical area and identify both good practice and topics where improvement is required. The wards and departments reviewed are provided with CQC style ratings for each domain and an overall rating, allowing them to prioritise the actions for improvement required. Action plans produced are managed through the governance structures within the relevant division.

The reviews, which happen twice weekly, are undertaken by a team, which consists of the quality and improvement lead, a senior member of the nursing team (either a matron, lead nurse or specialist nurse), infection control, pharmacy, patient experience, consultant medical staff, representation from the quality assurance team from Dudley CCG (twice per month) and a Trust governor (once per month). The diversity of the team members is an asset as it allows a broad perspective to be gained of the area under review. Feedback is provided on the same day following aggregation of the review team's findings and, where appropriate, a brief action plan is agreed. This multi-dimensional view of our services coupled with executive director and non-executive director 'back to the floor' walk rounds, ensures that we maximise our opportunity to learn and improve our services for the benefit of our patients and staff.

Some of the findings of the reviews included:

- Staff were able to describe the process of protected mealtimes and indicated that this was adhered to on the ward. Staff reported having the confidence to challenge all colleagues when they were undertaking tasks during this time frame.
- Staff were able to accurately describe the process of the 'red tray' system for patients at risk from malnutrition.
- Nursing documentation reviewed was complete for patients at risk of malnutrition.
- Single sex accommodation regulations were adhered to.
- Patient's privacy and dignity was maintained during delivery of personal care and during discussions with medical staff.
- Staff were able to describe the correct action to take if they believed a patient to be vulnerable and who to contact for assistance and advice o this issue.
- Staff spoken to all reported that they thought that they had received appropriate training to complete their role and were not asked to perform duties outside their competencies. Staff reported that they would be confident to challenge and/or escalate if this was the case.

3.3.3 Incident management

The Trust actively encourages its staff to report incidents believing that to improve safety it first needs to know what problems exist. This reflects the National Patient Safety Organisation which has stated:

''Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.''

The aim of this training was to further improve investigations skills in order to deliver more focused and improved action plans, thus facilitating wider learning from incidents with a view to reducing similar incidents across other parts of the Trust. The training has been cascaded down to other staff by the patient safety team with bi-monthly RCA training sessions being held.

The Integrated Governance Report is made available to divisions on a monthly basis. This was extended in September 2017 to include Directorate Integrated Governance reports. The reports have been further developed to include

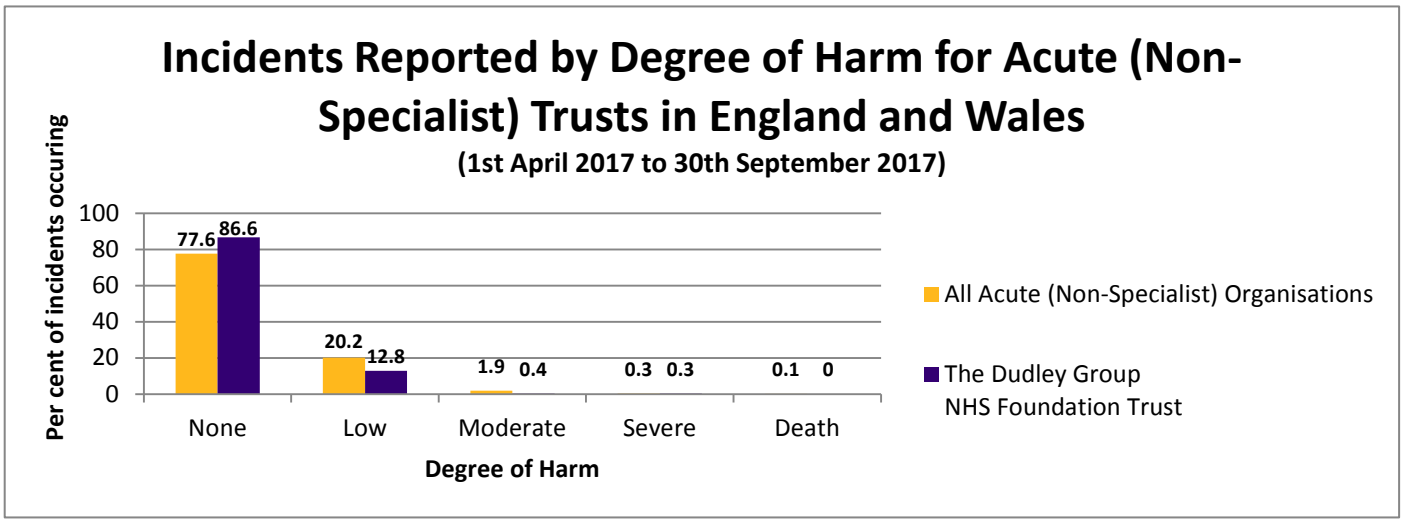
As a Trust, we are committed to learning from incidents. This is supported by an open culture which encourages any incident regardless of the level of harm (including 'near misses') to be reported through the Trust's electronic incident management system Datix.

During 2017/2018, the Trust once more engaged with an external training company to deliver Root Cause Analysis (RCA) training to a large number of staff, including clinicians and managers.

all aspects of patient safety and quality, allowing both divisions and directorates to identify trends or issues early and take action.

The Trust has established a number of KPIs for monitoring both its qualitative and quantitative performance in respect of registering and reporting serious incidents. Compliance is monitored within the Trust and discussed with our partners at the CCG.

The chart below shows the percentage of incidents reported by degree of harm at the Trust and for all acute (non-specialist) trusts in England and Wales, from 1st April 2017 to 30th September 2017.



With regards to the impact of the reported incidents, it can be seen from the chart overleaf that the Trust reported similar proportions of incidents to comparable trusts. Nationally, across all acute (non- specialist) trusts, 77.6 per cent of incidents are reported as no harm (the Trust reported 85.6 per cent) and 0.1 per cent as death (the Trust reported 0 per cent).

The Trust uploads incidents to the National Reporting and Learning System every two weeks, thereby minimising the amount of data that could be lost if one of these transmissions fails and, in addition, pre-upload and post-upload reconciliations are undertaken independently of the operational incident team.

During the year, the Trust has had three Never Events (a special class of serious incident that is defined as a serious preventable adverse incident that should not occur if the available preventative measures have been implemented). The Trust had 147 serious incidents*, all of which underwent investigation in line with the Trust's policy which is based on national requirements and, when relevant, action plans were initiated and changes made to practice.

**Serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.*

Some examples of changes made to practice in response to incidents have been:

- Following a Never Event involving a retained instrument, the Trust immediately introduced a two person check of all instruments mandated in all theatres.
- The pharmacy team has produced a list of medicines at risk of denaturing from ambient temperature extremes. This will be reviewed ahead of the summer months and be made available to pharmacy staff to enable them to proactively manage clinical and technical advice to ward teams.
- Review of incident trends within theatres identified issues in relation to equipment; this resulted in a change to the process of discussing these failings with the sterile services partner which now sees a senior member of staff from theatres attending the quarterly sterile services group where each incident is reviewed to identify process changes.
- The Trust moved from a local Track & Trigger process to the National Early Warning Score (NEWS) in August 2017. This was further developed within the Emergency Department following the CQC visit in December. This ensured the Trust was in line with national guidance on the management of deteriorating patients. The system will be embedded in the EPR system when launched next year. Every inpatient area which records vital signs for their patients has changed over to the National Early Warning Score (NEWS) system, this includes a new escalation plan for medical emergency and cardiac arrest calls.
- Operating theatres now use the swab board to record all decisions to leave in situ any swab prior to a break starting and then use the swab board to record relocation of any swab when the session restarts after the break.
- A head injury guideline has been developed and launched across the Trust and is available on the Trust intranet.
- To improve co-ordination across Trusts, both a clinical and information technology lead for NORSe at the Trust have been identified and clinical site co-ordinators have access to the system thus providing 24 hour access. There is now also a single point access at the Trust which receives letters from University Hospital Birmingham and the letters are now uploaded to the patient administration system allowing access to clinicians.

3.3.4 Duty of Candour

The Care Quality Commission (CQC) in November 2014 implemented Regulation 20: The Duty of Candour. The aim of this regulation is to ensure that staff are open and honest with patients when things go wrong with their care and treatment. This includes any event when a patient has been harmed. To ensure compliance to the regulation and to ensure this framework is embedded in the organisation, the Trust has taken the following actions to further ensure compliance and improve completion of the necessary documentation:

- The central patient safety team liaises with the lead investigator of an incident to ensure that the Duty is completed within the 10 day framework, and then on closure of the investigation, the team notify the lead investigator if the patient requires feedback, and co-ordinates any written feedback requests.
- Our commissioners are provided with evidence of the completion of the aspects of the initial discussion with families through the national serious incident reporting system (STEIS) and this is monitored by our commissioners.
- Duty of Candour training is provided on request.
- A Standard Operating Procedure has been developed detailing the process of how to complete the Duty of Candour documentation and is available to staff on the Trust's intranet.
- A quarterly audit of the completion of the Duty of Candour is undertaken and the results are presented to the Board of Directors and shared with commissioners.
- There is a dedicated page for staff on the Trust intranet, with this being promoted by a link to the information on the opening page of the intranet.

3.3.5 Quality Indicators

Every month, 10 nursing records and supporting documentation are audited at random in all general inpatient areas and specialist departments in the hospital, and in every nursing team in the community. These have previously been known as Nursing Care Indicators (NCIs). A total of 17 areas of care (approximately 370 records) are audited each month. The purpose of this audit is to ensure nursing staff are undertaking risk assessments, performing activities that patients require and accurately documenting what has taken place. The results of the audit for each area of the Trust compared to last year are shown below. They show some improvement since last year although direct comparison is difficult due to changes in the tools over time:

Area of Audit	2016/17	2017/2018
Community Children's	99%	100%
Community Neonatal	99%	100%
Critical Care	98%	95%
District Nurses	94%	95%
EAU/AMU	93%	86%
ED	88%	90%
General Wards	93%	93%
Maternity	92%	96%
Neo Natal	98%	99%
Paediatric	98%	97%
Renal	95%	98%

In addition, a number of other more specific audits, such as assessing the care of diabetes patients, are conducted monthly. The audit tools are reviewed regularly to reflect learning from incidents and changes in practice. These audits have an escalation framework to ensure that issues that could be improved are addressed by the lead nurse and matron for that area. As well as the monthly audit system, spot checks occur in all areas alongside the wider quality and safety reviews (see section 3.3.2). We have restructured the Nursing and Midwifery Departmental page on the Trust intranet to ensure that all audit results are available immediately to all staff in the Trust, as well as a tracker that includes the position of a ward/department compared to other areas.

This year we have developed a Quality Dashboard system so that both staff and patients can see the position of the ward/department on a monthly basis against a wide range of quality indicators. The dashboard is placed in a prominent position in all areas. As well as giving an indication of an individual ward/departments quality performance, both Trust-wide and divisional dashboards are also produced. As this is a new system, the compiling of a full set of indicators is still under development. An example of the dashboard is shown below:

QUALITY INDICATOR (All Wards)

Patient Safety & Quality	RATINGS			2016	2017											
KPI				Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Environmental Cleaning	<85%	85% - 95%	>=95%		96.48%	93.33%	96.42%	97.04%	96.00%	96.81%	95.62%	94.95%	94.61%	97.48%	89.03%	94.94%
Hand-hygiene compliance (Aug 2017 onwards)									97.6%	97.6%	94.4%	99.7%	99.7%	100.0%	99.4%	98.7%
MRSA Screening - elective					82.60%	87.00%	85.44%	85.84%	83.77%	79.13%	82.97%	78.05%	75.68%	83.54%		82.35%
MRSA Screening - emergency					89.31%	88.78%	91.73%	85.84%	89.24%	91.82%	87.76%	91.77%	88.32%	88.23%		89.30%
HCAI CDIFF – Due To Lapses In Care	>0		0	0	2	1	1	4	1	4	0	1	0	1	0	15
Saving Lives - 02b Peripheral Lines Ongoing Care	<75%	75% - 95%	>=95%	97%	97%	99%	96%	99%	98%	98%	99%	100%	99%	98%	95%	98%
Saving Lives - 06b Urinary Catheter Ongoing Care	<75%	75% - 95%	>=95%	100%	99%	100%	99%	99%	100%	100%	100%	100%	100%	98%	99%	99%
Total number of Datix incidents reported				567	529	571	539	641	601	556	574	539	486	540	494	6,637
Falls, Injuries or Accidents				113	107	111	75	109	75	75	91	99	76	83	87	1,101
Pressure Ulcers (Hospital Acquired) Grade 3/4	>0		0	5	2	4	1	1	5	2	0	0	0	6	1	27
Serious Incidents				6	5	7	2	5	6	4	2	5	2	9	4	57
Never Events	>0		0		0	0	1	0	0	0	0	0	0	0	0	1
Nutrition Audit	<85%	85% - 95%	>=95%	95%	97%	95%	93%	95%	95%	94%	95%	92%	95%	93%	92%	94%
Pain Score	<85%	85% - 95%	>=95%	91%	94%	95%	97%	87%	90%	87%	93%	93%	97%	91%	83%	92%
Medicines Management Audit (Announced)	<85%	85% - 95%	>=95%				89%	84%		76%	80%				79%	82%
Priorities of Care				40	39	41	38	31	34	43	41	29	24	41	33	434
Deteriorating patient trolley daily checked (1 month in arrears)	<85%	85% - 95%	>=95%		94.73%	88.88%	95.65%	94.11%	76.92%	76.92%	88.23%	100.00%	68.75%	94.44%	83.33%	88.33%

Clinical Indicators	RATINGS			2016	2017											
KPI				Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
National Early Warning System (NEWS/PEWS/MEOWS)	<85%	85% - 95%	>=95%											94.5%	90.4%	92.5%
***Newborn and Infant Physical Examination																
Fluid Balance Management Audit	<75%	75% - 93%	>=93%	89.94%	93.95%	91.72%	88.92%	92.59%	91.91%	92.30%	90.65%	92.70%	92.93%	88.83%	90.02%	91.40%
***Hearing Screening																
AKI (awaiting EPR)																
VTE Assessment Indicator (CQN01)	<95%		>=95%		94.43%	94.43%	95.33%	95.17%	95.41%	94.05%	95.47%	95.82%	94.12%	95.25%	96.21%	95.06%
***Retinopathy of Prematurity Screening																
NQA - Skin Bundle	<85%	85% - 95%	>=95%	96%	93%	97%	97%	96%	96%	96%	94%	96%	96%	96%	95%	96%

Patient Experience	RATINGS			2016	2017											
KPI				Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Friends & Family – Inpatients – Footfall	< 26%	26% - 35.1%	>= 35.1%	14.5%	17.4%	28.1%	29.4%	35.7%	28.2%	24.9%	37.4%	36.7%	31.9%	29.9%	28.5%	28.4%
Friends & Family – Inpatients – Recommended %	< 96.3%	96.3% - 97.4%	>=97.4%	95.2%	97.4%	94.5%	96%	96.6%	95.7%	94.2%	92.8%	94%	93.3%	92.5%	92%	94.4%
Friends & Family – Inpatients – Not Recommended %					0.7%	1.6%	1.1%	1%	1.9%	3.1%	3.5%	2.4%	3.8%	2.7%	4.2%	2.4%
Friends & Family – Maternity – Footfall	< 26%	26% - 35.1%	>= 35.1%	32.7%	30.9%	48.9%	40.4%	48.6%	56.3%	39.6%	34.8%	45.1%	23.6%	38.4%	35.9%	39.9%
Friends & Family – Maternity – Recommended %	< 96.3%	96.3% - 97.4%	>=97.4%	99%	98.8%	97.8%	98.2%	98.6%	97.6%	97.8%	98.6%	95%	98.4%	97.2%	97.9%	97.8%
Friends & Family – Maternity – Not Recommended %					0.5%	0.7%	0.5%	0.8%	1%	0.8%	0.6%	0.7%	0%	0.2%	0.5%	0.6%
Complaints					9	16	16	13	20	19	18	22	14	21	11	179
Compliments					508	298	60	188	206	333	387	301	482	487	372	3,622
Estimated Date Discharge (May 2018 onwards)																

Workforce & Safer Staffing	RATINGS			2016	2017											
KPI				Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	YTD
Appraisals	<80%	80% - 90%	>=90%	82.2%	79.6%	85%	85.3%	86.3%	87.3%	87.3%	89.3%	87.9%	86.8%	85.7%	80.6%	85.3%
Mandatory Training	<80%	80% - 90%	>=90%	79.2%	80.5%	81%	81%	83.3%	84%	85.3%	86.5%	87.7%	87.5%	86.7%	86.9%	84.1%

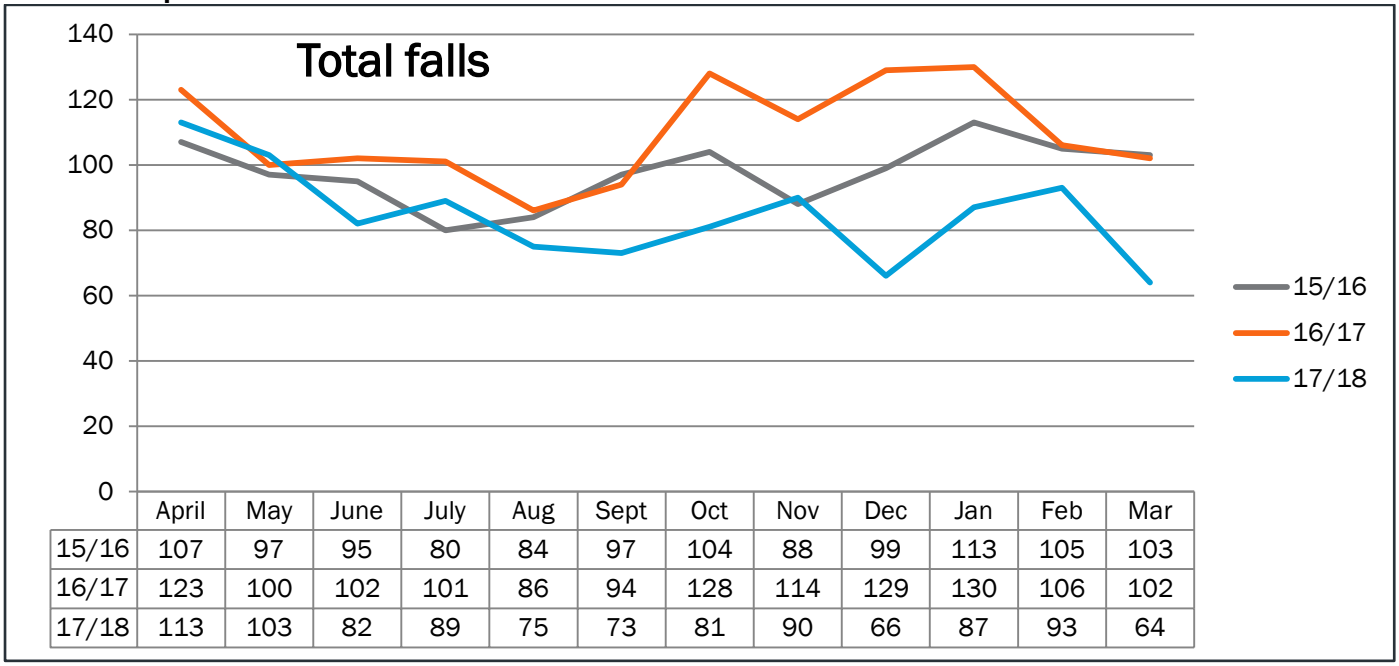
3.3.6 Falls Prevention

For part of the year in 2016, the Trust was above the national average in terms of the number of patient falls with harm. To address this, in 2017 the Trust joined the NHSi National Falls Prevention Collaborative, a 90 day project involving other trusts across the country with the aim of reducing all falls but focusing on falls with harm.
During the year, the following actions have occurred at the Trust:

- Labelled walking aids; red bands not in reach/green bands in reach of patients
- 'Call don't fall' signs at every patient bedside
- Grab bags initiative in every inpatient bathroom to reduce falls in the toilet
- Crash mats on high risk areas: wards C3 and C8
- 50 high/low beds purchased for use in Trust
- Falls Prevention Week June 2017 to share learning and developments
- 'Tag you're it' badges to remind staff that they should hand over their patient to another person before leaving the patient unattended. The badge acts as the tag baton and is passed to the next staff member caring for the patient on 1:1 or cohort basis.
- Falls under-reporting tool undertaken every six months
- Increasing medical engagement with elderly care handover meeting
- Review of all falls (not just those with harm) to confirm any learning from the falls with no harm
- Monthly falls audits for wards, results shared on dashboard
- Meetings with individual wards to explain their own falls data and discuss further actions
- Falls prevention mandatory training given a target of being above 90 per cent

The above actions and the impetus of working within the national collaborative have resulted in a considerable reduction in falls at the Trust as Table 1 below shows.

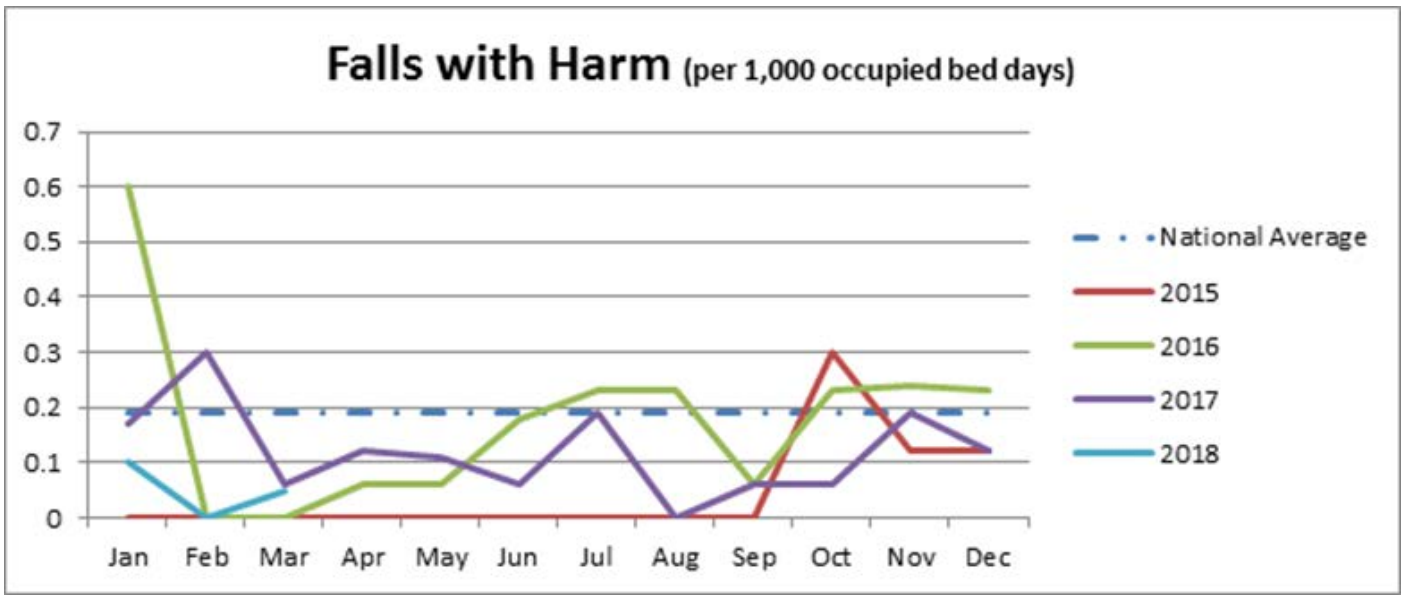
Table 1. All patient falls at the Trust



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
15/16	107	97	95	80	84	97	104	88	99	113	105	103
16/17	123	100	102	101	86	94	128	114	129	130	106	102
17/18	113	103	82	89	75	73	81	90	66	87	93	64

The recording of falls with harm per 1,000 Occupied Bed Days began nationally in October 2015, following the first National Falls Audit by the Royal College of Physicians. Table 2 below clearly shows the positive effect of the work undertaken at the Trust through the collaborative work and the Trust's Falls Group. The Trust has remained below the National Average for all falls and falls with harm since March 2017.

Table 2. Patient falls with harm at the Trust (per 1,000 occupied bed days) compared to the national average



3.3.7 Harm Free Care and NHS Safety Thermometer

The NHS Safety Thermometer used for adult patient care has been developed as a 'temperature check' on four key harm events – pressure ulcers, falls that cause harm, urinary tract infections in patients with a catheter and new venous thromboemboli. It is a mechanism to aid progress towards harm free care and is available across the whole of the NHS.

Each month, on a set day, an assessment is undertaken consisting of interviews with patients, accessing the patient's bedside nursing documentation and, when required, examining the main health record. On average, 480 adult inpatients (excluding day case patients and those attending for renal dialysis), and 580 patients being cared for in the community are assessed.

To ensure accuracy of audits submitted as well as improved lines of communication, access to the database has been restricted to staff who have received training.

The Children and Young People's Services Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with children and young people's services. It's a point of care survey that is carried out on one day per month which supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This process is led by the clinical governance lead for paediatrics. The Maternity Safety Thermometer allows maternity teams to take a temperature check on harm, and records the proportion of mothers who have experienced harm free care, but also records the number of harm(s) associated with maternity care. It supports improvements in patient care and patient experience, prompts immediate actions by healthcare staff and integrates measurement for improvement into daily routines. This process is led by the maternity matron.

The Trust regularly monitors its performance and, although direct comparisons need to be made with caution, it is pleasing to note its harm events fall below the national averages.

3.3.8 'Sign Up to Safety' Campaign

The Trust committed to partake in this national initiative by:

- Identifying the actions to take in response to the five Sign up to Safety pledges
- Publishing the agreed actions on the Trust website for staff, patients and the public to see
- Developing a safety improvement plan (including a driver diagram) to identify how improvements in patient safety and reductions in patient harm will be implemented and managed

The Trust launched a programme to improve patient safety in three key areas of care with the following aims:

1. Reduce by a third the number of inpatient falls that result in harm by March 2018

This has been achieved.

2. Identify all invasive procedures requiring NatSSIPS and provide assurance of compliance with the standards with the use of LocSSIPS by March 2018*

All procedures have been identified and are on a LocSSIP register indicating whether the checklist being used is the generic Trust version or a locally developed checklist. An audit process has been developed and is currently being undertaken and is due for completion in April 2018.

3. Reduce the number of omitted medication errors by 50% by March 2018

There has been a reduction in the number of omitted medication incidents recorded on the Trust incident reporting system from 2016/17 when the average number per quarter was 31. In 2017/18: the average number per quarter was 23 and so the reduction has been 25 per cent, not the 50 per cent as planned.

**The principle behind the NatSSIPs, an NHS England initiative, is that organisations will review their current local processes for invasive procedures and ensure that they are compliant with new national standards. This will be done by organisations working in collaboration with staff to develop their own set of 'Local Safety Standards for Invasive Procedures' (LocSSIPs).*

3.3.9 Examples of specific patient safety initiatives

Service developments in the care of children which enhance patient safety

The paediatric service has been instrumental in setting up and leading on a PATH (paediatric antibiotics at home) service which allows children to be treated at home with intravenous antibiotics after initial assessment on the ward. This avoids children having to return to hospital which can be perceived by them as a hostile environment. The service provides excellent safe care at home.
In addition, in conjunction with the diabetes team, transitional clinics for children and young people with Type 1 diabetes have commenced. We are the only Trust in the country to have separate transitional clinics for children with type 1 diabetes who are on multiple injections and insulin pumps. These clinics are staffed by both experts in diabetes and those specialising in the care of children, working alongside each other, which lessen any disruptions in care as children move from the child to the adult clinics.

Clinical guidelines enhancing patient safety

The Trust's clinical guidelines initiative has received national recognition for excellence in patient safety at a Royal Society of Medicine Conference. The clinical guidelines group was set up in September 2017 and has already made vast improvements to the accessibility and awareness of clinical guidelines across the Trust. The group have been particularly successful at engaging junior doctors in clinical guidelines development.

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

The group, consisting of Mr Jack Hamer, Dr Emma Low, Dr Justin Grandison, Dr Sarah Edwards, Dr Matthew Maw and Sandra Rider, successfully engaged junior doctors in the clinical guidelines process and worked with clinicians to identify gaps in clinical guidelines and develop them in line with best practice. The clinical guidelines group has also been responsible for driving the development of

nearly 20 new guidelines and has also consulted on many more.
The initiative has completely re-designed the clinical guidelines page on the Trust's intranet to improve accessibility of guidelines to clinicians and involved the refiling of nearly a thousand procedural documents. The main aim of the initiative is to promote safe, evidence based practice and ensure our clinicians can access guidelines in a timely manner, including whilst on call.

Improvements in sepsis care – 'Just ask, could this be sepsis? Together we can beat it.'

Sepsis is everyone's problem and kills more than 2000 people a day in Europe alone. In 2017/18 there has been considerable national publicity on recognising and reducing this condition. It is important that patients developing sepsis have prompt intravenous antibiotic administration within an hour of clinical staff recognising the symptoms. During the year, we employed a further sepsis nurse and an antimicrobial pharmacist to assist in ensuring staff act promptly to reduce morbidity and mortality. Our compliance with the antibiotic administration in less than an hour has increased from 27 per cent in inpatients and 53 per cent in the emergency department at the beginning of 2016 to 82 per cent (inpatients) and 78 per cent (ED) at the end of 2017.

Also during the year, the National Early Warning Score (NEWS) was introduced Trust wide by the Deteriorating Patient Group to unify the approach across the Emergency Department and inpatient areas. This was accompanied by targeted training incorporating NEWS and sepsis as an integral system to recognise all deteriorating patients. This has increased the compliance of a full set of vital signs being undertaken which forms a basis of deciding if the care of patients needs to be escalated to senior staff. Cardiac arrest trollies were replaced by deteriorating patient trollies containing equipment for all deteriorating patients including triple therapy antibiotics for adults with Red Flag sepsis. National mortality for sepsis is presently at 27 per cent. Following the implementation of the NEWS system, the crude mortality for sepsis across the Trust has reduced from the peak two years ago of 50 per cent to 14 per cent by December 2017, although this fluctuates with seasonal variation.

The RADAR (Recognise Acute Deterioration, Assess and Refer) programme has also been launched that has been accompanied by a guide that can be slotted into all staff's identification badge holders so it is always at hand. It reminds staff of the correct escalation process to ensure prompt treatment. The programme continues with regular reports on best practice and improvements undertaken.

3.3.10 Patient safety measures

	Actual 2013/14	Actual 2014/15	Actual 2015/16	Actual 2016/17	Actual 2017/18
Patients with MRSA infection per 1000 bed days* Trust Vs. National	0.004 Vs. 0.012	0 Vs. 0.009	0.009 Vs. 0.009	0 Vs. 0.009	0
Never events – events that should not happen whilst in hospital Source: adverse incidents database	1	1	1	1	3
Number of cases of deep vein thrombosis presenting within three months of hospital admission**	116	102	130	138	122

**Data source: For 2013/14 to 2016/17 from National Statistics on www.gov.uk For 2017/18 numerator data taken from infection control data system and denominator from the occupied bed statistics in patient administration system.*
***We review all diagnostic tests for deep vein thrombosis and pulmonary embolism (PE), cross referencing positive tests with past admissions. This methodology is only undertaken by relatively few hospitals as it is labour intensive, but is recognised as giving a more accurate figure for hospital acquired thrombosis. As a further check, we receive notification from the bereavement officer if PE was identified as the primary cause of death.*

Clinical effectiveness

3.4 Do patients receive a good standard of clinical care?

3.4.1 Introduction

This section includes the various initiatives occurring at the Trust to ensure patients receive a good standard of care and examples of where we excel compared to other organisations.

3.4.2 Examples of awards received in improving the quality of care

Clinical Research Network (CRN) West Midlands Awards 2017

The Trust's research laboratory team picked up the Support Service Award for their hard work around the recruitment of patients to research studies. Our research support officer was 'highly commended' for the Business Innovation category on behalf of the research team for implementing Edge, which is a research system that provides the most up to date data.

Nursing Times Awards 2017

Our continence advisors made the shortlist in two categories. The community based continence advisors introduced new roles to support care home staff to deliver the best possible continence care to patients and to troubleshooting in care homes to advise staff and treat complex patients to help avoid unnecessary hospital admissions. The Trust's project to improve the experience for children with learning disabilities visiting hospital also made the shortlist. Improvements include introducing pagers in the Children's Outpatient Department, which allows parents to leave the department if their child is anxious without the fear of missing their appointment.

West Midlands Academic Health Science Network Awards 2017

The Trust won the runner up award for the Medicines Optimisation category for the work in oncology clinics. The Trust's oncology prescribing pharmacist specialises in prostate cancer and he reviews patients in surgical urology clinics and also in medical oncology clinics. He optimises patient systemic anticancer therapy in both clinics and maintains contact with our prostate cancer patients throughout their treatment journey from surgery into oncology as disease sadly progresses.

Student Nursing Times Awards 2017

Three members of staff from the Trust received national recognition by making the shortlist in the category of Educator of the Year for inspiring students.

CHKS Awards 2017 CHKS Top Hospitals Awards 2017

CHKS is a leading provider of healthcare intelligence and quality improvement services. This year, the Trust was named as one of the top forty trusts against a range of indicators including efficiency, patient safety, quality of care, data quality and patient experience.

Health Service Journal Awards 2017 in the Patient Safety category.

The implementation of a new app which has transformed out-of-hours care at Russells Hall Hospital, and freed up more than 100 hours of nursing and doctor time every week, was shortlisted for the above award. A staggering 5000 clinical tasks, ranging from prescribing medication to interpreting blood results and X-rays, are logged and allocated each month using the app on handheld iPods.

Student Nursing Times Awards 2018

The Trust's learning disability simulation pathway has been shortlisted in the category of Student Experience. The simulation pathway, which was developed to improve education, helps student nurses to understand the needs of people with a learning disability when they visit hospital.

3.4.3 Examples of innovation

App for management of patients with Parkinson's disease

The Trust has launched a mobile IOS/android phone / tablet app for guidance on the management of patients with Parkinson's disease that are deemed nil by mouth. This means the guidelines, for patients with compromised swallowing or those deemed nil by mouth, are available for doctors across the world to download to help with the management of patients with Parkinson's disease. This allows staff to spend more time with patients to deliver the best quality care for each individual. The app offers information about feeding tube administration for patients who can tolerate a feeding tube as well as a Rotigotine Patch Conversion Calculator for the patients who cannot. It can be found by searching 'Parkinson's Nil By Mouth' on the app store.

Reminiscence Interactive Therapy (RITA)

The Trust has introduced new digital reminiscence therapy software to areas across Russells Hall Hospital to offer extra support to patients with dementia. The Reminiscence Interactive Therapy and Activities (RITA) software is a form of cognitive therapy that helps to calm, stimulate and reduce agitation in patients with dementia. The therapy has been proven to positively engage patients, who have a cognitive decline in mental abilities such as memory and thinking. The software, in the form of a tablet device, helps patients to relax, recall memories and encourage interaction between them and their families. Matron Rachel Tomkins has been involved in training staff on how to use the software across the hospital. She said: "The reminiscence software has already made a massive difference to our patients in such a short space of time. I really believe that this fantastic piece of technology is helping to make our patients feel more comfortable during their stay and that it is also contributing to a reduction in falls." The Trust has purchased ten tablets which hold a wide range of interactive activities for patients to access, such as a library of music from every generation, old and new films to watch and an app for families to create personalised life albums by uploading photos with their loved ones.

'Love your Heart'

An interactive online video programme called 'Love your Heart' developed by consultant rheumatologist, Dr. Holly John, in partnership with the National Rheumatoid Arthritis Society (NRAS) has been launched. It has been developed to help those with rheumatoid arthritis (RA) understand why they are at an increased risk of cardiovascular disease (CVD) and the impact RA can have on the most important organ - the heart! It originated following a four-year research study in how to educate patients with RA of the risks of CVD, which increase due to both their RA as well as established risk factors such as diabetes, high cholesterol or smoking for example. The study was part of a broader and longstanding programme of research projects conducted by the Rheumatology Department in Dudley (with collaborators from multiple universities) into CVD in RA, which has significantly contributed evidence which underpins national and international guidelines. A recruited participant in the educational programme described: "Doing this programme was life-changing for me – it gave me the knowledge, the confidence and the stimulation I needed to take action to change my life. I cancelled my Sky subscription, joined a gym and started swimming. It's changed my life in a very positive way." The promising results of the programme led to the collaboration with NRAS and the development of the Love Your Heart programme. NRAS is making the Love Your Heart programme widely available to everyone with RA (or inflammatory arthritis) so that they can find out why they are at increased risk of CVD and provide tools to help them lower that risk. The online programme stars some of the team that supported Dr. John in her study.

3.4.4 Examples of specific clinical effectiveness initiatives

Multi-disciplinary Virtual Biologic Clinic (VBC)

Biologic drugs are high cost drugs which have revolutionised the treatment of inflammatory conditions such as rheumatoid arthritis. They act on specific proteins or chemical molecules within the body which are involved in inflammation. The Rheumatology Department have implemented a multi-disciplinary virtual biologic clinic (VBC). Patients starting biologic therapies thereby have their screening investigations collated, funding secured through an electronic high cost drugs programme, prescriptions created and registration with homecare all done virtually. Subsequently patients attend dedicated group education. The VBC has improved efficiency, patient safety and recruitment into national biologic research registries as well as reducing delays for patients and facilitating maintenance of an accurate biologic database.

Improvements in diabetes care for pregnant women.

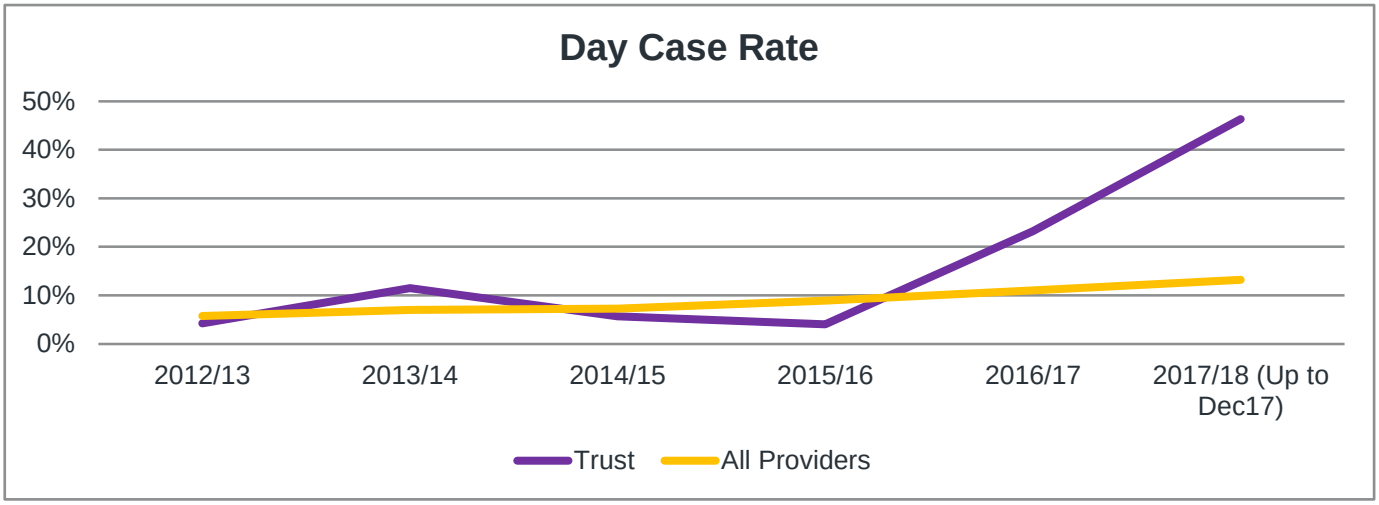
Following a recent research study that has shown significantly improved diabetes control and neonatal outcomes, including reduced stay in a neonatal unit, the Trust has changed its practice and now offers continuous glucose monitoring (CGM) to all patients with Type 1 diabetes during pregnancy. We refer patients for continuous monitoring with alarms if they have no awareness to hypoglycaemia and severe hypoglycaemic attacks. The Trust now runs weekly technology-based pregnancy multidisciplinary meeting. This is a new initiative and there not many such examples in other trusts. Patients download their continuous monitoring devices at home and the Trust remotely reviews the traces. In addition, we have started offering the device for patients with Type 1 diabetes as a part of preconception care.

While some of the devices have been purchased from local charity funds, many are funded through the local commissioning group. We are one of the first trusts in the country to obtain NHS approval. The team look forward to take part in a new diabetes-related study, which will look at closed loop (artificial pancreas) in pregnancy with Type 1 diabetes. If we are successful, we will be one of the very few centres in the UK to have the opportunity to take part in this innovative study, which will be led by the University of Cambridge team.

Day Case Mastectomy

It has now been established that mastectomy can be safely delivered as a day case procedure, but implementation of this nationally has been slow. The advantage for patients is minimum disruption to their lives and a smoother pathway with much lower risk of cancellation and healthcare associated infection. The advantage for the Trust is release of inpatient beds and easier planning of the elective waiting list.

The Breast Care Team here at the Trust commenced an initiative to increase our day case surgery rates for mastectomy. This required a multidisciplinary approach with re-designing the entire admission pathway and introducing a cultural change within the team. The progress since then has been very successful as the graph below indicates when comparing our rates with the national figures. Anecdotally, patients have expressed high levels of satisfaction with the day-case mastectomy pathway and staff have likewise found delivering this enhanced service to be very rewarding.



3.4.5 Clinical effectiveness measures

	Actual 2013/14	Actual 2014/15	Actual 2015/16	Actual* 2016/17	YTD 17/18
Trust readmission rate for Medicine and Integrated Care Division *Vs.* National peer group (acute and specialist trusts) *Source: UHB Hospital Healthcare Evaluation Data (HED)*	7.14% Vs. 8.61%	8.78% Vs. 6.38%	8.82% Vs. 8.39%	10.37% Vs. 9.38%	9.06%** Vs. 9.24%**
Number of cardiac arrests *Source: Logged switchboard calls*	158	189	144	136	118
% of patients admitted as emergency for fractured neck of femur operated on within 48 hours *Vs.* National average *Source: UHB Hospital Healthcare Evaluation Data (HED)*	84.04% Vs. 77.31%	83.97% Vs. 78.59%	85.58% Vs. 79.39%	86.10% Vs. 78.69%	83.23%+ Vs. 78.52%+

**These updated figures are for the whole year. Last year's report included the figures available at the time of printing.*
*** Both Trust and National Peer Figures are April 2017 to November 2017, the latest HES period available.*
+ Both Trust and national average figures are April 2017 to November 2017, the latest HES period available.

3.5 Our performance against the thresholds set out in the Risk Assessment and Single Oversight Frameworks of NHS Improvement

National targets and regulatory requirements	Trust 2013/14	Trust 2014/15	Trust 2015/16	Trust 2016/17	Target 2017/18	National 2017/18	Trust 2017/18	Target Achieved?
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway Ⓐ	96.74%	95.43%	95.06%	95.43%	92%	+	94.0%	☺
A&E: maximum waiting time of 4 hours from arrival to admission, transfer, discharge Ⓐ	93.74%	94.68%	98.18%	94.16%	95%	88.36%	86.56%	☹
All cancers: 62 day wait for first treatment from urgent GP referral for suspected cancer	89%	85.6%	84.3%	85.3%	85%	82.2%	86.3%	☺
All cancers: 62 day wait for first treatment from NHS Cancer Screening Service referral	99.6%	97.3%	96.2%	98.2%	90%	90.9%	98.3%	☺
Maximum 6 week wait for diagnostic procedures	99.25%	97.75%	98.97%	97.41%	99%	99.03%	97.86%	☹
Venous Thrombolism (VTE) Risk Assessment	95.16%	95.33%	95.96%	94.75%	95%	95.27%*	93.38%	☹

2017/18 National Figures taken from NHS Statistics and Cancer WaitingTimes Database (quarterly figures averaged)
*National figure only available for Q1 to Q3
+ National figures are not available

☺ = Target achieved
☹ = Target not achieved
Ⓐ = Data quality tested by external auditors (see below). For the A&E waiting time indicator, the testing undertaken was on the Trust's accident and emergency department data (78.38%), while the stated figure also includes the performance of the urgent care centre as required for national reporting.

For the two targets that have had the data quality tested:

Four-hour A & E wait: for a walk in patient, the clock start is the point at which the patient is booked onto the patient administration system by the reception staff. For an ambulance arrival, the start is when the ambulance staff book the patient in at ambulance triage reception in line with the definition of when hand over occurs or fifteen minutes after the ambulance arrives at A&E, whichever is earlier. Total time in the department ends when the patient is discharged home, transferred, or admitted onto the system by the clinician who has treated the patient. All patients arriving by ambulance and on foot attending the A & E Department have been included. The source of the data is the Trust's patient administration system, Allscripts PAS.

The reported indicator performance has been calculated based on all patients recorded as having attended the Emergency Department. Completeness of this information is, therefore, dependent on the complete and accurate entry of data at source by the clinician who carries out initial assessment or by the Emergency Department reception. The information provided is complete to the best of the knowledge of the Trust.

For RTT incomplete pathways: referrals to the Trust arrive by two routes a) paper based to a consultant's secretary who date stamps the referral and that date is recorded on the Trust patient administration system as the date when the clock starts and b) via the electronic based 'Choose and Book' system and the clock starts as soon as this electronic referral is received at the Trust. The national standard is that 92 per cent of patients on incomplete pathways should have been waiting no more than 18 weeks from referral to treatment. At the end of each month the percentage of patients who are referred and treated compared to those still waiting is calculated. All consultant referrals are included. The source of the data is the Trust's patient administration system, OASIS.

The reported indicator performance has been calculated based on all patients recorded as having been referred to the Trust for consultant led services and who are on incomplete

pathways at the end of the period. Completeness of this information is therefore dependent on the complete and accurate entry of data at source (referrals received for consultant led services) and the complete recording of all those on incomplete pathways at period end; it is not possible to check completeness to source because referrals may be received through different routes, for example, by letter, fax or via the live 'Choose and Book' system or may have been received in a prior period. Patients who have not been identified within the population will therefore not be included in the indictor calculation. The information provided is complete to the best of their knowledge of the Trust.

3.6 Glossary of terms

A&E	Accident and Emergency (also known as ED)
AAA	Abdominal Aortic Aneurysm
AKI	Acute Kidney Disease
AMBER	A care bundle that is a simple approach when clinicians are uncertain whether a patient may recover and are concerned that they may only have a few months left to live.
ANP	Advance Nurse Practitioner
App	A computing application, especially as downloaded by a user to a mobile device.
Bed Days	Unit used to calculate the availability and use of beds over time
BFI	Baby Friendly Initiative
CAMHS	Child and Adult Mental Health Service
C. diff	Clostridium difficile (C. difficile)
CCG	Clinical Commissioning Group
CHKS	A provider of healthcare intelligence and quality improvement products and services.
CNS	Clinical Nurse Specialist
CONCEPTT	Continuous Glucose Monitoring in Women with Type 1 Diabetes in Pregnancy Trial
CPA	Clinical Pathology Accreditation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation payment framework
CT	Computed Tomography
CTG	Cardiotocograph
CVD	Cardiovascular Disease
DATIX	Company name of incident management system
DVD	Optical disc storage format
DVT	Deep Vein Thrombosis
EAU	Emergency Assessment Unit
ED	Emergency Department (also known as A&E)
EDGE	Company that provides Clinical Research Software
EmLap	High Risk Emergency Laparotomy Pathway
ENT	Ear, Nose and Throat
EULAR	European League Against Rheumatism
FCE	Full Consultant Episode (measure of a stay in hospital)
FFT	Friends and Family Test
FY1/FY2	Foundation Year Doctors
GI	Gastrointestinal
GP	General Practitioner
HCAI	Healthcare Associated Infections
HDU	High Dependency Unit
HED	Healthcare Evaluation Data

HES	Hospital Episode Statistics
HPA	Health Protection Agency now called Public Health England
HQIP	Healthcare Quality Improvement Partnership
HSCIC	Health and Social Care Information Centre
ICNARC	Intensive Care National Audit & Research Centre
IPCS	Intermittent Pneumatic Compression
ISO	International Organization for Standardization
KPI	Key Performance Indicator
LocSSIPS	Local Safety Standards for Invasive Procedures
MBC	Metropolitan Borough Council
MCP	Multispecialty Community Provider
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MUST	Malnutrition Universal Screening Tool
NatSSIPS	National Safety Standards for Invasive Procedures
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NEWS	National Early Warning System
NHSI	NHS Improvement
NICE	National Institute for Health and Care Excellence
NORSe	Network of on-call referral service
NPSA	National Patient Safety Agency
NRSA	National Research Service Award
NVQ	National Vocational Qualification
PCSK9	Proprotein convertase subtilisin/kexin type 9 is an enzyme encoded by the PCSK9 gene in humans on chromosome
PFI	Private Finance Initiative
PLACE	Patient-led Assessments of the Care Environment
PROMs	Patient Reported Outcome Measures
RAG	Red/Amber/Green
RCA	Root Cause Analysis investigation
SHMI	Summary Hospital-level Mortality Indicator
SIRS	Systemic Inflammatory Response Syndrome
SMS	Short Message Service is a text messaging service
STEIS	Strategic Executive Information System is the national database for serious incidents
SUS	Secondary Uses Service
TTO	To take out medications once discharged as an inpatient
UGIB	Upper Gastrointestinal Bleeding
UNICEF	United Nations Children's Fund
VTE	Venous Thromboembolism

Annex

Comment from the Trust's Council of Governors (received 13/04/2018)

During 2017/18, the Council of Governors have worked closely with the Trust and held the non-executive directors (NEDs) to account for the performance of the Board and acknowledge the relentless challenge of ever increasing demand on Trust services against a back drop of severe financial challenge.

Governors fully support the Chief Executive's Statement in Section 1 of this report.

The council is pleased that the process used to ratify the Trust's choice of Quality Priorities gives a wide range of patients, members, governors, staff interest groups and the public the opportunity to be involved and to influence the choice of priorities. The council welcomes the addition of the two new Quality Priorities for 2018/19 – discharge management and incident reporting.

During the year, the council has received regularly reports and updates on progress made in respect of quality and other indicators. It has been disappointing to note the poor performance in some areas of the national Friends and Family Test (FFTs) and note the decline in percentage recommended scores for the emergency department that has experienced extreme pressure during the year. Governors also note that some priorities still require improvement where the targets had not been fully achieved including pressure ulcers, nutrition and hydration. The Council welcomes the retention of these for 2018/19 where there is still improvement required.

In addition to meetings of the council of Governors and its committees, governors have continued their involvement in Trust governance activity, including Quality and Safety Reviews, PLACE audits and continued membership of Board working groups and committees. Governors meet executive and non-executive directors regularly and are kept informed by the Board about all aspects of Trust activity and performance. The council wishes to place on record that there is ample opportunity for open debate and discussion about steps being taken to address related performance issues. Governors participated in the recent CQC inspection activity where a good proportion of the council met with members of the inspection team and comments were duly noted.

We are pleased to note that patient experience remains the Trust's number one strategic objective and note the increasing amount of feedback received from patients, families and their carers and the continuing improvements made. Examples of which are contained within this report. Our wards, departments and staff continue to receive high level of compliments particularly commenting on caring staff and good treatment.

During the year, the council has actively been involved with strategy development and planning via Board workshops and other fora with particular regard to projects including MCP, Black Country Pathology and quality of transformation projects which will have an impact on all stakeholders and users of healthcare in Dudley. All council committees will continue to ensure that governors have the information and assurance they need to hold the Board of Directors to account through its non-executive directors.

In summary, this report affirms that the Trust continues to be a listening and learning organisation, focussed on patient care, experience and safety. Trust staff continue to demonstrate commendably high levels of care and commitment. On behalf of patients, carers and the public, governors again wish to place on record their recognition and appreciation of the commitment and excellent work done by staff at all levels in the Trust

Comment from the Dudley Clinical Commissioning Group (received 03/05/2018)

We are pleased to comment on the Trusts 2017/18 Quality Account.

Dudley Clinical Commissioning Group (CCG) acknowledges this report reflects a continued focus by the Trust on the delivery of high quality care during a challenging year with increasing demands and financial pressures.

The latter part of 2017/18 has seen the Care Quality Commission (CQC) identify both areas of good practice and areas that require improvements particularly with regards to Urgent & Emergency Care. Whilst the CCG are concerned about some of the findings we have been encouraged by the Trusts commitment to improve services and engage with us and other stakeholders. This partnership working will continue into 2018/19 and we are confident that the efforts will result in significant enhancements to care and additional capacity and capability to deal with the ongoing system pressures.

The Trust has worked collaboratively throughout 2017 as demonstrated by the Maternity Quality Improvement Board. As a result the Maternity Services are able to evidence improvements in the safety and quality of care for mothers and babies; this was acknowledged during the CQC inspection which rated the service as Good. The work undertaken to continually improve investigation of Serious Incidents continues throughout the Trust alongside implementing subsequent recommendations.

The Trust compares well to both neighbouring Trusts and the national position in relation the feedback from patients through the "*Friends and Family Test*". Overall, the work carried out this year to improve the patient experience is encouraging; particularly the efforts to improve the experience of children and families in the hospital with the new play area. The opening of the fruit and vegetable stall at the entrance has shown innovation and has been a great success. There is however, more to do in terms of response rates for complaints. We will continue to pursue the required improvement in this area to ensure that the Trust are as responsive as they can be to patients whose experiences have not been as good as they should have been.

The Trust has continued to achieve a reduction in the number of patients with Clostridium difficile during 2017 and maintained its position of zero MRSA cases this year. We welcome the continued focus on reducing pressure ulcers where targets have not been achieved however positive progress has been made to reduce falls in the hospital. We also recognise significant efforts have been made to achieve challenging CQUIN initiatives this year with particular recognition of the important increase in the level of staff flu vaccinations.

Finally, we have been pleased to see the formation of a closer partnership between our primary care colleagues and the Trust. This new relationship is the foundation of a new era for healthcare in Dudley as we move to a new Multispecialty Community Provider (MCP). We look forward to working with the Trust and all other partners as we believe it is through collaboration and engagement that we will improve access, continuity and coordination of care and the overall health and wellbeing of the people of Dudley.

Yours Sincerely

Paul Maubach
Chief Accountable Officer
Dudley CCG

Comment from Healthwatch Dudley (received 11/05/2018)

Healthwatch Dudley has reviewed the 2017/18 Dudley Group NHS Foundation Trust annual quality report and account, which demonstrates a strong will towards improving patient experience through the Trust's quality priorities.

We note that Friends and Family Test results on the whole show trends predominately in line with the national average and compare favourably with neighbouring Trusts, however, it is concerning to see a decline in the experiences of people accessing the Emergency Department.

People have a right to high quality, safe and efficient health services and should expect for their views to be listened to and acted upon if they have any concerns.

Healthwatch Dudley was part of the Quality Improvement Board, which was set up to oversee and review the process for investigating serious adverse incidents into maternity services at Russells Hall Hospital. Our role was to ensure that the process was transparent and that people who may have been affected really were listened to and supported. It is reassuring to see Maternity Services received an overall 'good' rating by CQC during their inspection in December 2017 and January 2018 together with medical care (including older people's care) and community health services for adults.

It was however disappointing to see CQC rating urgent and emergency services, critical care and services for children and young people as 'inadequate' or 'requiring improvement'.

We note that services have experienced extreme pressures during the year, we hope to be reassured in the coming months that issues are being addressed. Healthwatch Dudley has offered to independently capture patient experience to support this journey.

We can see that a range of innovative methods are being introduced to maintain and improve standards of quality across the Trust and also look forward to seeing the results of these being embedded.

It is further reassuring to see that patient experience is the number one priority for the Trust in the coming year and we look forward to our continued involvement through our contribution to the Patient Experience Group, patient panels, carers tea and chat sessions, PLACE and mini PLACE, all enabling local people to provide meaningful feedback on hospital services.

Healthwatch Dudley volunteers have been positively engaged by the Trust throughout 2017/18 in activity around a number of issues including: accessibility and accessible information, dementia and the hospital environment, so that their views and experiences can influence service delivery.

Healthwatch Dudley is passionate about the Trust achieving the highest quality in all areas and will continue to support in any way possible, to ensure that patient voice stays at the forefront and influences decisions that are made across all service areas.

Jayne Emery

Chief Officer
Healthwatch Dudley

Comment from Dudley MBC Health and Adult Social Care Scrutiny Committee

No comments were received from Dudley MBC Health and Adult Social Care Scrutiny Committee.

Statement of directors' responsibilities in respect of the Quality Report 2017/18

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

• the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
• the content of the Quality Report is not inconsistent with internal and external sources of information including:
o board minutes and papers for the period April 2017 to March 2018
o papers relating to quality reported to the board over the period April 2017 to March 2018
o feedback from commissioners dated 03/05/2018
o feedback from governors dated 13/04/2018
o feedback from Dudley Healthwatch dated 11/05/2018
o the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2018
o the national patient survey was published May 2017
o the latest national staff survey 2017
o the Head of Internal Audit's annual opinion of the trust's control environment dated 22/05/2018
o CQC inspection report dated April 2018
• the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
• the performance information reported in the Quality Report is reliable and accurate
• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
• the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

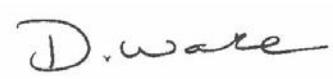
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Signed:
Date: 22nd of May 2018

Jenni Ord
Chairman

Signed:
Date: 22nd of May 2018



Diane Wake
Chief Executive

Independent Auditor's Report to the Council of Governors of The Dudley Group NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of The Dudley Group NHS Foundation Trust to perform an independent assurance engagement in respect of The Dudley Group NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement (NHSI)):

Specified Indicators	*Specified indicators criteria* (exact section the Quality Report where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways.	3.5 "Our performance against the thresholds set out in the Risk Assessment and Single Oversight Frameworks of NHS Improvement"
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	3.5 "Our performance against the thresholds set out in the Risk Assessment and Single Oversight Frameworks of NHS Improvement"

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2017/18" issued by NHSI.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the financial year, April 2017 and up to the date of signing this limited assurance report (the period);
- Papers relating to quality report reported to the Board over the period April 2017 to the date of signing this limited assurance report;
- Feedback from the Commissioners Dudley Clinical Commissioning Group dated 03/05/18;
- Feedback from Governors dated 13/04/18;
- Feedback from Local Healthwatch organisation Healthwatch Dudley dated 11/05/18;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 10/05/18;
- The latest national and local patient survey dated 31/05/17;
- The latest national and local staff survey dated 2017;
- Care Quality Commission inspection report, dated 18/04/18; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 22/05/18.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.
We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of The Dudley Group NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Dudley Group NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Dudley Group NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;

- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2017/18"and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by The Dudley Group NHS Foundation Trust.

Basis for Disclaimer Conclusion – Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The 18 week indicator is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal. The data reported is subsequently updated by the Trust for any identified errors through a monthly validation process. The process is, however, not applied to the whole data set, as it focuses only on the cases exceeding the 18 week target, and it is run on the final Sunday of the month and not at period end. This process operates similarly across the NHS.

In our testing we found three instances of cases where the clock had not been stopped on a timely basis following a qualifying stop event. The result was that those patients were incorrectly reported within the indicator until they were picked up by the validation team.

The use of data based on the final Sunday of the month rather than the final day also means that any changes in the data during the last days of the month would not be captured. This would include newly referred patient clock starts, clock stops and any patients moving across the eighteen week threshold. In our testing, we found one instance where the clock was stopped on the last day of the month but still included in the reported figures as an incomplete pathway due to the report being run on the incorrect date.

The Trust was not able to review and update the whole data set used to calculate the indicator. Therefore, we were unable to access accurate and complete data to check the waiting period from referral to treatment reported across the year.

Basis for Disclaimer Conclusion - Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

Under NHSI's guidance for "the Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge", there is provision for a Trust to report combined figures for themselves and any co-located independent service provider operating alongside them. The Dudley Group of Hospitals NHS Foundation Trust choose to do this by reporting their own figures for the type 1 A&E facility combined with Malling Health's figures for the type 3 Urgent Care Centre. Attendances at the Urgent Care Centre account for 38.95% of the patients reported by the Trust during the year. Due to patient confidentiality, the Trust and Malling Health cannot access each other's systems. We have been unable to access Malling Health' data and therefore cannot form a view on the accuracy of the reporting. This is an issue that has been identified at a number of trusts with third party hosts for Type 3 facilities.

In addition to the point above, our testing found one instance where a patient was recorded as treated in the type 1 facility and then discharged to the type 3 facility. NHSI's guidance sets out that patient activity should only be recorded by one of the two providers when they report figures combined, so the Trust's current methodology would result in the same patient being counted twice. The total number of patients referred from the type 1 facility to the type 3 facility who may have been double counted is 3.57% of the patients who attended A&E.

We also found that start clocks for ambulance arrivals are not being captured accurately. NHSI's definition for "the Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge" specifies that the clock start time for patients arriving by ambulance is when hand over occurs, or 15 minutes after the ambulance arrives at A&E, whichever is earlier.

The Trust receives data from the Ambulance Trust on ambulance arrival times; however, because of issues with the completeness and accuracy of the data received, the Trust is unable to determine the ambulance arrival time (plus 15 minutes) for each patient arriving by ambulance. The Trust does not have another reliable method as a proxy for ambulance arrival time (plus 15 minutes). Consequently, the Trust has been unable to demonstrate that for 2017/18, using the ambulance arrival would not impact on overall reported performance. The total number of arrivals by ambulance make up 22.82% of patients who attended A&E. The issue of difficulty in measuring ambulance arrival time due to lack of accurate data has been identified across a number of trusts, nationally.

The patient activity affected by the issues above makes up 65.34% of the attendances in the indicator population for The Dudley Group of Hospitals NHS Foundation Trust during 2017/18.

Disclaimer of conclusion/Qualified conclusion

Because the data required to support the Incomplete Pathways indicator is not available, as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the incomplete pathways indicator.

Because the data required to support the "Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge" indicator is not available, as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the indicator.

In addition, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; and
- The Quality Report is not consistent in all material respects with the documents specified above.

PricewaterhouseCoopers LLP.

PricewaterhouseCoopers LLP
Cornwall Court, Birmingham

Date: 25 May 2018.

The maintenance and integrity of The Dudley Group NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

If you would like this letter or information in an alternative language or format, for example in large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call us on 0800 073 0510 or email PALS@dgh.nhs.uk or write to Patient Advice and Liaison Service.

إذا كنت ترغب في أن تكون هذه الرسالة أو المعلومات بلغة أو قالب بديل، على سبيل المثال في بخط أكبر أو سهلة القراءة، أو إذا كنت بحاجة إلى مساعدة في التواصل معنا، على سبيل المثال، لأنك تستخدم لغة الإشارة البريطانية، يرجى إخبارنا بذلك. يمكنك الاتصال بنا على 0800 073 0510 أو على البريد الإلكتروني PALS@dgh.nhs.uk أو الكتابة إلى مشورة المريض أو خدمة التنسيق.

如果你想要得到这封信或这份资料的其他语言或格式的版本，例如大号字体版本或易读版本，或者如果您在与我们沟通方面需要帮助（例如因为你用英国手语而需要手语翻译），请告诉我们。您可以致电给0800 073 0510 或发电邮到PALS@dgh.nhs.uk，也可以写信给病人建议与联络服务中心。

Jeżeli chcą Państwo otrzymać ten list lub jakieś informacje w innym języku lub formacie, np. wydrukowany dużym drukiem lub w wersji uproszczonej bądź jeżeli potrzebują pomocy w komunikacji z nami, np. ponieważ używają brytyjskiego języka migowego, prosimy dać nam znać. Można do nas zadzwonić pod numer 0800 073 0510, wysłać nam e-mail PALS@dgh.nhs.uk lub napisać do Biura Porad dla Pacjentów (ang. Patient Advice and Liaison Service – PALS).

ਜੇਤ੍ ਸੀਂ ਇਹ ਚਿੱਠੀ ਜਾਂ ਜਾਣਕਾਰੀ ਕਿਸੇਬ ਦਲਵੀਂ ਭਾਸ਼ਾ ਜਾਂ ਰੂਪ ਵਿੱਚ ਲੈਣੀ ਚਾਹੋ, ਉਦਾਹਰਨ ਲਈ ਵੱਡੇ ਅੱਖਰਾਂ ਵਿੱਚ ਜਾਂ ਆਸਾਨੀ ਨਾਲ ਪੜ੍ਹੇ ਜਾ ਸਕਣ ਵਾਲੇਰ੍ਹ ਪ ਵਿੱਚ, ਜਾਂ ਜੇਤ੍ ਹਾਨ੍ਹੰ ਾਡੇਨ ਾਲ ਗੱਲਬਾਤ ਕਰਨ ਵਿੱਚ ਮਦਦ ਚਾਹੀਦੀ ਹੋਵ੍ੇ ਉਦਾਹਰਨ ਲਈ ਕਿਉਂਕਿ ਤੁਸੀਂ ਬ੍ਰਿਟਿਸ਼ ਸਾਈਨ ਲੈਂਗਵੇਜ਼ ਦੀ ਵਰਤੋਂਕ ਰਦੇਹੋ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇਸ ਾਨ੍ਹੰਦ ੱਸੋ। ਤੁਸੀਂ ਸਾਨ੍ਹੰ 0800 073 0510 'ਤੇ ਕਾਲ ਕਰ ਸਕਦੇਹੋ ਜ ਾ PALS@dgh.nhs.uk 'ਤੇ ਈਮੇਲ ਕਰ ਸਕਦੇਹੋ ਜ ਾ ਪੇਸ਼ੇਂਟ ਐਡਵਾਇਸ ਐਂਡ ਲਿਏਜਨ ਸਰਵਿਸ ਨ੍ਹੰ ੱਤਰ ਲਿਖ ਸਕਦੇਹੋ।

Daca doriti sa primiti aceasta scrisoare sau aceste informatii intr-o alta limba sau intr-un format alternativ (de exemplu, tiparit mare sau text simplificat) sau daca aveti nevoie de ajutor pentru a comunica cu noi (de exemplu, pentru ca aveti nevoie de un interpret in limbajul semnelor), va rugam sa ne anuntati. Puteti sa ne sunati la numarul de telefon 0800 073 0510 sau ne puteti trimite un e-mail la adresa PALS@dgh.nhs.uk; alternativ, puteti scrie Serviciului de Consultanta si Legatura pentru Pacienti.

اگر آپ کو یہ خط یا معلومات کسی متبادل زبان یا فارمیٹ میں، مثلاً بڑے حروف یا پڑھنے میں آسان متن درکار ہو یا آپ کو ہمارے ساتھ ابلاغ میں مدد درکار ہو مثلاً اگر آپ برٹش سائن لینگوئج استعمال کرتے ہوں، تو برائے مہربانی ہمیں بتائیں۔ ہمیں آپ 0800 073 0510 پر کال کر سکتے ہیں یا PALS@dgh.nhs.uk پر ہمیں ای میل بھیجیں یا پیشنٹ ایڈوائس اینڈ لیزان سروس کو خط لکھیں۔

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7th June 2018

TITLE:	Clinical Negligence Scheme for Trusts (CNST) incentive scheme compliance with the 10 maternity safety actions to the required standards.		
AUTHOR:	**Dawn Lewis** **Head of Midwifery**	**PRESENTER**	**Dawn Lewis** **Head of Midwifery**
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		

CORPORATE OBJECTIVE:

SO1: Deliver a great patient experience

SO2: Safe and Caring Services

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 background to the opportunity to apply for the CNST incentive scheme
- Issues that have been overcome to achieve some of the standards required
- Achievement of all 10 standards
- Evidence to assure the Trust Board of the achievement

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details** SAFE Are patients protected from abuse and avoidable harm 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
	NHSI	**N**	**Details:**
	Other	**Y**	**Details: NHS resolution- CNST**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD

To accept this paper as assurance that there is satisfactory evidence to show compliance and achievement of the 10 maternity safety actions to the required standard. This will then enable the Trust Board to sign the self-certification as accurate

Introduction

In December 2017 the Trust received a contribution notice (Appendix 1) from NHS Resolution, detailing the organisation's calculated contribution that was required by the Clinical Negligence Scheme for Trusts – CNST. The notification also included details of a maternity incentive scheme which would be implemented for 2018/2019.

The national Safer Maternity Care update to the Maternity Safety Strategy [11] sets out the Department of Health's ambition to reward those who have taken action to improve maternity safety. Obstetric claims represent the biggest area of spend for all CNST members around £500 million in 2016/17. Obstetric claims represent 10% of the volume and 50% of the value of all claims.

The maternity element of CNST contributions will be increased by 10% above all Trusts standard for the financial year 2018/19, to create a national maternity incentive fund. Maternity services that can demonstrate achievement of a specified set of 10 requirements detailed in the aforementioned notice letter will be eligible for a share of that incentive fund of at least 10% of their base contribution, plus a share of the balance of undistributed funds, the amount of which will be determined once the results from all services have been gathered. The specific 10 safety actions were detailed in a strategy document and will be explained in more detail within this paper. In order to qualify for refund of 10% of the premium the Trust must be able to demonstrate progress to the required standard against all 10 of the safety actions.

Maternity services that are unable to demonstrate achievement may be allocated a smaller sum from the fund to support them to implement the required actions.
The Trust was provided with full details for each action including the evidence required to demonstrate achievement and the proposed verifications process that would be undertaken. Once the full results are available for all maternity providers, NHS Resolution will confirm the value of the credit to be made to members.

Background

The Maternity Safety Strategy involves a number of initiatives with the overall aim of reducing stillbirth, perinatal deaths, maternal deaths and hypoxic brain injury. The intention is to make improvements in the areas of clinical care, multidisciplinary training, clinical leadership and overall leadership, involvement of women in the development of services and improving the quality of reviews when there are deaths or when babies show signs of brain injury due to hypoxia.

The Trust is heavily involved in the Maternity Transformation Programme (MTP) via the Local Maternity System (LMS) within the STP and the golden thread of safety runs through all of the workstreams in progress. Additionally the Perinatal Mental Health strategy is developing alongside the LMS work with the intention of improving perinatal mental health care for all women with additional needs. This is an important factor as mental health issues were the leading cause of indirect maternal mortality in the last MBRRACE report on maternal mortality in 2017. We have successfully piloted a perinatal mental health liaison clinic with staff from the Barberry unit in

[1] https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps

Birmingham for the past three months. The development of this clinic has been influential in the successful bid for a Black Country perinatal mental health liaison programme to continue this excellent work.

The Trust was successful in a bid for Maternity Safety Training funds in December 2016 and throughout 2017 we have utilised this money to send multi-disciplinary teams on a variety of identified courses. Theses have included Labour Ward Leadership, Human Factors, PROMPT, CTG analysis training, dealing with childbirth emergencies in community midwifery and neonatal life support. We are now embedding this learning into all of our pathways and processes.

The Trust is about to embark on the work of the Maternity Neonatal Safety Collaborative. A small multidisciplinary team (Head of Midwifery, Matron - Outpatients & Community, Governance Midwife and Consultant Obstetrician & Gynaecologist) attended the first of three learning events in May to enable the whole Maternity and Neonatal team to embark on a quality improvement programme focused on the aims of the Maternity Safety Strategy.

The development of multidisciplinary working within the team and the enthusiasm of all maternity staff to improve outcomes for women and their babies in our care has had a direct influence on the ability to achieve the 10 actions requested by NHS Improvement. A number of the actions were very easy to evidence as the work involved had been taking place for several years. Others required additional work to improve on the standards required, particularly around validity of data to a satisfactory standard.

One action in particular, Action 1 *evidence of use of the perinatal mortality review tool,* required the whole team to work efficiently and effectively in a short time frame. The review tool was not launched until February 2018; however the team have managed to use the tool to review all of the stillbirths and neonatal deaths reported via MBRRACE since January 2018, and gain additional learning from this process.

The Dudley Group
NHS Foundation Trust

Outline of 10 Safety Actions

Action 1- Are you using the National Perinatal Mortality Review Tool?

The National Perinatal Mortality Review Tool (NPRT) was launched in February 2018 providing a standardised approach to perinatal mortality. The tool is located within the MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) platform. The Trust already submits data related to perinatal mortality via MBRRACE and has done since its inception in 2013. The use of the Mortality Review Tool can be cross checked against cases reported via MBRRACE.

The multi-disciplinary team already had a process for reviewing all perinatal mortality within DGFT; namely reviewed at the weekly combined Obstetric & Neonatal Incident Review Meeting. This tool will enhance this process.

Despite the delayed release of the tool in February 2018, we have used the tool for all eligible cases since January 2018. The review of 8 cases has used the tool to date.

Action 2- Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

The Maternity Services Data Set (MSDS) collects information on each stage of care for women as they go through pregnancy. Since June 2015 there has been a requirement to submit this data centrally. Version 2.0 of the Maternity Services Data Set (MSDS) is currently in development, with go live planned for April 2019.

The Maternity Services Data Set (MSDS) sets out national definitions for the extraction of data for:

- routine booking appointment activities
- maternity care plan
- dating scan
- antenatal screening tests
- structural fetal anomaly screening
- labour & delivery
- newborn screening
- maternal or neonatal death

The MSDS provides a national standard for gathering data from Maternity healthcare providers in England. It covers key information captured from NHS-funded maternity services.

The MSDS will provide reliable information for:

- payment of Maternity Services
- local and national monitoring
- reporting for effective commissioning
- monitoring outcomes
- addressing health inequalities

A significant amount of work has been carried out by the Information team to ensure that DGFT are submitting data to the required standard. Trusts were required to accurately submit against 8 out of the 10 dataset criteria, to be judged as satisfactorily submitting to the required standard. DGFT reached 8 of the criteria in November 2017 and all 10 in December 2017.

Action 3- Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN programme?

The ATAIN programme has been developed to Avoid Term Admissions Into Neonatal units. Primarily the programme seeks to address the clinical care that can avoid or reduce the effect of respiratory conditions, hypoglycaemia, jaundice and asphyxia (perinatal hypoxia–ischaemia). Effective use of Transiotional care beds will also reduce the need for mother and baby to be separated for an admission of baby to the neonatal unit.

The neonatal unit and the maternity unit staff have been working collaboratively within a task and finish process to identify and address improvements in care that will lead to reduced admissions of term babies.

Additionally all midwives are being advised at their mandatory training sessions to complete the e-learning associated with the programme[2] which was launched in November 2017

Action 4 - Can you demonstrate an effective system of medical workforce planning?

The Royal College of Obstetricians and Gynaecologists developed a workforce monitoring tool that was shared with Trusts in March 2018. The requirement was to self-assess against a consecutive four week period in March or April. The intention was to evidence any Consultant Obstetricians acting down to fill middle grade sessions covering the labour ward. The required standard was for no more than 20% of sessions to be filled in this way.

[2] https://www.e-lfh.org.uk/programmes/avoiding-term-admissions-into-neonatal-units/

We do not utilise out consultant obstetricians in this way and so we are compliant with this action. The Clinical Director submitted our return to RCOG, providing this evidence.

Action 5 - Can you demonstrate an effective system of midwifery workforce planning?

Birthrate plus is generally accepted as the most reliable way to assess midwife to birth ratios. In January 2017, in response to a paper written by an external midwifery advisor, the Head of Midwifery presented a staffing paper to the Executive Directors Meeting. The paper included the Birthrate Plus table top calculation advising on the number of midwives required to deliver the service. The Head of Midwifery also requested that a full Birthrate plus assessment be commissioned in order to properly assess the acuity of the women using our services. There was agreement from the Executive Board and a full Birthrate Plus assessment was commenced in February 2018, is in progress, and is now nearing its conclusion.

In addition to the Birthrate Plus calculation the Head of Midwifery utilised the Table 6 Benchmark exercise in November 2017 to allocate the midwifery staff required to safely deliver the whole service based on the current establishment.

Action 6- Can you demonstrate compliance with all 4 elements of the Saving babies Lives (SBL) care bundle?

Saving Babies' Lives is designed to tackle stillbirth and early neonatal death and a significant driver to deliver the ambition to reduce the number of stillbirths, bringing four elements of care together:

1. Reducing smoking in pregnancy
2. Risk assessment and surveillance for fetal growth restriction
3. Raising awareness of reduced fetal movement
4. Effective fetal monitoring during labour

The package was developed by groups brought together by NHS England, including midwives, obstetricians and representatives from stillbirth charities. Though the NHS already follows much of this best practice, this is the first time that guidance specifically for reducing the risk of stillbirth and early neonatal death has been brought together in a coherent package.

The Trust has been submitting data since 2014 when the care bundle was in development. Each of the four elements of the care bundle has a number of metrics to evidence the degree of compliance. The Trust can show implementation and compliance with each of the elements. The maternity team continue to look at ways to improve and to this end we have attended to the two regional days led by the

Maternity Network to look at good practice across the country. The Matron and Head of Midwifery have also met with the Quality Improvement Officer from West Midlands Quality Networks to identify potential ways to improve compliance and effectiveness of the four elements.

Action 7 – Can you demonstrate that you have a patient feedback mechanism for maternity services, such as Maternity Voices Partnership Forum and that you regularly act on feedback?

A Maternity Voices Partnership (MVP) is a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

The MVP has superseded maternity services liaison committees (MSLC) which many Trusts had continued to support a local MSLC after the PCTs dissolved. Unfortunately in Dudley when the PCT dissolved the MSLC also ceased.

In order to have a formal mechanism to gauge the views of women and their families in the developments in maternity services the team felt it important to develop an MVP for Dudley. Working with our partners within the Clinical Commissioning Group the first meeting of the newly formed MVP was held in February 2018 with representation from service users, providers, commissioners and Healthwatch. A service user rep volunteered and was accepted as the new Chair of the group. As this group develops it will increasingly be involved in all decisions about the transformation of maternity services.

In addition the Trust has organised a Whose Shoes? ® event in March 2018. An exciting approach to service development, allowing you to 'walk in other people's shoes'. Through a very wide range of scenarios and topics, Whose Shoes?® tools help you explore many of the concerns, challenges and opportunities facing the different groups affected by the transformation of maternity services.

The use of comments from the Friends and Family returns has allowed the service to utilize the ‘you said ,we did’ approach. Each month an example of this feedback and actions that have resulted is included within the divisional governance meeting and within the Divisional Performance Review meeting presentation to Executive directors.

Action 8- Can you evidence that 90% of each maternity unit staff group have attended an ‘in house’ multi professional maternity emergencies training session within the last training year?

In house multi-professional training for midwives and obstetric staff for emergency situations has been a feature of mandatory training for a number of years. In 2017 a multi-disciplinary team including anaesthetic staff attended education and training sessions funded by money from the Maternity Safety Training fund. The plan moving forward for maternity emergencies training in 2018/19 is to utilise the PROMPT model together with Human Factors and include all staff involved in the multidisciplinary team for maternity care. In order to ensure that all maternity theatre and anaesthetic staff had attended multi-disciplinary emergency training sessions within the last 12 months additional sessions were planned and executed with midwives, obstetricians and support staff.

This has resulted in over 90% compliance for emergency skills training for all staff groups in the maternity multidisciplinary team.

Action 9- Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?

In April 2017 the Head of Midwifery was asked by the new Chief Nurse to combine all of the existing action plans in maternity into one Maternity Improvement plan. This included actions related to improved safety.

Since May 2017 the improvement plan together with the maternity dashboard has been presented by the Head of Midwifery and the Clinical Director for women's and children's directorate, both of whom are the maternity safety champions, at the Clinical Quality Safety and Patient Experience Board, on a monthly basis. The CQSPE membership includes the Board level maternity champion together with other member of the Executive and Non-Executive team. This has allowed for discussion, challenge, questioning and support . this process has led to a greater understanding of the challenges in maternity services together with a Trust commitment to support the development and improvement of the service.

Action 10- Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme?

The Trust governance department takes this responsibility. With the development of the Early Notification Scheme a process was developed to ensure good communication of potential cases to the Trust Patient Safety Officer via the Governance and Risk midwives. This process has worked well to date and 100% of qualifying incidents have been reported via the electronic platform.

The Dudley Group
NHS Foundation Trust

Board report on The Dudley Group NHS Foundation against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

Date: 15th May 2018

SECTION A: Evidence of Trust's progress against 10 safety actions:

W:\Maternity\CNST Incentive scheme maternity for folders containing evidence for each action- All Trust Board member should have access to this folder.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	• Evidence is held on perinatal mortality review tool. • Screen shots provided to Board as evidence of cases added • MBRRACE data will be utilised NHS R to cross check against cases reviewed NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.	**Yes**
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required	• Submissions to NHS Digital • Email included on 'W' drive confirming satisfactory submission of all 10 elements • NHS Resolution will also use data from NHS Digital to verify the Trust's	**Yes**

standard?	progress against this action.	
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	• Notes of task and finish group working to improve compliance with ATAIN programme • BAPM standards included to cross reference actions taken • Physical presence of Transitional Care facility on a day to day basis • BadgerNet records of babies cared for as transitional care NHS Resolution will cross-check trusts' self-reporting with Neonatal Operational Delivery Networks to verify the Trust's progress against this action.	**Yes**
4). Can you demonstrate an effective system of medical workforce planning?	• Copy of completed templates supplied by RCOG • Confirmation email from RCOG of receipt of submission W:\Maternity\CNST Incentive scheme maternity\Action 4\Copy of WC 2.4.18.xlsx	**Yes**
5). Can you demonstrate an effective system of midwifery workforce planning?	• Copy of paper submitted to weekly Executive Directors meeting • Above includes Birthrate plus table top exercise • Table 6 from NICE safer staffing – also submitted as CQC evidence following the inspection in December • Confirmation of Birthrate Plus full review	**Yes**
6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives	• Copies of the quarterly submission of compliance for Saving Babies Lives for the past year	**Yes**

(SBL) care bundle?		
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	• Maternity Voices Partnership minutes of newly formed group meeting • Friends and family feedback 'You said, We did' log for past year • The Graphic from the recent Whose Shoes event which is being used by the Local Maternity System to identify the areas for action by the Black Country LMS	**Yes**
8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	• Evidence of all attendances at the multi disciplinary emergency skills drills training. • Additional sessions held to include anaesthetic and theatre staff	**Yes**
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	• Minutes of the monthly CQSPE meeting for the past year evidence of the Head of Midwifery and Clinical Director discussing the safety improvements and the dashboard with both Executive and Non-Executive board members.	**Yes**
10). Have you reported 100% of qualifying 2017/18 incidents under NHS Resolution's Early	• Email evidence of the submissions made by Trust Governance team to the NHS Resolution's Early Notification scheme.	**Yes**

Notification scheme?		

SECTION B: Further action required:

If the Trust is unable to demonstrate the required progress against any of the 10 actions, please use this section to set out a detailed plan for how the Trust intends to achieve the required progress and over what time period. Where possible, please also include an estimate of the additional costs of delivering this.

The National Maternity Safety Champions and Steering group will review these details and NHS Resolution, at its absolute discretion, will agree whether any reimbursement of CNST contributions is to be made to the Trust. Any such payments would be at a much lower level than for those trusts able to demonstrate the required progress against the 10 actions and the 10% of the maternity contribution used to create the fund. If made, any such reimbursement must be used by the Trust for making progress against one or more of the 10 actions.

SECTION C: Sign-off

……..

For and on behalf of the Board of The Dudley Group NHS Foundation Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Position: **……**

Date: **……..**

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

……..

SECTION D: Appendices

Please list and attach copies of all relevant evidential appendices:

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 7th June 2018

TITLE:	Safeguarding Annual Report		
AUTHOR:	Christina Rogers Head of Safeguarding	**PRESENTER:**	Christina Rogers Head of Safeguarding
CLINICAL STRATEGIC AIMS			
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: SO2: Safe and Caring Services			

SUMMARY OF KEY ISSUES:

The report provides the annual report details safeguarding activity for 2017/18, informing the Trust Board on service developments in place to safeguard children and adults.

This report provides assurance to the Board that The Dudley Group NHS Foundation Trust (DGFT) is fulfilling its statutory responsibilities in relation to safeguarding children and adults who access services from the Trust.

Safeguarding activity across the Trust continues to intensify in volume and intricacy, the Safeguarding Team is committed to ensuring the provision of an integrated and highly robust safeguarding service for all ages.

Key Issues

There are a number of local influences in addition to the national context which continue to drive focus and demand for the Safeguarding Agenda within DGFT these encompass:

- Care Quality Commission (CQC) recommendations following 'Requires Improvement' Rating
- Growth in demand (with an increasing aged population/ greater awareness/ higher levels of scrutiny)
- Continued emphasis upon 'voice of the child' and 'making safeguarding personal'
- An extension of the categories of risk to include self-neglect and hoarding for Safeguarding Adults
- Continued drive and focus on radicalisation and the PREVENT agenda
- Increase in Serious Case Review (SCR), Serious Adult Review (SAR) and Domestic Homicide Review (DHR)
- Increase in safeguarding referrals for both children and adults.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:**
	Risk Register: Y		**Risk Score:** To be added and reviewed
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** SAFE: Are patients protected from abuse and avoidable harm
	NHSI	**Y/N**	**Details:**
	Other	**Y/N**	**Details:**

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

RECOMMENDATIONS FOR THE BOARD: This report outlines the work undertaken and in progress to safeguard children and adults within DGFT. Trust Board members are requested to note the report, the improvements made during 2017/18 and the priority areas for implementation during 2018/19.

NHS
The Dudley Group
NHS Foundation Trust

Safeguarding Annual Report 2017/18

The Dudley Group
NHS Foundation Trust

Safeguarding Annual Report
April 2017 – March 2018

The Dudley Group NHS Foundation Trust

CONTENTS

1.1 Foreword

The Dudley Group NHS Foundation Trust (DGFT) recognises that effective, timely and robust safeguarding is fundamental to protecting those at risk in our care and that this requires constant vigilance and a readiness to act where we suspect abuse, exploitation or neglect. The landscape of safeguarding is constantly evolving and as a Trust we endeavour to embrace and shape our key priorities in support of this. DGFT is an organisation with a vital role to fulfil in protecting the vulnerable whilst demonstrating a concerted obligation to respond with haste and flexibility to meet new demands as they arise. Above all, we are dedicated to ensuring that we listen to the voices of the vulnerable and act upon what we hear. Safeguarding is everyone's business.

"Safeguarding helps all children and adults who are at risk of abuse.
It protects children from harm and neglect and provides them with the best chance of developing into happy, well-adjusted and successful adults.
It brings kindness, respect, dignity and support to vulnerable adults, however challenging their lives may be, and protects them from harm.
It falls to all of us in the NHS to give our best efforts to these endeavours."
Ref: Dr Peter Green, Chair, National Network of Designated Health Professionals and Designated Doctor for Child Safeguarding, NHS Wandsworth CCG

1.2 Introduction

1.3 The statutory duties and Trust responsibilities for safeguarding children are set out in the Children Act 1989 and 2004 and Working Together to Safeguard Children 2015, a revised document which supersedes Working Together 2013, furthermore for Safeguarding Adults the Care Act 2014. Effective safeguarding and promotion of the welfare of children, young people and adults relies upon joint working and constructive relationships that are conducive to robust multi - agency partnership working. This can only be effective when all staff are knowledgeable, confident and equipped with the skills to deal with process and procedures when concerns arise relating to patient safety.

1.4 The annual report covers the period of April 2017 to March 2018 and will provide assurance to the Board by detailing priorities and activity, highlighting areas requiring focus and development and to inform of the intervention and change that has been made to strengthen the safeguarding processes within The Dudley Group NHS Foundation Trust (DGFT). Safeguarding has a high emphasis on a competent well-established workforce; up to date policies and procedures, robust governance arrangements and collaborative practices. This report details how this has been achieved in 2017/18.

1.5 The Care Quality Commission (CQC) undertook an inspection at DGFT between December 2017 and January 2018. As a result of this inspection, the trust received a rating of 'Requires Improvement'; with safeguarding practice being an area of specific concern. Furthermore this report will encompass key objectives and the proposed safeguarding strategy for 2018-21, to strengthen safeguarding systems, processes and practice within the Trust.

2. National Guidance and Key Legislation

2.1 Key Legislation

Children Act 1989
Human Rights Act 1998
Sexual Offences Act 2003
Female Genital Mutilation Act 2003
Data Protection Act 1998
United Nations Conventions on the rights of the child 1990
Children Act 2004; statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11
Children and Young Persons Act 2008
Mental Health Act 1983
Human Rights Act 1998
Article 5 - Right to Liberty and security
Article 8 - Respect for Private and family life
Article 14 - Prohibition of discrimination
Mental Capacity Act 2005
Health & Social Care Act 2008
Deprivation of Liberty Safeguards 2009
Care Act 2014
Counter Terrorism and Security Act 2015
Serious Crime Act 2015

2.2 **National Guidance**

Working Together to Safeguard Children 2015
PREVENT duty guidance 2015
RCPCH 2014 Intercollegiate Document - *Safeguarding children & young people roles and competencies for healthcare staff*
CQC Fundamental Standards *Statement on CQC's roles and responsibilities for safeguarding children and adults* June 2015
FGM enhanced data set 2015

3. The Dudley Group NHS Foundation Trust Safeguarding Team

3.1 The Safeguarding Team aim to ensure that all children and adults are effectively protected when using services provided by DGFT and that processes are robust for the early detection of abuse and neglect and the corresponding referral procedures. Working Together (2015) highlights that staff working within the Trust:

- Understand risk factors and recognise children and adults in need of support and/or safeguarding.
- Recognise the needs of parents who may need extra support in meeting the needs of their children and know where to refer for help.
- Recognise the risks of abuse or neglect.
- Communicate effectively with children and adults and stay focused on the child and / or adult's safety and welfare.
- Liaise closely with other agencies including other health professionals and share information as appropriate.

The Safeguarding Team:

- Provide advice, support and guidance to members of staff regarding safeguarding children matters.
- Ensure relevant policies and procedures are in place to support all staff.
- Provide supervision to staff to support areas of challenging work ensuring the focus of work remains on the safety and wellbeing of the child and / or adult concerned.
- Provide training and education for all staff to support them with their safeguarding work.
- Support staff in the production of statements to court or attendance at court for matters relating to safeguarding children.
- Undertake a programme of audit to provide assurance.
- Work closely with key stakeholders and other agencies to safeguard children.
- Supporting the Trust in governance arrangements.
- Disseminating good practice and learning outcomes across the organisation.
- Liaising with other agencies as a point of contact for safeguarding issues.
- Maintaining regular attendance at the partnership board meetings and sub groups.

3.2 Safeguarding Team; April 2017 – March 2018

3.3 It is recognised that safeguarding is a continuously evolving phenomenon with work stream demands increasing which then has resource and capacity implications. The Safeguarding Team has seen a period of instability during the course of 2017 to 2018; this has led to a team restructure to ensure safe service delivery and ensure the safeguarding improvement plan continued with momentum and pace. The recruitment to the Head of Safeguarding has provided the team with leadership and stability to ensure thorough oversight of the safeguarding agenda; including a full and systematic review of team processes and procedures.

2017		2018	
Designation	**WTE**	**Designation**	**WTE**
Named Nurse Safeguarding Children	0.5 WTE	Head of Safeguarding	1 WTE
Named Midwife	1 WTE	Named Nurse Safeguarding Children	1.5 WTE
Specialist Midwife for Substance Misuse	1 WTE	Named Midwife	1 WTE
Named Nurse Safeguarding Adults	1 WTE	Specialist Midwife for Substance Misuse	1 WTE
Lead Nurse Learning Disabilities	1 WTE	Named Nurse Safeguarding Adults	1 WTE
		Lead Nurse Learning Disabilities	1 WTE
Liaison Nurse Vulnerable Adults	0.8 WTE	Liaison Nurse Vulnerable Adults	0.8 WTE
		Peadiatric Liaison Nurse	1 WTE
Named Doctor for Safeguarding Children	1 WTE	Named Doctor for Safeguarding Children	1 WTE
Named Consultant for Safeguarding Adults	1 WTE	Named Consultant for Safeguarding Adults	1.WTE
Administrative support	0.4 WTE	Administrative support	1.0 WTE (TBC)

4 Safeguarding activity and performance for 2017/18

Safeguarding activity across DGFT has continued to intensify in volume and Complexity which is reflected both nationally and regionally, the Trust is committed to ensuring the provision of an integrated and highly robust safeguarding service for all ages.

4.1 Governance

Safeguarding was previously led by the Deputy Chief Nurse in 2016/17. In 2017, the newly appointed Chief Nurse recognised safeguarding as a priority which required executive leadership. This led to further development of the Internal Safeguarding Board to oversee the safeguarding agenda and resultant improvement plan and has served to strengthen and drive the safeguarding agenda forward. The frequency of the meeting has continued to be monthly with executive chairing from June 2017. Furthermore, the adult and children safeguarding team became formally integrated with relocation to the central safeguarding hub in order to streamline and strengthen the safeguarding agenda within DGFT.

The Internal Safeguarding Board is a subcommittee of the Clinical Quality and Patient Safety and Experience board gaining assurance on behalf of the Trust Board that its legal and statutory duties are met in respect to the safeguarding of adults, young people and children.

The Internal Safeguarding Board acts as a conduit for the following agendas and has representatives from the health economy, including, the Designated Nurse for Safeguarding:

- Safeguarding adults – including compliance with the Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DOLS), and the Mental Health Act (MHA).
- Response to the Trusts duties as part of the PREVENT strategy, working with partner agencies across the health economy.
- Safeguarding children – including domestic abuse, child sexual exploitation and female genital mutilation
- Gaining assurance from the Divisions that responses to external or internal inspection reports are met and that risks are managed and mitigated accordingly
- The Trust upholds its reputation and meets its responsibilities in relation to the Dudley Safeguarding Children and Adult's Boards and associated sub-groups.

4.2 Risk Register review

A robust Risk Register is required to ensure safe, effective and robust management of risks pertaining to safeguarding of children, young people and adults. The identification of safeguarding risks is fundamental to providing assurance of continued improvement and mitigation of risk. The corporate risk register has four risks pertaining to safeguarding which are graded at amber. No high risks have been identified within the time frame of this report.

4.3 Trust electronic flagging system

During 2017/18, the Trust had an electronic flagging system this has been led by the Governance Team. Children subject to a Child Protection Plan, either currently or formally are flagged within the electronic health system. A key priority for 2018 is to

review the internal electronic flagging system is to support a more robust process to facilitate the identification and recognition of children and adults with vulnerabilities who present to the Trust. This needs to include a review of the existing flags in place to ensure that they capture key vulnerabilities. Furthermore, management and monitoring of the current process is led by the Information Governance Manager, it is recognised that this needs to be led by the Safeguarding Team. In recognition of this risk, safeguarding administrative support is required to effectively manage this process.

4.4 Partnership working

For 2017/18, the Trust has contributed to engagement and effective partnership working and recognises the significance of its utilisation to shaping and informing safe safeguarding systems, processes and practice. Representation has been provided for both safeguarding Boards (DSCB and DSAB) and corresponding subgroups, however representation has not been consistent and due to reduced capacity within the safeguarding team, attendance has not always been achieved.

The Trust is a virtual member of the Multi Agency Safeguarding Hub [MASH] for adults & children. This process is for the multi-agency sharing of information where safeguarding concern arises and facilitates effective collaboration. The timescale to provide responses are time limited and place significant pressure to gather information from across the relevant division and respond.

4.5 Safeguarding Training

For the time frame of this report, mandatory safeguarding training has been subject to an in-depth review with a focus upon training needs analysis and workforce requisites. It had been recognised that present training in place did not meet the expected statutory requirements. The new mandatory training structure in place for both adults and children's safeguarding will be reflective of current statute and guidance and will support staff with the knowledge, skills and expertise required to effectively recognise and respond to safeguarding. Below is a table of the training figures as of 31st March 2018. All expected Trust trajectories are 90%, however the trajectory for WRAP is marked against a local target of 65% against a national target of 85%.

Safeguarding Adults level 1 and 2	88.7%
Safeguarding Children level 1 and 2	90%
Safeguarding Children level 3	83.1%
Mental Health Training and DoLs	81.8%
PREVENT	90.9%
WRAP	69.2%

4.6 Safeguarding Supervision

4.6.1 Safeguarding supervision involves a retrospective review of safeguarding cases with a trained safeguarding supervisor. The process provides a structured format in a one to one or group setting that involves both reflection and direction regarding case management. The aim of this framework is that it will support a variety of models of clinical supervision that can be developed in accordance with local circumstances and staff developmental needs; improving overall accountability and standards of

practice at the frontline.

4.6.2 The RCPCH (2014) identifies that case holders for child protection should receive supervision on a quarterly basis comprising of a 1:1 meeting. Safeguarding supervision has commenced within 2017/18 for the Community Midwives. Group supervision is also provided to the Diabetes team and also to Neonatal community team, however it is recognised that further development is required within this area to ensure all identified key staff groups are provided safeguarding supervision on a group basis. Sexual Health Services have also been identified as a staff group to receive supervision to support with safeguarding concerns and the identification and management of child sexual exploitation.

4.6.3 Safeguarding supervision for safeguarding adults has not been a mandatory requirement within the time frame of this report, however supervision has been offered to staff at the point of need on an ad-hoc basis.

4.6.4 In 2018, further development is required to ensure effective policy and guidance is in place which is supported by efficient record keeping documentation for all supervision sessions. Furthermore, monitoring of compliance with provide appropriate oversight.

4.7 Audit and Quality Assurance

The Safeguarding Team devised an audit programme which has been reviewed within the time frame of this report, this is provided as an appendix. Further development within this area is required with a need to consider a quality assurance framework to include the existing audit programme, whilst being responsive to issues faced by the Trust and practitioners; ensuring it also meets the commissioners' requirements. The Trust has continued to support DSCB and DSAB with external audits and is committed to meeting its statutory and regulatory requirements in this area. Within the time frame of this report a Section 11 (CA 2004) and Adult safeguarding assurance audit (Care Act 2014) has not been due.

4.8 Safeguarding Team current capacity and resource

The current TUPE process with Black Country Partnership Foundation Trust and the transfer of two safeguarding posts (Lead Nurse Child Death and Paediatric Liaison Nurse) to DGFT has presented capacity challenges as it is highly probable that both posts will transfer to DGFT as vacant posts. By way of risk mitigation, prompt communication has been cascaded in respect to the provision of both posts being presented as secondment opportunities. Furthermore, this will be added and monitored via the Trust Risk Register. Review of the Safeguarding Team has taken place by the Chief Nurse, giving due consideration to the provision of sound strategic leadership, operational management, performance, roles and responsibilities and staffing requirements; in order to bring together the safeguarding of children, young people and adults, enabling a strong effective interface between all three. A risk has been identified in respect to lack of adequate administrative support within the team; this will be added to the safeguarding Risk Register. Further review in this area is required to ensure that the role and responsibilities of all safeguarding team members including, the named doctor for safeguarding children and young people is communicated and understood by all relevant practitioners and senior staff.

4.9 PREVENT Strategy

The Prevent Strategy is a cross-government policy that forms one of the four strands of CONTEST; the Government's Counter Terrorism Strategy. Its focus is the safeguarding and protection of vulnerable individuals who may be at a greater risk of radicalisation. The fact that the NHS facilitates in excess of 1 million patient contacts every 36 hours has led to it being seen as a major player in the support and delivery of the Strategy at Government level. Statutory frontline staff have been identified as a key group that can make an important contribution to the identification of and provision of support to individuals who may be vulnerable to radicalisation by violent extremists. This has created a significant training need as awareness and understanding of the Prevent agenda amongst many frontline staff is minimal or non-existent. Contest has four key areas:

- **Pursue:** to stop terrorist attacks
- **Prevent:** to stop people becoming terrorists or supporting terrorism
- **Protect:** to strengthen our protection against a terrorist attack
- **Prepare:** to mitigate the impact of a terrorist attack.

Healthcare professionals have a key role in Prevent where the focus is on working with vulnerable individuals who may be at risk of being exploited by radicalisers and subsequently drawn into terrorist-related activity. Prevent does not require healthcare staff to do anything in addition to normal duties. What is important is that where staff have concerns that a vulnerable individual is being exploited in this way, systems are in place for them to safely, sensitively and confidentially raise these concerns ***'in a non-criminal*** context' in accordance with the Trust's policies and procedures.

Support for vulnerable individuals may be arranged and provided through the local multi-agency partnership group called Channel. Dudley Channel group provides a mechanism for supporting people who may be vulnerable to violent extremism by assessing the nature and extent of the potential risk and, where necessary, providing an appropriate support package tailored to the specific needs of the individual. A multi-agency panel, chaired by Dudley Local Authority, decides on the most appropriate action to support individuals, taking their circumstances into account. In order to achieve this it is important for staff to attend *Workshops for Raising Awareness of Prevent (WRAP) sessions* provided by DGFT and for staff to be sure that they are:

- Aware of their professional responsibilities, particularly in relation to the safeguarding of vulnerable adults and children
- Familiar with the Trust's protocols, policies and procedures
- Aware of whom within DGFT should be contact to discuss your concerns
- Aware if the processes and support available when concerns are raised
- Aware of current patient confidentiality policies.

4.10 Learning Disability

NHS England continues regional roll out of a Learning Disabilities Mortality Review (LeDeR) Programme. NHS England is committed to ensuring that people with learning disabilities receive the right care in the right settings, with the right support. This is one of their national priorities. NHS England state the urgent need to understand and reduce health inequalities amongst this group, which is why, as part of their programme of work they have commissioned the Learning Disabilities Mortality Review (LeDeR) Programme. Further work is being developed within this

area including training staff to undertake reviews, this will support the timeliness of the process. The Trust has a dedicated Learning Disability Strategy which is due for review in 2018.

4.10 Key areas of vulnerabilities including, Domestic Abuse, FGM and CSE

The Trust has commenced improvement within priority areas with a focus upon training provision; this will be reported upon in the next Annual Report. Furthermore, developments are in progress in relation to the Trust electronic flagging system in relation to identification of vulnerable patient groups.

Key objectives for 2018/19

Key objectives have been detailed within the Improvement Plan 2018/19 and the Safeguarding Strategy 2018/21 (both appendix items). The CQC recommendations have been incorporated and reflected within both documents.

Conclusion

A review of safeguarding within The Dudley Group NHS Foundation Trust has took place which has highlighted a series of areas requiring focus and improvement; this has led to an Improvement Action Plan being formulated and added to the overarching Trust CQC improvement plan to ensure that quality assurance remains at the forefront of the Safeguarding Team. Furthermore, a Safeguarding Strategy 2018/21 has been developed to strengthen a Trust wide concerted focus. Although work has been completed, the team remain committed to continue to embed changes and demonstrate an on-going awareness that the focus of work will always require a continual review of service outcomes to maintain quality assurance and effective service delivery.

Appendix: 1

Trust vison and values

Appendix: 2

Audit plan 2018/19

Appendix 3

Safeguarding Improvement Plan 2018

The Dudley Group
NHS Foundation Trust

SAFEGUARDING STRATEGY

2018 - 2019

CONTENTS PAGE

The Dudley Group NHS Foundation Trust

Safeguarding Strategy for Children, Young People and Adults

2018-2021

Introduction

This is the first Safeguarding Strategy for The Dudley Group NHS Foundation Trust in relation to children, young people and adults as an integrated service. The strategy outlines the objectives the Trust will achieve over the next three years to strengthen its safeguarding arrangements whilst working in partnership with other key stakeholders.

This strategy sets out how we will improve services in five key domains:

- Mainstream safeguarding children, young people and adults into everyday business
- Effective safeguarding structures and governance
- Learning through experience and the development of knowledge and skills for staff
- Engaging with service users
- Working in partnerships

Our Duties

All providers of healthcare services are required to be registered with the Care Quality Commission (CQC). In order to be registered, providers must ensure that those who use the services are safeguarded and that staff are suitably trained, skilled and supported.

The government has published guidance to all NHS organisations on their responsibilities to safeguard children and adults at risk. Part 1 of the Care Act 2014 came into force on the 1st April 2015; this establishes a clear legal framework for how local authorities and other statutory agencies should protect adults with care and support needs who are at risk of abuse or neglect.

CQC outcome 4 and 7 for adults includes the implementation of the Mental Capacity Act and the Deprivation of Liberty Safeguards. Outcome 7 also relates to children.

Section 11 of the Children Act 2004, places a statutory duty upon the Trust to ensure its functions are discharged with regard to the need to safeguard and promote the welfare of children (including young persons).

Standards for better Health, DH 2004, include safeguarding children within the 'safety' domain. Core standard two states:

"Healthcare organisations protect children by following national child protection guidance

within their own activities and in their dealings with other organisations"

As a health provider we are required to demonstrate and evidence that we have safeguarding leadership and commitment at all levels of the organisation, and that we are fully engaged and in support of local accountability and assurance structures, in particular via the Dudley Safeguarding Children Board , Dudley Safeguarding Adults Board and commissioners.

Our Vision

There will be a whole organisational approach to safeguarding and promoting the welfare of children, young people and adults. Safeguarding and promoting the welfare of children, young people and adults will be embedded across all divisions and services provided by the Trust and in every aspect of the Trust's work. There will be robust governance arrangements around the safeguarding agenda and all staff working within The Dudley Group NHS Foundation Trust will be able to discharge their statutory responsibilities within their professional boundaries. Shared learning will enhance and shape service provision. The patient and carer's experience will be enhanced by the provision of effective partnership working with other agencies, which will aid seamless service provision.

Our Aims

Mainstream Safeguarding Children, Young People and Adults

Safeguarding and promoting the welfare of all children, young people and adults will be reflected in all areas of the Trust activities and business.

Effective Safeguarding Structures and Governance

Safeguarding children, young people and adults will be under taken by everyone; however there will be staff employed in dedicated roles and structures within the Trust. This will provide a framework that supports best practice and allows the Trust to fulfil its key responsibilities. All Trust business and activity relating to safeguarding will follow the Trust's governance processes for oversight and monitoring purposes

Learning through experience and development of knowledge and skills

We will systematically learn through experience and ensure that services are developed and monitored through these opportunities. Staff will demonstrate the values and competence required to effectively safeguard and promote the welfare of children, young people and adults.

Engaging with service users

We will work together with families in relation to safeguarding and promoting the welfare of children, young people and adults to shape services that are meaningful and have positive outcomes.

Working in Partnerships

We will work professionally and in partnership with key agencies to protect, promote and provide services that meet all statutory regulations and local requirements of the population that we serve.

The Trust will use this strategy over the next 3 years to drive forward the Safeguarding agenda across the organisation. The Trust's promises and standards will underpin the strategy in the way we conduct our daily business to improve services, enhance quality and positively impact on the patient; service user's and staff experience.

BENCHMARKING AND STRATEGIC PERFORMANCE SCHEDULE 2018-2021

Where we are now 2017/2018	Where we want to be 2020/2021
Mainstreaming safeguarding • Incorporated into some Trust processes (clinical incident reporting, Human resources processes, RCA's) • Relevant policies available • Ad hoc audits available for specific topics related to clinical practice • Safeguarding intranet page available for children services • Safer recruitment and DBS processes in place • Variance in safeguarding practice between departments.	• Robust Trust processes widely used across the organisation and easily accessible for all staff • Library of safeguarding policies that are accessible, relevant and updated and available for staff guidance • Departmental audits widely untaken relating to safeguarding issues to identify and improve clinical practice • Integrated children's, young person and adults HUB page for information and communication Trust wide and for use by partner agencies and service users • Robust monitoring of HR processes and compliance with safeguarding legislation in relation to recruitment • Comparative information relating to clinical practice in all wards/depts. which will impact on outcomes for service users.
Effective safeguarding structures and governance • Established safeguarding Committee • Ad hoc reports for Trust Board • Review and redesign of the Safeguarding Team • Full integration of the children and adult's team to address operational issues, combine governance and provide robust cross-cover. • Ad hoc representation at partner agency meetings • Safeguarding not an agenda item at all divisional meetings • Adults and children's reports not yet integrated	• An effective Safeguarding Committee that oversees and monitors all safeguarding business and activities. • Regular and scheduled safeguarding reports that inform the Trust board of daily business and risks. • Regular and scheduled attendance at all partner agency meetings (as appropriate) • Safeguarding Champions to promote the profile and importance of safeguarding across the Trust • Programme of work and effective use of the Safeguarding champions across the Trust • Divisional Quality Teams that discuss safeguarding as an agenda item

Learning through experience and the development of knowledge and skills • A proportion of mandatory safeguarding training attendance is below acceptable levels (level 1,2,3, DOLS and mental capacity) • Safeguarding not routinely discussed at IPDR Trust wide • Serious case reviews/ RCA's and clinical incident investigations are not shared widely across the Trust for learning purposes (ad hoc events in the community) • No integrated forward Audit plan in place for safeguarding	• Provision of a new safeguarding training strategy • Implementation of the training strategy • Improvement in training attendance to achieve targets agreed with the CCG • All key staff groups to have received Supervision in line with the revised Supervision policy • All staff to have safeguarding addressed at their IPDR • Process in place for sharing learning relating to RCA's, clinical incidents and serious case reviews Trust wide • Provision of a robust integrated safeguarding forward audit plan
Engaging with service users • We engage with service users and their families individually but not in a systematic or standardised way • No patient information available for service users	• Provision of patient information that informs families of our statutory duties to safeguard children, young people and adults • Functional focus group to assist us with shaping services • Annual patient experience feedback reports
Working in Partnership • Executive attendance at DSCB and DSAB • Ad hoc attendance at some agency sub group meetings from various members of the safeguarding team • Some interface with processes to share information with partner agencies • Review of the TOR's and appropriateness of Trust staff attending all interagency meetings.	• Continued attendance at DSCB and DSAB with regular communication at a senior level to inform/direct the wider safeguarding agenda across the economy. • Planned programme of attendance at partnership agencies and sub groups with evidence of effectiveness. • I.T systems that interface and 'information sharing agreements' in place to aid seamless service provision and communication between agencies.

Final Dudley Group NHS Foundation Trust - Single Agency Audit Programme/Calendar 2018/19

Month	Audit area	Audit Process	Timescale	Responsible person/Lead	Presented	RAG rating
April 2018	Safeguarding Children	DSCB external audit : Undertake Section 11 audit	Completion May 2018	Named Nurse Safeguarding Children		
TBC: July 2018	Safeguarding Adults	DSAB external audit: Assurance Audit Tool	Plan: Annual completion	Named Nurse Safeguarding Adults		
May 2018	Safeguarding Adults and Children's	Audit of level of recognition of adult issues that may affect their ability to parent their children or pose a risk of harm to their children e.g. substance misuse, mental health issues and domestic abuse who attend the Emergency Department	Completion August 2018	Named Nurse Safeguarding Children/Named Nurse Safeguarding Adults/Lead Nurse Emergency Department/Vulnerable Adults Liaison Nurse/Paediatric Liaison Nurse		
May 2018	Safeguarding Children	DSCB and NSPCC– Harmful Sexual Behaviours Audit	June 2018	Named Nurse Safeguarding Children (with support from ED, CASH, GUM, Peaditrics and Maternity)		
June 2018	Safeguarding Children	Safeguarding Children Referral forms completed –	Completion October 2018	Named Nurse Safeguarding Children		

		Quality assurance to be undertaken using audit tool specific to this. Random selection of 50 referral forms.				
June 2018	Safeguarding Adults	Safeguarding Adult Referral forms completed– Quality assurance to be undertaken using audit tool specific to this. Random selection of 50 referral forms.	Completion October 2018	Named Nurse Safeguarding Adults		
October 2018	Safeguarding Children and the emergency Department	ED audit of recognition of vulnerabilities of older young people (age 13 to 18) in relation to CSE	Completed by December 2018	Named Nurse Safeguarding Children/Lead Nurse Emergency Department		
December 2018	Medical audit by Consultant Paediatrician	Consultant Paediatricians to confirm	TBC	DGNHST Lead		
February 2019	Safeguarding Children	Case file audit of records to ensure the voice of the child is evident	Completed March 2019	Named Nurse Safeguarding Children		
April 2018-March 2019	Learning Disability	Mortality audit for adults with Learning Disabilities	Ongoing annual audit	Learning Disability Liaison Nurse		
May 2018	Maternity	Audit the impact of the perinatal mental health	Completion April 2019	Named Midwife Safeguarding		

		clinic and its effect on parenting and safeguarding of the unborn				

The Dudley Group NHS Foundation Trust

Safeguarding Improvement/Action Plan

Project/Improvement Area	Safeguarding	**Strategic Objective**	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*
Manager/Lead	Christina Rogers Head of Safeguarding	**Executive Sponsor**	
Date Action Plan first agreed	20.03.2018	**Updated**	03.05.2018 V2

Action not started	**Action underway not yet completed**	**Action completed and assurance received**	**Action In progress**

Date action added	Actions Required	By whom	Progress to date	Date For Completion	Status (BRAG)
1. Governance					
20.03.2018	***Internal electronic flagging system review*** to include: • Review of current flags utilised pertaining to safeguarding • Review of current management and monitoring of flags (adding, amending and removing). • Administrative safeguarding support required to lead of flagging • Risk identified in respect to nil flags in place for children with high vulnerabilities, including Looked after Children (LAC), Children in Need (CIN Sec 17 CA 1989), at risk of Domestic Abuse (DA) and children at risk of child sexual exploitation (CSE) – to add to Trust Corporate Risk Register	Christina Rogers (CR) Head of Safeguarding	• CR had meeting had with current flagging lead Sharon Williams (SW) to establish current process • Escalated lack of LAC, CSE and CIN data to LAC Designated Nurse. Safeguarding Children Designated Nurse and CSC Head of Safeguarding • -Updated 03.05.2018: CR has had further meeting had with Sharon Williams on 30.04.2018 to update. -CR has reviewed administrative support to ensure reflective of the additional workstream of electronic CPP flag management, plan to provide business case for additional 0.5WTE -Go live date for electronic CPP flag management will be 01.06.2018 -CR has discussed and escalated formally to Head of Safeguarding CSC	Original date: 01 May 2018 Revised date: 01.06.2018	

			and a meeting is scheduled to discuss process for recieving LAC information		
20.03.2018	***External flagging system: Child Protection Information System (CP-IS)*** • SW will attend UTC to see how the system works in practice prior to the introduction across the acute trust. It was agreed that the system would be introduced within ED, Maternity and Paediatrics (OPD, PAU and C2) • CR to liaise with key Matrons to identify staff requiring system access and resultant Smart card access • SW - Issue Smartcards to identified staff • CR - Provide written guidance to support staff • Safeguarding Team - Audit the process once implemented to ensure it is embedded	Christina Rogers (CR) Head of Safeguarding Sharon Williams (SW) Information Governance Manager	• CR has had meetings with SW, CCG Designated Nurse Sue Vincent (SV) and NHS Digital. • Action plan in place led by SV • SW has applied for accelerated funding from NHS Digital • Updated 03.05.2018 - CR has provided SW with a list of staff whom require smartcard access - CR had meeting with SW on 30.04.2018, SW provided update in respect of staff who have received smartcard. This work is in progress. - CR has provided CP-IS guidelines to staff - CR to produce SOP to support process	Original date: 1st April 2018 Revised date: 01.06.2018	
20.03.2018	***Review of current Risk Register*** to ensure safe, effective and robust management of risks pertaining to safeguarding of children, young people and adults. • Meet with Sharon Philips (SP) to review and revise current Risk Register, ensuring any newly identified risks are added accordingly • Review previous work undertaken concerning the corporate risk register and ensure the safeguarding team has a comprehensive knowledge of risk management and responsibilities as individual practitioners.	Christina Rogers (CR) Head of Safeguarding	• Initial meeting had between CR and SP, whereby a need for review of the current Risk Register was identified • Further meeting scheduled for May 2018 between SP and CR	Revised date: 31.05.2018 Original date: 10.04.2018	
20.03.2018	***Safeguarding reports*** • Annual Report 2017-18 – Due April 2018 • Review the structure and content of the safeguarding annual report to ensure the Board has a wide-ranging update and vigorous assurance, providing an overview on arrangements to discharge the trust's statutory responsibilities, current provision of services and the challenges ahead. Due consideration should be given to including commissioner requirements. • Quarterly Safeguarding reports	Christina Rogers (CR) Head of Safeguarding All members of the Safeguarding Team	• CR has requested information requested from Karen Anderson (KA) (Matron Paediatrics) who has commenced this work and completed a draft version	April 2018	

20.03.2018	***Safeguarding Declaration*** • Publish and communicate a yearly safeguarding declaration on the trust's website as evidence of the board's commitment to safeguarding children, young people and adults.	Christina Rogers (CR) Head of Safeguarding		30.04.2018	
20.03.2018	***Modern slavery Trust Statement*** • Publish and communicate a yearly Modern Slavery Statement on the trust's website as evidence of the board's commitment to safeguarding children, young people and adults.	Christina Rogers (CR) Head of Safeguarding		30.04.2018	
20.03.2018	***Review of internal and external safeguarding meetings and Trust representation*** • Continue to attend meetings and review existing ToR to support decision making • Ensure receiving all relevant communication for respective meetings • Ensure that the SCR, SAR and DHR process has a trust lead, guidance and relevant training, in order to embed the appropriate processes that enable lessons learnt to be aligned to training, development and improved practice outcomes. • Action plans should be explicitly understood and operational arrangements robust.	Christina Rogers (CR) Head of Safeguarding All team members of the Safeguarding Team	• CR has met with Liz Murphy (Chair of DSCB and DSAB Boards) to agree Trust representation at Board and Subgroup meetings • CR has commenced attendance at meetings since commencement into post • CR	30.04.2018	
20.03.2018	***Review of existing safeguarding policies and procedures*** • Ensure up to date and alignment with current statute and guidance • Safeguarding page on the Trust online Hub – requires urgent review	Christina Rogers (CR) Head of Safeguarding All team members of the Safeguarding Team	• CR has reviewed and commented on a selection of existing safeguarding policies	May 2018	
2. Staffing and Safeguarding Team processes					
20.03.2018	***Safeguarding Team current capacity and resource*** • Review the Safeguarding Team, giving due consideration to the provision of sound strategic leadership, operational management, performance, roles and responsibilities and staffing requirements; in	Christina Rogers (CR) Head of Safeguarding	• Meet with all team members • Arrange regular 1:1 meetings with team members • Produce and communicate Expression of Interest for posts subject to TUPE	May 2018	

	order to bring together the safeguarding of children, young people and adults, enabling a strong effective interface between all three. • Review current team structure to ensure fit for purpose – Risk apparent that there is no Safeguarding Team administrative support. • Recruitment processes to be commenced for vacant posts – TUPE Process (Lead Nurse for Child Deaths and Paediatric Liaison Nurse) • Commencement of new Named Nurse for Safeguarding Children on: April 2018		process (Lead Nurse for Child Deaths and Paediatric Liaison Nurse) • Siobhan Jordan (SJ) Chief Nurse has liaised with CEO of Birmingham Trust with a view to transferring across current Lead Nurse for Child Death who has expressed interest. A request has been made for interim support. • CR has liaised with BCPFT Associate Director of Safeguarding for continued support in the interim.		
20.03.2018	***Team communication*** • Generic team email address and team contact telephone number urgently required to ensure appropriate calls and correspondence are accessed by all team members and triaged and responded to appropriately	Christina Rogers (CR) Head of Safeguarding All Safeguarding Team members IT Helpdesk support		April 2018	
20.03.2018	***Safeguarding Team processes review*** • Review internal processes • Ensure electronic process for all safeguarding information	Christina Rogers (CR) Head of Safeguarding All Safeguarding Team members	• CR has commenced review of internal team processes • Team ops meeting held fortnightly	May 2018	
20.03.2018	***Safeguarding Supervision*** • Review the supervision policy and documentation to ensure all staff fully understand their roles, responsibilities, development needs and the necessary sound practice that is consistent with trust and LSCB organisational procedures. • In addition, make provision for a strong supervision process, which addresses the needs of case load holders, the named nurses and named doctor with safeguarding responsibilities. • As part of the review consider a range of reflective practice activities that could be programmed, including more opportunity for case study reflection via peer	Christina Rogers (CR) Head of Safeguarding All Safeguarding Team members	• CR has conducted scoping of Named Doctor and Named Nurses and established current Safeguarding Supervision arrangements in place.	June 2018	

	review and possible learning sets. • Ensure evaluation is undertaken to inform ongoing training programs.				
20.03.2018	***Ensure that the role and responsibilities of the named nurses and named doctor with safeguarding responsibilities is communicated and understood by all relevant practitioners and senior staff.*** • Review training and safeguarding supervision arrangements of key medical safeguarding staff • Revisit the appraisal system and processes to ensure all staff have clear objectives and relevant performance management for delivering the safeguarding agenda, which should be linked to the improvement plan and /or the agreed annual work programme. • Update all pertinent job descriptions and ensure the process of appraisal includes this function on a yearly basis. • Review the sessional commitment for the Designated Doctor for children's safeguarding and Named doctor for Adults Safeguarding agree key role, responsibilities and accountabilities	Christina Rogers (CR) Head of Safeguarding All Safeguarding Team members Zala Ibrahim (Designated Doctor for Safeguarding Children) Julian Hobbs (Chief Medical Officer)	• CR has had meetings with ZI and Dr Jain (Named Doctor) • CR has attended one Peer Review session held by ZI and her colleagues	May 2018	
20.03.2018	***Domestic Abuse Agenda*** • Set out trust agenda for the service of Domestic Abuse, which goes beyond current engagement in MARAC; this should apply to both vulnerable children and adults. • Recent local and regional review of these services should be noted and the recommendations that emerge need to be addressed in terms of healthcare services contribution to any necessary changes. • Refer to previous action re: Flagging and align with this action	Christina Rogers (CR) Head of Safeguarding All Safeguarding Team members	• MARAC process is currently being reviewed by CR	May 2018	
3. Training					
20.03.2018	***Safeguarding Training*** • Review all current training packages • Review TNA • Review training compliance • Schedule additional Safeguarding Children level 3	Christina Rogers (CR) Head of Safeguarding	• TNA information reviewed by CR • CR has had meeting with Rachel Andrews (L&D Lead) • CR has organised additional Safeguarding Children level 3 Training	01.04.2018	

	Training facilitated by external provider	All Safeguarding Team members Learning and Development Team	facilitated by external provider to be available to staff in high priority paediatric areas (ED, Paediatrics, Maternity, GUM and CASH).		
5. Audit					
20.03.2018	***Safeguarding Team Audit work plan*** • Review recently devised Audit work-plan to ensure alignment to safeguarding priorities and quality assurance practices	Christina Rogers (CR) Head of Safeguarding	• Audit work-plan reviewed and deemed satisfactory	19.03.2018	
20.03.2018	***Safeguarding Team external Audit*** • Complete DSCB Section 11 Audit – Due May 2018 • Collate all evidence required from Safeguarding Team members	Christina Rogers (CR) Head of Safeguarding	• Request made by CR to safeguarding team members for evidence to support collation of this report	May 2018	

Enclosure 11

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 7th June, 2018

TITLE:	**Integrated Performance Report**		
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
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

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 / COMMITTEE / GROUP: ***(Please tick or enter Y/N below)***

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

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

The Dudley Group
NHS Foundation Trust

Integrated Performance Report - Board




April 2018

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

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

The Dudley Group NHS Foundation Trust

Quality Dashboard

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Complaints	798	44	-	-	-	-	-	-	-	-	-	-	-	44
Friends & Family – Community – Footfall	3.10%	2.90%	-	-	-	-	-	-	-	-	-	-	-	2.90%
Friends & Family – Community – Recommended %	96.60%	96.60%	-	-	-	-	-	-	-	-	-	-	-	96.60%
Friends & Family – ED – Footfall	19.10%	17.90%	-	-	-	-	-	-	-	-	-	-	-	17.90%
Friends & Family – ED – Recommended %	77.30%	81.80%	-	-	-	-	-	-	-	-	-	-	-	81.80%
Friends & Family – Inpatients – Footfall	32.10%	32.20%	-	-	-	-	-	-	-	-	-	-	-	32.20%
Friends & Family – Inpatients – Not Recommended %	1.50%	1.80%	-	-	-	-	-	-	-	-	-	-	-	1.80%
Friends & Family – Inpatients – Recommended %	95.40%	94.90%	-	-	-	-	-	-	-	-	-	-	-	94.90%
Friends & Family – Maternity – Footfall	40.30%	30.30%	-	-	-	-	-	-	-	-	-	-	-	30.30%
Friends & Family – Maternity – Not Recommended %	0.60%	1.20%	-	-	-	-	-	-	-	-	-	-	-	1.20%
Friends & Family – Maternity – Recommended %	97.80%	98.10%	-	-	-	-	-	-	-	-	-	-	-	98.10%
Friends & Family – Outpatients – Footfall	4.30%	4.90%	-	-	-	-	-	-	-	-	-	-	-	4.90%
Friends & Family – Outpatients – Recommended %	91.80%	90.10%	-	-	-	-	-	-	-	-	-	-	-	90.10%
HCAI – Post 48 hour MRSA	0	0	-	-	-	-	-	-	-	-	-	-	-	0
HCAI CDIFF – Due To Lapses In Care	17	0	-	-	-	-	-	-	-	-	-	-	-	0
HCAI CDIFF – Not Due To Lapses In Care	11	0	-	-	-	-	-	-	-	-	-	-	-	0
HCAI CDIFF – Total Number Of Cases	30	4	-	-	-	-	-	-	-	-	-	-	-	4
HCAI CDIFF – Under Review	2	4	-	-	-	-	-	-	-	-	-	-	-	4
Incidents - Appointments, Discharge & Transfers	1,028	78	-	-	-	-	-	-	-	-	-	-	-	78
Incidents - Blood Transfusions	88	9	-	-	-	-	-	-	-	-	-	-	-	9
Incidents - Clinical Care (Assessment/Monitoring)	1,375	149	-	-	-	-	-	-	-	-	-	-	-	149
Incidents - Diagnosis & Tests	397	42	-	-	-	-	-	-	-	-	-	-	-	42
Incidents - Equipment	290	29	-	-	-	-	-	-	-	-	-	-	-	29
Incidents - Facilities (Security, Estates, Transport, Fire etc.)	491	36	-	-	-	-	-	-	-	-	-	-	-	36
Incidents - Falls, Injuries or Accidents	1,442	106	-	-	-	-	-	-	-	-	-	-	-	106
Incidents - Health & Safety	331	33	-	-	-	-	-	-	-	-	-	-	-	33
Incidents - Infection Control	112	12	-	-	-	-	-	-	-	-	-	-	-	12
Incidents - Medication	4,160	412	-	-	-	-	-	-	-	-	-	-	-	412

The Dudley Group NHS Foundation Trust

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Incidents - Obstetrics	990	52	-	-	-	-	-	-	-	-	-	-	-	52
Incidents - Pressure Ulcer	3,492	303	-	-	-	-	-	-	-	-	-	-	-	303
Incidents - Records, Communication & Information	825	77	-	-	-	-	-	-	-	-	-	-	-	77
Incidents - Safeguarding	866	86	-	-	-	-	-	-	-	-	-	-	-	86
Incidents - Theatres	208	24	-	-	-	-	-	-	-	-	-	-	-	24
Incidents - Venous Thrombo Embolism (VTE)	127	16	-	-	-	-	-	-	-	-	-	-	-	16
Incidents - Violence, Aggression & Self Harm	734	52	-	-	-	-	-	-	-	-	-	-	-	52
Incidents - Workforce	679	53	-	-	-	-	-	-	-	-	-	-	-	53
Maternity : Early Booking KPI: % of women who see midwife/maternity healthcare professional	100%	100%	-	-	-	-	-	-	-	-	-	-	-	100%
Maternity : Increase in breast feeding initiation rates by 2% per year	56.85%	59.22%	-	-	-	-	-	-	-	-	-	-	-	59.22%
Maternity : Smoking In Pregnancy : Reduce to a prevalence of 12.1% across the year	15.61%	14.28%	-	-	-	-	-	-	-	-	-	-	-	14.28%
Mixed Sex Sleeping Accommodation Breaches	51	3	-	-	-	-	-	-	-	-	-	-	-	3
Never Events	3	0	-	-	-	-	-	-	-	-	-	-	-	0
NQA - Midwifery Audit	97%	98%	-	-	-	-	-	-	-	-	-	-	-	98%
NQA - Nutrition Audit	94%	94%	-	-	-	-	-	-	-	-	-	-	-	94%
NQA - Paediatric Nutrition Audit	98%	98%	-	-	-	-	-	-	-	-	-	-	-	98%
NQA - Skin Bundle	95%	95%	-	-	-	-	-	-	-	-	-	-	-	95%
NQA - Think Glucose - EAU/SAU	77%	90%	-	-	-	-	-	-	-	-	-	-	-	90%
NQA - Think Glucose - General Wards	94%	96%	-	-	-	-	-	-	-	-	-	-	-	96%
Nursing Care Indicators - Community Childrens	99%	100%	-	-	-	-	-	-	-	-	-	-	-	100%
Nursing Care Indicators - Community Neonatal	100%	100%	-	-	-	-	-	-	-	-	-	-	-	100%
Nursing Care Indicators - Critical Care	98%	100%	-	-	-	-	-	-	-	-	-	-	-	100%
Nursing Care Indicators - District Nurses	94%	95%	-	-	-	-	-	-	-	-	-	-	-	95%
Nursing Care Indicators - EAU	90%	96%	-	-	-	-	-	-	-	-	-	-	-	96%
Nursing Care Indicators - ED	88%	95%	-	-	-	-	-	-	-	-	-	-	-	95%
Nursing Care Indicators - General Wards	95%	97%	-	-	-	-	-	-	-	-	-	-	-	97%
Nursing Care Indicators - Medicines Management	91%	94%	-	-	-	-	-	-	-	-	-	-	-	94%
Nursing Care Indicators - Neonatal	99%	96%	-	-	-	-	-	-	-	-	-	-	-	96%

The Dudley Group NHS Foundation Trust

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Nursing Care Indicators - Paediatric	95%	96%	-	-	-	-	-	-	-	-	-	-	-	96%
Nursing Care Indicators - Renal	97%	98%	-	-	-	-	-	-	-	-	-	-	-	98%
Nursing Care Indicators - Surgical Assessment Unit	94%	98%	-	-	-	-	-	-	-	-	-	-	-	98%
Serious Incidents - Action Plan overdue	74	3	-	-	-	-	-	-	-	-	-	-	-	3
Serious Incidents - Clinical Care (Assessment/Monitoring)	20	1	-	-	-	-	-	-	-	-	-	-	-	1
Serious Incidents - Infection Control	5	2	-	-	-	-	-	-	-	-	-	-	-	2
Serious Incidents - Pressure Ulcer	98	8	-	-	-	-	-	-	-	-	-	-	-	8
Stroke Admissions : Swallowing Screen	82.84%	94.44%	-	-	-	-	-	-	-	-	-	-	-	94.44%
Stroke Admissions to Thrombolysis Time	57.69%	42.85%	-	-	-	-	-	-	-	-	-	-	-	42.85%
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)	92.56%	91.89%	-	-	-	-	-	-	-	-	-	-	-	91.89%
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation	94.15%	90%	-	-	-	-	-	-	-	-	-	-	-	90%
Time to Procedure: Emergency Procedures (Upper GI Diagnostic endoscopic)	66.66%	65.30%	-	-	-	-	-	-	-	-	-	-	-	65.30%
Time to Surgery - Elective admissions operated on within two days for all procedures	86.89%	99.77%	-	-	-	-	-	-	-	-	-	-	-	99.77%
Time to Surgery : Emergency Procedures (Appendectomy)	97%	92.50%	-	-	-	-	-	-	-	-	-	-	-	92.50%
Time to Surgery : Emergency Procedures (Femur Replacement #NOF)	93.23%	95.23%	-	-	-	-	-	-	-	-	-	-	-	95.23%
Time to Surgery : Emergency Procedures (Reduction of fracture of bone excl. #NOF)	91.68%	88.57%	-	-	-	-	-	-	-	-	-	-	-	88.57%
VTE Assessment Indicator (CQN01)	93.37%	95.30%	-	-	-	-	-	-	-	-	-	-	-	95.30%

The Dudley Group NHS Foundation Trust

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)	78.38%	77.09%	-	-	-	-	-	-	-	-	-	-	-	77.09%
A&E - 4 Hour UCC Dept Only % (Type 3)	99.38%	99.44%	-	-	-	-	-	-	-	-	-	-	-	99.44%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	86.56%	86.29%	-	-	-	-	-	-	-	-	-	-	-	86.29%
A&E - Patients who Left Without Being Seen %	2.60%	1.70%	-	-	-	-	-	-	-	-	-	-	-	1.70%
A&E - Time to Initial Assessment (95th Percentile)	9	4	-	-	-	-	-	-	-	-	-	-	-	4
A&E - Time to Treatment Median Wait (Minutes)	70	49	-	-	-	-	-	-	-	-	-	-	-	49
A&E - Total Time in A&E (95th Percentile)	731	593	-	-	-	-	-	-	-	-	-	-	-	593
A&E - Unplanned Re-Attendance Rate %	1.50%	1.30%	-	-	-	-	-	-	-	-	-	-	-	1.30%
Activity - A&E Attendances	103,426	8,299	-	-	-	-	-	-	-	-	-	-	-	8,299
Activity - Cancer MDT	5,131	492	-	-	-	-	-	-	-	-	-	-	-	492
Activity - Community Attendances	376,548	30,413	-	-	-	-	-	-	-	-	-	-	-	30,413
Activity - Critical Care Bed Days	7,612	529	-	-	-	-	-	-	-	-	-	-	-	529
Activity - Day Care Attendances	4,150	533	-	-	-	-	-	-	-	-	-	-	-	533
Activity - Diagnostic Imaging whilst Out-Patient	52,692	4,169	-	-	-	-	-	-	-	-	-	-	-	4,169
Activity - Direct Access Pathology	1,970,646	164,711	-	-	-	-	-	-	-	-	-	-	-	164,711
Activity - Direct Access Radiology	75,450	6,213	-	-	-	-	-	-	-	-	-	-	-	6,213
Activity - Elective Day Case Spells	48,682	4,174	-	-	-	-	-	-	-	-	-	-	-	4,174
Activity - Elective Inpatients Spells	5,828	447	-	-	-	-	-	-	-	-	-	-	-	447
Activity - Emergency Inpatient Spells	50,160	3,287	-	-	-	-	-	-	-	-	-	-	-	3,287
Activity - Excess Bed Days	11,066	372	-	-	-	-	-	-	-	-	-	-	-	372
Activity - Maternity Pathway	7,636	389	-	-	-	-	-	-	-	-	-	-	-	389
Activity - Neo Natal Bed Days	7,111	600	-	-	-	-	-	-	-	-	-	-	-	600
Activity - Outpatient First Attendances	146,246	12,318	-	-	-	-	-	-	-	-	-	-	-	12,318
Activity - Outpatient Follow Up Attendances	295,301	24,268	-	-	-	-	-	-	-	-	-	-	-	24,268
Activity - Outpatient Procedure Attendances	71,502	7,468	-	-	-	-	-	-	-	-	-	-	-	7,468
Activity - Rehab Bed Days	20,079	1,537	-	-	-	-	-	-	-	-	-	-	-	1,537
Activity - Renal Dialysis	52,070	4,141	-	-	-	-	-	-	-	-	-	-	-	4,141
Ambulance Handover - 30 min – breaches (DGH view)	4,608	180	-	-	-	-	-	-	-	-	-	-	-	180

The Dudley Group NHS Foundation Trust

Performance														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Ambulance Handover - 30 min – breaches (WMAS view)	5,803	240	-	-	-	-	-	-	-	-	-	-	-	240
Ambulance Handover - 60 min – breaches (DGH view)	716	8	-	-	-	-	-	-	-	-	-	-	-	8
Ambulance Handover - 60 min – breaches (WMAS view)	876	9	-	-	-	-	-	-	-	-	-	-	-	9
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	94.70%	88%	-	-	-	-	-	-	-	-	-	-	-	88%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	97.30%	91.80%	-	-	-	-	-	-	-	-	-	-	-	91.80%
Cancer - 31 day - from diagnosis to treatment for all cancers	98.80%	98.70%	-	-	-	-	-	-	-	-	-	-	-	98.70%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	-	-	-	-	-	-	-	-	-	-	-	100%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	98.90%	100%	-	-	-	-	-	-	-	-	-	-	-	100%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	99.40%	100%	-	-	-	-	-	-	-	-	-	-	-	100%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	93.30%	86.90%	-	-	-	-	-	-	-	-	-	-	-	86.90%
Cancer - 62 day - From Referral for Treatment following national screening referral	98.40%	96.40%	-	-	-	-	-	-	-	-	-	-	-	96.40%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85.30%	80.60%	-	-	-	-	-	-	-	-	-	-	-	80.60%
Maternity: Breastfeeding Data Coverage Rates	100%	100%	-	-	-	-	-	-	-	-	-	-	-	100%
Number of Births Within the Trust	4,435	351	-	-	-	-	-	-	-	-	-	-	-	351
RTT - Admitted Pathways within 18 weeks %	87.90%	84.60%	-	-	-	-	-	-	-	-	-	-	-	84.60%
RTT - Incomplete Waits within 18 weeks %	94%	92.40%	-	-	-	-	-	-	-	-	-	-	-	92.40%
RTT - Non-Admitted Pathways within 18 weeks %	93.10%	94.40%	-	-	-	-	-	-	-	-	-	-	-	94.40%
Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	97.85%	99.31%	-	-	-	-	-	-	-	-	-	-	-	99.31%

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	£11,613k	£860k	-	-	-	-	-	-	-	-	-	-	-	£860k
Bank spend	£16,404k	£1,481k	-	-	-	-	-	-	-	-	-	-	-	£1,481k
Budgetary Performance	(£20,622)k	(£640)k	-	-	-	-	-	-	-	-	-	-	-	(£640)k
SLA Performance	(£3,902)k	(£747)k	-	-	-	-	-	-	-	-	-	-	-	(£747)k

Staff/HR Dashboard

Staff/HR														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Appraisals	70.50%	17.40%	-	-	-	-	-	-	-	-	-	-	-	17.40%
Mandatory Training	85.90%	87.80%	-	-	-	-	-	-	-	-	-	-	-	87.80%
RN average fill rate (DAY shifts)	89.64%	83.89%	-	-	-	-	-	-	-	-	-	-	-	83.89%
RN average fill rate (NIGHT shifts)	92.85%	85.65%	-	-	-	-	-	-	-	-	-	-	-	85.65%
Sickness Rate	4.40%	3.90%	-	-	-	-	-	-	-	-	-	-	-	3.90%
Staff In Post (Contracted WTE)	4,270.43	3,980.39	-	-	-	-	-	-	-	-	-	-	-	3,980.39
Turnover Rate (Rolling 12 Months)	9.74%	9.95%	-	-	-	-	-	-	-	-	-	-	-	9.95%
Vacancy Rate	6.63%	11.30%	-	-	-	-	-	-	-	-	-	-	-	11.30%

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 86.29%. Whilst, the Trust only (Type 1) performance was 77.09%.

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

	Attendances	Breaches	Performance
A&E Dept. Type 1	8259	1892	77.09%
UCC Type 3	5783	32	99.44%

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 80% (Provisional as at 22/05). Previous month confirmed performance was 84.4%

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

No. of Patients treated on or over 104 days (DGFT) 1

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

No. of Patients treated on or over 104 days (Combined) 5

2WW

The target was achieved once again in month. During this period a total of 1185 patients attended a 2ww appointment with 80 patients attending their appointments outside of the 2 week standard, achieving a performance 93.33% against the 93% target.

Referral To Treatment (RTT)

The performance of the key target RTT Incomplete Waiting Time indicator remained above target, with performance of 92.4% in month against a target of 92%, a decrease in performance from 92.8% in the previous month. Urology did not meet the target in month at 88.2% up from 86.46% in previous month. Ophthalmology is at 83.87% down from 83.89% in the previous month. Plastic Surgery at 90.54% up from 87.74%. General Surgery at 90.82% up from 90.22%. 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 99.31%. The number of patients waiting over 6 weeks was 46.

Of the 46, MRI accounted for 35 (11 other).

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

2 Financial Performance Matters — Committee: F&P

The Trust has a number of stretching financial assumptions within its plans for 2018/19 particularly for income growth and cost reduction. Underpinning the delivery of the financial plan is an ambitious CIP programme.

For April 2018, the Trust incurred an in month deficit of £2.5m which is a £0.6m adverse movement when compared to plan. The main driver for the variance is a shortfall in income in April, mainly related to emergency admissions and community attendances The shortfall in emergency admissions is primarily because of pathway changes rather than reduced patient flow or complexity. Note that the reported figures are based on an earlier data extract and updated information improves the income position by £0.3m, thus reducing the deficit to £2.2m (adverse variance of £0.3m against plan).

In aggregate, expenditure plans are broadly in line with plan and the CIP plan has been delivered for Month 1.
Agency costs are reducing but are slightly above the agency cap for Month 1 .

The Trusts cash position at the end of April is as per the original plan

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 4.

	April	YTD
Total No. of cases due to lapses in care	N/A	0
Total No. of cases NOT due to lapses in care	N/A	0
No. of cases currently under review (ytd)	4	N/A
Total No. of cases ytd.	N/A	4

There were 0 post 48 hour MRSA cases reported in month. The last post 48 hours MRSA cases was in Septmber 2016, 946 days ago.

Friends and Family Scores

We continue to focus on engaging with our patients and their families. The Chief Nurse will oversee the volunteers from 1 May 2018 and we will focus activity of engagement and improving our Friend and Family scores.

Falls

We continue to reduce the number of patients who fall in our care and also the level of harm incurred.

Pressure Ulcers

We continue to focus on improvement and learning in relation to Pressure Ulcers in both the community and the hospital. Additional details and assurance is provided to the CQPSEC.

Never Events

There were 0 never events in month.

Mixed Sex Sleeping Accommodation Breaches (MSA)

There are 3 MSA breaches in month.

VTE Assessment On Admission: Indicator

The indicator achieved the target in month with provisional performance at 95.3% against a target of 95%.

Executive Summary by Exception cont.

Key Messages

4 Workforce — Committee: F&P

Staff Appraisals:

This includes all non-medical appraisals in the Trust. As a result of the new Appraisal Window running between 1st April and 30th June the current performance is under target. However, this is to be expected as the window is still open for another 5 weeks. There is a trajectory in place for ensuring performance of 90% is achieved by 30th June 2018. At the most recent performance review meetings, all Divisional Management Teams confirmed that they would achieve at least 90% compliance with this target. The areas where completed appraisals are at their lowest have been invited to meet with members of the Executive Team to understand that plans are in place to ensure their department and the Trust achieve the expected rate of compliance.

Mandatory Training:

There have been significant efforts to improve our mandatory training rates with a particular emphasis on specific areas such as Safeguarding and Infection Control. The increased emphasis has seen a rise of nearly 2% in our compliance rates with the Trust just over 2% away from meetings its compliance target. There are trajectories in place for each Division with performance reviews focusing on compliance for every member of staff.

Sickness Rate:

The Trust has seen an improvement in absence rates since February 2018. The report last month attributed some of this to expected seasonal trends with the expectation that this would improve further in April 2018. It is encouraging to see that we have moved out of the red and into amber with absence rates 3.9%. This is higher than this time last year with the challenge to sustain and improve on this performance based on the new interventions in place. The rate as it stands in April is ahead of our projected target that we submitted to NHSI as part of our annual plan.

Turnover & Vacancy Rate:

The turnover rate has increased for the 7th month in a row and currently sits at 9.96%. This is significantly above our target of 8.5% but continues to be below the average turnover rate for acute NHS Trusts in England. The appointment of the new Staff Engagement lead will have a particular focus on understanding the feedback from exit interviews, listening to staff and developing strategies to support improved retention at the Trust.

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)	Mar-18	Apr-18	Trend	Month Status
Friends & Family Test - Footfall					
Friends & Family Test - ED	14.5%	19.5%	17.9%	↓	
Friends & Family Test - Inpatients	26.0%	34.9%	32.3%	↓	
Friends & Family Test - Maternity	21.7%	36.3%	30.4%	↓	
Friends & Family Test - Outpatients	4.7%	4.6%	4.9%	↑	
Friends & Family Test - Community	3.5%	3.5%	2.9%	↓	
Friends & Family Test - Recommended					
Friends & Family Test - ED	89.9%	74.5%	81.9%	↑	
Friends & Family Test - Inpatients	96.3%	93.7%	95.0%	↑	
Friends & Family Test - Maternity	96.0%	97.9%	98.1%	↑	
Friends & Family Test - Outpatients	94.6%	91.7%	90.1%	↓	
Friends & Family Test - Community	96.4%	97.4%	96.6%	↓	
Complaints					
Total no. of complaints		19	45	↑	
Complaints re-opened		0	5	↑	
PALs Numbers		286	306	↑	
Complaints opened at month end			231		
Compliments received			509		
Dementia (1 month in arrears)					
Find/Assess		87.1%	93.3%	↑	
Investigate		100.0%	100.0%	↔	
Refer		95.1%	100.0%	↑	
Falls	National average 6.63 per 1000 bed days				
No. of Falls		64	67	↑	
Falls per 1000 bed days		3.40	3.90	↑	
No. of Multiple Falls		3	8	↑	
Falls resulting in moderate harm or above		1	1	↔	
Falls resulting in moderate harm or above per 1000 bed days		0.05	1	↑	
Pressure Ulcers (Grades 3 & 4)					
Hospital Avoidable		2	1	↓	
Hospital Non-avoidable		0	1	↑	
Community Avoidable		1	2	↑	
Community Non-avoidable		5	4	↓	
Handwash					
Handwashing		99.6%	99.6%		

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Mar-18	Apr-18	Trend	Month Status
Mixed Sex Accommodation Breaches						
Single Sex Breaches		0	11	3	↓	
Mortality (Quality Strategy Goal 3)						
HSMR Rolling 12 months (**Latest data Feb 18**)	110	105	110	109		
SHMI Rolling 12 months (**Latest data Dec17**)	1.10	1.05	0.98	1.03		
HSMR Year to date (**Not available**)						
Infections						
Cumulative C-Diff due to lapses in care		17	16	0	↓	
MRSA Bacteraemia		0	0	0	↔	
MSSA Bacteraemia		0	3	3	↔	
E. Coli - Total hospital		0	2	3	↑	
Stroke Admissions - PROVISIONAL						
Stroke Admissions: Swallowing Screen		75%	100.0%	94.4%	↓	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	89.8%	91.9%	↑	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	87.5%	90.0%	↑	
VTE - PROVISIONAL						
VTE On Admission		95%	94.1%	95.3%	↑	
Incidents						
Total Incidents			1397	1466	↑	
Recorded Medication Incidents			328	235	↓	
Never Events			0	0	↔	
Serious Incidents			11	11	↔	
of which, pressure ulcers			5	8	↑	
Incident Grading by Degree of Harm						
Death			1	0	↓	
Severe			3	1	↓	
Moderate			5	17	↑	
Low			248	253	↑	
No Harm			1209	1061	↓	
Percentage of incidents causing harm		28%	17.5%	20.3%	↑	
NQA Think Glucose						
NQA Think Glucose - AMU/SAU	85%	95%	90%	90%	↔	
NQA Think Glucose - General Wards	85%	95%	93%	96%	↑	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Mar-18	Apr-18	Trend	Month Status
Cancer Reporting - TRUST (provisional)					
All Cancer 2 week waits	93%	93.5%	88.0%	↓	
2 week wait - Breast Symptomatic	93%	93.7%	91.9%	↓	
31 day diagnostic to 1st treatment	96%	99.3%	98.8%	↓	
31 day subsequent treatment - Surgery	94%	95.8%	100.0%	↑	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	↔	
62 day urgent GP referral to treatment	85%	86.1%	80.0%	↓	
62 day screening programme	90%	100.0%	96.4%	↓	
62 day consultant upgrades	85%	91.6%	87.7%	↓	
Referral to Treatment					
RTT Incomplete Pathways - % still waiting	92%	92.8%	93.5%	↑	
RTT Admitted - % treatment within 18 weeks	90%	85.4%	84.7%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	95.2%	94.5%	↓	
Wait from referral to 1st OPD	26	22	22	↔	
Wait from Add to Waiting List to Removal	39	40	45	↑	
ASI List		2252	2277	↑	
% Missing Outcomes RTT		0.1%	0.1%	↓	
% Missing Outcomes Non-RTT		7.4%	5.3%	↓	
DM01					
No. of diagnostic tests waiting over 6 weeks	0	34	46	↑	
% of diagnostic tests waiting less than 6 weeks	99%	99.4%	99.3%	↓	
ED - TRUST					
Patients treated < 4 hours Type 1 (Trust ED)	95%	70.0%	77.1%	↑	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	81.6%	86.3%	↑	
Emergency Department Attendances	N/A	8425	8259	↓	
12 Hours Trolley Waits	0	0	0	↔	
Ambulance to ED Handover Time - TRUST					
30-59 minute breaches		288	240	↓	
60+ minute breaches		35	9	↓	
Ambulance to Assessment Area Handover Time - TRUST					
30-59 minute breaches		18	27	↑	
60+ minute breaches		9	7	↓	

Performance - Key Performance Indicators cont.

	Target	Mar-18	Apr-18	Trend	Month Status
Cancelled Operations - TRUST					
% Cancelled Operations	1.0%	2.0%	1.0%	↓	
Cancelled operations - breaches of 28 day rule	0	2	0	↓	
Urgent operations - cancelled twice	0	0	0	↔	
GP Discharge Letters					
GP Discharge Letters	90%	76.7%	62.2%	↓	
Theatre Utilisation - TRUST					
Theatre Utilisation - Day Case (RHH & Corbett)		76.4%	75.8%	↓	
Theatre Utilisation - Main		89.5%	86.7%	↓	
Theatre Utilisation - Trauma		90.0%	93.4%	↑	
GP Referrals					
GP Written Referrals - made		7977	7594	↓	
GP Written Referrals - seen		6995	5546	↓	
Other Referrals - Made		2541	3161	↑	
Throughput					
Patients Discharged with a LoS >= 7 Days		7%	7%	↓	
Patients Discharged with a LoS >= 14 Days		4%	3%	↓	
7 Day Readmissions		4%	4%	↑	
30 Day Readmissions - PbR		7%	8%	↑	
Bed Occupancy - %		93%	92%	↓	
Bed Occupancy - % Medicine & IC		94%	95%	↑	
Bed Occupancy - % Surgery, W&C		91%	88%	↓	
Bed Occupancy - Paediatric %		92%	82%	↓	
Bed Occupancy - Orthopaedic Elective %		82%	78%	↓	
Bed Occupancy - Trauma and Hip # %		94%	96%	↑	
Number of Patient Moves between 8pm and 8am		109	86	↓	
Discharged by Midday		14%	14%	↓	
Outpatients					
New outpatient appointment DNA rate	8%	12.3%	10.4%	↓	
Follow-up outpatient appointment DNA rate	8%	10.3%	7.4%	↓	
Total outpatient appointment DNA rate	8%	11.1%	8.4%	↓	
Clinic Utilisation		74.7%	75.7%	↑	
Average Length of stay (Quality Strategy Goal 3)					
Average Length of Stay - Elective	0.0	3.0	3.0	↓	
Average Length of Stay - Non-Elective	3.4	6.1	5.9	↓	

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	480	447	-6.9%	-33	6,635	5,842	-12.0%	-793
Day Cases	3,847	4,417	14.8%	570	48,182	49,439	2.6%	1,257
Non-elective inpatients	3,912	3,287	-16.0%	-625	60,511	52,370	-13.5%	-8,141
Outpatients	36,916	36,516	-1.1%	-400	453,523	448,801	-1.0%	-4,722
A&E	8,014	8,259	3.1%	245	101,059	0	-100.0%	-101,059
Total activity	**53,169**	**52,926**	**-0.5%**	**-243**	**669,910**	**556,452**	**-16.9%**	**-113,458**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	13	235	1707.4%	222	13	235	1707.4%	222
Pay	225	252	11.9%	27	225	252	11.9%	27
Non-Pay	448	247	-44.8%	-201	448	247	-44.8%	-201
Total CIP	**686**	**734**	**7.0%**	**48**	**686**	**734**	**7.0%**	**48**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	26,542	25,836	-2.7%	-706	26,542	25,836	-2.7%	-706
Other Clinical	126	147	17.1%	22	126	147	17.1%	22
STF Funding	452	452	0.0%	0	452	452	0.0%	0
Other	1,861	1,941	4.3%	80	1,861	1,941	4.3%	80
Total income	**28,981**	**28,376**	**-2.1%**	**-605**	**28,981**	**28,376**	**-2.1%**	**-605**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-18,607	-18,270	-1.8%	337	-18,607	-18,270	-1.8%	337
Drugs	-2,816	-2,969	5.4%	-153	-2,816	-2,969	5.4%	-153
Non-Pay	-6,947	-7,153	3.0%	-206	-6,947	-7,153	3.0%	-206
Total Costs								

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	**612**	**-15**	**-102.5%**	**-627**	**612**	**-15**	**-102.5%**	**-627**
Depreciation	-814	-832	2.2%	-18	-814	-832	2.2%	-18
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,231	-1,226	-0.4%	5	-1,231	-1226	-0.4%	5
SURPLUS/(DEFICIT)	**-1,433**	**-2,073**	44.7%	**-640**	**-1,433**	**-2073**	**44.7%**	**-640**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	1,026	614	-40.2%	-412	1,026	614	-40.2%	0
Inventory					3,034	3,106	2.4%	0
Receivables & Prepayments					14,047	13,068	-7.0%	0
Payables					-22,010	-22,106	0.4%	0
Accruals							n/a	0
Deferred Income					-3,429	-3,518	2.6%	0
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					12,720	13,899	9.3%	1,179
Loan Funding							n/a	0
KPIs								
EBITDA %	2.10%	-0.10%	-2.2%		2.10%	-0.10%	-2.2%	
Deficit %	-4.90%	-7.20%	-2%		-4.90%	-7.30%	-2.4%	
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								

The Dudley Group NHS Foundation Trust

Workforce - "At a glance"

Executive Lead: Andrew McMenemy

People	Target 18/19	Mar-18	Apr-18	Trend	Month Status
Workforce					
Sickness Absence Rate	3.75%	4.26%	3.90%	↓	
Staff Turnover	8.5%	9.7%	9.95%	↑	
Mandatory Training	90.0%	85.9%	87.8%	↑	
Appraisal Rates - Total	90.0%	70.5%	17.4%	↓	

Enclosure 12

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7 June 2018

TITLE:	**Finance and Performance Committee Exception Report**		
AUTHOR:	Tom Jackson Director of Finance	**PRESENTER**	Jonathan 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 report from the Finance and Performance Committee meeting held on 31 May 2018.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Achievement of Finance Goals
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well led
	NHSI	**Y**	**Details:** Achievement of all Terms of Authorisation
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or action.

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**31 May 2018**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

2018/19 Planning

- The Committee received an update on detailed budget sign off for 2018/19. Assurance was sought regarding the way forward for the small number of budgets still in dispute.
- A paper was received on lessons learned from the 2017/18 CQUIN programme to take forward into 2018/19. As with many financial assumptions for 2018/19 the Committee noted that income assumptions were ambitious.
- Summary NHSI annual planning returns, key risks and high level benchmarking was discussed. Assurance was received that NHSI's views of the Trusts key risks and the downside scenario were aligned with the Trusts own assessment.

2018/19 Finance and Efficiency Performance

- Month 1 data was discussed and it was established that later iterations of the activity data showed a more favourable position than that reported initially. However, income is lower than the original Month 1 plan driving a £2.2m deficit (£2.5m reported) compared to a planned deficit of £1.9m.
- Cash balances in April were better than planned with the liquidity ratio remaining at (minus) 7.8
- The CIP plan and enhanced monitoring was discussed. The Committee acknowledged the robustness of plans to date and were keen for officers to push to identify further opportunities.

Performance

- The rectification plan for A and E was noted following a detailed conversation.
- The Committee discussed the requirements of a rectification plan for challenged cancer targets with an objective of getting back on track for Q1.
- The Trust Emergency Preparedness, Resilience and Response (EPRR) Strategy was approved

Workforce

- Nursing/midwifery staffing and medical agency reports were received. There is a strong focus on safer staffing, recruitment to establishment and reduction in agency spend

Estates and Procurement

- Update reports were noted and the PFI contract continues to be monitored closely

Decisions Made / Items Approved

- EPRR Strategy approved
- FIG to provide oversight to the CQUIN programme in 2018/19
- EPRR to be reflected in the Corporate Risk Register

Actions to come back to Committee

- Update on delivery of cancer targets

Performance Issues to be referred into Executive Performance Management Process
• None
Areas of Risk to be escalated onto the Corporate or Divisional Risk Register
• EPRR Strategy
Items referred to the Board for decision or action
• None

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to Trust Board on
6th June, 2018

TITLE:	**Trust Operating Plan 2018/19**		
AUTHOR:	**Lisa Peaty, Deputy Director of Strategy and Business Development** **Liz Abbiss, Head of Communications**	**PRESENTER**	**Lisa Peaty, Deputy Director of Strategy and Business Development**

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 Strategic Objectives

SUMMARY OF KEY ISSUES:

At the Trust Board meeting on 12th April 2018, a draft of the Trust's Operating Plan narrative was presented and amendments were requested. All of the amendments requested by the Board have been undertaken. The Communications Team have adapted this amended document to make it suitable for a staff/patient audience. This is attached as Appendix One. It is proposed that this is published on the Trust's internal and external websites.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Operating Plans are an element of the Well Led element of the CQC framework.
	NHSI	**Y**	**Details:** The plan supports the Trust to deliver NHS I annual planning requirements
	Other	**N**	**Details:**

ACTION REQUIRED OF TRUST BOARD:

Decision	Approval	Discussion	Other
			To note

The Dudley Group
NHS Foundation Trust

RECOMMENDATIONS FOR THE TRUST BOARD:

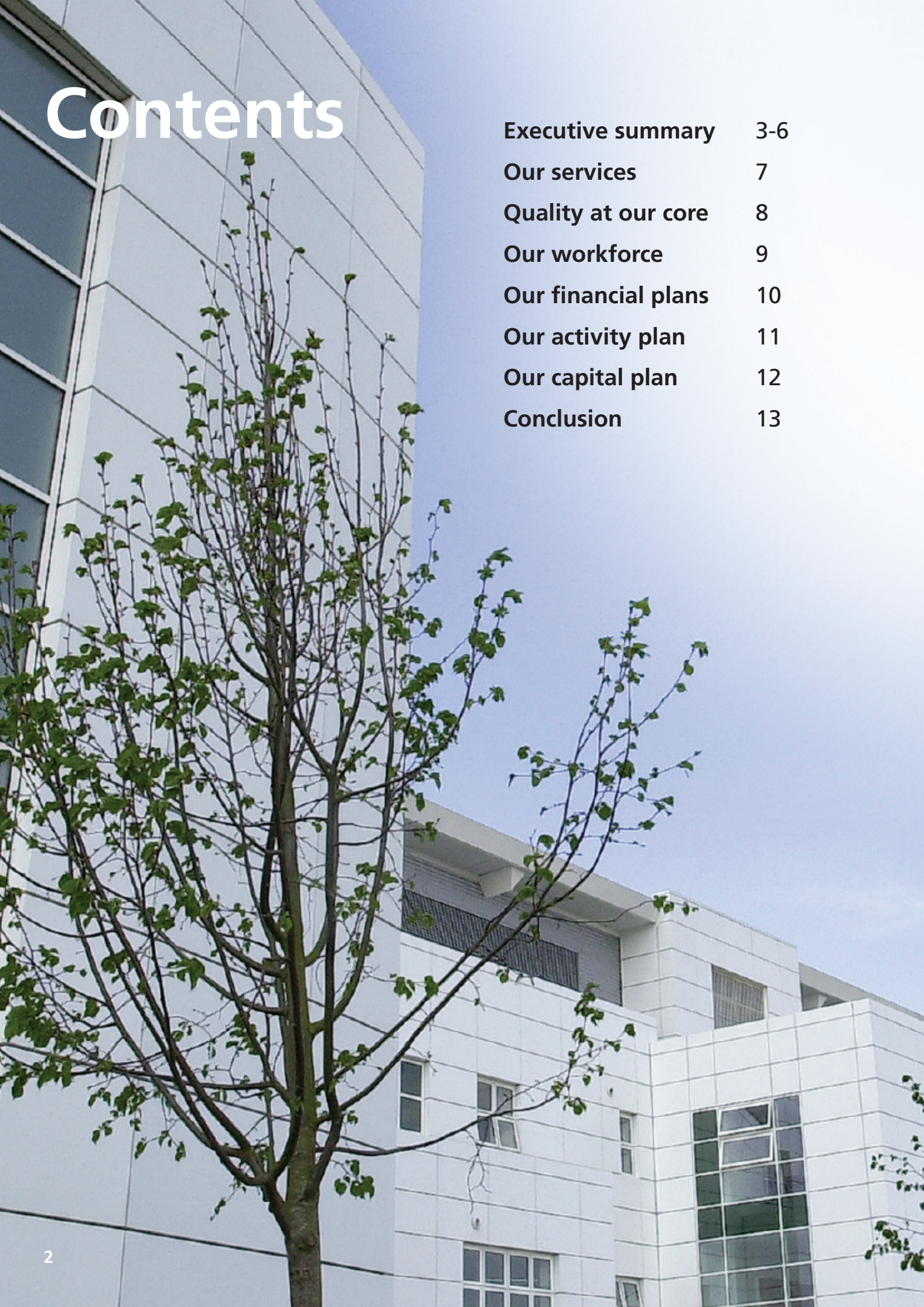
- To note the amended plan.

The Dudley Group
NHS Foundation Trust

Operational Plan 2018/19

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

Contents



Executive summary

This operational plan describes the journey we are on to deliver our vision of being an organisation that is "trusted to provide safe, caring and effective services because people matter".

This summary supports our operational plan 2017/19 which includes detailed finance, workforce and activity returns demonstrating how we intend to deliver high quality services and remain financially sustainable whilst delivering NHS England's Five Year Forward View requirements and taking an active part in the Black Country Sustainability and Transformation Programme (STP).

We entered into a two-year contract with Dudley Clinical Commissioning Group (CCG) for 2017/18 and 2018/19 which follows the national NHS Improvement Operational Planning and Contracting Guidance for 2017/19. We have refreshed this contract with our commissioners for year two (2018/19) following the publication of the CCG's commissioning intentions for 2018/19 and NHS England and NHS Improvement Joint Planning Guidance.

The CCG is commissioning a Multi-specialty Community Provider (MCP) for Dudley and is planning to award this contract in 2018. This will be a new organisation which will integrate health and social care services transforming the way we provide care to patients. We are a leading partner of this process.

Some services currently provided by us will be delivered through the MCP, including some outpatient and most community based services, intermediate care and end of life services.

"Fantastic staff made me feel really comfortable and at ease."

The four Black Country acute provider trusts agreed to create a Black Country Pathology Service (BCPS). The service will have a hub at New Cross Hospital in Wolverhampton with essential service laboratories at Russells Hall Hospital in Dudley, Walsall Manor Hospital and the Midland Metropolitan Hospital. Detailed work has been underway since September 2017 to plan for this, including developing the operating model, logistics, estates and IT infrastructure. There is a phased approach to implementation of the service through to March 2020.

The NHS faced unprecedented demands last year. The Emergency Department at Russells Hall Hospital has seen a 9.4 per cent increase in attendances over the last five years. Within this is a 41.3 per cent increase in attendances for patients aged 85 and older. This is very significant as these patients are often seriously ill, with multiple health problems, requiring various diagnostic tests, longer stays in hospital and substantial support in the community to be discharged from hospital safely.

We continue to redesign how we see and treat emergency patients. The brand new £2.6m Emergency Treatment Centre was completed this year providing new facilities for the Urgent Treatment Centre, run by Malling Health, and our Emergency Department waiting area. Through this new build, we took the opportunity to relocate our minor injuries and ambulance triage area to help with better patient flow. We also moved the Emergency Assessment Unit (EAU) and created an Acute Medical Unit (AMU) to again help in ensuring the best care is delivered to patients.

Further investments have been made at the Guest Outpatient Centre for a new £3.5 million imaging suite including a new MRI scanner and refurbishment of our renal satellite centres in Tipton and Kidderminster. The new facilities at the Guest will be able to handle almost 20,000 extra scans a year and reduce waiting times for patients. All patients sent for an MRI or CT scan by their GP will no longer have to visit Russells Hall Hospital or Corbett Outpatient Centre but will, instead, go to Guest.

The success of our plan will depend on how we deliver our services with a sustainable workforce and manage the money that we have available. We monitor the progress of this plan through the Board of Directors every quarter.

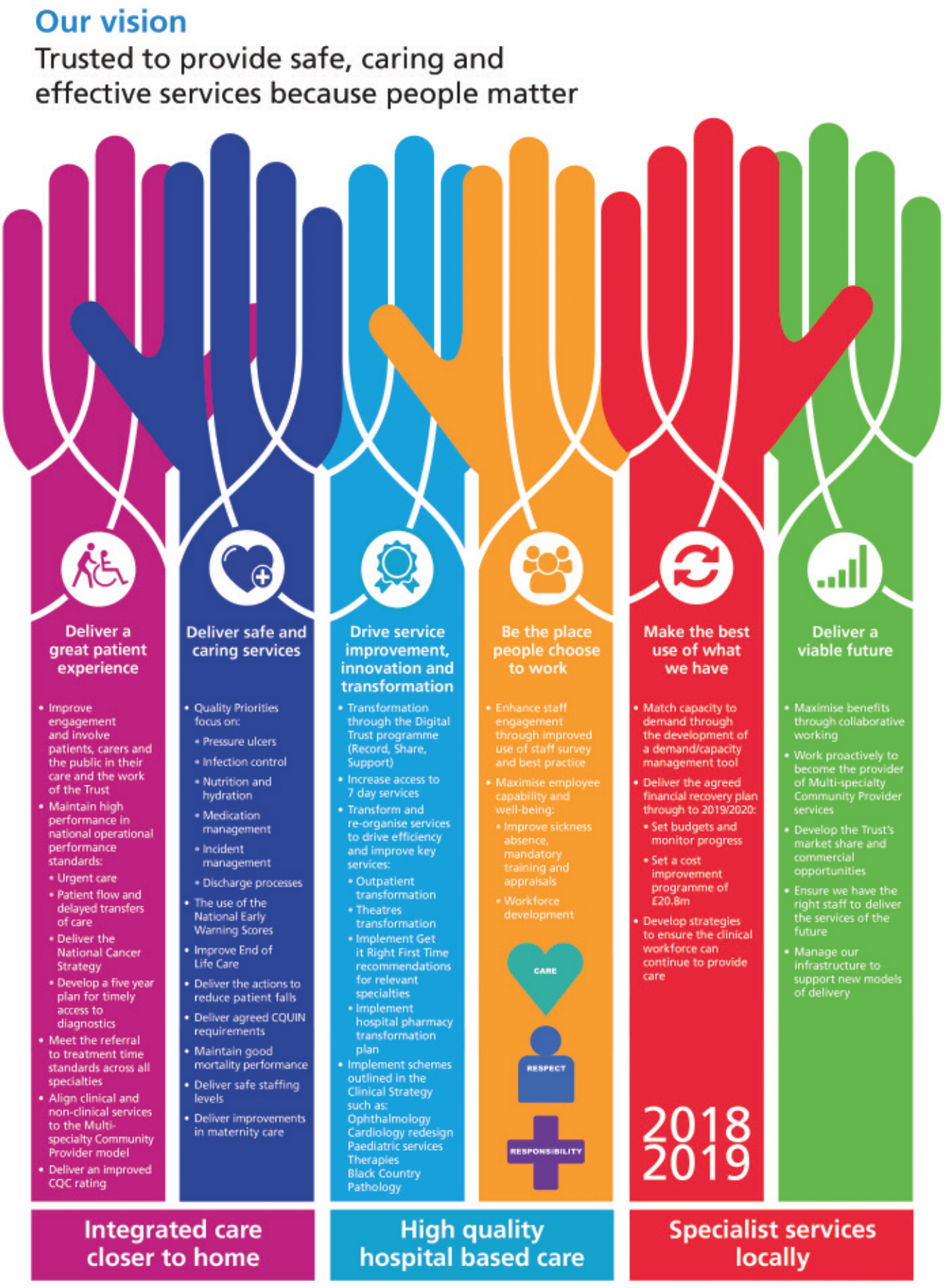
We have introduced a quality improvement programme which will help us to review the services we provide and continuously improve those services.

Summary of achievements

- We are the vascular hub for the Black Country
- We continue to achieve key standards for patients
  - cancer patients are treated within 62 days of referral and this has been achieved since September 2017, with the exception of February 2018
  - patients receive diagnostic procedures within six weeks
  - the vast majority of patients referred to us are treated within 18 weeks
- We protect our patients from infection
  - No cases of Meticillin-resistant Staphylococcus aureus (MRSA) since September 2015
  - Some of the lowest levels of Clostridium difficile (C. diff)
- We are reducing the number of avoidable falls that result in harm in our inpatient services
- We ensure we learn from all in hospital deaths having a multidisciplinary review
- We have reduced neonatal deaths and not had any avoidable maternal deaths
- We have reviewed and redesigned how we provide outpatient services and have a theatres transformation programme
- We have invested in our workforce development and have introduced an employee development programme for executive and divisional staff, as well as a programme for management staff for 2018/19
- We encouraged staff to look after their well-being through events taking place throughout the year which focused on their physical and mental health. We also offered them rapid access to physiotherapy.

We have invested in our workforce development.

To bring this plan to life for our staff and patients we have a plan on a page which is an at a glance page detailing our strategic objectives, what actions we are taking to deliver them and the key priorities that underpin them.



Our services

We provide acute and community services to the population of Dudley but also from other parts of the Black Country, West Birmingham, South Staffordshire and North Worcestershire.

We provide a range of specialist services, some of which are accessed by patients from across the country. These include vascular surgery, endoscopic procedures, stem cell transplants and specialist genitourinary reconstruction.

We have a workforce of just over 4,600 staff making us the second largest employer in the borough. Our staff are our greatest asset and provide a range of secondary and tertiary services including:

- Adult community services including community nursing, end of life care, podiatry, therapies and outpatient services from a range of community venues across the borough.
- Russells Hall Hospital in Dudley, which has more than 650 beds, including intensive care beds and neonatal cots, provides secondary and tertiary services such as maternity, critical care and outpatients, and an Emergency Department that features a brand new Emergency Treatment Centre.
- The Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge provide a range of outpatient and day case services.

We are also proud to be the vascular services hub for the Black Country and have an active research and development team.

"The nurses and doctors are very helpful and kind and have time for you and explain everything"

Quality at our core

We have a set of quality priorities we develop with our stakeholders, patients and governors and share widely every year through our annual review summary. These priorities help us to focus on certain areas that need attention and we all want to make improvements to. The detail of these can be found in our Annual Report and Quality Account. This year the priorities focus on:

- Patient experience and how we get feedback from our patients.
- Infection prevention and control – NHS England has a zero tolerance of MRSA bacteraemia and the Trust has a challenging nationally set target of no more than 28 C. diff cases due to lapses in care for 2018/19.
- Pressure ulcer prevention.
- Nutrition and hydration – a nutritional assessment within 24 hours of first contact with patients in both the hospital and community is a priority. In addition, an audit tool is in use to help monitor and improve in this area.
- Medications – an indicator of the overall quality of patient care is that patients receive their prescribed medication appropriately and on time.
- Discharge management – it is important that we safely and effectively discharge our patients.
- Incident management – incident reporting, learning and consequent changes in practice are priorities both locally and nationally.

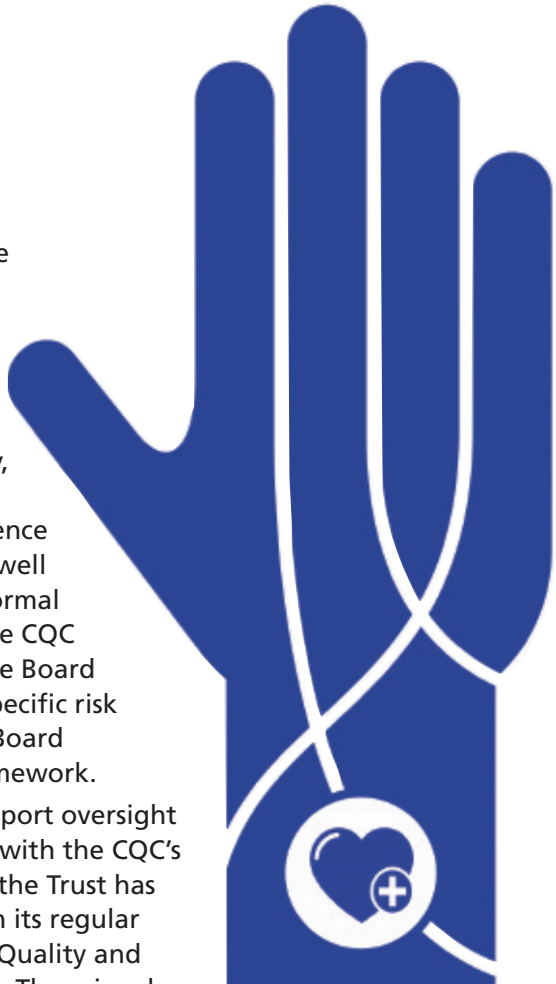
We also ensure we take part in all national clinical audits and audits of compliance with the National Institute for Clinical Excellence (NICE), which complements our wide ranging clinical audit programme. We also aim to achieve all of our Commissioning for Quality and Innovation targets which provide extra income whilst improving quality for things such as timely identification and treatment of sepsis, preventing ill health by risky behaviours and medicines optimisation. The estimated value of CQUINs for 2018/19 is approximately £6.8m.

We have been rated as 'Requires Improvement' by our regulators the Care Quality Commission (CQC) and we want our services to be rated 'Good or Outstanding' so quality improvement is at our core.

The Trust has put a comprehensive improvement plan in place which not only addresses the CQC concerns (many of which were addressed immediately as they were raised), but also planned service improvements.

Progress on 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 oversight of compliance with the CQC's requirements, the Trust has continued with its regular unannounced Quality and Safety Reviews. These involve a multi-disciplinary team visiting clinical areas. They include members of our Council of Governors and representatives of the Dudley Clinical Commissioning Group's Quality Team. During the visits, clinical practices are observed, staff are questioned on their knowledge and compliance with Trust policies and patients are asked for immediate feedback on their experiences. The outcomes are reported back to the clinical area on the same day allowing them to continue with identified good practice and make any enhancements swiftly. Learning is shared across the Trust to allow areas to learn from each other.



Deliver safe and caring services

- Quality Priorities focus on:
  - Pressure ulcers
  - Infection control
  - Nutrition and hydration
  - Medication management
  - Incident management
  - Discharge processes
- 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

Our workforce

Planning approach to workforce

Our Workforce Strategy that outlines the key actions we will take to ensure we have a workforce with the capacity and capability to meet the Trust's aspirations, and to deliver safe and effective patient care.

Workforce planning is an essential part of our operational planning process. Divisions develop workforce plans which take into account their activity and capacity forecasts.

We plan to have a workforce of 4,677 staff in 2018/19. This is an increase of 296 whole time equivalents (WTE) compared to what we had originally forecasted for March 2018. The increase is linked to vacant posts being filled and an increase in the number of posts because of approved business cases and quality initiatives. Pay costs will account for 61.5 per cent of our expenditure budget in 2018/19 which amounts to £219m. The planned vacancy rate is expected to average 6.3 per cent during 2018/19 (higher at the outset but reducing throughout the year as vacancies are recruited to).

We spent £11.7m on agency staff in 2017/18 which is £2.4m less than 2016/17. The Trust has a target to reduce this spend to £6.2m in 2018/19. A number of initiatives are in place to support recruitment of permanent staff and conversion of agency to bank staff. The aim of the Workforce Strategy is to develop a sustainable workforce, with particular focus on supporting 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. The Trust supports cooperative working across the region and is actively involved in STP workforce initiatives.

The annual target for the number of apprenticeships is set nationally as 2.3 per cent of our workforce which is equivalent to 111 apprentices, which is our target for 2018/19.

Workforce monitoring and skills development

Key workforce indicator, including vacancy, turnover, sickness absence, appraisal and mandatory training are monitored monthly at divisional performance meetings and are presented to the Board of Directors.

The appraisal process, which takes place between April and July, helps staff to understand how their role relates to service delivery and the Trust's strategic objectives. This means that appraisals take account of the revision of the Trust's annual plan. The appraisal information also provides a training needs analysis by staff group and by area. Our appraisal training programme will provide assurance around the quality of appraisal meetings and outcomes.

We are currently implementing new opportunities for staff development. A new Executive Development programme was introduced in December 2017 and the Leadership Forum, which includes the top 100 leaders in the Trust, was introduced in November 2017. It is underpinned by a new leadership development programme that will run in partnership with NHS Elect. This commenced in January 2018. It provides coaching for medical managers and a development plan.

Workforce engagement

Our overall staff engagement score continues to be better than the national average and 25 of the survey's 32 key findings are equal to or better than similar trusts. However, we are working to:

- increase the percentage of staff/colleagues reporting an experience of violence;
- increase the percentage of staff agreeing that their role improves patient experience;
- decrease the percentage of staff working extra hours;
- increase the percentage of staff satisfied with 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. The first Staff Health and Wellbeing Fair took place in February 2017 and offered staff a free NHS health check and advice on eating and living well. Further events are planned for 2018/19.

We engage with staff through monthly team briefings by the chief executive, 'Breakfast with the Boss' and Directors' Blogs as well as regular updates on the staff internet, the Hub. Staff achievements are recognised through Healthcare Heroes and annual Committed to Excellence Awards. We are further developing our benefits for employees to broaden our offer to new and existing staff and encourage people to stay with The Dudley Group.

Our Financial Plans

How we plan to use our money in 2018/19

In 2017/18, the Trust had a deficit of £10.6m (£13.130m adrift from the control total). Detailed financial plans have been developed for 2018/19 via budget setting, capacity planning and contract discussions with commissioners. The 2018/19 plan takes account of the pressures experienced in 2017/18 along with in-year developments that were agreed. The Multi-specialty Community Provider (MCP) could have a significant impact upon the Trust's financial position which will need to be considered in the longer term.

Efficiency Savings for 2018/19

We planned to achieve an internal cost improvement programme of £12.4m in 2017/18 and delivered £9.8m. The current financial pressures mean that the Trust will need to develop a significantly increased savings plan for 2018/19 of £15.4m in order to develop an overall plan that is consistent with the agreed control total.

Efficiency schemes include local efficiency plans as well as ideas developed alongside partners within the Black Country and the STP. The Model Hospital (Lord Carter) benchmarks (please see below) are used to help develop efficiency schemes. Best practice tariffs are also being implemented to provide increased income opportunities whilst improving patient experience.

Lord Carter Model Hospital

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 by removing unwarranted variations. The report outlined potential saving opportunities and recommendations for how they can be achieved.

We are participating in the NHS England Elective Care Transformation Programme to reconfigure patient pathways in urology, ENT and cardiology. The aim of this programme is to manage demand and improve patient experience and the efficiency of services. In April 2018, the Trust was successful in its application to be part of the NHS Improvement LEAN programme and is one of seven trusts to be selected. The programme will focus on improving the efficiency of services. In addition, the Trust is working with the Advancing Quality Alliance (AQuA) which is providing a bespoke programme of support for key quality issues.

Our Activity Plan

Activity plans set out the level of demand we expect in 2018/19 and indicate the resources (e.g. theatres, beds) we will need to deliver that demand (workforce is considered on page 9). Activity includes planned referrals from GPs and other health professionals for outpatient and community services. It also includes emergency activity (either referred from GPs, brought by ambulance or patient self-referrals).

Activity is modelled from a baseline period and includes growth and other relevant amendments. The table below shows the activity that we expect to provide in 2018/19. The forecast activity for 2018/19 is at a lower level because less activity was delivered in 2017/18 than we originally planned.

The national planning guidance and additional funding allocated to our commissioners in 2018/19 mean that they must ensure activity plans adequately reflect growth assumptions and maintain/improvement Referral To Treatment (RTT) levels. However, the Clinical Commissioning Group (CCG) also has several Quality, Innovation, Productivity and Prevention (QIPP) schemes designed to reduce demand (e.g. procedures of limited clinical value, Urgent Care Centre). The Trust is working with the CCG to deliver these.

We use capacity modelling tools developed by NHSI and NHSE to maximise the use of our facilities. The number of available general and acute inpatient beds will be flexed to cater for peaks in demand, particularly over the winter period. In addition, we will continue to reduce length of stay by working with the local authority to reduce delayed transfers of care (DTOC). There has been national funding made available to social care in Dudley to support winter pressures and reduce DTOCs over the next three years. By ensuring the Trust matches demand and capacity, we will work to deliver the national operational performance standards.

	2017/18 planned	2018/19 planned	% Change
A&E	101,381	105,108	3.7%
Elective	6,630	5,843	-11.9%
Daycase	47,755	48,690	2.0%
Emergency	54,123	41,166*	2.2%*
Outpatient first	125,671	151,685*	2.0%*
Outpatient follow up	322,415	303,994	-5.7%
Outpatient Procedure	67,005	70,979	5.9%
Births	4,518	4,364	-3.4%
Community	391,603	399,471	2.0%

*A coding change during 2017/18 changed assessment unit activity from an emergency admission to an outpatient first. The estimated impact on the 2018/19 plan is a reduction of 13,850 emergency admissions and an increase of 23,083 outpatients.

Our Capital Plan

We delivered a number of significant capital schemes in 2017/18 which included the development of a community imaging hub at the Guest Outpatient Centre and a co-located Urgent Care Centre and Emergency Department at Russells Hall Hospital.

We are implementing an Electronic Patient Record which will give clinicians fast access to patient information wherever they need it. This will help the Trust to meet the aspirations of the NHS Five Year Forward View to become 'paper-free at the point of care' by 2020.

In 2018/19, we will focus on two capital investments, which are:

- the development of a hybrid theatre that will assist in the management of emergency vascular patients and provide theatre capacity to support additional elective activity;
- reconfiguration of the Emergency Department to provide a better environment for patients.

Risks

The Trust has a risk and assurance framework in place with processes 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, and updated on a regular basis. The key risks in the delivery of this annual plan are listed below.

Risk	Mitigation
Adverse financial settlement	The Financial Improvement Group in place to rigorously monitor Trust finances and cost improvement measures
Not delivering the Cost Improvement Programme	The Financial Improvement Group is in place to rigorously monitor Trust finances and cost improvement measures
Workforce recruitment and retention	Recruitment and retention plans are in place, along with workforce development initiatives
Skill mix of staffing	Recruitment plans are in place, especially for hard to recruit to posts. Skills development programmes are in place
Not getting control of agency spend	Robust rules around requesting use of agency staff are in place. Recruitment and retention plans are in place
Uncontrollable demand for services	Robust directorate planning processes are in place which will be reviewed regularly. Reconfiguration of urgent care and acute medicine services
Changes in external environment	The Trust has mechanisms for horizon scanning in place with a regular review of our 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	A robust action plan is in place with rigorous monitoring

Conclusion

2018/19 will be a challenging year considering the financial position of the Trust. However, we are committed to delivering the Cost Improvement Programme and achieving financial balance. Progress will be monitored, any slippage will be addressed and staff will be supported to remove anything that prevents the achievement of their plans.

The Trust is committed to providing high quality, timely care to the population it serves and will implement the priorities outlined in this plan, particularly the national standards and the improvements outlined in the CQC action plan. We will work towards embracing the opportunities presented by the implementation of the MCP, the STP and through the implementation of new technologies (particularly the Electronic Patient Record). We will develop new market opportunities and maximise the benefits of collaborative working. In doing this, the Trust recognises that it needs to continue to invest in, and develop, its workforce and continue to engage with patients. We will act on their feedback and continue to focus on our quality priorities.

This 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 delivery against the plan to improve the care provided to the population the Trust serves.

The Trust is committed to providing high quality, timely care to the population it serves and will implement the priorities outlined in this plan.

Enclosure 14

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board
June 2018

TITLE:	**Digital Trust Programme Committee Update**		
AUTHOR:	**Mark Stanton (CIO)**	**PRESENTER**	**Anne Becke**
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		

CORPORATE OBJECTIVE:

SO3: Drive service improvements, innovation and transformation
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

Rollout 1 eObs of the Digital Trust successfully went live on 17th May 2018 2am

- Adoption and feedback from staff on the wards has been excellent
- The product is functioning well with the majority of issues resolved within the first 24 Hours.
- An additional 400 devices including Workstations and tablets have been deployed to the wards with over 3,500 eObs taken daily.
- With the exception of any Clinical safety issues the eObs code will be frozen and any enhancements minor fixes will be addressed in a new release in Q3 2018.
- eObs has been transitioned to a Business as Usual service with the majority of the team now focused on future rollouts.
- Various press releases have gone out with some interviews lined up with trade press.

A plan is being developed for presentation at the June DTPC to look at moving to a model of delivering smaller but frequent deliveries to keep momentum in the project.

IMPLICATIONS OF PAPER:

RISK	**Y COR089**	**Risk Description:** EPR programme is delayed or fails to deliver benefits
	Risk Register: Y	**Risk Score:** 16

COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD

The Board is asked to note the successful rollout of eObs and expect a plan for future phases at the July 2018 board.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board
June 2018

Committee	Meeting Date	Chair	Quorate	
			yes	no
Digital Trust Programme Committee	23rd May 2018	Ann Becke	X	

Declarations of Interest Made

None

Assurances received

Project status – Digital Trust R1 Go-live – Successful Implementation

1. eObs was cut-live across the Hospital at 2am 17th May 2018 with the following exceptions :-
    a. ED was delayed due to issues with the client on the legacy workstations in the Medics area, this was resolved by 6am
    b. Wards that were not open until 8am.
    c. Individual Nurses continued with paper Obs for an assortment of reasons within the first 12 hours.

    By COB 18/5/18 the majority of low level individual issues had been resolved for each shift and the entire Trust was live as per the project plan.

2. A total of 70 Workstation on Wheels (WOW) with single tap using ID card , session persistence, 225 Tablets and 90 Tracking boards to Nurses stations were ready for Service 17th May along with the application dropped to Legacy workstations.

3. A Number of low level issues were managed :-
    a. Numerous login issues occurred due to staff not having used Net work account logins for some considerable time and requiring a reset (Actioned on a proactive basis)
    b. Sunrise logins not completed (actioned on a proactive basis)
    c. Locum Nurses required accounts (Solution to transfer to wards in progress)
    d. A Server issue resulted in several short occurrences of intermittent access restricted to the 70 WOW devices (< 1 Hour each)

A 24/7 Command centre was in place from 17/5 to 22/5 at which point support dropped back to Business as usual support through the helpdesk with some enhanced hours of working temporarily to 9pm.

Usage and adoption have been good during a number of walks around the wards with 2,000 logons within the first 24 Hours alone. Observations are increasing daily with around 3,500 recorded per day.

A full lesson learnt review will take place to inform the next phase of the programme.

Project status – Digital Trust Next Phase

The changes to the initial plan in early 2018 to meet the Trust objectives around deteriorating patients has facilitated the need to re-focus the remainder of the rollout.

The successful rollout of eObs will move staff to a more comfortable position with the use of technology in the day to day care of patients increasing the adoption rate in future rollouts.

In order to maintain momentum a review is underway to look at the feasibility of providing functionality in small deliveries spread across the year starting with eSepsis in June 2018.

Once we have agreement we can understand any impact to project costs and to the Benefits case to be presented at the June DTPC.

The Trust Annual plan is for EPR rollout by 31/3/19, this plan will meet this objective.

Decisions Made / Items Approved
• Approval to review the rollout phasing • A code freeze on eObs will be in place until 30/6/18. Only Clinical safety issues will be addressed all other requests and low level issues will be logged, communicated back and resolved later in an update release.

Actions to come back to Committee (items Committee keeping an eye on)
• Timeline and cost impact of rescheduling the rollout plan.

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 15

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 7 June 2018

TITLE:	**22 May Audit Committee Summary Report**		
AUTHOR:	Richard Miner Committee Chair	**PRESENTER**	Richard Miner 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 OBJECTIVE: All

SUMMARY OF KEY ISSUES:

The attached provides a summary of the assurances received at this meeting, the decisions taken, the tracking of action 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:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** links all domains
	NHSI	**Y**	**Details:** links to good governance
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	X

RECOMMENDATIONS FOR THE BOARD:

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

Audit Committee highlights report to Board of Directors

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	**22/5/2018**	**Richard Miner**	**yes**	**no**
			x	

Declarations of Interest Made

None

Assurances Received

- The (ISA 260) report from PwC (the external auditors) on their audit work on the Trust's accounts for the 2017/18, including use of resources (value for money) showing an unmodified (clean) opinion except for items I have specifically referred to the Board (below).
- The (ISA 260) report from PwC on the Charitable Funds.
- The unqualified limited assurance provided by PwC in respect of the Quality Account and Report except for items I have specifically referred to the Board (below).
- The Head of Internal Audit (HoIA) Opinion for 2017/18 – an adequate and effective framework for risk management, governance and internal control notwithstanding some "further enhancements" that could be applied. This report is the same as last year, the second highest level of confidence, and the enhancements were set out in my previous report. The Opinion supports the Annual Governance Statement.
- That work had been followed up in the 3 previously outstanding areas (but see below) together with one other:
  - Data quality – VTE – management actions, checking, data input and areas of non-compliance
  - No assurance around compliance with policy on oxygen prescribing
  - Incomplete actions in respect of CQC's review of health services for children and safeguarding
  - Cyber security review – reasonable assurance
- The LCFS Annual Report for 2017/18 including the self-review tool which reflected an overall amber rating (this is fairly normal).
- The Trust's Year End Clinical Audit figures for 2017/18 and the objectives for 2018/19.
- The overall positive response from the Audit Committee self-assessment subject to some follow up work I refer to below.

Decisions Made / Items Approved

The Committee, and where required using powers delegated to it by the Board on 12 April 2018:

- Approved the signing of the Letter of Representation on the Trust's annual accounts for 2017/18.
- Approved the Trust's Annual Accounts for 2017/18.
- Approved the draft Annual Report including the Annual Governance Statement noting a number of modifications and changes necessary and that will be circulated to members of the Audit Committee before 29 May.
- Approved the signing of the Letter of Representation on the Quality Accounts.

Audit Committee highlights report to Board of Directors

- Approved the draft Quality Account and Report for 2017/18 noting a number of modifications and changes necessary and that will be circulated to members of the Audit Committee before 29 May.
- Approved the signing of the Letter of Representation on the Charitable Funds for 2017/18.
- Approved the Charitable Funds Accounts and Annual Report for 2017/18.
- Noting the Local Counter Fraud Specialist Annual Report for 2017/18 and being cognisant of the Audit Committee's (and Board's) attitude to fraud, confirmed its continued commitment to a strong anti-fraud culture within the Trust as well as an effective fraud risk management programme.
- Approved the Audit Committee's Annual Report subject to some additional information and some minor changes necessary on completion of certain audit work and which has now been done (attached at Appendix 1)
- Debated and approved changes to the Risk Management strategy.
- Noted the loss report for Quarter 4 and for 2016/17.

Actions to come back to Committee / Group (Items Committee / Group keeping an eye on)

- Recommendations arising from the external audit work.
- Monitoring of management actions and timescales identified in the HoIA opinion.

Items referred to the Board / Parent Committee for decision or action

- That the Trust Annual Accounts for 2017/18 have highlighted an additional "going concern" risk in the accounting policies arising from losses incurred and depleted cash balances which is also reflected as a material uncertainty note in the (unmodified) opinion from external auditors PwC.
- That the PwC Use of Resources (Value for Money) opinion is an "except for" one as a consequence of "gaps in the Trust's application of the principles and values of sound governance in relation to A&E".
- That the Limited Assurance Report provided by PwC on the Quality Accounts contained:
  - A disclaimed opinion on the A&E 4 hour wait indicator. The data provided was insufficient to demonstrate compliance with the national priority indicator.
  - A disclaimed opinion on the 18 week RTT indicator. This is because the validation process is not applied to the whole data set as well as the date it is run to. The clock had also not been stopped on a timely basis in some instances. This issue affects a number of trusts.
- The Audit Committee's Annual Report for 2017/18.
- Agreed actions following the Audit Committee Effectiveness Self-Assessment including
  - Specific agenda item covering consideration of risks identified by other committees
  - Demonstration of feedback from Board
  - Demonstration of AC chair's role
- The loss report for 2017/18 where amounts appear to be within reasonable tolerance.

Audit Committee highlights report to Board of Directors

- Referral back to CQSPE in respect of VTE, oxygen prescribing and children and safeguarding.

APPENDIX 1

The Dudley Group
NHS Foundation Trust

ANNUAL REPORT OF THE AUDIT COMMITTEE FOR THE YEAR 2017/18

1. Introduction

The Audit Committee is established to provide assurance to the Board that there is an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives and that this system is established and maintained.

The purpose of this report is for the Audit Committee to account to the Trust Board of Directors on its activities relating to the financial year 2017/18. In practice this covers the period up to the approval and sign off of the Trust's Annual Report and Accounts, which is due to take place on 22 May 2018. The Board gives delegated powers to the Audit Committee to approve these documents.

After each of its meetings during the year, the Audit Committee provides a written report to the Trust Board that details the matters discussed, key issues identified and any items requiring referral to Trust Board. This annual report draws from the information contained in these regular reports.

The Committee's responsibilities are set out in detail below.

Although financial scrutiny remains vitally important, Audit Committees have increasingly recognised that there is a widening range of activities which require comprehensive and effective controls and which should therefore fall within the remit of the Audit Committee. For NHS organisations, this typically includes clinical governance issues, such as the collection and reporting of performance and quality data, the preparation of annual clinical audit plans and processes and the measures taken to combat fraud.

In order to discharge its key functions, the Audit Committee prepares an Annual Report for the Trust Board and the Chief Executive as Accounting Officer of the Trust and expresses its considered opinion based upon the evidence placed before it.

2. Audit Committee's Responsibilities

During the year, the Audit Committee operated in accordance with its responsibilities as set out in its Terms of Reference, which are:

a) To review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the organisation's activities, both clinical and non-clinical, that supports the achievement of the organisation's objectives;

b) To ensure that there is an effective Internal Audit function that meets Government Internal Audit Standards and that provides appropriate independent assurance to the Audit Committee, Chief Executive and Trust Board;

c) To review the work and findings of the External Auditors and consider the implications of and management's responses to their work;

d) To review the findings of other significant assurance functions, both internal and external to the Trust and including in particular local and national clinical audit activity and outcomes and consider the implications for the governance of the organisation;

e) To satisfy itself that the organisation has adequate arrangements in place for countering fraud and to review the outcomes of counter fraud work;

f) To receive and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. The Committee also requests specific reports from individual functions within the organisation (for example, clinical audit) where these are appropriate to the overall arrangements;

g) To monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance;

h) To ensure that the systems for financial reporting to the Trust Board, including those of budgetary control, are subject to review in order to establish the completeness and accuracy of the information provided to the Trust Board;

i) To review the Annual Report, Quality Report and financial statements before submission to the Trust Board focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- Changes in and compliance with accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements and significant judgments used in the preparation of the financial statements
- Significant adjustments resulting from the audit
- The letter of management representations
- Qualitative aspects of financial reporting
- Contents of the Quality Report

3. Audit Committee Membership

The Audit Committee is constituted as a sub-committee of the Trust Board with approved terms of reference that are aligned with the *Audit Committee Handbook 2014* published by the HFMA and Department of Health. (An updated version was published in March 2018). The required quorum for meetings is two Non- Executive Directors.

It is recommended that the Chair of the committee is a suitably (CCAB) qualified accountant. Richard Miner is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA).

Certain individuals were required to attend Audit Committee meetings. These included the Trust Director of Finance & Information, senior representatives of the External Auditors of the Trust, senior representatives of the Internal Auditors of the Trust and the Local Counter Fraud Specialist (LCFS).

The table below records attendance at each meeting, including the last meeting of the 2016/17 cycle; the 2017/18 cycle of 5 meeting is due to complete at the forthcoming meeting on 22 May 2018:

Date of Meeting	Audit Chair	Other NEDs	Finance Director	External Auditors	Internal Auditors	LCFS
16 May 2017	Yes	2	No*	Yes	Yes	Yes
22 August 2017	Yes	1	No*	Yes	Yes	Yes
28 November 2017	Yes	2	Yes	Yes	Yes	Yes
30 January 2018	Yes	1	Yes#	Yes	Yes	Yes
19 March 2018	Yes	2	No*	Yes	Yes	Yes

* The Deputy Director of Finance, Financial Reporting was present on each occasion.

The Deputy Director of Finance, Financial Reporting held the role of Interim Director of Finance.

Other individuals from the Trust are invited to attend meetings including the Chief Executive, Chief Nurse and the Director for Governance.

The Committee is able to draw on the independent advice of the Trust's auditors and any other officers or outside agencies it considers necessary. The Committee also met with both the External and Internal auditors in private during the year in order to ensure that they had the freedom to raise any issues of concern. These meetings centered primarily on the auditors' assessment of business risks and the management of these; transparency and openness of working relationships with management; and confirmation that management had not attempted to place any restrictions on the scope of their audit work. There were no matters to report as a result of these meetings.

The Terms of Reference for the Audit Committee are reviewed annually and the most recent update was approved at the November meeting and presented to the Board at its December 2017 meeting. Whilst all Non-Executive Directors can attend meetings of the Audit Committee should they wish to do so, two specific Non- Executive Directors have been appointed to serve on the Audit Committee, in addition to the Chair of the Committee in order to provide the Committee with sufficient balance and ex perience.

4. Internal Audit

Internal Audit services for the 2017/18 year were provided by RSM. Internal Audit supports the work of the Audit Committee in two key areas:

a) by providing an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's strategic objectives; and

b) by providing an independent and objective service to help improve risk management, control and governance.

As is normal, a risk- based approach was taken to establish the internal audit plan for 2017/18. This took account of the strategic and operational risks relating to quality and safety issues; service delivery standards and targets; workforce; finance and business, as identified by both management and the Committee, as well as the need to review key financial systems to ensure that External Audit could continue to place reliance on the work of Internal Audit. The plan is updated throughout the year.

The Committee noted, once again, that the risk from cyber crime is continuing to have a growing impact on the shape of the assurance the Committee is seeking. Following the presentation of the Cyber Security Strategy in January 2017, an updated was presented to the Audit Committee at its November meeting. The Trust passed its first year audit for its ISO27001 accreditation.

Internal Audit has undertaken a number of advisory assignments as well as risk assurance assignments for which it issues a range of opinions between green (substantial assurance) and red (no assurance). Red reports were issued last year in the following areas:

- Data quality on Venous Thromboembolism Evaluation (VTE) and s troke suspected Transient Ischaemic Attacks (TIA) key performance indicators.
- IT Data Security Review
- IT Disaster Recovery

The latter two were followed up and closed down in 2017/18 notwithstanding the logging of follow up action points.

All issued reports have their agreed actions tracked and followed up, with Internal Audit providing a report on the progress made by management in implementing the agreed actions.

Other areas reviewed were in most cases rated as providing substantial or reasonable assurance or reviewed in an advisory capacity:

- High and m edium priority management actions (Phase 1) – reasonable assurance
- National Patient Safety Alerts (central processes) – substantial assurance
- Appraisals and mandatory training – advisory
- Do not attempt cardiopulmonary resuscitation – reasonable assurance
- Data Quality (6 week diagnostics) – substantial assurance
- Payroll (data analysis) - advisory
- IT Key Control Framework – substantial assurance
- General ledger and financial reporting – substantial assurance

- Payments to staff – substantial assurance
- Data quality (RTT) – substantial assurance
- Transformation programme – substantial assurance
- Creditor payments – substantial assurance
- Income and debtors – substantial assurance
- Risk management – reasonable assurance
- Information governance toolkit – 6/8 requirements attainments levels agreed with 2 unsubstantiated
- CQC Provider Information Return (Trust self-assessment) – advisory
- Cyber security review – reasonable assurance

Following the receipt of management responses in respect of VTE data quality follow up (ongoing work still required), oxygen prescribing (no assurance) and CQC's review of health services for children (incomplete actions) Internal Audit were able to complete their outstanding reports. Management follow up will be monitored and they have also been referred to CQSPE.

As a result of this work, the proposed opinion from the Head of Internal Audit is that:

"The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

Internal Audit also concluded, based on their work, that there were no significant internal control weaknesses that required reporting within the Trust's Annual Governance Statement.

The further enhancements relate to those framework areas (above) which provided less than substantial assurance but given Internal Audit is directed towards those more challenging or "uncomfortable" areas, this should not come as a complete surprise.

The Business Assurance Framework (BAF) is currently undergoing further development so that it more readily identifies the sources of assurance and risk mitigation actions particularly in respect of key corporate risks that threaten the Trust's strategic objectives. Two of the outcomes of this greater scrutiny are that:

- The executive led risk and assurance group are now meeting monthly rather than quarterly.
- Divisions will be required to attend the Audit Committee if gaps in risk management are identified and continue.

5. Clinical Governance

The core business of every NHS organisation is healthcare and consequently it is appropriate and necessary for the Audit Committee to consider the clinical objectives and risks in the Assurance Framework and report to the Trust Board on the controls and assurances relating to these. The Director of Governance reports to the Audit

Committee on the progress of the Clinical Audit Plan and the Chief Nurse is also available to attend the Audit Committee as necessary.

A total of 86 clinical audits were commenced in respect of 2017/18. At the last quarterly report date in [January] 2018, [13 audits had been completed and 73 were outstanding – to be updated following the May meeting].

The Trust participated in 35 National Clinical Audits linked to the Department of Health Quality Account list.

As set out above, in the summary of internal audit work undertaken, some of this work related to the measuring the effectiveness and compliance of clinical procedures and identified some breaches in policy. [At the time of writing this report, a follow up report on VTE data quality as well as the finalisation of reports on oxygen prescribing and also CQC's review of health services for children were awaited]. The CQC visits in December 2017 and January 2018 only served to emphasise the need to attach even greater importance to clinical audit (currently undergoing review) and the Audit Committee will also work to provide greater assurance to the Clinical Quality, Safety and Patient Experience (CQSPE) Committee.

A fundamental consideration for any healthcare organisation is the rostering, use of agency staff, competence and supervision of its workforce and the Audit Committee is awaiting the results of another key piece of work relating to workforce management. A member of the HR team presented at the November meeting of the Audit Committee on improvements that had been made to the system and process of appraisal and mandatory training.

The Audit Committee also received quarterly reports from the Research and Development Directorate.

6. Counter Fraud Services

The Local Counter Fraud Services (LCFS) have continued to provide a combination of fraud awareness newsletters and training, hold meetings with key managers and engage in active investigations. The essence of their work is preventative. Highest risks have continued to include the following areas:

- Consultant job plans (a national issue)
- Secondary employment/working when off sick
- Cyber crime

The LCFS concluded based on their work that there were no significant fraud risks that required reporting within the Trust's Annual Governance Statement.

7. External Audit

This will be the third year that PriceWaterhouseCoopers (PwC) has acted as external auditor. Ali Breadon is Engagement Lead and Joanna Watson has taken over from Matthew Elmer as Engagement Senior Manager.

The following audit risks were identified:

- Risk of management override controls
- Risk of fraud in revenue and expenditure recognition
- Valuation of land and buildings

Other areas that have been considered include:

- Going concern – particularly this year
- The Trust Quality Report, which is reported on separately
- The accounts of the Charitable Funds Committee and those of Dudley Clinical Services Limited, both of which are consolidated into the Trust's annual financial statements.

The audit of the Financial Statements requires the setting of a materiality level in order to assess the impact of any adjustments that might be necessary.

The audit is planned on the basis that the Trust has an effective financial control environment and this is subsequently tested along with application of various substantive analytical procedures. They also take into account the work of the internal auditors.

The Trust is required to demonstrate its Economy, Efficiency and Effectiveness in its Use of Resources which PwC reported as an "except for" opinion as a consequence of gaps in the Trusts governance processes in A&E. Otherwise, PwC issued an unmodified (clean) audit opinion which reflects that they had been able to satisfy themselves as to the truth and fairness of the financial accounts. This year has seen reference to the "going concern" situation in the Trust's accounting policies and PwC's reference to this "material uncertainty" in their report.

As far as the Quality Account is concerned, this is a "limited assurance" style of report but 2017/18 highlights a disclaimer of opinion in respect of A&E 4 hour waits due to data inconsistencies and a disclaimer of opinion on the 18 week RTT measure due the way data sets had been validated and to the application of the patient "clock".

8. Review of Audit Committee Effectiveness and Other Matters

During the year the Committee carried out a (self) review of its effectiveness and reported positively notwithstanding some actions follow up action points arising.

Members of the Audit Committee have access to a number of training, development and networking opportunities through some of the larger private sector accounting firms as well as NHS Providers which, because of the technical and risk based work of the Audit Committee, they are encouraged to attend. As CCAB qualified accountants, Richard Miner and Jonathan Fellows have a professional obligation to maintain their CPD in activities relevant to their responsibilities.

9. Conclusion and Audit Committee Opinion 2017/18

The Committee once again wishes to express its sincere gratitude and appreciation to everyone who has supported the work of the Audit Committee during the year and contributed to the effective functioning of the Audit Committee.

The Audit Committee considers it has obtained adequate assurance that the key controls and processes within the Trust to ensure corporate and financial governance continue to operate effectively and that this conclusion is supported by the reports of the Internal and External Auditors received by the Committee during the year. The recent CQC inspection has, however, highlighted areas in which the Audit Committee will be seeking further assurance in the future.

The Audit Committee is able to provide reasonable assurance to the Trust Board that there are no major weaknesses in the Trust's risk management, control and governance processes. The Trust Board should however recognise that assurance given can never be absolute and systems and the assurances around them must continue to improve.

[The Audit Committee reviewed the Trust's Annual Governance Statement and confirms, based on the information it has received, the statement is a balanced view of the Trust's systems of risk management, governance and internal control].

Richard Miner FCA
Chair of Audit Committee
May 2018

Enclosure 16

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Trust Board on 7 June 2018

TITLE:	**Research & Development 6- monthly Report**		
AUTHOR:	**Claire Phillips R&D Manager;**	**PRESENTER**	**Jeff Neilson, Director of R&D**

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 through to SO6 (research seeks to improve all aspects of patient care)

SUMMARY OF KEY ISSUES:

- NIHR study portfolio balance
- Support Department Capacity Issues – pharmacy
- Research Data Archiving

IMPLICATIONS OF PAPER:

RISK	**Y**		• **Risk Description:** • Identification of suitable archiving space • Finding funding for research data archiving when income is diminishing
	Risk Register: Y		**Risk Score:** 16
	Risk Register: N		**Risk Descriptions**: • Lack of clinical support department capacity is affecting our ability to take on new research.
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Safe, effective, caring, responsive, well led
	NHSI	**Y**	**Details:** R&D activity included in the Annual Report
	Other	**Y**	**Details:** Recruitment activity is monitored by CRN:WM, NIHR, DH

ACTION REQUIRED OF BOARD :

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD

The Board is requested to note the key issues arising and identify any further actions required.

Research & Development Report

Strategic Direction
Work on the R&D plan, based on the R&D strategy is on-going. The trust is to make research everyone's business and thereby increase overall research activity by broadening engagement with respect to both specialties and disciplines involved.
We have meetings set up with the West Midlands Academic Health Sciences Network (WMAHSN) to ascertain any future opportunities for R&D.

Accolades for The Dudley Group
The Dudley Group was the top recruiter in the UK and globally for a commercial ulcerative colitis study and a dermatology study. Top UK recruiter for FLO-ELA trial, (anaesthetics - 44 patients) and second largest recruiter in UK for critical care '65 Trial' (48 patients).

Dr Holly John's PhD (2011) looked at providing patient information to address the cardiovascular disease associated with rheumatoid arthritis (RA). Since then, the results have been developed into an online education programme delivered through the National RA Society website, launched on 14/2/18. It is a novel interactive web programme designed to increase the chances of lifestyle modification. Various Dudley employees were all filmed in 2016, for the programme including dietetics, Smoking cessation, health psychology and our research collaborator (in Wolverhampton University), as well as some of our RA patients. This is a clear example of research translating into tangible results for patients and of Dudley delivering a national/international resource. Holly is a Consultant Rheumatologist here and Head of Service.

Professor Mike Douglas, Consultant Neurologist, was a joint senior author of an important paper published in May 2018 which was the culmination of seven years' work (http://dx.doi.org/ 10.1136/jnnp-2018-317947). The study examined the use of a novel test on spinal fluid and its ability to predict prognosis in multiple sclerosis patients.

Dr Helen Ashby has recently been appointed Metabolic and Endocrine Clinical Research Service Lead for Clinical Research Network: West Midlands.

National developments and performance management

High level objectives
End of year 2017-18 performance targets relating to HLO1, patient recruitment (currently 99% of target) and activity based funding (ABF), at 78% of target, have been steadily increasing from around May/June 2017. Our current performance for HLO2 'recruitment to time and target' is at 60%. Performance against HLO4 'time taken to confirm site' (40 days of receiving an initial Health Research Authority assessment letter and full set of documents from the Sponsor), we are rated at 63% (previous year 58%). From 'site confirmed to first patient recruited' we are ranked 84/207 West Midlands Trusts. There are still some capacity issues and financial constraints affecting study initiation and ability to recruit to time and target, as we have a number of imminent staff changes. New processes have now been implemented to try and improve on the ABF figure.

Capacity for research support departments
Procurement and IT approvals can delay some studies opening due to approval of research equipment, and so will continue to monitor. New processes are now in place to have assessments performed at an earlier stage.
Pharmacy will have some staff shortages, June until possibly September 2018, due to three Band 8's leaving the department. This will have an impact on the number of new studies that require pharmacy involvement, to be set up and opened during this time period.

Finance and Staffing

Recruitment of participants to NIHR research studies is directly linked to the amount of Clinical Research Network WM (CRN WM) core funding received by each Trust. The confirmed core funding from CRN WM for 2018-19 is £497,716 (amount received 2017/18 £500,426), so very minimal reduction in funding for 2018/19.

The Trust has been successful with two strategic funding bids (until end March 2019). One is for a WTE ITU nurse/s to work on DGH's expanding Anaesthetics portfolio studies, to assist with patient recruitment, for which 2 part time nurses have now commenced into post. The second bid to support a Research Assistant to cover maternity leave until end October 2018.

The EDGE finance tool is now being rolled out to all R&D staff to manage and project our income and expenditure more efficiently.

Pharmacy drug cost savings figure for 2017/18: Trust/CCG savings of £16,895 and NHSE savings (specialised high cost drugs) £141,943.

Electronic Patient Record/IT/Archiving
R&D is represented at the EPR meetings to highlight any R&D issues and to address ways of how EPR can enable research.
Acquiring external secure space for long term clinical data storage is now a priority task and continues to be addressed by R&D Manager, Claire Phillips.

General Data Protection Regulations – readiness for research
Guidelines have been circulated to all R&D staff, as well Health Research Authority (HRA) guidelines. A review of all Trust sponsored studies will be undertaken to access if any amendments are required. Information has also been published on the Trust website and The Hub.

Education/Professional Development/Promotion
The Student Nurse Mentor Programme with Wolverhampton University whereby a placement within R&D can be selected is proving popular Regular presentations have been delivered at Student Nurse Inductions.

Dudley-based half-day refresher courses in Good Clinical Practice for research purposes continue to be led by Margaret Marriott. GCP Fundamentals and PI Master Class are now also available.

A regular R&D newsletter is now available and accessible on the Hub. This is also now circulated to Community Staff.

Regular fundraising events have now been arranged.

The Hub is currently being updated, and the Trust's external website to be updated soon to promote R&D more widely.

Lunchtime Research Club meetings were now well established and advertised on the R&D website on the Hub. These were held bi-monthly and regularly had 8-12 attendees.

International Clinical Trials Day was celebrated at The Hub, Main Reception 21st May 2018, with representatives from R&D Team, CRN;WM and two Patient Research Ambassadors for The Dudley Group.

Publications

46 publications January 2018 – May 2018. See attached list

Published research – January to May 2018

The Dudley Group NHS
NHS Foundation Trust

1. Agha, A., H. Bajwa, L. Bloomer, W. Walker, **H. Horrobin**, J. Vamvakopoulos and **H. Siddique** (2018). "Venous thromboembolism prophylaxis in patient with diabetes-related acute Charcot's arthropathy on total contact cast: A need for protocol." Diabetic Medicine 35: 137.

2. **Agha, A**. and W. Hanif (2018). "Assessing burnout syndrome among diabetes specialist trainee registrars across England, Scotland and Wales." Diabetic Medicine 35: 177.

3. Aladin, H., **A. Jennings, M. Hodges and A. Tameem** (2018). "Major lower limb amputation audit - introduction and implementation of a multimodal perioperative pain management guideline." British Journal of Pain.

4. **Barrett-Lee, J., J. Vatish, M. Vazirian-Zadeh and P. Waterland** (2018). "Routine blood group and antibody screening prior to emergency laparoscopy." Annals of the Royal College of Surgeons of England 100(4): 322-325.

5. **Bashar, K.,** M. Medani, T. Aherne, T. Moloney, H. Bashar, K. Ahmed and S. R. Walsh (2018). "End-To-Side versus Side-To-Side Anastomosis in Upper Limb Arteriovenous Fistula for Dialysis Access: A Systematic Review and a Meta-Analysis." Annals of Vascular Surgery 47: 43-53.

6. Brunning, T. and **S. Saba** (2018). "Morale and welfare in hospital doctors." British Journal of Hospital Medicine (17508460) 79(5): 244-245.

7. Cadoni, S., P. Gallittu, M. Liggi, D. Mura, L. Fuccio, M. Koo and S. **Ishaq** (2018). "Underwater endoscopic colorectal polyp resection: Feasibility in everyday clinical practice." United European Gastroenterology Journal 6(3): 454-462.

8. Cadoni, S. and **S. Ishaq** (2018). "How to perform water-aided colonoscopy, with differences between water immersion and water exchange: a teaching video demonstration." VideoGIE 3(5): 169-170

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Enclosure 17

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on the 7th June 2018

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

CORPORATE OBJECTIVES:

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

The report covers the following elements:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Board of Directors

Guardian of Safe Working Report June 2018

Purpose

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

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

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

Background and Links to Previous Papers

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

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

This is the 7th GSW report and covers the period of 21st Feb 2018 to 21st May 2018. The Guardian has been working closely with colleagues from medical staffing and rostering, post graduate medical education staff, human resources and finance to establish his role in the Trust and build relationships.

Challenges

<u>Engagement</u>

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

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

how to make exception reports.

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

As part of the above mention strategy, Guardian has been engaging with junior doctors by one to one contact both formally and informally.

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

Trust Exception Reporting Policy

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

Guardian Fine Disbursement

As reported in the previous Guardian Report. Guardian fines pot had **£2215**. It was fairly disbursed among 8 junior doctors who applied to this pot. This was offered as additional study leave expense. The disbursement was agreed mutually by the Guardian and the junior doctors in the last Guardian forum.

Junior Doctors Contract

In the last Guardian forum some junior doctors raised concern with regards to delay in receiving their new contract. Medical Director formed a task force comprising GOSW, HR Director, Head of HR Operations, Medical Workforce Resourcing and Planning Leads and Junior Doctors Representative to resolve the issue. Regular meetings were held and weekly progress on the issue were reported by medical workforce. I am pleased to inform the Board that all contract related issues have been resolved now.

Junior Doctors GMC Concerns

2 junior doctors from our trust have raised concern on GMC website. The trust has responded to those concerns promptly.
The first concern was with regards to tracking of patients, to which trust has already implemented electronic tool. The second concern was with regards to staffing of rota. Trust has now covered those with short term locums.

Exception Reports by Department – From 21st February to 21st May 2018 Total

Number of exceptions carried over	Number of exceptions raised	Number of exceptions closed	Number of exceptions outstanding	Specialty
None	2	2 0 EAU		-1 Surgery - 1

Exception Reports by Grade

Grade	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	0	1 0 0		
ST2	0	0 1 0		

Response Time

Within 48 hours	Within 7 days	Longer than 7 days	Still open
0	1 1 0		

Exception Reports and Fines.

We have received 2 exception reports by 2 doctors

- There were no immediate Safety Concerns reported.
- 1 exception report has been completed with no further action agreed by the supervisor and the junior doctor.
- 1 has resulted in compensation: overtime payment.
- 1 has taken longer than 7 days due to inaccurate supervisor information added to the report.

High level data

Number of doctors/dentists in training (total): **198** (this number includes current vacancies and MTI posts)

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

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

Gaps as at May 2018

Speciality / Grade	**FY1**	**FY2**	**ST 1-2**	**GPVTS**	**ST 3-8**	**Trust SHO**	**Trust Middle Grade**	**Total**	**Notes**
Cardiology					1			1	**Pakistani MTI- Currently in progress**
Diabetes			1		1			2	
Elderly Care				3	1	4	2	10	**Pakistani MTI- Currently in progress**

EAU			1			1		2	**Pakistani MTI- Currently in progress**
Gastro	1		2					3	**Pakistani MTI- Currently in progress**
ED					1	11		12	**Please note the 11 vacancies are additional trust posts.** **Calcutta MTI - currently being discussed**
General Surgery	1			1			4	6	**Pakistani MTI- Currently in progress**
Vascular Surgery	0	1			1			2	**Pakistani MTI- Currently in progress**
Haematology					2			2	
T & O			0					0	**Pakistani MTI- Currently in progress**
Obs & Gynae					2			2	
Paeds					2			2	
Pathology								0	
Plastics								0	
Respiratory				1				1	**Pakistani MTI- Currently in progress**
Stroke					1			1	**Pakistani MTI- Currently in progress**
Urology							1	1	**Pakistani MTI- Currently in progress**

Total	**2**	**1**	**4**	**4**	11	**16**	7	47	

Next Steps

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

1. Conclusion

Guardian can give as surance to the Trust Board that Juni or Doctors in Training (JDT) are safely rostered and their working hours are compliant with the Terms and C onditions of Service for NHS Doctors and Dentists in Training (England) 2016 (TCS).

2. Recommendation

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

Author	**Babar Elahi** **Guardian of Safe Working**
Executive Lead	**Chief Executive**
Date	**27th May 2018**