Agenda

The Dudley Group NHS Foundation Trust

Full Council of Governors meeting

Thursday 8 March 2018, 5.45pm
Clinical Education Centre, Russells Hall Hospital, Dudley

Meeting in public session

No.	Time	Item	Enclosure	By
1	5.45	Welcome (Public & Press) 1.1 Introductions 1.2 Apologies 1.3 Declaration of interests 1.4 Quoracy 1.5 Announcements including welcoming of new governors		Jenni Ord, Chairman
2		Presentations:		
	5.50	2.1 End of Life care update		Dr Joanne Bowen, Palliative Care Consultant
	6.10	2.2 Staff Story – nursing strategy		Siobhan Jordan, Chief Nurse
3	6.20	Previous meeting 3.1 Minutes of the previous full Council of Governors meeting held on 7 Dec ' 17 3.2 Matters arising there from 3.3 Action points	Enclosure 1	Jenni Ord, Chairman
4	6.25	Chief Executive update	Enclosure 2	Diane Wake, Chief Executive
5		Strategy		
	6.35	5.1 Strategy Committee update (workshop 20 Feb '18)	Verbal	Glen Palethorpe, Director of Governance/ Board Secretary
6		Safe, caring and responsive		
	6.40	6.1 Experience and Engagement Committee 17 Jan '18	Verbal	Fred Allen, Lead Governor
	6.45	6.2 Chief Nurse update including Quarterly Quality Priorities update	Enclosure 3	Siobhan Jordan, Chief Nurse
	6.55	6.3 Patient Experience report Q3, 2017/18 including complaints and PALS	Enclosure 4	Jill Faulkner, Head of Patient Experience
	7.05	6.4 Aggregated Learning Report	Enclosure 5	Glen Palethorpe, Director of Governance/ Board Secretary
	7.15	6.5 Report on CQC inspection	Enclosure 6	Glen Palethorpe, Director of Governance/ Board Secretary
7		Effective		
	7.25	7.1 Finance report Q3, 2017/18	Enclosure 7	Tom Jackson, Director of Finance
		7.2 Performance report Q3	Enclosure 8	Karen Kelly, Chief Operating Officer
	7.40	7.3 Workforce report	Enclosure 9	Andrew McMenemy, Director of HR
8		Well-Led		
	7.50	8.1 Governance Committee 21 Dec '17 & 22 Feb '18	Enclosure 10	Fred Allen, Public Elected Governor

	7.55 8.05	8.2 Board Secretary update - CoG elections - Annual Members Meeting 2018 8.3 FT Membership summary Q3, 2017/18	Enclosure 11 Enclosure 12	Glen Palethorpe, Director of Governance/ Board Secretary Helen Board, Patient and Governor Engagement Lead
9	8.10	Any Other Business (to be notified to the Chair)		Jenni Ord, Chairman
10	8.15	Close of meeting and forward dates 2018: 7 June, 6 Sept, 6 December		Jenni Ord, Chairman

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Full Council of Governors meeting
Thursday 7 December 2017, 5.45pm, Clinical Education Centre, Russells Hall Hospital, Dudley

Present:

Name	Status	Representing
Mr Fred Allen	Public Elected Governor	Central Dudley
Mr Arthur Brown	Public Elected Governor	Stourbridge
Mr Sohail Butt	Staff Elected Governor	Medical and Dental
Mr Bill Dainty	Staff Elected Governor	Nursing & Midwifery
Dr Richard Gee	Appointed Governor	Dudley CCG
Ms Sandra Harris	Public Elected Governor	Central Dudley
Mrs Viv Kerry	Public Elected Governor	Halesowen
Mrs Natalie Neale	Public Elected Governor	Brierley Hill
Mrs Jenni Ord	**Chair of Council**	DGH NHS FT
Mr Rex Parmley	Public Elected Governor	Halesowen
Mrs Karen Phillips	Staff Elected Governor	Non Clinical Staff
Mrs Patricia Price	Public Elected Governor	Rest of the West Midlands
Mr Peter Siviter	Public Elected Governor	South Staffs & Wyre Forest
Mrs Mary Turner	Appointed Governor	Dudley CVS
Mr Alan Walker	Appointed Governor	Partner Organisations
Mrs Farzana Zaidi	Public Elected Governor	Tipton & Rowley Regis

In Attendance:

Name	Status	Representing
Mr Julian Atkins	Non-executive Director	DG NHS FT
Mrs Helen Board	Patient & Governor Engagement Lead	DG NHS FT
Ms Jill Faulkner	Head of Patient Experience	DG NHS FT
Ms Siobhan Jordan	Interim Chief Nurse	DG NHS FT
Mr Andrew McMenemy	Director of Human Resources	DG NHS FT
Mr Glen Palethorpe	Director of Governance/Board Secretary	DG NHS FT
Ms Diane Wake	Chief Executive Officer	DG NHS FT

Apologies:

Name	Status	Representing
Cllr Adam Aston	Appointed Governor	Dudley MBC
Mr Terry Brearley	Public Elected Governor	Brierley Hill
Mrs Lydia Ellis	Public Elected Governor	Stourbridge
Dr Anthea Gregory	Appointed Governor	University of Wolverhampton
Ms Michelle Lawrence	Staff Elected Governor	Nursing & Midwifery
Ms Yvonne Peers	Public Elected Governor	North Dudley
Ms Nicola Piggott	Public Elected Governor	Dudley North
Mr Mark Stanton	Chief Information Officer	DG NHS FT
Mr Paul Taylor	Director of Finance & Information	DG NHS FT
Mr Michael Woods	Interim Chief Operating Officer	DG NHS FT

COG 17/26 **Welcome and introductions (Public & Press)**

17.45 Mrs Ord opened the meeting and welcomed all to the meeting.

Mrs Ord noted her thanks for the dedication and support to the Council of the following Governors who had recently reached their end of term of office;

Mrs Morgan Dudley Central, Ms Snowden Nursing and Midwifery, Mr Brookes Brierley Hill and Mr Pearson Jenkins Tipton and Rowley Regis. Mrs Ord also acknowledged the three terms of office served by Mr Johnson Halesowen, Mr Adams Stourbridge, and Mrs Jones South Staffordshire and Wyre Forest.

Mrs Ord welcomed the following governors to the meeting who had been returned at the conclusion of recent elections and appointments:

Mr Brown – Public, Stourbridge
Dr Gregory – University of Wolverhampton
Mr Parmley – Public, Halesowen
Mr Siviter – Public, South staffs & Wyre Forest
Ms Harris – Public Dudley Central
Mrs Zaidi – Public, Tipton & Rowley Regis
Mrs Neale – Public, Brierley Hill

COG 17/26.1 **Introductions**

Mrs Ord introduced Mr Woods who had recently joined the Trust as Interim Chief Operating Officer.

COG 17/26.2 **Apologies**

Apologies had been received and recorded as above.

COG 17/26.3 **Declarations of Interest**

There Council were reminded of the standing declaration in respect of Dr R Gee and his work for the CCG on the MCP procurement but that this did not conflict with any decisions required at the meeting. There were no other Declarations of Interest received relating to any agenda item.

COG 17/26.4 **Quoracy**

The meeting was declared quorate.

COG 17/26.5. **Announcements**

There were no others than those provided earlier in respect of newly returned governors being welcomed to the meeting.

COG 17/27 **Presentations**

COG 17/27.1 **Emergency Department and Winter Plan**

17.55 Mr Woods, Interim Chief Operating Officer, presented an update on the present ED performance and the Trust's plans for the next three months in respect of Winter. Items highlighted included the deterioration on performance against the four hour target, the increase in demand and the short term and longer term steps being taken to make improvements.

Mrs Ord thanked Mr Woods for the update and invited questions.

Dr Gee asked how the opening of the new Emergency Treatment Centre would impact on the ED performance.

Mr Woods commented that the new Emergency Treatment Centre would open in the New Year and would offer an improved environment for patients and have a larger assessment area which would assist the Trust in dealing with ambulance demands.

COG 17/27.2 **Patient Story**

18.20 Ms Jordan presented a video that featured a patient who had recently undergone a knee replacement who had spoken positively about the pre-op planning process and the care she had received whilst on the ward and post operatively.

COG 17/28 **Previous Meeting (Enclosure 1)**

COG 17/28.1 **Minutes of the previous full Council of Governors (Enclosure 1)**

18.40 The minutes of the previous meeting held on 7 September 2017 were approved as a correct record of that meeting and signed by the chairman as such.

COG 17/28.2 **Matters arising**

There were none.

COG 17/28.3 **Action points**

17/24 – start time of the Full Council of Governors meeting to be changed to 5.45pm. this was **complete** and would be removed from the list.

COG 17/29 **Update from Chief Executive (Enclosure 2)**

18.45 Ms Wake presented her report given as enclosure two and asked those present to note its contents and highlighted the following points:

Board Members Ms Wake provided an update on Board member changes as follows:

- Mrs Younes who had been appointed as Director of Strategy and Business Development in September 2017.

- Ms Jordan who had joined the Trust on April 2017 as the interim Chief Nurse and had been appointed into the permanent post in September 2017.

- Mr Woods had been appointed as the Interim Chief Operating Officer and was currently in post until January 2018 when Ms Kelly would join the Trust on a permanent basis.

- Mr Hobbs had been appointed as Medical Director.

CQC inspection Ms Wake advised that the CQC had recently spent two days in the Trust and were scheduled to return for further assessment activity in January 2018. There had been a few issues raised with the Trust and all had been shared with the teams responsible for action required. The Trust expects to receive a full report in due course and would work closely with the CQC to deliver any improvement actions identified. The findings would be reported to a future meeting of the full Council and gave assurance that interim information would be shared as required.

Santa Cycle Dash four teams had participated to raise funds to support the End of Life campaign . More than £700 was raised to help fund the purchase of ceiling LED skylights to bring the outside in for those in their last days of life.

Black Country Pathology plans were progressing for the development of services with a hub at Wolverhampton and centres based at other hospitals with improved efficiencies and planned recurrent annual savings.

Mrs Ord thanked Ms Wake for the update and asked those present to note the contents of the report and noted that she would be happy to receive any questions arising via email after the meeting.

COG 17/30 Strategy

COG 17/30.1 Strategy Committee update (workshop 15th Nov and Committee 20th Nov) Enclosure 3

18.50 Mr Palethorpe presented the enclosure on behalf of Mr Allen, Public Elected Governor and asked those present to note the contents. Mr Palethorpe noted the poor attendance by governors at the strategy workshop held in Novembers and emphasised that all governors were invited and encouraged to attend the next one to be held in February.

COG 17/31 Safe, Caring and Responsive

COG 17/31.1 Experience and Engagement Committee (Enclosure 4)

18.54 Mrs Phillips, Chair of Committee, presented the report of the meeting held in October 2017 given as enclosure four and asked those present to note the reports received by the committee and the assurance provided and that issues were being addressed with action plans in place as needed.

Mrs Phillips emphasised that all governors are encouraged to be involved with 'Governors out there' and not just those on the committee are actively networking and connecting with community groups.

COG 17/31.2 Chief Nurse update including Quarterly (Enclosure 5)

19.00 Ms Jordan presented her report given as enclosure 5 and highlighted the following items:

Quality Priorities These had been determined for 2018/19 by listening to what our patients told us, what the governors fed back at the last Annual Members Meeting and those that were carried forward from 2017/18 where the targets had not been achieved.

Ms Jordan asked Governors to consider the suggestion for the introduction of two new quality priorities to include:

Incident reporting to encourage a higher level of reporting as this forms a valuable tool for learning and service improvement.

Discharge management where the focus would be on ensuring that our patients only spend the time they need to within our hospital and support our drive for ensuring that patients at end of life are cared for in their preferred place.

Nursing Care indicators Ms Jordan confirmed that these had been reviewed and had also recently developed a new quality dashboard for each ward providing information in a user friendly way for staff and patients/families that included key indicators such as complaints, staffing levels and workforce metrics.

Mrs Ord thanked Ms Jordan for the update and asked Governors to note the contents of the report and acknowledged that it potentially represented a lot of information for the new governors to take in but that this standing report was a useful tool for governors to assess Trust performance. Mrs Ord confirmed that training

sessions for new governors would be taking place shortly and these would provide an opportunity to learn more about governance and its reporting to the Council.

Mrs Neale asked how the nursing indicators were monitored and whether Governors were involved with any review activity.

Mrs Price replied that Governors are invited to participate in Quality Assurance Reviews that they are useful as they are unannounced visits by a team made up of senior clinical, nursing and pharmacy staff and do involve governors to wards and clinical departments. Governors also participate in the annual Patient Led Assessment of the Care Environment (PLACE) reviews.

Mr Palethorpe added that the results of the Quality Assurance Reviews are discussed by the inspection group and then shared with the ward/department lead with an agreed plan for improvement. The delivery of these actions are then monitored with revisits scheduled to assess this progress.

Ms Jordan highlighted the areas visited as listed in the report and confirmed that Governors are provided with an opportunity to speak to patients about the patient experience as part of these reviews.

Infection prevention and control The Trust adopts a zero tolerance for MRSA and had no reported instances since December 2015. The Trust had reported 22 C. difficile cases this year. Recently introduced metrics mean that the responsibility is apportioned and each case is reviewed and the case is attributed to the Trust or not. At least 14 instances had been attributed to the Trust in the year to date. The focus remains on staff training and ensuring cleaning is undertaken thoroughly with all staff encouraged to challenge poor practice if observed. NHS Improvement had recently been invited to undertake a review of the Trust's infection and prevention control practices with a view to shape improvements. Their report had highlighted some areas for improvement and an action plan has been developed to address these. Ms Wake confirmed that there had been a recent outbreak of Norovirus, but that this had been limited to one ward area due to the enacting of the Trust's plan for dealing with such an issue.

Mrs Ord thanked Ms Jordan for the update and emphasised the importance the Trust placed on effective infection prevention and control practices.

Mrs Ord asked those present to consider and approve the proposal for the retention of the existing Quality Priorities for 2018/19 with the addition of two new priorities relating to discharge and incidents.

All present **agreed** without abstention.

Dr Gee asked if a Root Cause Analysis (RCA) was conducted on all instances of C diff and especially if they were the same strain.

Ms Jordan confirmed that this was the case and all incidences were subject to a RCA to establish possible cause and checking for strain involved. Best practice approach used fogging to clean rooms and whilst the Trust does not have access to this service 24 hours a day a business case has been submitted to improve access to this service.

COG 17/31.3 **Patient Experience Report Q2 (Enclosure 6)**

19.10 Ms Faulkner presented the report given as enclosure six and highlighted the following:

Complaints There had been an increase in the number of complaints. The Trust had received 118 in Q3 compared to 81 in previous quarter.

Maternity survey 2017 the first cut of results had been received and would be under embargo until publication in early 2018. There had been a few areas identified for improvement and an action plan has been developed to address.

Mrs Kerry asked if the increase in complaints related to any particular area.

Ms Jordan advised that there had been several relating to temporary ED waiting area which was currently provided using a Portacabin.

Ms Faulkner confirmed that this can affect the patients overall impression when attending ED.

Mrs Ord noted that the provision of the new Emergency Treatment Centre scheduled for handover in early 2018 should address the environmental issues currently experienced by patients.

Patient feedback more than 14,700 pieces of feedback were received during Q2 with more than 75% reporting positively about their experience and just over 20% reporting a negative experience. Key themes that remain a focus area for improvement include appointments and discharge, communication, access, care and treatment. Ms Faulkner advised that “Feedback Friday” was to be launched in December to raise awareness to staff and patients of the different ways that feedback can be given and its importance.

Mrs Ord asked all present to note the contents of the report and take assurance from the fact that all feedback is monitored closely and improvement actions undertaken as required.

COG 17/31.4 **Aggregated Learning Report (Enclosure 7)**

19.15

Mr Palethorpe presented the report given as enclosure 7 that provided an overview of the learning from claims, incidents, complaints, PALS, NPSA alerts and also included examples of changes / improvements in practice.

Mr Palethorpe added that the Trust records all levels of incidents from minor through to serious as well as details of external visits which include the outcomes from the national ‘Getting it Right First Time’ initiative where a number of reviews of the surgical pathways have been completed.

Mr Palethorpe gave examples of learning and improvement projects delivered including action taken in response to patient feedback received about the need to provide access to play facilities for children with complex needs which had resulted in the Trust had developing a new secret garden play area. This had been officially opened in November 2018 by the Mayor of Dudley.

Mr Palethorpe asked Governors to note the contents of the report and take assurance that all incidents are investigated fully seeking out every opportunity for learning.

Mrs Ord thanked Mr Palethorpe for his report and emphasised that learning is critical to support continued improvement of Trust services.

Dr Gee commended the Trust on the report as it proved the Trust is a learning organisation and took safety very seriously.

Mrs Ord confirmed that the learning information is shared widely within the Trust and is shared with our commissioners.

Mrs Neale asked who had access to the Datix system and how incidents are monitored.

Mr Palethorpe confirmed that all staff have access to the Datix system and that all incidents were administered via the central governance team which ensures they are investigated and supports the tracking and reporting of learning across the Trust.

Mr Walker confirmed that all Trust partners can also access the Datix system and participate fully in the process when required.

COG 17/32 **Effective**

COG 17/32.1 **Finance and Performance report Q2 (Enclosure 8)**

19.25 Mr Price presented the report given as enclosure 8 and highlighted the following items considered at the Finance and Performance Committee of Board that met in November:

Financial position cumulative surplus to October 2017 was £0.35m and was behind plan of £2.2m. The Trust was forecasting an unmitigated shortfall of £7.6m against its control total for end of year surplus of £2.486m. This was attributed to higher spend and actual income received lower than planned.

Pay spend had exceeded budget by £2.811m to October 2017. There remained a challenge to reduce agency spend that whilst lower than in the previous year had exceeded budget and was creating significant financial pressure.

Sustainability Transformation Funding (STF) for the remainder of the year is projected to earn less than planned with the likelihood that £6m of the potential amount of £8.5m would not be earned.

Performance targets The A&E target had not been met in October 2017 (90.06%). The performance of the main cancer target had also fell short at 88.8% for October and asked Governors to note that action had been taken and the target was projected to be achieved for Q3 on beyond.

Mrs Ord thanked Mr Price for the report and asked Governors to note the financial and budgetary challenges faced by the Trust. The Trust continues to carefully monitor the best use of public funds to provide services to the benefit of our patients.

Mrs Price asked for clarification as to whether the increase in sickness absence was attributed to long term or short term sickness.

Mr McMenemy replied that it was linked to long term sickness absence.

Mrs Ord asked those present to note the current position and actions being taken to address in the coming months.

COG 17/32.2 **Workforce Report (Enclosure 9)**

19.35 Mr McMenemy presented the workforce report given as enclosure 9 and highlighted the following items:

Substantive workforce this had seen an increase and the Trust was working to reduce the dependency on agency and more recruitment activity was ongoing.

Absence management this had risen to 4.62% but was lower than the previous year. Actions taken to continue the decrease include training and greater analysis of the data to identify themes and trends related to sickness absence allowing local actions to be taken. Staff who had achieved 100% attendance in a 12 month period will receive a letter of recognition from the Chief Executive.

Flu vaccination uptake by staff was 69% against a national target of 70%. Two years ago, the Trust performance with this initiative had been only been at 23%. The Governors noted the significant improvement made and the Trust aimed to achieve 80% by end of February 2018.

Mrs Neale asked if flu jabs were given to staff in ward areas who may have difficulty attending a clinic.

Mr McMenemy confirmed that the Trust had more than 50 peer vaccinators available to go out and about across the Trust and had held regular 'jabathons'.

Mrs Phillips acknowledged that there had been videos stories circulating on social media from staff at other trusts providing their stories, both good and bad, and how it can affect their health and that of the patient.

Mr Siviter asked if flu vaccination were available to all staff including agency staff.

Mr McMenemy confirmed that flu vaccinations were offered and available to all partner staff and agency staff.

COG 17/33 **Well-led**

COG 17/33.1 **Governance Committee (Enclosure 10)**

19.45 Mr Allen presented the report given as enclosure ten and highlighted the items discussed at the meeting held on 28th September.

The Committee had actively sought assurance about the actions being taken to address the key financial risks and received a briefing on plans the Trust is instigating to achieve its control total.

The Director of HR had provided a comprehensive update on staff recruitment and retention activity and the expected positive impact on the continued use of agency.

Mrs Ord noted the opportunity this Committee offers Governors to test out the information received and tabled by the executives and an opportunity to offer robust

challenge and ask questions to make sure they are satisfied that systems are in place for improvement.

Mr Palethorpe noted that the next meeting would be held on 21 December and new governors are encouraged attend.

Mrs Ord thanked Mr Allen for the update and asked those present to note the contents of the report.

COG 17/33.2 Governor Development Group (Enclosure 11)

19.50 Mr Allen asked all to note the report and the points discussed at the meeting held in November. Mr Allen explained that an informal governor meeting would be scheduled for January and was open to all governors. The date and time would be circulated shortly.

Mrs Ord thanked Mr Allen for his report and asked those present to note the items discussed at Governance Committee meeting held in November.

COG 17/33.3 Board Secretary Update (Enclosure 12)

19.55 Mr Palethorpe asked those present to receive the report and note the updates relating to the following items:

CoG effectiveness action plan
Annual Members Meeting
Strategy Committee Terms of Reference
Council of Governor workshops Mr Allen reminded all governors to make every effort to attend the workshops that provided valuable information and the opportunity to discuss key strategic issues with Directors and provide their views.

20.00 **Trust Constitution review 2017 (Enclosure 12a)**

Mrs Ord advised that the Trust's Constitution was reviewed each year. As part of this review the Chair has been considering, in consultation with the Trust's Chief Executive and other Non-executive Directors (NEDs), the current composition of the Board of Directors.

Mrs Ord explained that there have been, and would continue to be, increasing demands made on NEDs time. The dedication of the current NEDs and their time commitment to the expanding demands as has been discussed with the Council of Governors Appointments and Remuneration Committee has not been an issue. However, reliance on this is no longer a sustainable approach.

Sustainability Transformation (STP) wide transformation projects expect NED involvement; this is seen through the Pathology Transformation which is only the first of such STP wide initiatives. There will be more demands on their time that require a different approach. The Multi-Speciality Community Provider (MCP) will also likely require representation from the Trust Board NEDs on its Board of Directors. The increasing focus on well-led and the sector regulators sets an expectation for more independent corroboration of reported information to the Board and whilst the current NEDs take an active role in internal Quality and Safety reviews / NED walk rounds the number of these will be very likely to be expected to increase.

Therefore it is being proposed that the Board composition is to increase to 6 voting NEDs plus the chair and matched with an increase to 6 voting Executives. This is an increase of one voting NED and one voting Executive.

Other minor amends proposed to the Constitution include:

- the removal of any references to the superfluous mention of appointment / removal of initial directors and NEDs.
- the removal of references to Monitor and have these replaced with references to NHS Improvement.
- the removal of a need for a member to obtain two sponsors from the current membership to support their election nomination. This is possible as changes have been made to the Model Election Rules which now remove a practical barrier to members standing for election as the Trust does not and would not wish to make its register of members of public document.
- changes to the Trust's declaration of interest criteria relating to share ownership be adjusted to align to that within the Trust's revised Standards of Business Conduct Policy (which was updated in this year to take account of revised Department of Health mandatory guidance)

Mrs Ord invited questions from those present ahead of submitting the proposed changes for approval.

Mrs Neale asked if NEDs are paid for the work that they do and if so whether governors need to look at budgets and assess if it is cost effective to expand the number of NEDs and if there would be a specific allocated role for the additional NED.

All remuneration for executive and non-executive directors were reported in annual report and represented value for money. Remuneration is in region of £13k per year in lieu of at least 3 or 4 days per month and it often exceeds this level of commitment by more than double this amount.

Ms Wake confirmed that the additional budget required had been built into next year's financial plan.

Mrs Ord referred to benchmarking information relating to other organisations in the Black Country and it is clear that the number of NEDs on their boards is greater than ours.

Mr Parmley asked why the Board is being expanded now and why this had not been done before. He also asked if the addition of one NED would be enough and if there was a natural progression in place where the Trust would grow their own NEDs.

Mrs Ord noted that the Constitution is reviewed each year and it had become apparent in the most recent annual appraisal of NEDs that there was a need in light of the additional demands and involvement in quality and other projects including the MCP. Mrs Ord added that two long serving NEDs would reach their end of term of office in October 2018 and there is the challenge that we may not successfully recruit replacements if the package and portfolio was not attractive. She added that the Trust focused on developing a talent pool for executive appointments whereas the appointment of NEDs relies on a competitive search conducted in an open and transparent way.

Mrs Pat Price confirmed that the recruitment and interview process is robust and transparent and actively includes Governors.

Mrs Ord acknowledged that newer governors would be keen to test the process. Mrs Ord confirmed that the Trust had an associate NED who supported the NEDs with an external view but he had limited ability to increase his time for this role. Mrs Ord added that the recruitment process would allow time for the new appointee to shadow the existing NEDs before they reached their end of term.

Ms Wake noted that the Black Country Pathology project involved a NED to chair the Group and felt that there was a danger that the Trust would be so well represented without the appointment of an additional NED.

Mrs Price asked when interviews would take place.

Mr Palethorpe advised that the recruitment activity would commence in the New Year and that more information would follow and governor participation would be sought. Mrs Ord asked those present if they were content to approve the recommendations as detailed above.

With a show of hands, those present **agreed** with one abstention, N Neale due to her being a recent appointment and she felt she needed to know more about the Board before she would be able to meaningfully contribute.

COG 17/33.4 **FT Membership summary Q2 (Enclosure 13)**

20:20 Mrs Board presented the report given as enclosure 13 and asked those present to note the continuing compliance with membership requirements as required by the Trust Terms of Authorisation.

COG 17/34 **Any other business**

Mrs Ord advised that no items had been notified prior to the meeting.

Dr Gee commented that all MCP partners were continuing to discuss the options of the form of the organisation to host the MCP. He noted that this had important implications for the Trust and asked when Governors would have further opportunity to discuss those options.

Mrs Ord confirmed that this would be the case and would be discussed as planned at the workshop scheduled for February and encouraged all governors to attend.

COG 17/35 **Close of meeting and forward dates**
20:25

8th March, 7th June, 6th September, 6th December
The meeting closed at 8.30pm. The next meeting of the Full Council of Governors would be held on 8th March and commence at the earlier time of 17.45

Mrs Jenni Ord, Chair of meeting

Signed…….…….. Dated …….

Outstanding	Item to be addressed
To be updated	Item to be updated
Complete	Item complete

Council of Governors meeting held December 2017

Item No	***Subject***	***Action***	***Responsible***	***Due Date***	***Comments***
17/19.1	Digital Trust Project	Digital Trust project update to be brought to the council at a later date to be agreed	Mark Stanton	June 18	

Enclosure 2

The Dudley Group NHS Foundation Trust

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

TITLE:	**Chief Executive Board Report**		
AUTHOR:	**Diane Wake, Chief Executive**	**PRESENTER**	**Diane Wake, Chief Executive**
CORPORATE OBJECTIVE: SO1, SO2, SO3, SO4, SO5, SO6			

SUMMARY OF KEY ISSUES:

- Visits and Events
- Black Country Pathology
- Flu Update
- Healthcare Heroes
- Emergency Treatment Centre
- Digital Trust Staff Engagement
- Recognition
- Charity Update
- Social Media Activity
- National NHS News
- Regional NHS News

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		Y	**Y**

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

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – March 2018

This report is intended to give a brief outline of some of the key activities undertaken as Chief Executive since the last meeting and a highlight a number of items of interest.

Items below are not reported in any order of priority.

Visits and Events

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

Black Country Pathology

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

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

Flu update

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

Healthcare Heroes

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

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

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

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

Emergency Treatment Centre open

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

Digital Trust Staff Engagement

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

Recognition

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

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

Clinical trials undertaken by our pharmacy team involve:

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

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

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

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

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

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

Charity Update

The Big Push Wheelchair Campaign

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

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

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

Neon 5k Colour Dash

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

Social Media Activity Update

Communications activity
February 2018

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

We have 2,980 followers on Twitter

Highest post in February

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

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

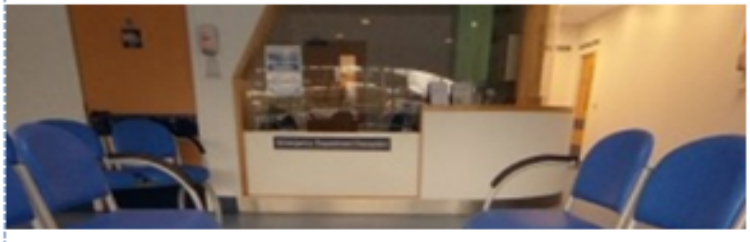
We have 4,261 likes on Facebook

Highest post in February

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

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

Here's a sneak peak!



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

National NHS News

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regional NHS News

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

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

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

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

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

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

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

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

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

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors on 8th March 2018

TITLE:	**CHIEF NURSE REPORT** **1. Quality Priorities. Targets: Present position in 2017/18 and proposals for 2018/19 2. Local Indicator for External Audit 3. Nursing Care Indicators (NCIs) 4. Quality and Safety Reviews**		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER**	Siobhan Jordan Chief Nurse

CLINICAL STRATEGIC AIMS

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

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

SUMMARY OF KEY ISSUES:

1. Quality Priorities

At its December 2017 meeting the Clinical Quality, Safety and Patient Experience (CQSPE) Committee agreed to continue with the present quality priority topics and in addition, it agreed to add two new topics: Discharge Management and Incident Reporting. As we are coming to the end of the year the position with the present targets is clear and details are included in this paper as are the proposals for the 2018/19 targets which are being presented to the Board of Directors at their 8th March meeting.

2. Local indicator for External Review

Each year a local indicator for external audit has to be agreed by the Governors and the proposal this year is the important issue of incidents of patient falls, as this topic has not been assessed by the external auditors previously.

3. NCIs 4. Quality and Safety Reviews

The results of the NCIs are included for the last three months together with actions being taken. A summary of the Quality and Safety Reviews undertaken in February are also included.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
✓	✓	✓	

RECOMMENDATIONS FOR THE COUNCIL: The Governors are asked to:

1. Note: a) the situation with the 2017/18 priority targets and b) the priority targets for 2018/19.
2. Agree on: a) the process for commenting on the Quality Account 2017/18 and b) the local indicator for external audit.
3. Note the current position with the NCIs and Quality and Safety Reviews

THE DUDLEY GROUP NHS FOUNDATION TRUST

1. QUALITY PRIORITIES
TARGETS: PRESENT POSITION IN 2017/18 AND SUGGESTIONS FOR 2018/19

A. Introduction

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

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

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

- Discharge Management
- Incident Reporting

This paper contains the Trust's position with the present quality priority targets for 2017/18. It also contains the proposed targets for next year (2018/19) that the Board of Directors will make a decision on at its 8th March 2018 meeting.

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

Priority 1: Patient experience

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

Present position 2017/18

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

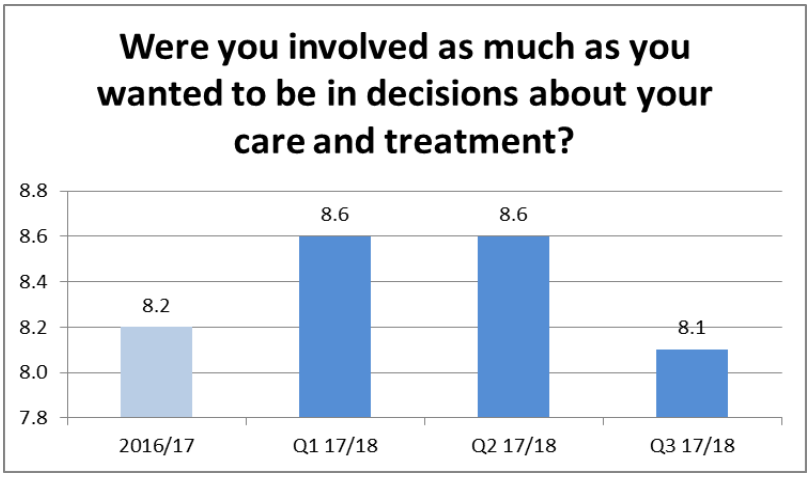
Inpatient	A & E	Antenatal	Birth	Postnatal Ward	Postnatal Community	Community	Outpatients
4	0	6	7	7	6	6	3

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

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

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

Present Position 2017/18



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

Proposed Target 2018/19

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

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

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

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

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

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

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

Proposed New Target 2018/19

TARGET 4: The FFT target above (TARGET 1) relates to the percentage scores of the patients who do respond to the survey. It is also important for the Trust to encourage as many patients as possible to respond and so it is proposed that a target relating to the numbers responding is also included with the following words:

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

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

Present Position 2017/18

Hospital – Avoidable Pressure Ulcers

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

Community - Avoidable Pressure Ulcers

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

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

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

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

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

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

b) Ensure that the number of avoidable stage 3 acquired pressure ulcers in 2018/19 reduces from the number in 20176/18: i) in the hospital and ii) on the district nurse caseload.

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

Present Position 2017/18

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

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

Proposed Targets 2018/19

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

Priority 4: Nutrition and Hydration

a) HOSPITAL: Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items):

- is 95% or above in each of the first three quarters for the Trust as a whole
- has a 'Green' rating (95% or above) in the final quarter for every ward in the hospital

Present position 2017/18

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

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

Proposed Target 2018/19

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

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

Present Position 2017/18

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

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

Proposed Target 2018/19

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

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

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

Present Position 2017/18

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

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

Proposed Target 2018/19

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

Priority 5: Medications

Ensure that in 95% or more cases, all prescribed medications will either be: a) signed and dated as administered or b) have an omission code recorded.

Present Position 2017/18

Medications Signed and Dated

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

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

Proposed Target 2018/19

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

Proposed new target

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

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.

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

Priority 6: Discharge Management

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

Proposed targets are:

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

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

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

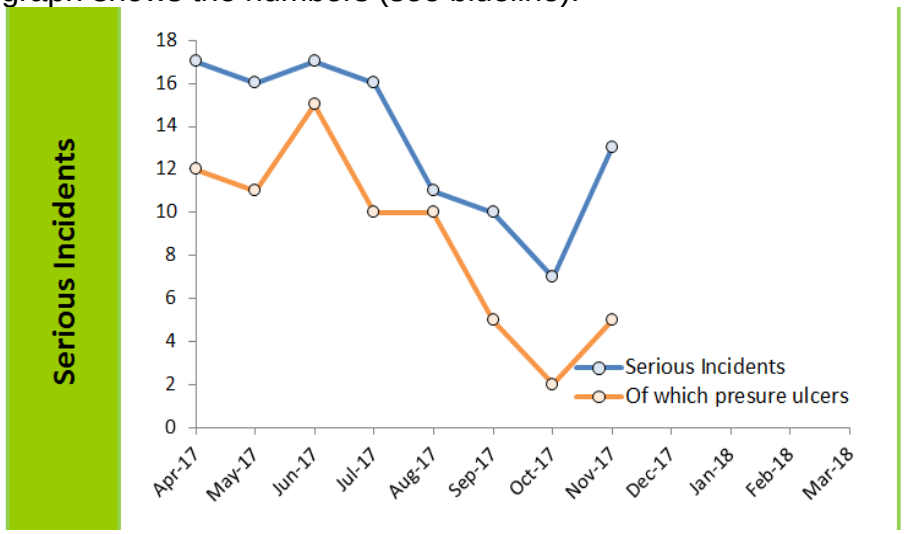
Priority 7: Incident Reporting

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

With regards to the overall reporting rate, comparative figures are published every six months from the NRLS (National Reporting and Learning System). At the time of writing this report, the latest comparative figures available are for the period of October 2016 to March 2017 which were published on 27th September 2017. The Trust reporting rate was 79th of 136 organisations which is an improvement of the previous six months when we were 97th. It is acknowledged that there is room for further improvement. The following target is therefore proposed:

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

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



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

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

2. QUALITY ACCOUNT 2017/18 – GOVERNORS COMMENTS AND AGREEMENT ON THE LOCAL INDICATOR FOR EXTERNAL AUDIT

Each year the Governors have the opportunity of commenting on the contents of the quality account and on the overall quality of care at the Trust. The first draft will be available between mid and the end of March. The Governors need to consider and agree the process for agreeing on the comments they wish to make which will be printed within the report.

In addition, each year, the Governors are asked to choose a local indicator for external audit (in addition to two mandated national indicators). Over the last three years the Governors have chosen:

- FFT for the Emergency Department
- C.Difficile (Infection Control)
- NCI target (Nutrition)

This year it is suggested that the important issue of incidents of patient falls is audited as this topic has not been assessed by the external auditors previously.

3. NURSING CARE INDICATORS (NCIS)

The audit tools are continuously reviewed to ensure they are relevant and capture quality issues within each area. The title of the indicators has also been reviewed and in the future they will be known as Quality Key Performance Indicators (QKPIs) as they do not all refer to nursing. The results of the last three months for both are hospital and community are listed below (Green: 95% and above, Amber 94%- 85%, Red 84% and below)

Hospital

	Dec 17	Jan 18	Feb 18
A2	96	87	78
B1	98	94	96
B2H	98	98	98
B2T	96	97	98
B3	87	98	96
B4	97	98	96
B5	98	99	94
C1	98	97	96
C2	97	95	97
C3	98	98	98
C4	100	91	88
C5	97	99	84
C6	100	91	94
C7	89	85	78
C8	98	95	98
CCU/PCCU	98	98	97
MHDU	100	100	100
Critical Care	99	98	93
Maternity	98	97	98
Maternity OPD/Community	86	88	84
NNU	99	98	99
EAU/AMU	97	63	86
Inpt Theatres	98	100	98
DSU Theatres	90	99	100
ED	86	83	90
AEC	100	84	67
EMU	91	87	94
Renal Unit	96	98	98

Actions being taken:

1. Quality and Improvement Lead to remove medication section from the quality audit from March 2018 as stand-alone audit continues to be strengthened.
2. Quality Key Performance Indicators will continue to be discussed at monthly performance meetings, with the focus on wards/departments of non-compliance.

3. When required meetings to be arranged between lead nurses/Matrons of areas of poor compliance with the Deputy Chief Nurse/Chief Nurse (meetings arranged for 06/03/18).
4. Quality and Improvement Lead to attend monthly Quality Review meetings with Surgery and Medicine
5. Quality and Improvement Lead to seek assurance that escalation process is being followed and that meetings are arranged for consistent non-compliance.
6. Amendments to Matron Audit required following NHSi walk round with infection control. Already reviewed by Quality and Improvement Lead and Infection Control.

Community:

	Dec 17	Jan 18	Feb 18
Community Paeds	100	100	100
Community NNU	100	100	100
KAB Zone 1 DN	ND	100	99
KAB Zone 3 DN	95	96	95
CSG Zone 1 DN	100	96	94
CSG Zone 2 DN	93	98	97
DN Zone 1 DN	95	100	96
DN Zone 2 DN	100	82	95
HQ Zone1 DN	100	100	100
HQ Zone 2 DN	56	94	97
SLW Zone 1 DN	93	95	98
SLW Zone 3 DN	ND	82	100
Tiled House	ND	ND	84
CRRT	95	98	ND
CHNP	100	100	ND
CSN	100	93	100
CIV	ND	100	ND
LUC Brierley Hill	98	98	93
LUC Ladies Walk	ND	97	96

(ND * No data submitted)

Actions being taken:

1. Arrange for spot audits of community KPIs
2. Quality and Improvement Lead to attend Community Quality review meeting monthly
3. Email sent to Community Matron and Deputy Matron to highlight no data submissions prior to data being analysed.

4. QUALITY AND SAFETY REVIEWS

The Quality and Improvement Lead undertakes two Quality and Safety reviews per week, this has been the case since October 2017. However, due to capacity pressures and CQC inspection, no reviews took place in December or January.

Recent reviews (February 2018)

EMU: Elective Medical Unit demonstrated considerable improvement in various areas within each domain in comparison to their previous review in October 2017. Overall rating remains the same: **Requires Improvement**.

IMAA (Intermediate Medical Assessment Area): There were concerns raised regarding IMAA in relation to all the domains reviewed. The main concerns related to NEWS, sepsis management, staffing, medicine management and governance. (At time of writing this report, finalisation of Quality and Safety review report still to be completed. Rating likely to be **Inadequate**, confirmation will be provided in the next report along with the rating of each domain.)

B3: This ward was reviewed 22/02/2018. The report is in the process of being completed. Issues found included NEWS calculation. This was recognised and shared with individual staff nurses and shift lead. (At time of writing this report, finalisation of Quality and Safety review report still to be completed. Rating likely to be **Requires Improvement**, confirmation will be provided in the next report along with the rating of each domain.)

C3: This area was reviewed 26/02/2018. The report is in the process of being completed. Some issues with infection control were identified. Verbal feedback given to the Acting Lead Nurse and Matron on 28/02/2018 for actions to be identified. (At time of writing this report, finalisation of Quality and Safety review report still to be completed. Rating likely to be **Good**, confirmation will be provided in the next report along with the rating of each domain.)

The Dudley Group NHS Foundation Trust

Enclosure 4

Paper for submission to the Council of Governors 8 March 2018

TITLE:	**Patient Experience Report – Quarter 3, 2017/18 (including PALS and Complaints)**		
AUTHOR:	Helen Board, Patient & Governor Engagement Lead Paul Cummings, Patient Experience Co-ordinator	**PRESENTER**	Jill Faulkner Head of Patient Experience

CORPORATE OBJECTIVE: SO1: Deliver a great patient experience

SUMMARY OF KEY ISSUES:

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

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

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE BOARD:

To note the content of the Q3 Patient Experience report.

Patient Experience Report Quarter 3 (Oct-Dec) 2017-18

NHS
The Dudley Group
NHS Foundation Trust

Total FFT Returns
18,394

THANK YOU
1,966 Compliments received this quarter
(1200 received in Q2 17/18)

Friends and Family Test (FFT)

Percentage Recommened	Oct	Nov	Dec	Quality Priority
Inpatient	95%	95%	N/A	
A&E	84%	80%	N/A	
Community	95%	96%	N/A	
Outpatients	91%	90%	N/A	
Maternity*				
Antental	99%	N/A	N/A	
Birth	99%	N/A	N/A	
Postnatal Ward	98%	N/A	N/A	
Postnatal Community	100%	N/A	N/A	

* Maternity quality priority based on October data only

Quality Priority 2017/18

On target Not on target

Achieve monthly scores in Friends and Family Test (FFT) for all areas that are equal to or better than the national average (based on nationally available data)

Complaints received in Q3
101
115 received in Q2

Patients are saying...

You said ... We Have

It would be good to have free parking when attending for chemotherapy treatment

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.

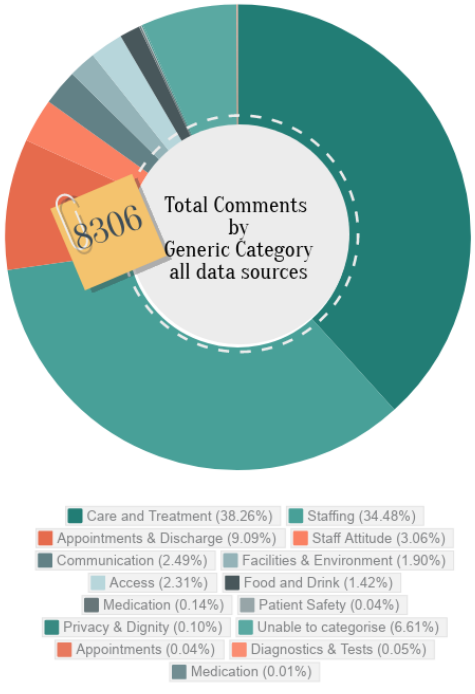
We want to spend more time with our partner after the birth of our baby

We have 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 Outpatients Centre to include CT and MRI scanning.

NHS Choices based on 278 ratings
(NHS Choices/ Russells Hall Hospital 12.01.18)



To find out more please visit

www.dudleygroup.nhs.uk/patientexperience
or contact the team on 01384 456111 ext 1124

Developed by *Dudley Clinical Commissioning Group*

Patient Experience Report

1. Introduction

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

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

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

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

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

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

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

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

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

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

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

Within Q3 we successfully implemented:

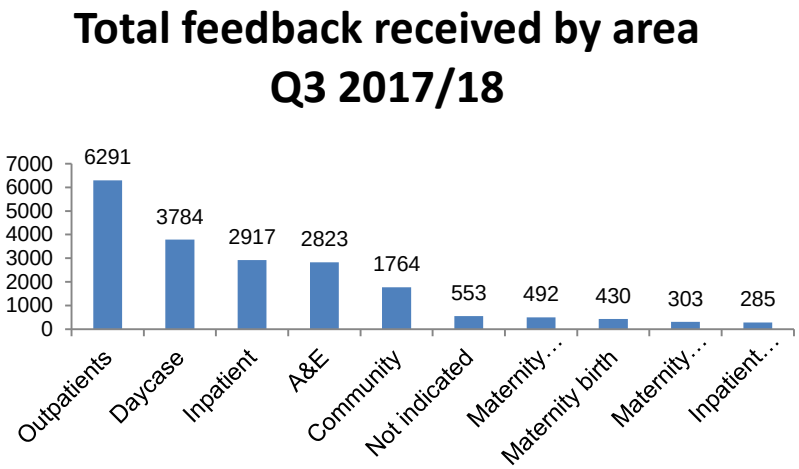
- Fruit & vegetable stall which benefits both patients and staff.
- Refreshments and water fountains available in waiting areas and the Emergency Department.
- Increased the number of parking passes for patients undergoing chemotherapy and parents of neonatal patients.
- Funding has been secured for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

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

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

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

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



2. Friends and Family Test (FFT)

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

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

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

The FFT percentage recommended scores for Q3 are as follows:

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

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

Community Services Response rates

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

ED services Response Rates

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

Maternity services Response Rates

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

Outpatient services Response Rates

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

Inpatients services Response Rates

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

3. NHS Choices

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

4. Complaints

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

Two key metrics within the complaints service is that:

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

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

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

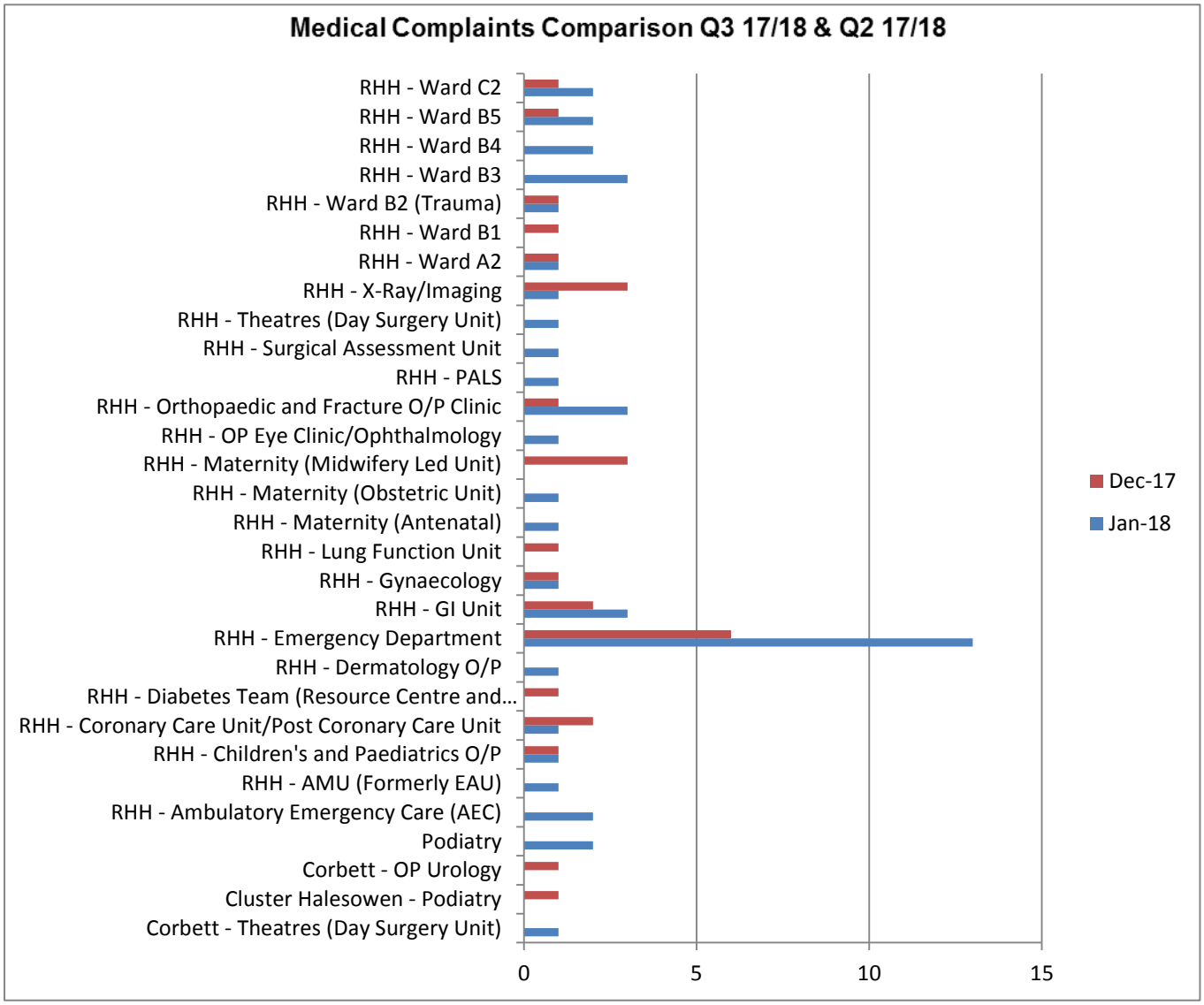
The divisional performance during Q3 is as follows:

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

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

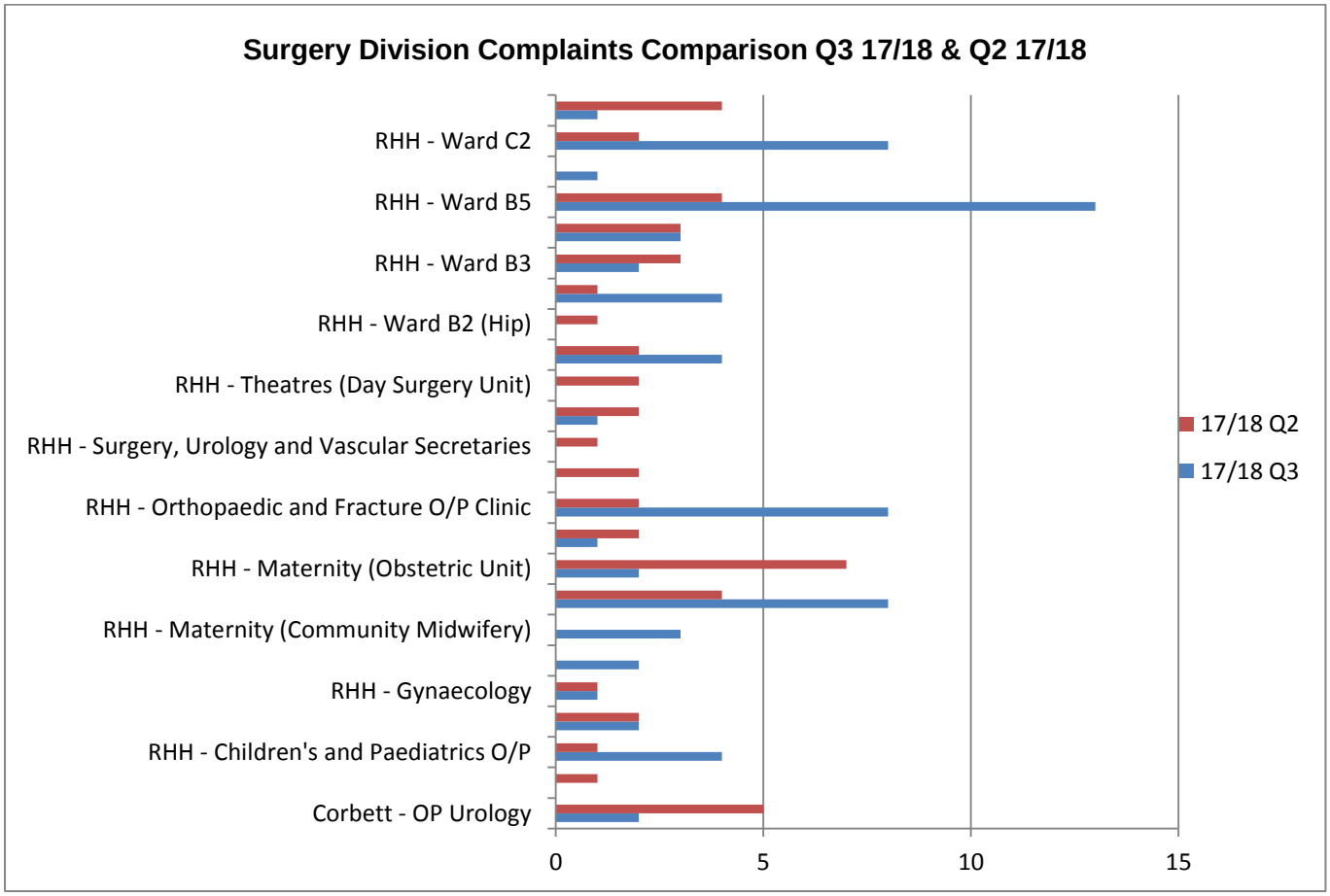
The following graphs illustrate complaints received within the division and which specific area of the Trust. They also demonstrate a comparison between Q2 and Q3.

Table 1



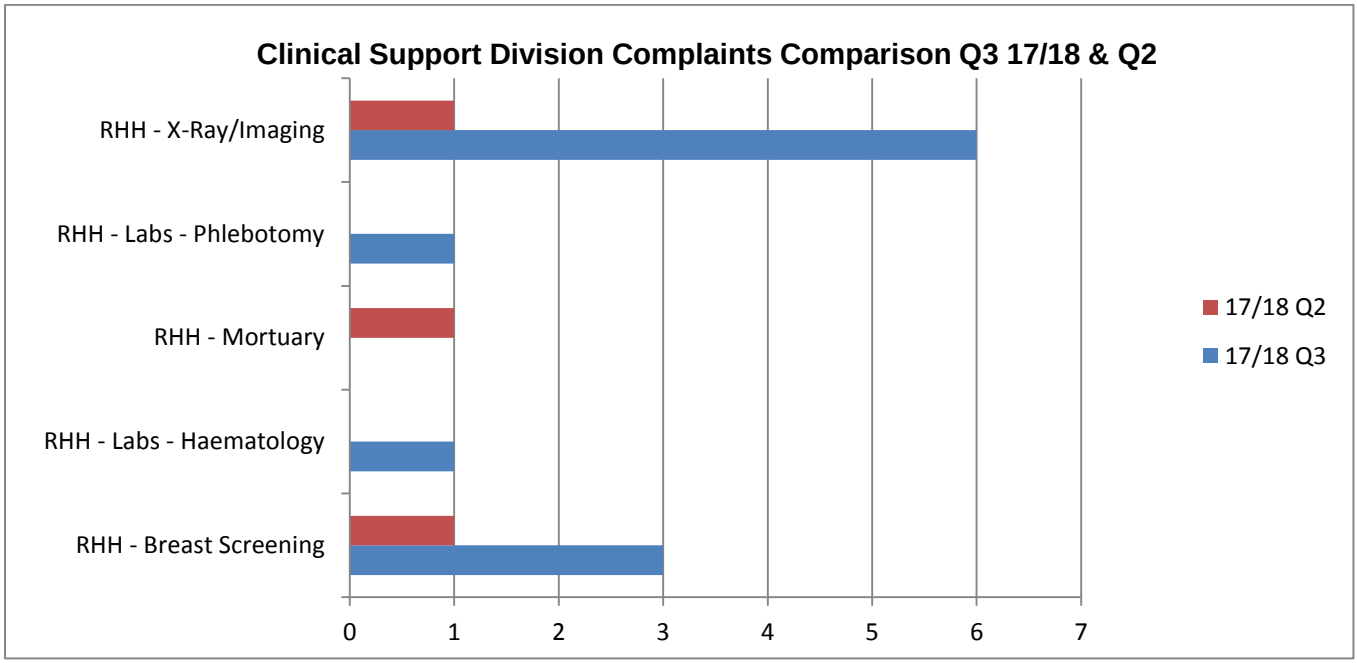
The Emergency Department has seen a significant rise in complaints. Wards C5 and C7 have also seen an increase in complaints received. The Head of Patient Experience has discussed these increases with the leaders within the Divisions of each area.

Table 2



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

Table 3



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

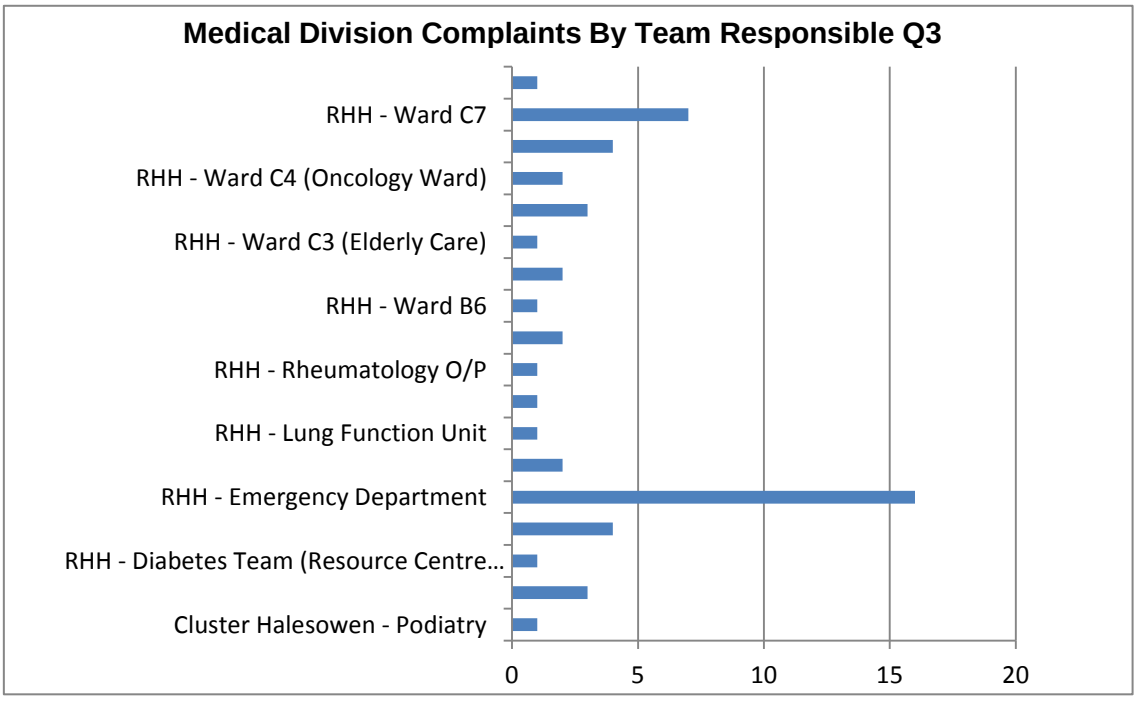
There has been one complaint received regarding community services relating to podiatry at Halesowen. To ensure concerns are raised within the community setting the community booklet is being updated with robust details of how to make a complaint or raise concerns. The Chief Nurse is concerned by the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

Medicine & Integrated Care Division

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

Table 4 details complaints received by service:

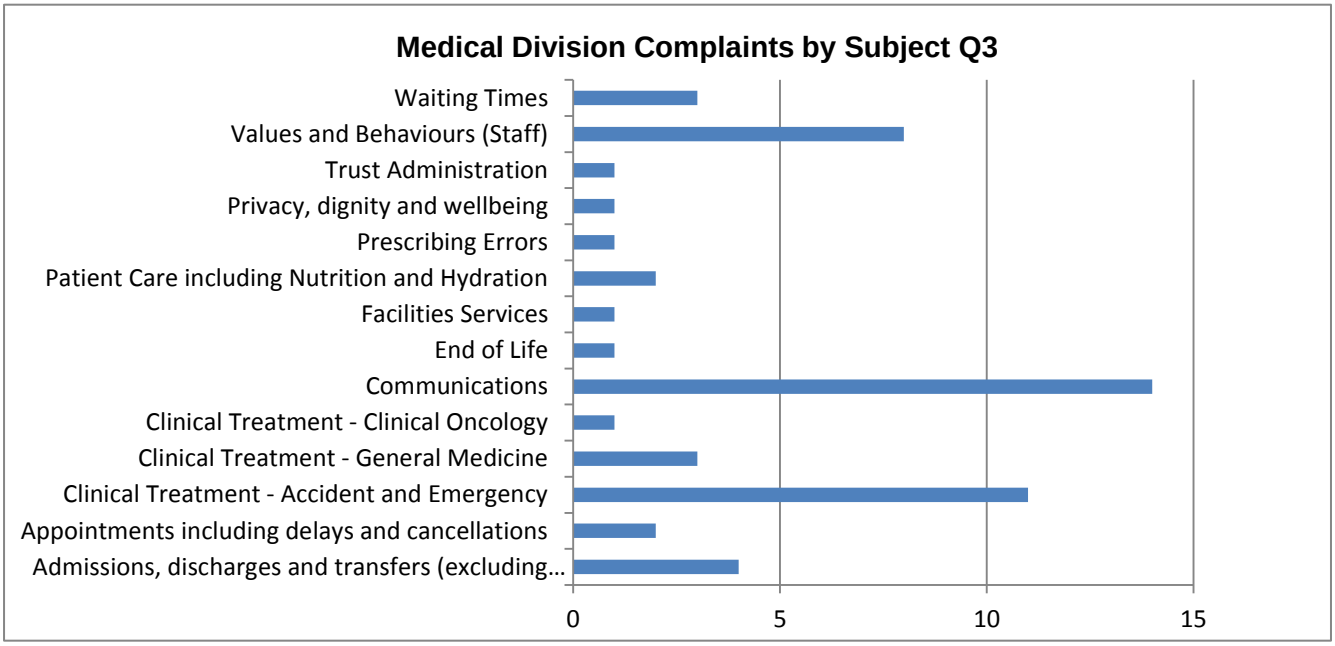
Table 4



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

Table 5 details complaints received by subject.

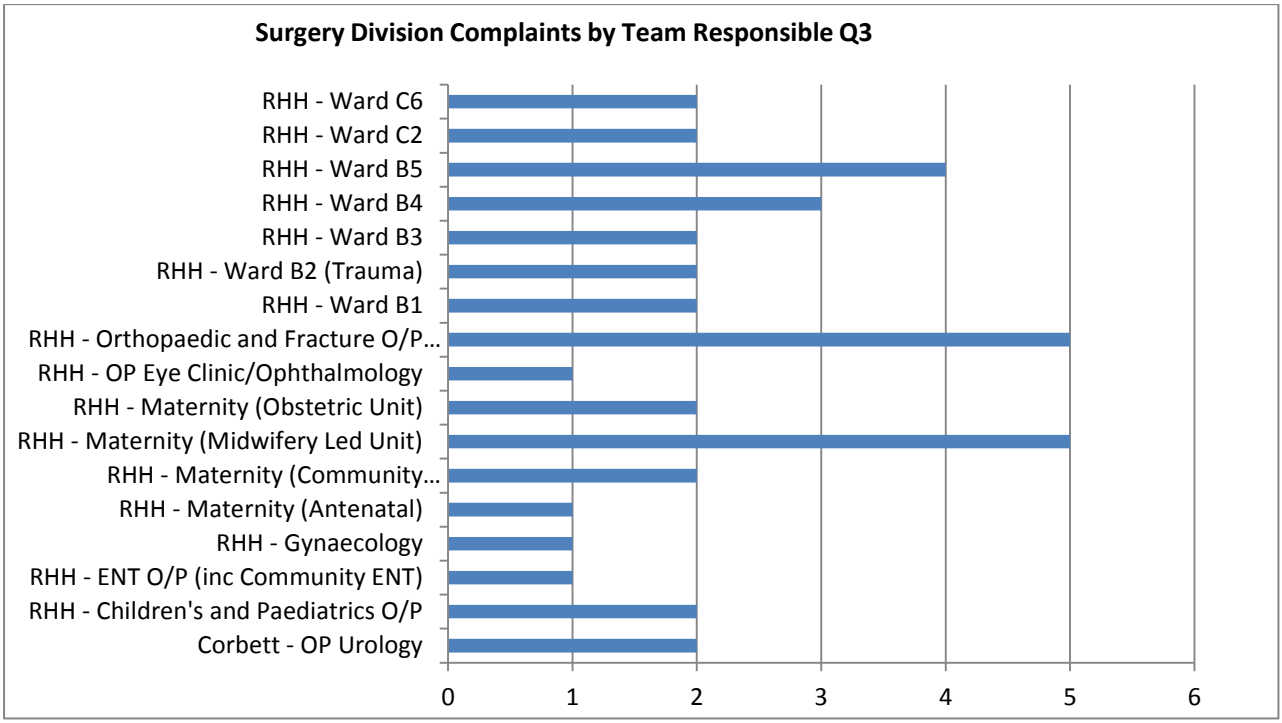
Table 5



Surgery Division

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

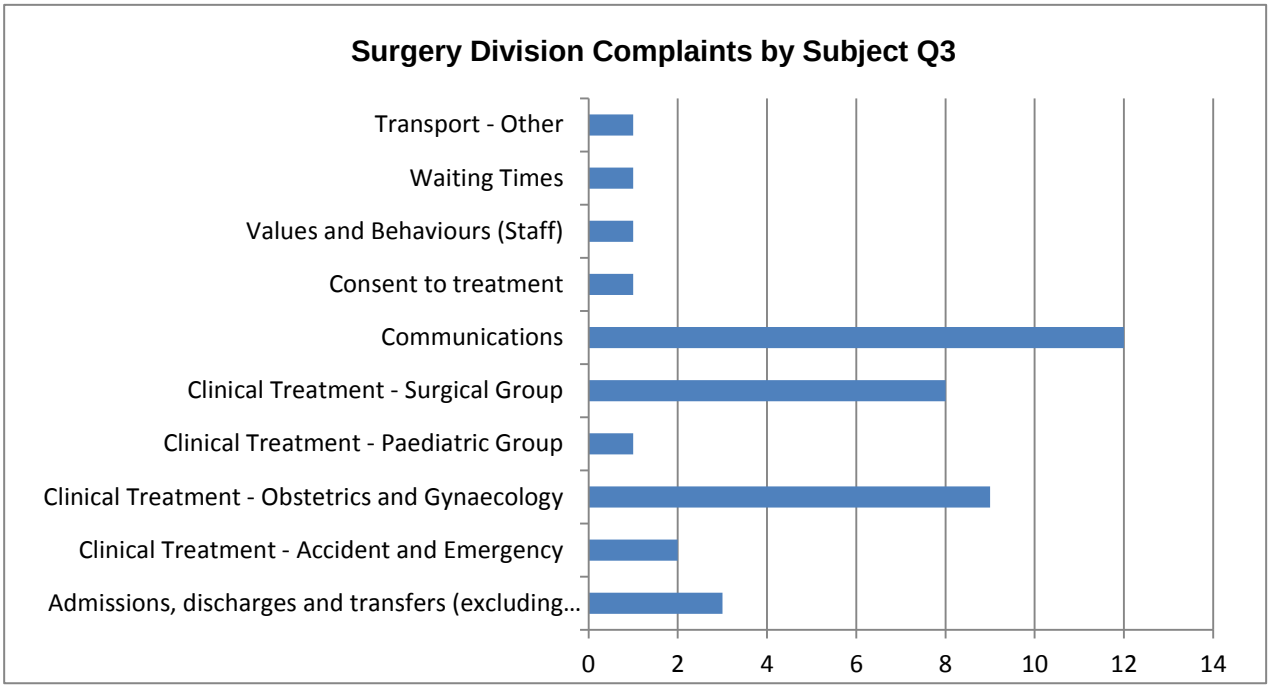
Table 6



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

Table 7 details complaints received by subject.

Table 7



Clinical Support Division

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

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

Table 8 details complaints received by service:

Table 8

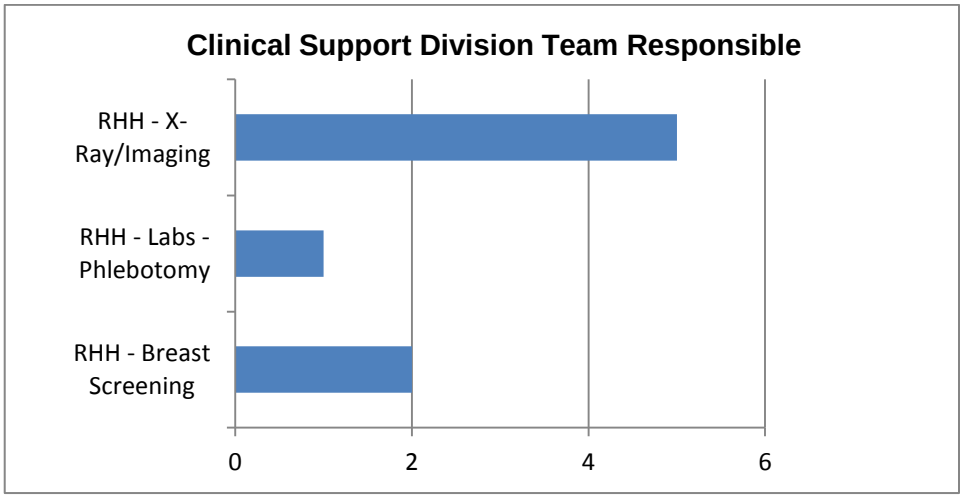
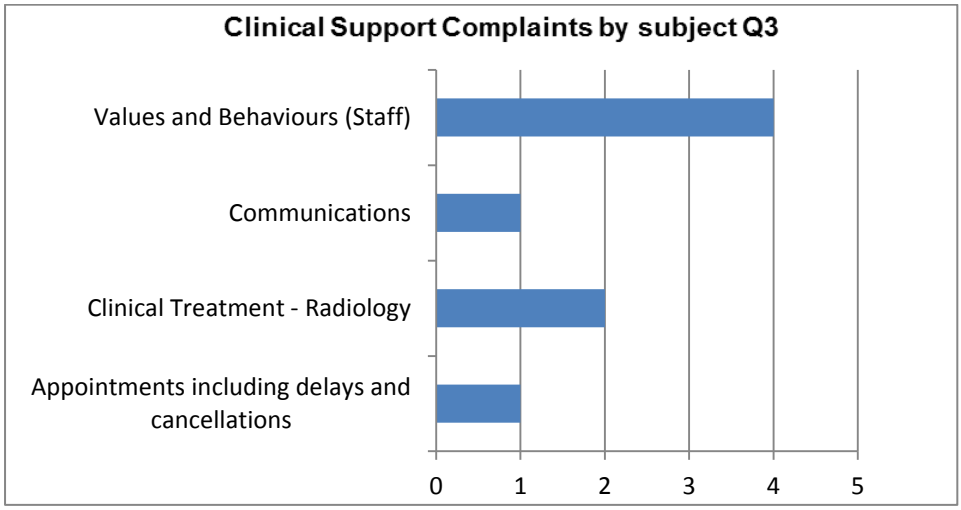


Table 9 details complaints received by subject.

Table 9



Complaint Themes

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

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

Reopened Complaints

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

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

These related to:

- Surgery Division 4
- Medicine & Integrated Care Division 2

Complaint responses

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

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

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

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

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

Complaint Outcomes

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

- 4 upheld
- 35 partially upheld
- 45 not upheld

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

Member of Parliament

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

Local Government Ombudsman

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

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

Parliamentary Health Service Ombudsman

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

Complaints Satisfaction Surveys

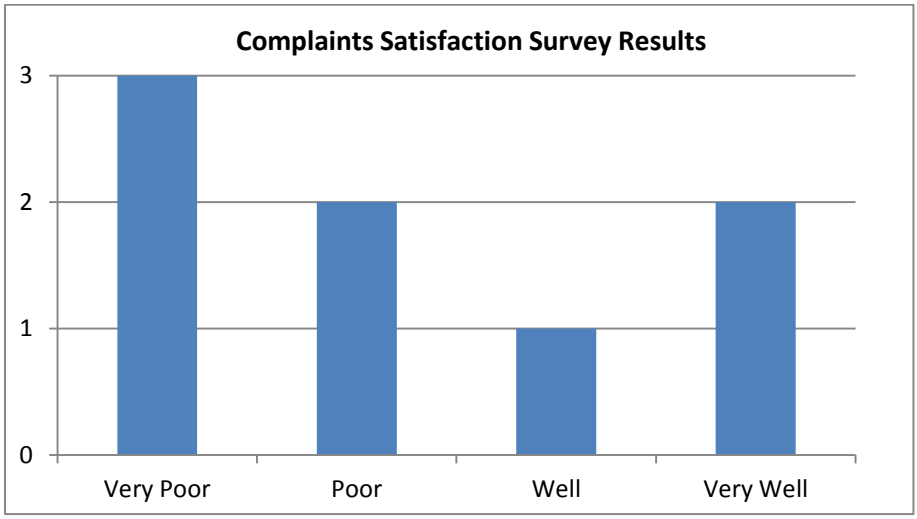
It is mandated that all trusts participate in the complaints satisfaction survey and is part of the NHS Complaints Legislation (2009). All complainants have the opportunity to complete a complaint satisfaction survey.

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

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

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

Table 10



5. Compliments

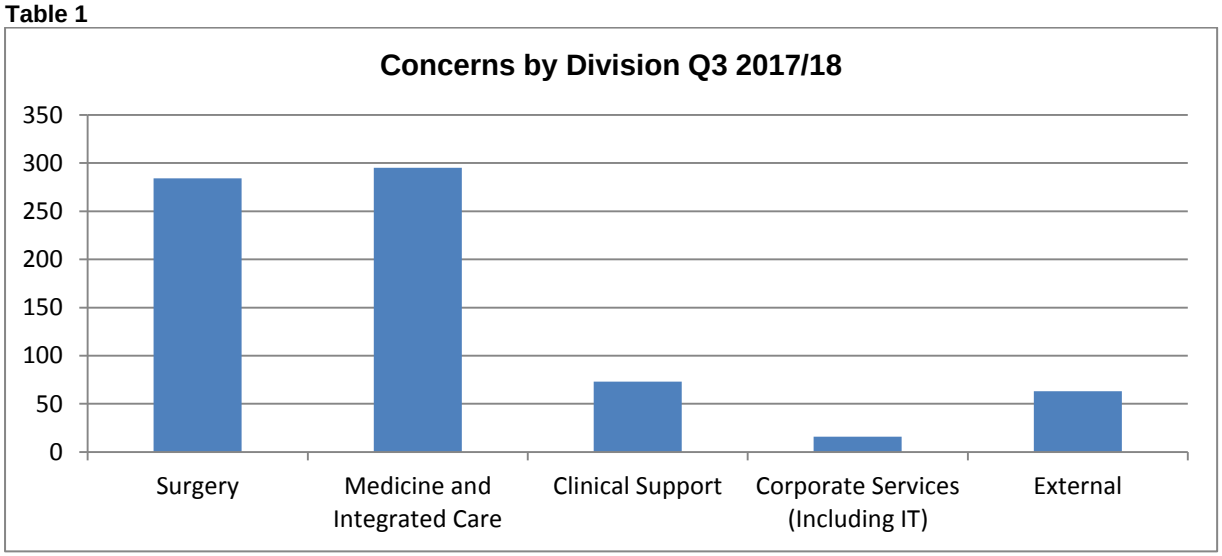
The Trust continues to receive a high number of compliments equating to around 0.4% of patient activity. All compliments received by the Chief Executive and the Chief Nurse are acknowledged personally and shared with the staff involved. A total of 1,966 compliments were received in Q3 which indicates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

6. Patient Advice Liaison Service

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

Table 1 details the breakdown by division during Q3:

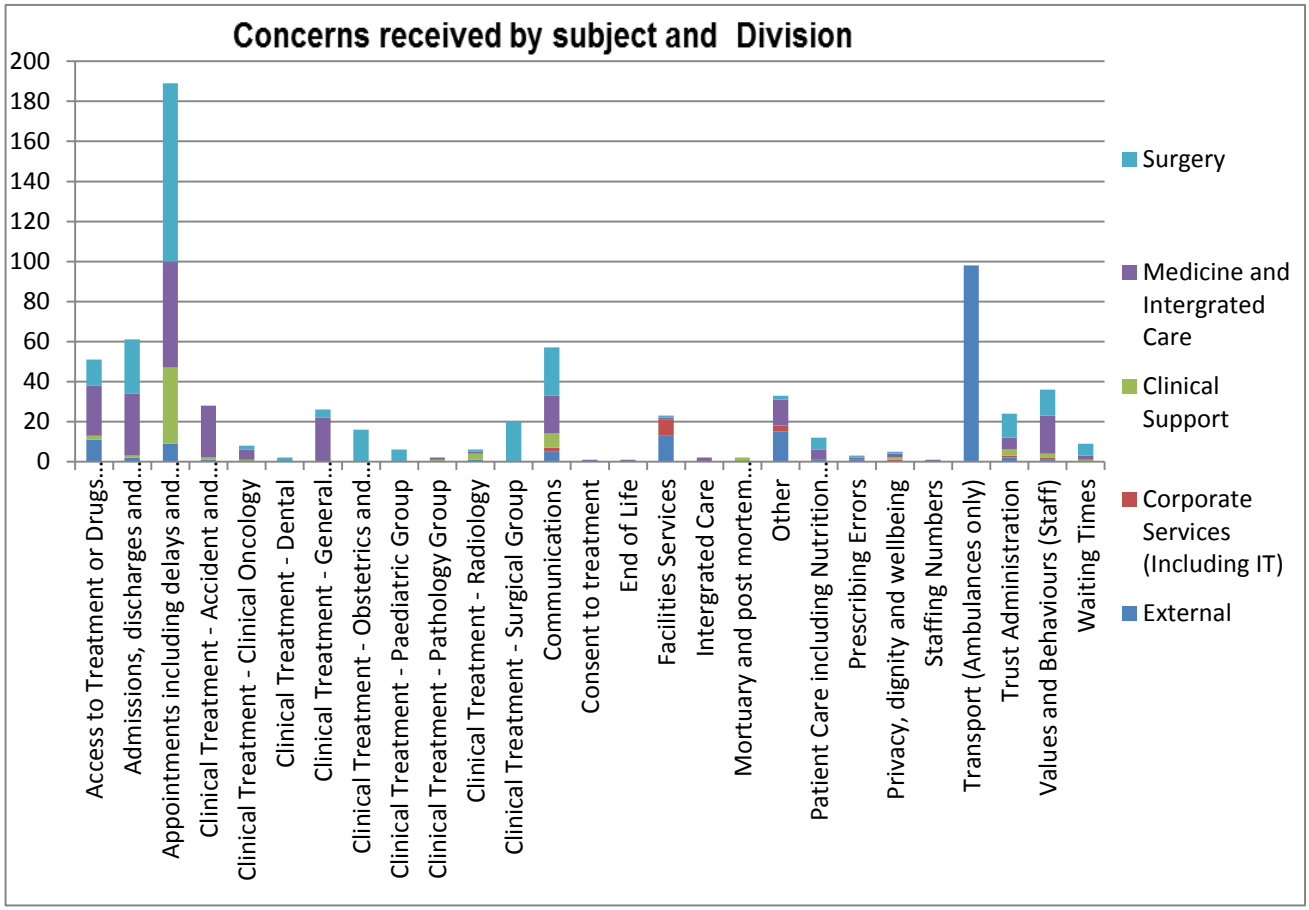
Table 1



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

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

Table 2



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

Conclusion

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

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

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

The Dudley Group NHS Foundation Trust

PAPER FOR SUBMISSION TO THE COUNCIL OF GOVERNORS
8 MARCH 2018

TITLE:	Aggregated Learning Report from Incidents, Complaints, PALS, and Corporate Learning - Quarter 3 1st October 2017 to 31st December 2017		
AUTHOR:	Justine Edwards – Patient Safety Manager Paul Cummings – Complaints Manager Karen Obrenovic – Claims and Litigation Manager Sharon Phillips – Deputy Director of Governance Diane Lynch – Clinical Audit Manager	**PRESENTER**	Glen Palethorpe Director of Governance/Board Secretary

CORPORATE OBJECTIVE:
SO1: Deliver a great patient experience
SO2: Safe and Caring Services

SUMMARY OF KEY ISSUES:

The following report provides an overview of Learning Report from Incidents, Complaints, PALS, and Corporate Learning and changes in practice as a response to their investigations.

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description:**
	Risk Register: Y		**Risk Score:** 12: Stage 3 and 4 Pressure Ulcers potentially can increase 9: The outcome of the National Falls Audit was released in October 2015. It defines best practice for Trusts regarding falls management, the average falls incident rate for all falls and for falls resulting in serious harm 12: Failure to embed improvements from CQC visits
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** All care domains
	NHSI	**Y**	**Details:** Contribution to the Monitor Governance Rating
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE

Decision	Approval	Discussion	Other
			√

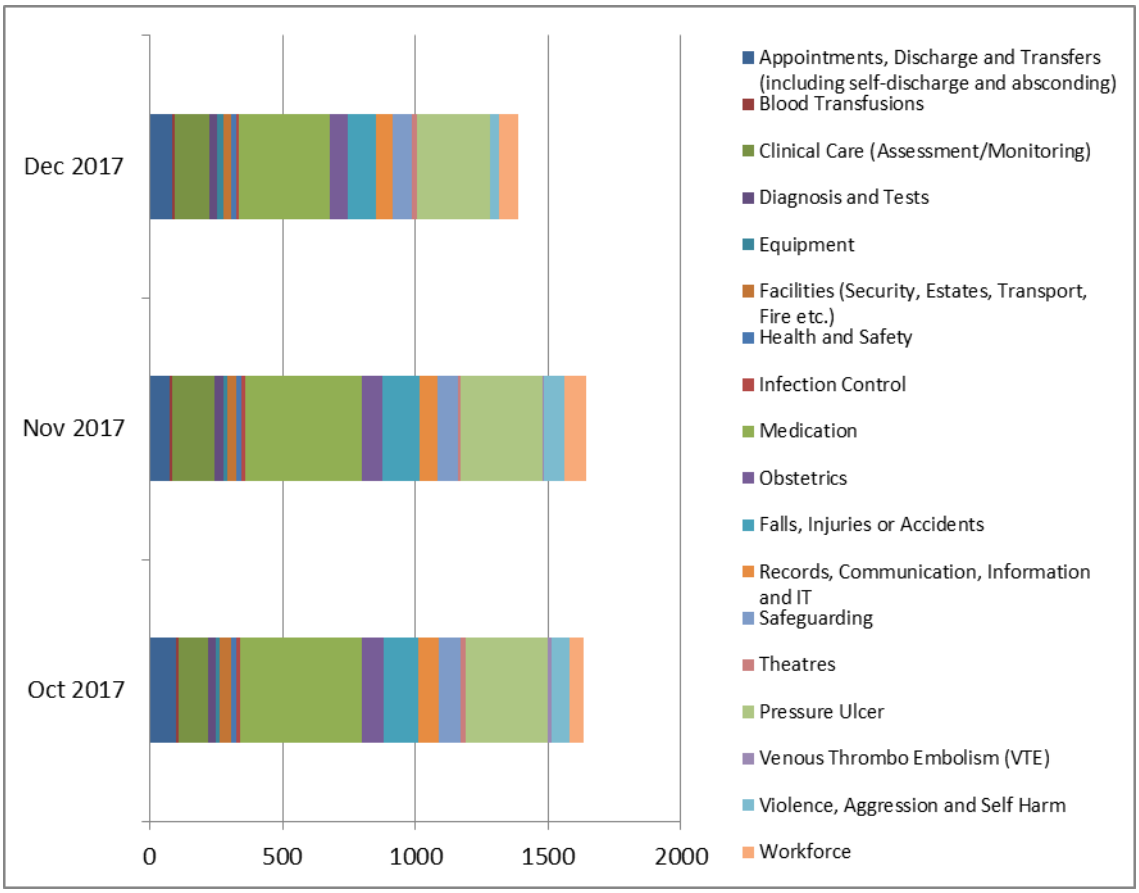
RECOMMENDATIONS FOR THE COMMITTEE:
- To note key issues identified.
- To note learning

AGGREGATED REPORT/LEARNING FROM INCIDENTS COMPLAINTS AND PALS

1. INTRODUCTION

This report provides a summary of the learning and revised processes applied in response to investigations into incidents, complaints and PALs concerns, in addition learning identified from coroners and claims.

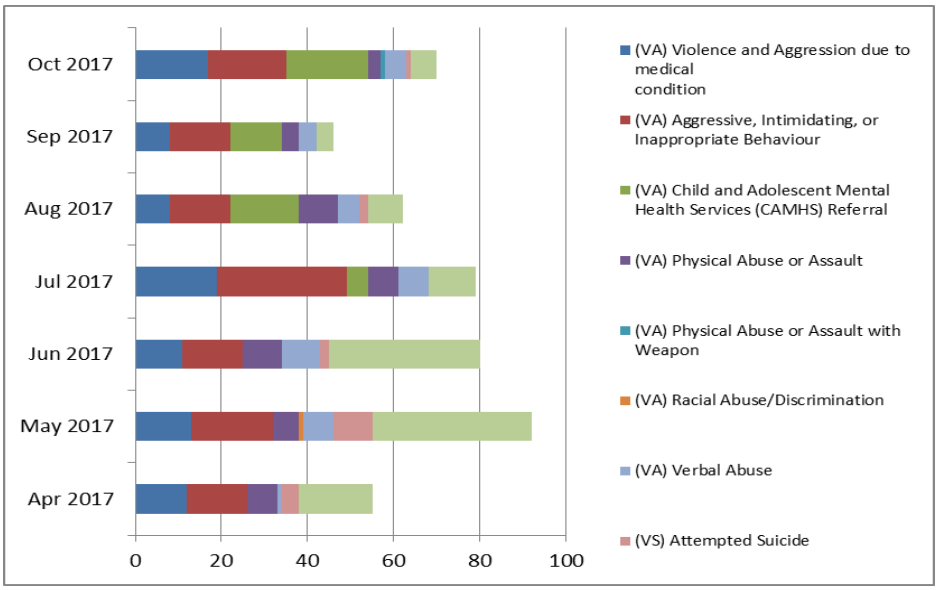
2. INCIDENTS REPORTED IN QUARTER 3 – 1st October 2017 to 31st December 2017



The chart above provides an overview of the incidents reported by Type from 1st October 2017 to 31st December 2017.

2.1 LEARNING FROM INCIDENTS

2.1.1 Violence and Aggression



The Trust has seen constant reporting in relation to violence and aggression incidents, especially in relation to incidents involving violence and aggression from patients with a medical condition. In response to this the staff are invited to reflect on the incident with a senior member of staff and invited to attend a De-escalation and Breakaway session. These discussions and informal sessions allow for the member of staff to identify if they require any further training or additional support. Attendance at these sessions is monitored to identify the efficiency of this service. Conflict resolution training has also been reviewed to ensure that it incorporates management of patients with a medical condition demonstrating violence and aggression.

2.1.2 Medication incidents

There has been an increase in medication incidents relating to the administration of topical patches e.g. fentanyl, buprenorphine, nicotine, rotigotine.

Further investigation identified that there were a number of issues

- Patches were not being applied or removed in accordance with the prescribers' intention.
- Drug administration was being poorly documented on the prescription chart. It was sometimes difficult for staff to identify where a patients' previous patch had been applied resulting in patients erroneously receiving multiple patches.

It was identified that some clinical areas were using a transdermal patch application record ("body map") but this document was not accessible for all nursing staff. The transdermal patch application record was reviewed and a standard operating procedure (SOP) was developed to reduce potential risk of multiple patch application, epidermal irritation, inappropriate delivery rate, or unintended absorption of residual medicines remaining in transdermal delivery prescriptions. The SOP will be made available on the Hub. Nursing staff awareness will be raised through education and training e.g. medicines link nurse newsletter and medicines management update.

Incidents are monitored by the Trust Safe Medicines Practice Group to evaluate the impact and sustainability of this change.

The expansion of the pharmacy tracking system is providing audit data on the safe and secure transportation of medication within the hospital. This has seen a reduction in the number of incidents in relation to missing medicines.

Following 3 “Near Misses” in pharmacy relating to cyclophosphamide 50mg and cyclizine 50 mg, where the two drugs were confused and labelled (not dispensed). This has prompted pharmacy to introduce a new caddy system and this clearly separates the products on the shelves in the pharmacy.

Incidents have been raised in relation to dispensing errors and delays with the supply of veldolizumab to Medical Day Case. As a high cost Pbr exempt drug the product needs costing to individual patients so the process was focused on that allocation at the start of the process. Stocking veldolizumab on Medical Day Case unit has reduced the risk of incorrect dispensing and reduces delays and a retrospective patient costing process has been employed to recover the income due.

2.1.3 Radiology

In response to 2 incidents reported to IMER which involved the incorrect patient being x-rayed the checking procedure within Radiology has been reviewed and improved to reduce error. Previously a 3 point check was undertaken which included checking the name, address and date of birth. This has been replaced with a 6 point check, which is included on the request form and the additions are clinical details, previous examinations and site (area of body)/side (which limb) of the area to be x-rayed. The success of this will be monitored through incident reporting and audit of compliance.

2.1.4 Obstetric incidents

It has been identified within both serious incident and lower level incidents investigations that carbon monoxide testing of women in the antenatal period is not always undertaken. Staff awareness has been raised through the monthly newsletter and via global email to all staff within Maternity. Maternity have responded to this by incorporating carbon monoxide testing into the Maternity Care Indicators. Compliance is monitored within the Directorate Quality and Governance meeting and a quarterly report is reported into the Quality and Safety group.

2.1.5 Positive Learning

There was a case in theatres where an ODP spoke up and prevented a Never Event. The ODP stopped the Anaesthetist from proceeding with a nerve block on the wrong side. This positive learning has been presented at a multi-disciplinary Governance meeting including Theatre staff as an example of the importance of challenging hierarchy when patient safety could be compromised.

2.1.6 Needlestick Injuries

In response to preventable needlestick injuries within theatre the management team have highlighted the need for extra vigilance in order to prevent poor practice. The investigation into these two incidents identified that there was poor practice in relation to re-sheathing needles, needles being kept intraoperatively for further use and sharps being left on theatre trays. It was acknowledge by theatres that there was a need to address this poor practice with all staff. Staff have been informed via the theatre newsletter of this need for extra vigilance and reminding staff that they are responsible for their own sharps. Staff have been asked to revisit the waste management policy on the HUB and compliance will be monitored through incident reporting and through infection control audit. Sharps awareness is also raised at every theatre team meeting and at the daily huddle board.

2.1.7 Delay in Transfer to Transitional Care

Incidents have been reported in relation to delays in transferring babies to Transitional Care (TC) highlighted that there was no standard criteria for ensuring babies were transferred timely. This identified that there was a need to set a standard time within which babies are transferred to Transitional Care. A standard of 1 hour has been set (allowing time to arrange transfer and ensuring a space in TC is available), this is from when the medical decision is made for admission to Transitional Care.

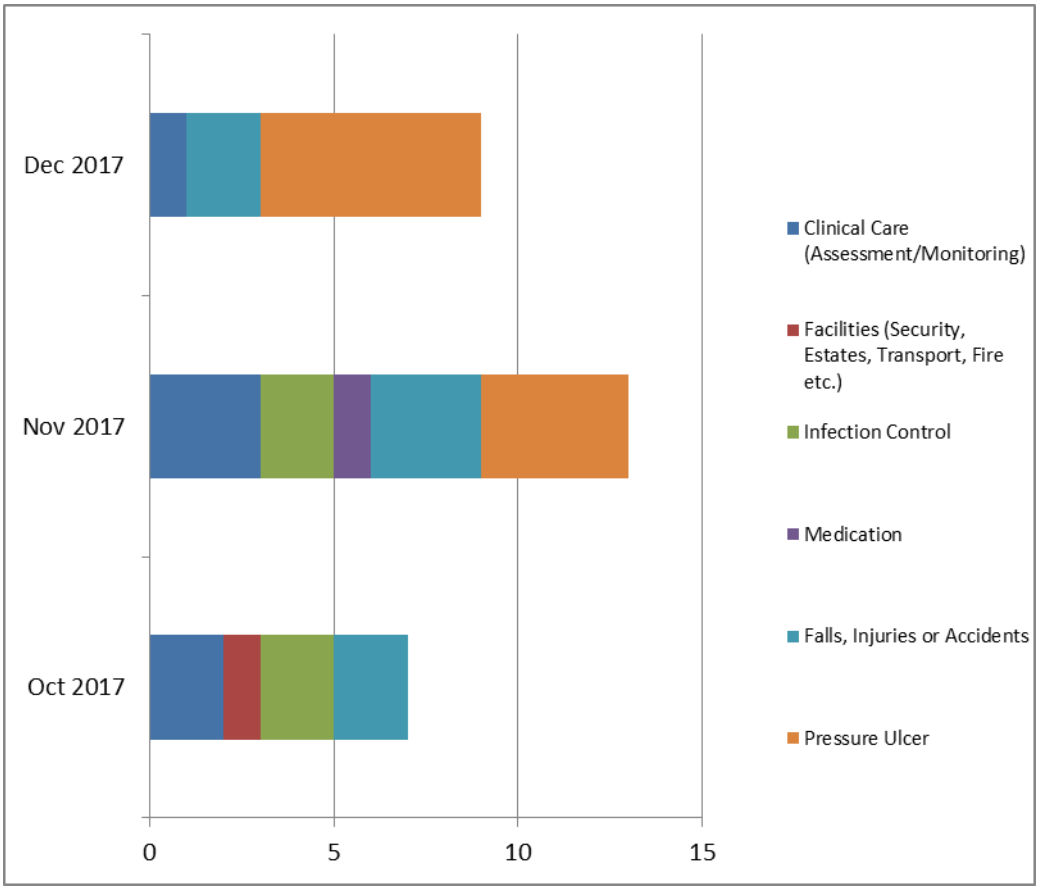
2.1.8 Readmission of Mothers to Maternity

Maternity Triage has seen an increase in incidents relating to readmission of mothers due to sepsis. The sepsis team have undertaken simulation assessments with the staff from Maternity Triage and this has received positive feedback. The sepsis team expressed how caring and attentive both the Maternity Support Worker and the Midwife were when providing the simulated care. The sepsis pathway was followed correctly and communication was noted to be excellent. The simulation highlighted that guidelines were not being followed in relation to recording the pulse and respiratory rate and that staff were sending a blood sample for lactate levels, rather than utilising a venous blood gas which provides an instant result. Staff have been informed that there was the necessity to ensure when undertaking the maternal observations that the respiratory rate and pulse rate need to be recorded for a full minute, this will be monitored through spot checks and escalation of non-compliance. The undertaking of blood gases to identify lactate will be monitored as part of the sepsis 6 pathway.

2.1.9 Pressure ulcers as a result of cast or orthotic device

A number of investigations into avoidable pressure ulcers on the orthopaedic wards identified that the pressure ulcers were a direct result from cast or orthotic devices. The trust skin bundle did not include any specific checks required when a patient has a cast or device. This led to the development of a plaster bundle which incorporates specific checks in relation to the cast or device. The plaster bundle was trialled successfully on B1 orthopaedics and is now in use on the orthopaedic wards. This will monitored via the monthly skin bundle audit.

3. SERIOUS INCIDENTS



The chart above provides an overview of the serious incidents reported by Type from 1st October 2017 to 31st December 2017.

3.1 LEARNING FROM SERIOUS INCIDENTS

3.1.1 Delay in Care and Treatment

There was an investigation into a 17 year old patient; diagnosed with hydrocephalus as a baby for which intervention had not been required. The 17 year old presented initially at Russell's Hall Hospital Emergency Department with a 2 week history of headaches and was referred to and seen by Neurosurgeons at the Queen Elizabeth Hospital. The patient attended Russell's Hall Hospital on subsequent occasions, radiological diagnostic scans were performed on each occasion and there appeared to be no evidence of deterioration in their condition. The 17 year old was brought in by ambulance to the Emergency Department, where their condition suddenly deteriorated. Despite urgent transfer to the University Hospital Birmingham and the emergency treatment they received, they sadly passed away. This incident went to Coroners and this resulted in a Regulation 28 which identified the need for improvement in communication and the need for education in relation to the referring to Tertiary centres.

A robust action plan was developed to address the concerns from the Coroner and to address the findings in the investigation. When patients are now seen in the HOT clinic at the University of Birmingham (UHB) hospital the letter is dictated, reviewed and dispatched within 48 hours of the appointment and a discharge summary is copied into the referring Consultant, GP and patient. This ensures that the clinic findings are communicated between all required professions and the patient also has a copy that they can refer to at any other appointments or admissions.

Both a clinical and IT lead for Norse at DGFT have been identified and Clinical Site Co-ordinators (CSC) now have access to NORSE thus providing 24 hour access to the system. Training has been provided to the CSC's and this has enabled them to see NORSE referrals and how to share referrals. NORSE training has been incorporated to the doctors IT training and provides new doctors and awareness of the system and this includes direction on the specialities that are included within the NORSE system. A number of guides have been developed to support managing the NORSE system and a guideline on the management of patients with hydrocephalus that present in ED, this includes an information leaflet "Hydrocephalus Alert".

There is a single point access at the DGFT which receives letters from UHB and the letters are now uploaded to the SOARIAN system allowing access to clinicians.

Training will be monitored through compliance with attendance and as part of the doctor's appraisal and CPD.

3.1.2 Inaccurate Test Results

The Royal Wolverhampton hospital alerted DGFT to an incident where a patient was anaesthetised and a Trans Oesophageal Echocardiogram (TOE) performed prior to the procedure, the Consultant noted that the TOE was incompatible with the original echocardiogram. Following investigation it was identified that the details of the echocardiogram were copied onto the wrong patient in CRISS (Radiology) system.

The investigation recognised inputting echo reports involved a 2 stage cut and paste process from echopac (a clinical software package for viewing, analyzing, and reporting of multi-dimensional echo, vascular and abdominal ultrasound images) to CRIS and that there are multiple interruptions for staff members during reporting sessions. Therefore the staff that undertakes this task have been moved to a separate room to alleviate distraction and the work load has been reduced to 10 per session. A business case has been approved and IT equipment is being purchased that will link echopac directly to SOARIAN. Assurance will be gained through there being no further incidents with all these controls being put into place. IT are monitoring along with Cardiology system the interface between the 2 systems to ensure that there are no errors.

3.1.3 Query with a swab

There was an incident during a laparoscopic abdominal - perineal resection procedure the swab, these are small to accommodate the laparoscope, was placed to protect the ureter and remained in position whist surgery continued. At the time of needing to remove the swab (midway through the procedure) it could not be located. At this point imaging was requested to identify the location. Imaging was unable to locate the swab and the surgeon was unable to visualise the swab through thorough inspection via the laparoscopic instrument. The surgeon then made the decision to convert to a laparotomy (an open procedure) to locate the swab. The swab, again through imaging and visual check was unable to be located. The patient the deteriorated and therefore a clinical decision was made in the interest of patient safety to close the laparotomy to stabilise the patient with the intent of further review of the abdomen to determine the next step. The patient went to ITU. The following day the patient had a CT scan to locate the position of the swab to continue then to undertake the procedure to remove the swab.

In response to this theatre now use the swab board to record all decisions to leave in situ any swab prior to the break starting and then use the swab board to record relocation of any swab when the session restarts after the break. The Standard Operating Procedure has been updated to reflect these changes and is available on the HUB. Compliance with this is monitored through observational audit. The investigation identified that C Arm X-ray imaging had limitations in detecting swabs, the limitations have been communicated to all theatre staff and staff have been informed if C Arm x-ray is unable to locate a swab the patient would need to be transferred to Radiology for a CT scan.

3.1.4 Failure to Monitor Health Needs

A patient had a cardiac arrest on ward. On reviewing the observation chart post arrest it was noted that no observations had not been undertaken throughout the day. Observations were not performed 4 hourly. Resuscitation was successful, then following a medical decision was made to put a DNAR in place and the patient died.

The incident identified concerns when patients were transferred onto the ward at weekends and ensuring that a Consultant review was undertaken. To address this, a weekend nurse-in-charge checklist has been implemented, the ward clerk provides the lead nurse with names of all patients and the checklist is prepared by the lead nurse prior to the ward round. All staff on this ward have attended NEWS (National Early Warning Score) training and competency documents have been completed.

3.1.5 Incorrect/incomplete pre-assessment

When interviewing a member of staff involved in two incidents it was highlighted that the policy was not being adhered to in relation to sample collection for blood bank, when collecting samples for the two sample procedure. Further investigation identified this practice was being carried out by all the members of staff who collect samples within pre-op assessment within the theatre daycase unit , and has done for some time. Those patients who have had two samples taken at pre-operative assessment (with no other historical sample on file) were treated as though, only one positive patient identification had occurred and only one venepuncture.

The investigation identified the need for a senior nurse to be available to oversee the operational management of the area and a Band 6 nurse has been appointed. The training package has been reviewed to incorporate and now defines the process for undertaking the task correctly, the consequences if not followed and a short questionnaire has been implemented to evaluate staffs comprehension. Compliance with practice will be monitored through audit. Taking blood samples for pre-transfusion testing has been included in the Patient Safety Bulletin which is sent out to every member of staff in the Trust thus ensuring Trust wide learning and this has also been made available on the HUB. This will reduce the risk of a patient receiving an ABO-incompatible transfusion.

3.1.6 Failure of Treatment

Patient admitted to the Trust with a head injury and was found unresponsive with a reduced Glasgow coma scale of 3. An Initial round table was held which identified. The investigation identified that there was a need for clarity of neurological observations with regards to the frequency and documentation and it was also identified that there was a of lack guidance on the management of a patient with a head injury that wards could refer too. A guideline has been developed, launched across the Trust and is available on the HUB.

The Resuscitation policy has been amended and the title amended to “Resuscitation Policy (deteriorating and high risk patient)

3.1.7 Falls

There have been 2 serious incidents relating to falls with harm in the Emergency Assessment unit and ED. The initial investigations identified that both patients had the appropriate care decisions at the time. However these decisions were based on limited knowledge of the patients as they had only just come to the hospital and cannot be compared to the ongoing assessments that happen when patients are admitted to the Ward areas. The lesson learned from this is that extra vigilance is required by staff in the emergency department and AMU when patients are newly admitted and their behaviour not known – this combined with dynamic action to change care plans quickly and efficiently. Both of these areas are above 95% in fall awareness training, therefore staff within these areas have been alerted to the need for extra vigilance. The falls coordinator undertakes an assessment of all falls, which will identify if these considerations are not taken into account with patients who are at high risk of falls.

4. COMPLAINTS

4.1 LEARNING FROM COMPLAINTS

It is essential that the trust continues to learn from complaints and concerns, ensuring service improvements are embedded into every day practice. The following section provides an overview of trust wide service improvements during Q2:

Medical Division:

- How easily a negative impression can be formed by appearances and words used. Reflection and discussion has taken place.
- To ensure all staff reduces the risk of lost patient's property by implemented the approved policy in completing the relevant trust documentation regarding valuables.
- To ensure effective communication with patients to allay anxiety and provide a quality patient experience.
- To ensure complaints processes are monitored to reduce any poor patient experience and ensure efficiency.
- To promote high nursing standards and monitor any patient negative nursing experiences and take action.

Surgery Division:

- To follow protocols i.e. sepsis 6.
- To be mindful of patient's requests such as to continue with breastfeeding.
- To provide fluid and antibiotics as soon as they are prescribed.
- To record all dealing accurately on medical records.
- Clearer communication with patients.
- To document all conversations and discussions fully with family/patients.

- To be mindful of manner when dealing with patients/families particularly on sensitive and emotional issues.

- To ensure clear communication with patients/families again on sensitive and emotional issues.

Clinical Support Division:

During Quarter 2, Clinical Support Division closed 1 complaint and this was not upheld, therefore there were no actions or lessons to be learnt from this complaint.

5. CLAIMS

5.1 LEARNING FROM CLAIMS

5.1.2 Delayed diagnosis

In relation to the Trust's admissions of a breach of duty (and pending settlement of a claim) where the matter concerned an alleged delay in diagnosing metastatic lung cancer from an x-ray taken in July 2016, the cancer was eventually noted December 2016.

The case has been reviewed and the Radiologists involved were all advised. This case was also one of shared learning among the whole body of Radiologists with the breaches defined in the expert report being shared within the Radiology Department.

The Trust has introduced actions that will address the identified breaches and these are contained within the recently ratified standard operating procedure (SOP), which is available on the Hub. Radiology has defined responsibilities around reporting and appropriate delegation to certain specialties and where the Radiologists are responsible. This will be audited by Radiology. The SOP also clearly states the statutory duties of the referring clinicians to comply with the IRMER regulations around the provision of a written clinical evaluation of X-rays in the patient's notes, and to regularly undertake audit to ensure compliance. Points applicable to all medical and surgical clinical teams have been communicated to Chief of Surgery and Chief of Medicine for information and cooperation in dissemination to clinicians.

5.1.3 Equipment

A further claim currently being investigated puts forward allegations pertaining to substandard perioperative management during an elective vascular surgery procedure, resulting in burns to sacrum and buttocks of the claimant.

The allegations relate to the warming mattress used during surgery and which is a standard piece of equipment across all operating theatres. The manufacturer was contacted to inform them of the incident and to request a check of the equipment - No fault was found.

The incident was raised in both the vascular morbidity and mortality meeting and governance meeting to discuss concerns and whether this was in relation to the heating mattress.

Through the governance meeting use of the heating mattress was temporarily stopped for ALL vascular procedures until the M&M where following review of the notes and further discussion it was agreed that surgeons would rationalise this to not using the heating mattress in vascular procedures where the aorta and iliac arteries were clamped.

The hypothesis being that in these procedures the reduced blood flow to the pelvis may have led to the heat mattress creating the skin burns that the patient received. For these procedures theatres have moved back to the old method of heating with a Bair hugger on the torso and head. This is

only hypothetical, but this change was introduced to try and prevent a further occurrence of this complication.

It was further considered incident could be a result of surgical prepping agent pooling underneath the patient and being warmed by the mattress. The Trust has subsequently changed practice by introducing an absorbent trolley sheet and incopads to soak up any pooling prep prior to draping. If these are noted as particularly wet they are now also changed prior to the drapes being applied. Change also introduced to the patient prep used. Traditionally sponges that absorbed lots of prep were used but now use raytec swabs that reduce the amount absorbed and the amount pooling.

5.2 LEARNING FROM CORONER'S INQUESTS

5.2.1 Prevention of Future Deaths Reports

The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. The report is sent to organisations that are in a position to take action to reduce this risk and they must reply within 56 days to say what action it "the Trust" plans to take.

A 'Regulation 28' report was issued by the Coroner following an inquest in November 2017 and the Trust response was forwarded to the Coroner on 26 January 2018 (within the required time scale).

The matters of concern that emerged during the inquest were related to delays in ordering Debrisoft, a product which may have helped in managing the wound with the Coroner stating there was evidence of poor communication and poor systems in place in ordering Debrisoft with confusion about the process and overall responsibility.

Following a meeting with community nursing senior leads and the Chief Nurse, a Debrisoft management pathway has been introduced. To ensure there are no delays Debrisoft is now a stock item ordered through procurement and orders have been placed by the 5 community localities. Community nurses also have stock items of Debrisoft (1 box of 5) in nursing bags at all times. Delays in community nursing prescription requests have been highlighted to CCG who will further discuss with GP leads. Debrisoft Representative will liaise with GP surgeries and local pharmacies in order to cascade educational advice regarding the product and FP10s. The Trust has scheduled a follow up meeting with the rep to ensure revised processes are working.

6. LEARNING FROM AUDIT

This section provides the learning from clinical audit.

6.1 Management of DVT in Ambulatory Emergency Care

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Standards:

- Wells' score is documented in 22% of patients
- 18% of patients had scan performed within 24 hours of presentation .
- 46% of patients had documented correspondence to GP about scan outcome.
- 50% of patients documentation of correspondence to GP(Re scan outcome) was not easily accessible as notes were not available.

Recommendations:

- Include wells' score in electronic Doppler request forms.
- Generate electronic GP notification form with scan outcome
- Aim for Doppler scan within 24 hours off suspected diagnosis
- Improve accessibility to documentation of GP notification of scan outcome
- Improve wells' score documentation in patients suspected of DVT
- Liaise with radiology to arrange a fixed No of slots /day for DVT scans
- Generate electronic GP notification form with scan outcome
- Include wells' score in electronic Doppler request forms.

6.2 An audit into the efficacy of the recording process following Outpatient prescription Controlled Drug issue.

To determine to what extent The Dudley Group NHS Foundation Trust standard operating procedures are followed with regards to the issuing and record keeping of Controlled Drugs

- 100% of all Controlled Drug Outpatient prescriptions have a 'Controlled Drug Outpatient Issue Record' sheet attached
  Trust compliance 99%
- 100% of identification requested from the person collecting the Controlled Drug prescription; including patient, patient's representative or Healthcare Professional
  Trust compliance 99%
- 100% of person collecting data recorded within corresponding Controlled Drug register.
  Trust compliance 41%

Recommendations:

- Update Standard Operating Procedure D-C-20 'Controlled Drugs – Final Checking & Issuing Outpatient Prescriptions' to be more prescriptive and accurate
- Outlining the type of identification that is acceptable upon collection as per Pharmaceutical Services Negotiating Committee guidance
- Carry out education and training to staff regarding the altered 'Controlled Drug Outpatient Issue Record' sheet and Standard Operating Procedure and to the public regarding expectations on their input to the process

7. TRUST MANDATORY AUDIT OF PRIORITIES FOR CARE OF THE DYING 2017/18

7.1 RESULTS

Priority 1 - Recognise
The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

The audit showed that the death was expected from the patient's condition in 251 cases (85%) and death occurred within 48 hours of admission in 58 cases (20%).

Recognition that the patient was dying was documented in 236 (79%) of the 297 records audited.

Priority 2 - Communicate
Sensitive communication takes place between staff and the dying person, and those identified as important to them.

In the 236 cases where recognition that the patient was dying was documented this was discussed with the patient in 75 cases (32%). Where this was not discussed with the patient or the patient lacked capacity it was discussed with the patient's family in 149 cases (93%).

Documentation and recognition of the patient dying was not discussed with either the patient or their family in the remaining 12 cases (7%).

Priority 3 - Involve
The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.

- **DNACPR**

A DNACPR was in place for 260 patients (88%) and this was documented (on the DNACPR form) as being discussed with the patient or the patient's family/NOK in 248 cases (95%).

For the 12 remaining cases the DNACPR was not discussed with an IMCA on the 4 applicable cases (0%) , the further 8 cases were marked as not applicable.

Some comments recorded relating to documentation of DNACPR included:

" *Was awaiting discussion with IMCA…."*

Where the DNACPR was completed by a registrar, it was documented as being countersigned by a Consultant in 94 out of 153 occurrences (61%).

Priority 4 - Support
The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

Priority 5 - Plan & Do
An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion.

- **Planning Care**

Blood samples were obtained for 17 patients and the rationale for this was recorded in 8 patients (47%).

Regular medications were rationalised for 153 patients (67%) and active treatment was reviewed for 189 patients (83%).

- **Symptom Control**

The audit recorded if anticipatory medications were prescribed for symptom control of pain and shortness of breath (86%), agitation (82%), secretions (73%) and nausea and vomiting (75%). illustrates the overall prescribing of anticipatory medications.

7. LEARNING FROM NPSA ALERTS

NPSA alerts provide guidance on preventing potential incidents that may lead to harm or death. They are identified using the national reporting system to spot emerging patterns at a national level, so that appropriate guidance can be developed and issued. The chart below identifies learning and changes in practice.

7.1 Risk of death and severe harm from failure to obtain continued flow from oxygen cylinders

DETAIL

The alert was issued following a series of incidents nationally (over 400in the last 3 years) involving incorrect operation of oxygen cylinder controls. Out of these 6 patients died and a further 5 had respiratory / cardiac arrest and were successfully resuscitated. A particular issue that was identified related to the fact that the current oxygen cylinders have integral valves and require additional steps before oxygen starts to flow. This potentially led to staff believing oxygen was flowing when it wasn't as well as inability to turn oxygen on in an emergency.

Three alerts have been issued since 2009 looking at incidents involving oxygen over a total of 10 years. NPSA reviewed over 800 incidents linked to the use of oxygen and identified areas for action. Despite declaring compliance to these alerts within the Trust, incidents continue to occur.

RISK FACTORS

- Although there have been no incidents within the organisation specifically relating to the cylinder valve, there have been incidents relating to patients oxygen cylinders running out whilst patient is being transferred for investigations and patients desaturating whilst being transferred between departments.
- In addition to this, an impromptu survey undertaken on the day the alert was issued showed that oxygen cylinders in use on the wards had the valve left open when not in use. This breached health and safety, fire safety, manufacturer's recommendations and the NPSA alert.
- Following discussion at the working group that was set up for this alert, it became obvious that senior staff from the wards were unaware of the issue relating to the valves.
- There are 5 risks on the risk register relating to prescribing, administration, transportation and storage of oxygen scoring between 10 (Moderate) and 15 (Major)

ACTIONS THE TRUST HAS TAKEN

- Training on correct use of oxygen cylinders for all ward / department staff immediately, with updates on annual / 3 yearly basis to ensure ongoing compliance.
- Reference Guide/ Posters have been developed and distributed to all areas detailing the correct steps to follow prior to administering to patient
- Medical Gases Policy / Summit Policy to reflect changes made from this patient safety alert
- Safety guide signage to be developed to go on Cylinder Necks
- Resus Trolley Daily Checklist developed so that staff can audit compliance of cylinder storage and valve closure compliance on ward.
- Publicise the alert through Patient safety Bulletin, Hub Page story, Learning Report, Governance Newsletter and face to face teaching
- Audit plan built in to assess compliance to the policy and provide assurance on effectiveness and embeddedness of actions.

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors
8 March 2018

TITLE:	**Report on the CQC Inspection**		
AUTHOR:	Glen Palethorpe – Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe – Director of Governance / Board Secretary
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 **ALL**			

SUMMARY OF KEY ISSUES:

The CQC undertook a series of service inspections in December 2017 to January 2018 along with their well led review in January 2018.

The CQC inspected

- Urgent and Emergency Care
- Critical Care
- Medicine
- Children and Young People
- Maternity
- Community including adult sexual health

Within Urgent and Emergency Care the CQC has issued 2 Section 31 notices. Neither notice put any restrictions on the Trust's registration but both require the Trust to provide enhanced assurance through weekly reporting to the CQC.

Following receipt of the CQC notices a specific risk was placed on the Trust's Corporate Risk Register and Board Assurance Framework with this risk to be supported by specific risks within the Medicine and Integrated Care divisional risk register.

A comprehensive quality and service improvement has been established to track the delivery all issues raised by the CQC. This action plan is reported to the Clinical Quality, Safety and Patient Experience Committee who provide scrutiny over its delivery.

A Dudley System Oversight and Assurance Group has been established which is to be chaired by NHS Improvement and attended by the Trust, the CCG, NHS England and the CQC where the system issues around Emergency Care will be discussed and as part of this group's remit will be a review of the Trust's service improvement plan.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description:** 501 - The Trust's ability to provide a safe, caring and effective service within ED and all associated areas at all times.
	Risk Register: Y COR501		**Risk Score: 20**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: compliance with issued s31 notice**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE			
Decision	**Approval**	**Discussion**	**Other**
			Y

RECOMMENDATIONS FOR THE COUNCIL

To note

- The Trust has responded to the conditions as set out by the CQC within their Section 31 Notices.
- A specific Corporate and given its significance a Board Assurance Framework risk has been identified.
- Robust routine reporting from the Executives and the Divisions to CQSPE has been established to provide assurance on the specific Section 31 requirements along with progress on the wider service inspection action plans.

CQC Inspection

1 Background

The CQC undertook a series of service inspections in December 2017 to January 2018 along with their well led review in January 2018.

The CQC inspected

- Urgent and Emergency Care
- Critical Care
- Medicine
- Children and Young People
- Maternity
- Community including adult sexual health

2 Service Inspections

2.1 Urgent and Emergency Care

During the initial service visit to this service the inspection team noted a number of concerns and the CQC confirmed the high level findings in a letter to the Trust on the 11 December. Subsequent to this initial feedback the CQC in completing its normal processes following service inspections wrote to the Trust on the 22 December indicating it may take possible urgent enforcement action by way of use of Section 31 of the Health and Social Care Act 2008: Imposition of Conditions on Registration.

The Trust responded to this letter on the 2 January indicating immediate and longer term actions being undertaken within ED picking up the concerns raised by the CCQ during and after their visit on the 5 and 5 December. The CQC also sought information on how the Executive Team were assuring themselves daily on the safety of the emergency department. The process of daily audits was described to the CQC in the Trust's response.

On 11 January 2018 a team undertook a further unannounced inspection of the Emergency Department. The inspection also looked at the newly created Immediate Medical Assessment Area and identified significant failings similar to those identified in ED on the visit in December specifically in respect of the management of the deteriorating patient and the use of the SEPSIS pathway. They also raised concerns over the lack of a clear Standard Operating Procedure for the IMA area and the reliance on agency staff within that area.

During the well led review in January the CQC undertook further reviews of the Emergency Department, specifically looking at Triage and Safeguarding practices within the department. During this visit the CQC raised a number of concerns in relation to the Trust's triage policy and the departments understanding of it application, the ability to clinically assess patients within the 15 minute standard along with some specific examples of safeguarding practices.

2.2 Critical Care

During the initial service visit to this service the inspection team noted a number of concerns and the CQC confirmed the high level findings in a letter to the Trust on the 11 December.

The Trust formulated an action plan to address the concerns raised within the letter of the 11 December.

Many of the concerns related to Coronary Care Unit and were raised in judging this unit against the Critical Service Standards, whereas if it was judged against Medicine, which is where it was judged previously, these concerns would not be relevant.

Following further engagement with the CQC and the provision of more information the CQC are minded to move the Coronary Care Unit into Medicine and not judge it against critical care service standards which are not relevant.

The Trust is awaiting the final outcome the CQC's deliberations.

2.3 Maternity, Children and Young People and Medicine

The inspection team were broadly complimentary about these services and provided high level feedback on the outcome of their inspection in a letter dated 18 December.

The Trust has built the findings from these reviews into its comprehensive quality and service improvement plan.

2.4 Community Services including Adult Sexual Health

The inspection team were very complimentary about these services and provided high level feedback on the outcome of their inspection in a letter dated 24 January 2018

Although there were only a few areas for action within the feedback letter these are also being built into the Trust's comprehensive quality and service improvement plan.

2.5 Well Led

The inspection team provided feedback to the Chief Executive and Chair initially and followed this up with a high level discussion with the Board on the 15 February 2018.

The Trust is still awaiting the CQC's formal feedback, but the high level discussion corroborated many of the actions being taken as a result of the tri annual external well led inspection undertaken in last months of 2017.

3 The Section 31 Notices

3.1 Notice issued on 12 January 2018

The CQC issued a Section 31 notice on the 12 January after providing feedback on the phone to the Executive Team. The notice imposed the following conditions with immediate effect from 12 January 2018.

From 19 January 2018 and on the Friday of each week thereafter, the registered provider shall report to the Care Quality Commission describing:

> *The actions taken to ensure that an effective deteriorating patient and sepsis management systems are in place and how these are being audited, monitored and acted upon.*
>
> *This should include results of any audits undertaken that provide assurance to the board that an effective sepsis management and deteriorating patient system is in place.*

From 19 January 2018 and on the Friday of each week thereafter, the registered provider shall report to the Care Quality Commission describing:

> *The staffing levels and leadership cover for this area. This information should include grades of staff and numbers covering the 24 hour period.*

3.2 Notice issued on the 5 February

The CQC issued a Section 31 notice on the 5 February after providing feedback on the phone to the Executive Team. The notice imposed the following conditions with immediate effect.

On the 9th February 2018 by 4pm the registered provider shall give written assurance to the Care Quality Commission that interim arrangements are in place and implemented to clinically assess all patients within 15 minutes of arrival at the emergency department.

From 9th February 2018 and on the Friday of each week thereafter by 4pm until further notice, the registered provider shall report to the Care Quality Commission confirming:

> *a) The action taken to ensure that an effective system is in place to clinically assess all patients within 15 minutes of arrival at the emergency department and progress on its implementation*
>
> b) The process and outcome of auditing, monitoring and implementing this system.
>
> c) The results of all audits undertaken and assurance given to the Board of The Dudley Group NHS Foundation Trust that an effective system is in place.

By 4pm on 5th February 2018 (this was changed to the 9th February 2018) the provider must confirm in writing to the Care Quality Commission the arrangements in place with all third party organizations providing healthcare services at the Emergency Department at Russells Hall Hospital to communicate concerns relating to any and all care delivered in order to ensure patient safety.

From 9th February and on the last Friday of each month thereafter until further notice, the registered provider shall report to the Care Quality Commission confirming the ongoing governance arrangements and monitoring relating to any and all third party organisations providing healthcare services within its Emergency Department at Russells Hall Hospital.

4 Risk Assessment

The Executive Team met to discuss the enhanced processes established since the CQC visit on the 11 January that led to their first Section 31 notice and the processes by which assurance will be provided on a daily basis ahead of the weekly reporting to the CQC.

Following receipt of the CQC notice a specific risk was placed on the Trust's Corporate Risk Register and Board Assurance Framework supported by specific risks within the Medicine and Integrated Care divisional risk register.

Risk Title	initial	Cause/Effect of the Risk	Impact of the Risk	Controls in place	Gaps in Control	Current	Action Description	Due date	Action completed	Target
COR501 Ability to provide a safe, caring and effective service within ED at all times	20	Concerns flagged by CQC during inspection review Concerns verified by increased scrutiny by MD, COO and CN.	Patient experience and safety in relation to deteriorating patient and sepsis pathway	Daily quality audits and assurance provided to Chief Exec. Policies and guidelines to support deteriorating patient and Sepsis management Duty rosters singed off	Compliance to deteriorating patient pathway Compliance to sepsis pathway Reliance on agency staff	20	Introduction of Huddle with staff - review of checklist	12/01/2018		8
							Review of leadership in the department (IMAA)	31/01/2018	15/01/2018	
							Review skill mix and introduction of assurance sign off process for skill mix	15/01/2018	15/01/2018	
							Production of CQC action plan	15/01/2018		
							Development Quality dashboard assurance tool for Board Assurance	02/01/2018	02/01/2018	

The Executive Team met to agree the actions needed to respond to the second Section 31 Notice and secure the required weekly assurance, recognizing that it has established daily audits in relation to triage performance against the 15 minute standard from the earlier CQC feedback.

The Executive reviewed the established corporate risk and determined that it did not need adjusting despite the second Section 31 notice as that also related to the Emergency Department.

5 Monitoring and oversight of actions being taken

All of the CQC feedback especially those that resulted in the two Section 31 notices requirements have been incorporated into a comprehensive quality and service improvement action plan. This action plan is reported to the Clinical Quality, Safety and Patient Experience Committee who provide scrutiny over its delivery prior to reporting to the Board.

A Dudley System Oversight and Assurance Group has been established which is to be chaired by NHS Improvement and attended by the Trust, the CCG, NHS England and the CQC where the system issues around Emergency Care will be discussed and as part of this group's remit will be a review of the Trust's service improvement plan.

6 Conclusions

The Trust has responded to the conditions as set out by the CQC within their Section 31 Notices.

A specific Corporate and given its significance a Board Assurance Framework risk has been identified.

Robust routine reporting from the Executives and the Divisions to CQSPE has been established to provide assurance on the specific Section 31 requirements along with progress on the wider service inspection action plans.

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors
On 8 March 2018

TITLE	Finance and Performance Committee Exception Report		
AUTHOR	Tom Jackson Director of Finance	**PRESENTER**	Tom Jackson Director of Finance

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

CORPORATE OBJECTIVE: S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

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

RISKS	**Risk Register**	**Risk Score Y**	**Details:** Risk to achievement of the overall financial target for the year
COMPLIANCE	**CQC**	**Y**	**Details:** CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.
	NHSLA	**N**	
	NHSI	**Y**	**Details:** Achievement of all Terms of Authorisation
	Other	**Y**	**Details:**

ACTION REQUIRED OF BOARD:

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

RECOMMENDATIONS FOR THE BOARD:

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

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**22 February 2018**	**Richard Miner**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

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

Decisions Made / Items Approved

- None

Actions to come back to Committee

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

Performance Issues to be referred into Executive Performance Management Process

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

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

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

Items referred to the Board for decision or action

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

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors on 8th March 2018

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

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

CORPORATE OBJECTIVE:

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

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

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

RECOMMENDATIONS FOR THE BOARD:

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

The Dudley Group
NHS Foundation Trust

Integrated Performance Report - Council of Governors




January 2018

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

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

The Dudley Group NHS Foundation Trust

Quality Dashboard

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

The Dudley Group NHS Foundation Trust

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

The Dudley Group NHS Foundation Trust

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

The Dudley Group NHS Foundation Trust

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

The Dudley Group NHS Foundation Trust

Executive Summary by Exception

Key Messages

1 Performance Matters — Committee: F&P

A&E 4 hour wait

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

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

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

Cancer Waits

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

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

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

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

2WW

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

Referral To Treatment (RTT)

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

Diagnostic waits

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

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

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

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

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

Executive Summary by Exception cont.

Key Messages

CQSPE

HCAI

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

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

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

Never Events

There werre zero never events in month.

Mixed Sex Sleeping Accommodation Breaches (MSA)

There were 5 breaches reported in month.

VTE Assessment On Admission: Indicator

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

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

4 Workforce — Committee: F&P

Appraisals:

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

Mandatory Training:

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

Sickness:

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

The Dudley Group NHS Foundation Trust

Patients will experience safe care - "At a glance"

Executive Lead: Siobhan Jordan

Patients will experience safe care - Quality & Experience

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

Patients will experience safe care - Patient Safety

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

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

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

Performance - Key Performance Indicators cont.

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

Financial Performance - "At a glance"

Executive Lead: Tom Jackson

The Dudley Group NHS Foundation Trust

Performance - Financial Overview

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

Performance - Financial Overview - TRUST LEVEL ONLY

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

The Dudley Group NHS Foundation Trust

Workforce - "At a glance"

Executive Lead: Andrew McMenemy

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

Enclosure 9

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors on 8th March 2018

TITLE:	Workforce Key Performance Indicators		
AUTHOR:	Greg Ferris Workforces Information Analyst	**PRESENTER:**	Andrew McMenemy Director of Human Resources

CORPORATE OBJECTIVE:
SO4: Be the place people choose to work SO5: Make the best use of what we have.

SUMMARY OF KEY ISSUES:

The workforce KPI report is attached and is designed to be comprehensive in order to provide assurance to the committee on a range of workforce indicators for all staff Groups.

The format of the following pages provides information at a trust level, divisional level and staff group level where appropriate. Key indicators include absence, mandatory training, appraisal and recruitment.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details**: Training designed to cover all training required by statute and regulatory authorities.
	NHSI	Y	**Details:** Training designed to cover all training required by statute and regulatory authorities.
	Other	Y	**Details**: Training designed to cover all training required by statute and regulatory authorities.

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		✓	

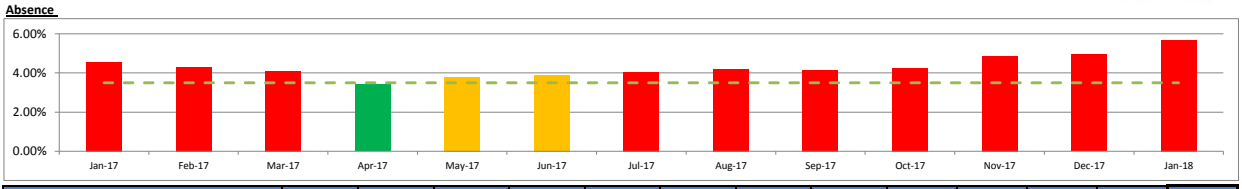
RECOMMENDATIONS FOR THE COUNCIL:

That the Council note the report and actions being undertaken to improve compliance with targets.

Workforce Performance

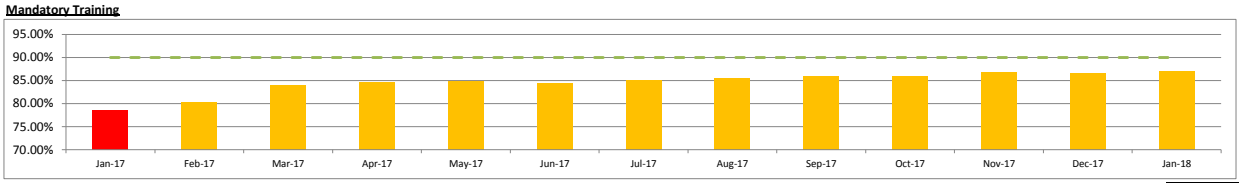
The Dudley Group NHS Foundation Trust

Absence



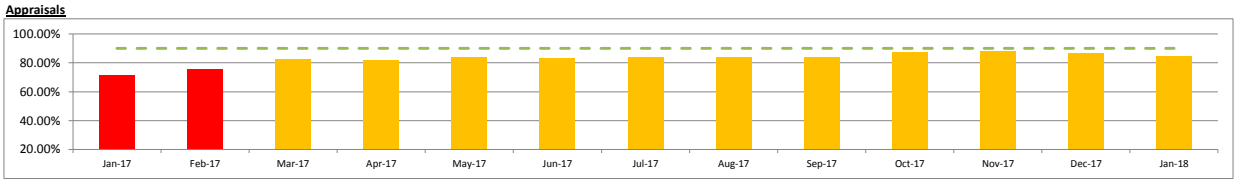
Workforce	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Monthly Absence Rate	4.56%	4.32%	4.07%	3.41%	3.78%	3.88%	4.04%	4.21%	4.15%	4.26%	4.88%	4.94%	5.70%
Target	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%	3.50%

Mandatory Training



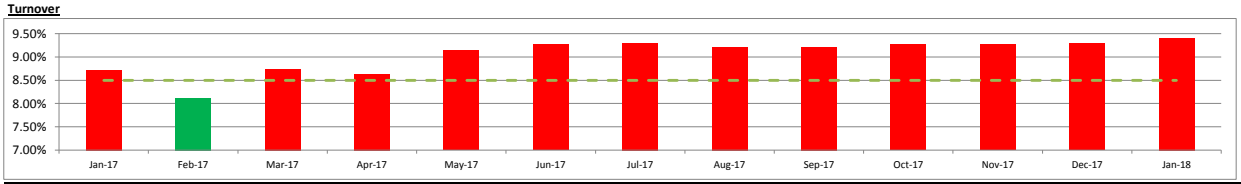
Workforce	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Monthly Compliance	78.62%	80.28%	83.90%	84.61%	84.87%	84.57%	85.07%	85.47%	86.04%	85.93%	86.93%	86.64%	87.14%
Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

Appraisals



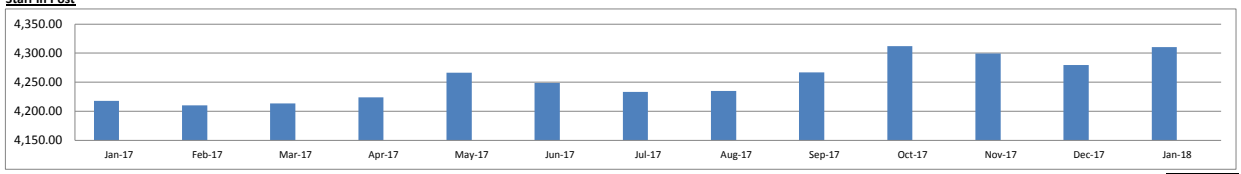
Workforce	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Monthly Compliance	71.71%	75.98%	82.90%	81.96%	83.64%	82.99%	83.91%	83.93%	84.07%	87.27%	88.12%	86.96%	84.42%
Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%

Turnover



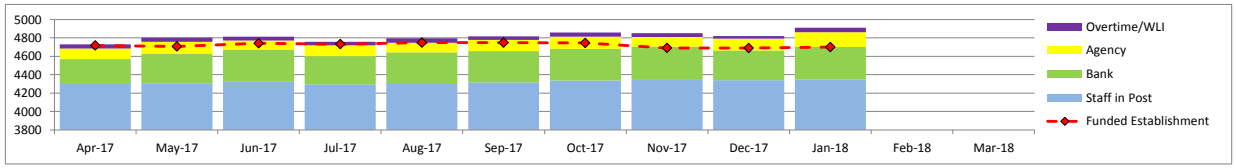
Workforce	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Monthly Turnover Rate	8.71%	8.12%	8.74%	8.63%	9.14%	9.26%	9.30%	9.21%	9.21%	9.26%	9.26%	9.29%	9.40%
Target	8.50%	8.50%	8.50%	8.50%	8.50%	8.50%	8.50%	8.50%	8.50%	8.50%	8.50%	8.50%	8.50%

Staff in Post



Workforce	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Monthly Staff in Post(FTE)	4218.06	4209.90	4213.33	4224.06	4266.50	4248.74	4233.13	4235.05	4266.81	4311.87	4299.51	4279.26	4310.35

WTE Analysis Compared to Funded Establishment



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Funded Establishment	4717.91	4707.61	4741.17	4732.23	4748.33	4747.28	4744.22	4690.83	4689.54	4699.97		
Staff in Post	4309.81	4301.72	4323.76	4294.41	4299.12	4315.13	4337.3	4343.2	4341.19	4347.04		
Bank	261.26	323.97	350.32	307.54	343.02	342.6	344.99	361.91	323.06	355.68		
Agency	114.57	131.42	97.32	118.33	105.46	119.3	131.55	103.49	127.59	160.11		
Overtime/WLI	43.84	46.53	42.81	38.52	46.46	38.28	44.24	43.61	28.36	47.91		

Enclosure 10

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors meeting

on 8 March 2018

TITLE:	**Report from the Council of Governors Governance Committee meeting of the 22 February 2018**		
AUTHOR:	Nicola Piggott Committee Chair	**PRESENTER**	Nicola Piggott Committee Chair

The Committee was quorate.

The Committee received reports from the Board of Directors Finance and Performance Committee Chair and the Board of Directors Audit Committee Chair in respect of their recent meetings, along with reports from the Trust's Finance Director, Director of Workforce and the Director of Governance. These reports covered the Trust's Financial and Operational Performance including key Workforce Metrics, the Trust's Board Assurance Framework and a report on the CQC inspection.

The Committee actively sought assurance from the Non Executive Director, the Audit Committee Chair, over the work of the Finance and Performance Committee, the actions being undertaken to address the key financial risks facing the Trust and over the areas of underperformance. The Committee asked questions in respect of the Trust's performance with regard to bank and agency use and were provided within an update on the actions being taken and future plans to pursue initiatives in respect of staff retention whilst continuing with the successful recruitment projects. The Committee acknowledged that HR were being very proactive in relation to developing initiatives to retain staff and encourage staff to join the bank. In respect of performance the Committee was briefed on the impact of the high emergency activity demand on the Trusts performance not only in respect of the 4 hour target which remains a key challenge but also in the areas of diagnostics, 18 week RTT and cancer where the Trust's performance has remained strong.

The Committee in receiving the report from Audit Committee Chair were updated on the work of the Audit Committee and was able to be assured that the work of the Trust's auditors (clinical audit, internal audit and external audit) is progressing as planned and that areas where action is needed by Trust Management are being followed up by the Committee. The Audit Committee chair also confirmed that they were actively seeking assurance in respect of the bank and agency usage processes for managing that key financial and operational performance risk

The Committee considered the Trust's Board Assurance Framework for the 3rd Quarter of the year and noted its revised layout, (this is attached as appendix 2 to this report). The Committee noted that the new format contained a forward projection from the Trust's executives on the expected view of the level of risk for the next quarter and felt this addition to the document was helpful (a summary of this is attached as appendix 1 to this report).

The Committee also noted the role the Audit Committee play in considering the detail of the assurances supporting the Executives' view of the Trust's risks and was assured through the feedback from the Chair of the Audit Committee's report that this was appropriate. The Committee asked questions of the risks and assurances and from the responses provided to questions on its content provided by the Director of Governance was reassured of its robustness.

The Committee received a report on the outcome of the latest CQC inspection noting that the CQC had a number of concerns in respect of the Trust's Emergency Department. The Committee was updated as to the actions being taken by the Trust Executive team in respect of these and the enhanced assurance the Trust was providing to the CQC on a weekly basis.

The Committee was also updated by the Director of Governance on the actions being taken by the Trust to secure a rebate in respect of its maternity insurance premium, which is there to reward good service providers.

ACTION REQUIRED OF COUNCIL

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COUNCIL

To note the actions taken by the Committee in holding to account the Trust in respect of its performance and systems of risk management and internal control.

To note the Trust's key risks, as recorded within appendix 2 (the BAF) to this report.

APPENDIX 1 Summary of the Trust's risk profile against each of the Trust's objectives

	Total number of risks	Total inherent risk score	Total value of risks at Q2	Predicted movement in these risks by end of next quarter (Q3)	Current value of risks at Q3	Expected movement in these risks by end of next quarter (Q4)	Total target risk score
Objective 1 – deliver a great patient experience	9	180	162	↓	133	↓	89
Objective 2 – safe and caring services	7	145	94	↓	105*	↓	65
Objective 3 – drive service improvement, innovation and transformation	1	20	16	→	16	→	15
Objective 4 – be the place people choose to work	Key risks relating to "people" are in effect recorded across many of the other Trust objectives, to prevent duplication they are not repeated within this objective.				20 (new risk)	→	10
Objective 5 – make the best of what we have	3	65	48	→	48	→	31
Objective 6 – deliver a viable future	3	65	40	→	60**	→	29

**The predicted downward movment was achieved with a score of 85 but the addition of a new risk with a current risk score of 20 increased the current value to 105.*

***The predicted movement was achieved with a score of 40 but the additon of a new risk with a current score of 20 increased the value to 60.*

Appendix 2 Board Assurance Framework to 02/01/18

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

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Current Risk Score 27/12/17	Movement in risk	Expected movement by next quarter	Target Risk Score
F	COO	COR378	**Risk Title** Failure to meet the 18wk performance target	20	10	10	10	➔		10
			Key Controls • *Review of theatre productivity* • *Review of performance*		+Pos level 2 Report to F&P	+Pos level 2 Report to F&P	+Pos level 2 Report to F&P			
			Strength of assurance logged (L1 / L2 / L3)		G	G	G		➔	
F	COO	COR099	**Risk Title** Failure to reduce the number of delayed transfer of care may result in poor patient experience	20	20	20	20	➔		16
			Key Controls • *Dudley economy MoU* • *Daily review of discharges* • *Application of Red 2 Green initiative*		+ Pos level 1 A&E delivery plan	+ Pos level 1 A&E delivery plan	- Neg level 1 Local reporting/coding is not consistent with other organisations + Pos level 2 Apt three month secondment for managerial lead Agreed escalation of non-achievement of the MOU (inc out of area) and Action Plan for Integration of actions between Dudley Group/ CCG / Local Authority. CQSPE Dec 2017 unable to demonstrate improvement/embedding across organisation of red to green			
			Strength of assurance logged (L1 / L2 / L3)		G	G	R A		➔	
CQSPE	MD	COR244	**Risk Title** Failure to Monitor and to Learn From Deaths	20	20	20	15	➘		8
			Key Controls • *Mortality review process* • *Mortality Surveillance Group* • *Learning from deaths policy*		+Pos level 2 Policy approved and presented to CQSPE	+Pos level 2 New report in line with national guidance. Policy approved and presented to CQSPE	+Pos Level 2 Reports presented to CQSPE Oct 2017/Nov 2017. Learning demonstrated through audit Reports presented to Board Dec 2017. focus on learning to be picked up within audits			
			Strength of assurance logged (L1 / L2 / L3)		G	G	G		➘	
CQSPE	CN	COR259	**Risk Title** Friend and Family (Patient Survey) outcome scores extremely low	20	20	20	12	➘		9
			Key Controls • *Review of real time surveys* • *Oversight of action plans through Patient Experience Improvement Group*		+Pos level 1 Patient Experience Improvement group overseeing improvement plan.	Pos level 1 Patient Experience Improvement group overseeing improvement plan. Positive engagement across Trust. +Pos level 2 FFT response rates improving.	Pos level 1 Pt Experience inpatient survey action plan completed (exc 5 actions which are ongoing)			
			Strength of assurance logged (L1 / L2 / L3)		G	G G	G		➔	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Current Risk Score 27/12/17	Movement in risk	Expected movement by next quarter	Target Risk Score
CQSPE	COO	COR121 (OOS004)	**Risk Title** Ophthalmology Outpatient Appointment Capacity	20	**20**	**20**	**16**	➔		16
			Key Controls • *Review of RAG rating for each appointment* • *Application of formal escalation for delayed appointments* • *Project management of procured extra resource to deal with backlog*		+Pos level 2 External resources approved -Neg level 2 increase in delays reported to F&P	+Pos level 2 Reduction in delayed FU appt. ASI extract confirms reduction -Neg level 2 May-Aug - increase in delayed FU appt.	+Pos Level 2 Repatriation of 2 consultants/ Increased orthoptic combined clinics / Macular Nurse led clinics CQSPE – new ophthalmologist starting Jan 2018 -Neg Level 2 CQSPE Nov 2017 behind trajectory due workforce			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**	A		➔	
F	DF	COR101	**Risk Title** Capital Schemes fail to be delivered impacting on patient experience of the Trust	20	**12**	**12**	12	➔		8
			Key Controls • *Capital programme project management process*		+Pos level 1 Project Boards for Capital Programme for UCC and Guest imaging +Pos level 2 Capitol report to F&P	+Pos level 1 Project Boards for Capital Programme for UCC and Guest imaging +Pos level 2 Regular reports to F&P -Neg level 2 Report to F&P detailing UCC programme 5 weeks behind plan; review of plan due to be reported Oct 17	+Pos Level 2 Report F&P imaging HUB at Guest on track to complete 20 Nov 2017 -Neg Level 2 UCC scheme not complete until late Jan 2018			
			Strength of assurance logged (L1 / L2 / L3)		**G** **G**	**G** **A**	A		➔	
			SUMMARY	**180**	**162**	**162**	**133**	➔	➔	**91**
Objectives: SO2 Safe and Caring services										
F	DF	COR241	**Risk Title** Failure of the PFI provider to maintain the building in line with statutory requirements and to ensure a resilient estate	25	**20**	**20**	20	➔		8
			Key Controls • *Board to Board meetings* • *Contract management processes*		+Pos level 2 Regular senior management meetings with provider, incorporating rigorous review of contract improvements	+Pos level 2 Quarterly Board to Board meetings; performance of estates discussed. Monthly reports to CQSPE and F&P Performance of estates improved but still requires improvement. Rigorus monitoring and reporting to continue until at least Dec	-Neg Level 2 Performance to F& P continues show issues with estates service and PFI contract. Large nubmer deductin and def points being applied +Pos level 2 F&P Dec 2017 – impoved performance Nov – needs to now be sustained			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**G**	A		➔	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Current Risk Score 27/12/17	Movement in risk	Expected movement by next quarter	Target Risk Score
CQSPE	CN	COR436	**Risk Title** Reduced capacity within safeguarding adults/children team due to infrastructure vulnerabilities	**20**			20	➔		15
			Key Controls • *Matron has oversight and two weekly operational meeting* • *Mand/stat Training programme in line with ICD* • *Framework/KPIs for safeguarding investigation process* • *Framework for reporting and learning from incidents* • *Framework for internal and external investigations* • *Network meetings/working*			**New 06/11/17**	+Pos level 2 Interview scheduled safeguarding lead CQSPE Nov 2017 – New Safeguarding Lead appointed (commence March 2018) - Maternity now reporting all safeguarding incidents			
			Strength of assurance logged (L1 / L2 / L3)				G		➔	
CQSPE	CN	COR085	**Risk Title** An inability to maintain the delivery of the safer staffing levels in relation to ward nurse staffing	**20**	**20**	**20**	20	➔		10
			Key Controls • *Established staff banks* • *Review of staffing dashboards* • *Recruitment plan*		+Pos level 2 Approved recruitment for substantive staff Report to Board -Neg level 2 Attrition of staff higher than recruitment	+Pos level 2 Report to F&P; recruited 35 RNs. Approved recruitment for substantive staff -Neg level 2 Attrition of staff higher than recruitment	+Pos level 2 Completed staffing review for med/surgery 9 additional nurses recruited			
			Strength of assurance logged (L1 / L2 / L3)		A	A	G		➔	
CQSPE	CN	COR096	**Risk Title** Failure to prevent avoidable deterioration of patients leading to cardiac arrests	**20**	**15**	**15**	10	➔		10
			Key Controls • *Use of track and trigger tool* • *Mandatory training* • *Post MET call review of processes followed*		+Pos level 1 Launch of NEWS track & trigger	+Pos level 1 Launch of NEWS track & trigger	+Pos level 2 Audit comfimred embedding Tradk trigger complete. Review completed of MET calls shows no significant changes to activity			
			Strength of assurance logged (L1 / L2 / L3)		G	G	G		➔	
CQSPE	CN	COR093	**Risk Title** Delays in the management of young people requiring section under the Mental Health Act (Tier 4)	**20**	**12**	**12**	**12**	➔		8
			Key Controls • *CAMHS tier 3.5 service commissioned* • *Conflict resolution and safeguarding staff training programmes*		+Pos level 2 Report to Children's services group - improvement for children not requiring Tier 4 care. -Neg level 2 Report to Children's services group-no improvement for children requiring Tier 4 care	+Pos level 2 Report to Children's services group - improvement for children not requiring Tier 4 care. -Neg level 2 Report to Children's services group - no improvement for children requiring Tier 4 care	+Pos level 2 Report presented to CCG by Dudley and Walsall Mental Health identified positive impact of commissioned 3.5 tier service -Neg level 2 Report to Children's services group - no improvement for children requiring Tier 4 care			
			Strength of assurance logged (L1 / L2 / L3)		A	A	A		➔	

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score	Q2 Risk Score	Current Risk Score	Movement in risk	Expected movement by next quarter	Target Risk Score
					31/07/17	30/09/17	27/12/17			
F	DF	COR100	**Risk Title** Failure to comply with fire safety requirements	20	**12**	**12**	**8**	↓		4
			Key Controls • *Fire Safety risk assessments* • *Electric fire detection system designed to provide early warnings of fire* • *Regular maintenance of the system*		+Pos level 1 Reviews of building cladding, verbal positive feedback – awaiting report	+Pos level 1 Reports received and reviewed, confirm cladding adheres to NHSI requirements. +Pos level 3 Independent report confirms cladding on PFI buidlings meets NHSI requirements - P	+Pos level 1 Independent review of North Block 4th November 2017.			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**G** **G**	**G**		↓	
F	COO	COR032	**Risk Title** Trust Major Incident Plan does not deliver intended business continuity	20	**10**	**15**	15	→		10
			Key Controls • *Trust has developed a major incident plan and processes* • *Periodic test of the plan*		+Pos level 1 Action plan being monitored and reported	+ Pos level 1 Awareness sessions for emergency preparedness and workshops for portering and security staff -Neg level 1 Several partners were unable to attend the sessions	+Pos Level 2 Pandemic flu, mass casualty and evacuation workshops held - action plans developed Development of EPRR exercise training and exerciseing strate2 Development of EPRR exercise training and exerciseing strategyDevelopment of pandemic flu			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**A**	G		→	
			SUMMARY	**145**	**89**	**94**	105	↑	↓	**65**
Objectives: SO3 Drive Service improvements, innovation and transformation										
CQSPE	MD	COR083	**Risk Title** Failure to have a workforce/infrastructure that supports the delivery of 7-day working	20	**16**	**16**	16	→		15
			Key Controls • *Use of nerve centre to direct tasks out of hours* • *Delivery of 7/7 audit action plan*		+Pos level 1 Clinical audit shows positive delivery against standards in Medicine -Neg level 1 Clinical audit shows negative delivery against standards for surgery, T&O & O&G - N	+Pos level 1 Clinical audit shows positive delivery against standards in Medicine -Neg level 1 Clinical audit shows negative delivery against standards for surgery, T&O & O&G - N	-Neg Level 2 Business cases to be developed by each of divisions Audit results presented CQSPE confirming poor delivery			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**	R		→	
			SUMMARY	**20**	**16**	**16**	16	→	→	**15**

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Current Risk Score 27/12/17	Movement in risk	Expected movement by next quarter	Target Risk Score
Objectives: SO4 Be the place people choose to work										
CQSPE	MD	COR461	**Title Risk** Competing demands on clinicians time lead to lack of quality clinical input across key Trust projects	**20**		**New 17/11/17**	20		➔	10
			Key Controls • Job planning				Level 1 assurance work on job planning commenced – have as amber as not all done yet			
			Strength of assurance logged (L1 / L2 / L3)				**A**			
			SUMMARY	**20**			20		➔	**10**
Objectives: SO5 Make the best use of what we have										
F	DF	COR080	**Risk Title** Failure to deliver 2017/18 Cost Improvement Programme	**25**	**16**	**20**	20	➔		12
			Key Controls • *Programme governance structure monitored by TEC* • *Programme PID and QIP process*		+Pos level 2 Report to F&P - achieving plan	+Pos level 2 Transformation and CIP report to F&P. Month 4 on track, forcast to deliver by year end -Neg level 2 F&P increased risk score to 20. September report identifies £2.5m shortfall due to agency spend	-Neg Level 2 F&P Dec 2017 - highlighted £2.3m shortfall forecase on delivery for 2017/18			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**A**	R		➔	
F	DF	COR234	**Risk Title** Trust plans assume a significant level of income at risk from commissioners	**20**	**20**	**20**	20	➔		15
			Key Controls • *Monthly reconciliations of activity and coding* • *Regular dialogue through formal meeting with CCGs*		+Pos level 2 Monthly report to CCG contract review meetings; agreed process with CCG	+Pos level 2 Monthly report to CCG contract review meetings; agreed process with CCG -Neg level 2 Month 5 income fell; reduced forecast outurn. Additional F&P meeting in Oct to review position	-Neg Level 2 F&P Dec 2017 - Current gap between DGFTs income over acvitiy with CCG is circa £2 million.			
			Strength of assurance logged (L1 / L2 / L3)		**G**	**A**	R		➔	
F	DIT	COR091 (FI003)	**Risk Title** The IT DR arrangements are not effective	**20**	**8**	**8**	**8**	➔		4
			Key Controls • *Established BC Plans* • *System backups taken and tested* • *Patient Information back up system in operation*		+Pos level 1 Recovery time for top 5 systems would be 2-24 hrs +Pos level 2 Datacentre refresh programme approved by Board	+Pos level 1 Recovery time for top 5 systems would be 2-24 hrs +Pos level 2 Datacentre refresh programme approved by Board	-Neg level 2 Trust does not have assurance of tested disaster recovery for all key systems			
			Strength of assurance logged (L1 / L2 / L3)		**G** **G**	**G** **G**	R		➔	
			SUMMARY	**65**	**44**	**48**	48	➔	➔	**31**

Oversight committee	Executive Risk Lead	Ref		Initial Risk Score	Q1 Risk Score 31/07/17	Q2 Risk Score 30/09/17	Current Risk Score 27/12/17	Movement in risk	Expected movement by next quarter	Target Risk Score
Objectives: SO6 Deliver a viable future										
F	MD	COR116	**Risk Title** High dependency on agency staff particularly in clinical areas	**25**	**20**	**20**	20	➔		4
			Key Controls • *Review of agency use by Executives* • *Nursing and Medic STAR chamber review and approval* • *VAR panel review and approval*		+Pos level 1 Recruitment of staff to ED +Pos level 2 Approved resources for substantive nurse recruitment -Neg level 2 Report to Workforce committee shows higher attrition to recruitment.	+Pos level 2 Approved resources for nurse recruitment -Neg level 2 Report to F&P – trajectory suggests full year target will not be met . -Neg level 2 Report to Workforce committee shows higher attrition to recruitment.	+Pos Level 2 - Nurse staff reviews completed for medicine / Surgery / Paeds - Report to F&P medical agency reduction trajectory and actions presented to the Committee -Neg level 2 Report to F&P Medical Staff Agency Spend in ED			
			Strength of assurance logged (L1 / L2 / L3)		**G** **A**	**A**	A		➔	
F	DF	COR061	**Risk Title** Failure to remain financially sustainable in 2017-18 and beyond	**20**	**20**	**20**	20	➔		16
			Key Controls • *Trust's business planning and budget setting process* • *Regular up to date financial reporting reviewed* • *Developed CIP Programme* *Agency controls*		+Pos level 2 Report to F&P include schemes to achieve control. Total surplus at month 4 above forecast. Report to F&P on achievemnet of Q1 STF money. -Neg level 2 Month 5 financial position below plan. Directorates asked to find addition CIP. Additional F&P meeting Oct to discuss remedial plan.	+Pos level 2 Report to F&P include schemes to achieve control. Total surplus at month 4 above forecast. Report to F&P on achievemnet of Q1 STF money. -Neg level 2 Month 5 financial position below plan. Directorates asked to find addition CIP. Additional F&P meeting Oct to discuss remedial plan.	-Neg Level 2 - F&P reported a £7.5m deficit whti is £10M away from control total			
			Strength of assurance logged (L1 / L2 / L3)		**A**	**A**	R		➔	
W	COO	COR421	**Risk Title** Lack of paediatric medical workforce capacity to meet service demands, standards and recommendations resulting in overdue follow up appointments	**20**			20			9
			Key Controls • **Job plans** • **Validation of children whose appointment over target** • **Notes review post validation by a consultant**			**New 01/11/17**	+Pos Level 1 3 new consultants in post +Pos Level 2 Nov 2017 (CQSPE) ahead of trajectory			
			Strength of assurance logged (L1 / L2 / L3)		G	G	**G** **G**		➔	
			SUMMARY	**65**	**40**	**40**	40	➔	➔	*20*

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

DSP	Director of Strategy and Business Planning		**SO6:** Plan for a viable future			
DG	Director of Governance					
DHR	Director of HR					
DIT	Director of IT					

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors meeting

on 8 March 2018

TITLE:	**Report from the Council of Governors Governance Committee meeting of the 21 December 2017**		
AUTHOR:	Mr F Allen Committee Chair	**PRESENTER**	Mr F Allen Committee Chair

The Committee was quorate.

The Committee received reports from the Board of Directors Finance and Performance Committee Chair and the Board of Directors Audit Committee Chair in respect of their recent meetings, along with reports from the Trust's Finance Director and the Director of Governance. These reports covered the Trust's Financial and Operational Performance, the Trust's Corporate Risk and Assurance Register Report, a report on the Trust's Clinical Audit activity, information in action taken in respect of external reviews undertaken of the Trust and actions taken as a result of patient safety alerts.

The Committee actively sought assurance from the Non Executive Director Chair of the Finance and Performance Committee over the work of the Finance and Performance Committee, the actions being undertaken to address the key financial risks facing the Trust and over the areas of underperformance. The Committee was briefed on the plans the Trust is instigating to achieve its control total and the risks associated with these actions. In respect of performance the Committee was briefed on the impact of the high emergency activity demand on the Trusts performance not only in respect of the 4 hour target but also in the areas of diagnostics and cancer performance.

The Committee in receiving the report of Audit Committee Chair on the work of the Audit Committee was able to be assured that the work of the Trust's auditors (clinical audit, internal audit and external audit) is progressing as planned and that areas where action is needed by Trust Management are being followed up by the Committee.

The Committee considered the Trust's Board Assurance Framework for the 3rd Quarter of the year and noted its revised layout, previously this had been reported within its two constituent parts namely the Corporate Risk Register and the Assurance Register. The Committee asked questions of the risks and assurances and from the responses provided to questions on its content provided by the Director of Governance was reassured of its robustness. The Committee noted that the new format contained a forward projection from the Trust's executives on the expected view of the level of risk for the next quarter and felt this addition to the document was helpful. The Committee also noted the role the Audit Committee play in considering the detail of the assurances supporting the Executives' view of the Trust's risks and was assured through the feedback from the Chair of the Audit

Committee's report that this was appropriate.

The Committee also received a report on the Clinical Audit activity of the Trust, detailing the breadth of activity undertaken and the outcomes reported as a result and the focus on learning from its clinical audit activity.

The Committee also received a report on the Trust's processes for tracking the improvements identified from the external reviews undertaken over the Trust's services. The Committee was assured over the process being applied and that any overdue recommendations or those of significance were linked to the Trust's operational risk registers.

The Committee also received a report on the process followed when the Trust receives a patient safety alert and was assured that the Trust is complying with all alerts received.

ACTION REQUIRED OF COUNCIL

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COUNCIL

To note the actions taken by the Committee in holding to account the Trust in respect of its performance and systems of risk management and internal control.

Enclosure 11

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors
8 March 2018

TITLE:	**Board Secretary Report**		
AUTHOR:	Glen Palethorpe – Director of Governance / Board Secretary	**PRESENTER:**	Glen Palethorpe – Director of Governance / Board Secretary

1 Annual Members Meeting

As reported previously there is to be the Annual Members Meeting in July to consider the annual financial and quality accounts and the relevant audit opinions and this would be publicised to the members to allow them to come and ask any questions on these documents. A date for this has yet to be finalised but is likely to be 19th July. There will be a separate event to show case the services of the Trust, as the NHS is 70 years old this year, the Trust is keen to use the national focus this will generate to encourage the public to attend an event in Dudley and the Trust is working with the CCG to deliver one pan Dudley event.

2. Outcomes of recent elections.

The staff governor vacancies were re-advertised as no one stood for election at the last election. This election saw all three posts successfully elected to, and the outcomes are summarised below

Constituency	**Name of elected Governor**
Staff: Allied Health Professionals and Health Care Scientists	**Ann Marsh**
Staff: Allied Health Professionals and Health Care Scientists	**Edith Rollinson**
Staff: Nursing and Midwifery	**Margaret Parker**

Unfortunately the medical and dental constituency secured no nominations at this point, the position become vacant as Mr Butt's term of office ends.

We also ran the staff partner organisation representative election at the same time to save costs and this returned **Alan Walker** who will continue as this constituent member from July 2018.

3. Recruitment of a new Non Executive Director

In line with the revised constitution approved by the Council of Governors at the last meeting in December 2017 the Trust has undertaken a Non-executive Director recruitment process. This involved a stakeholder presentation from shortlisted candidates on the 28 February followed by formal interviews on the 5 March. The stakeholder panel commented positively on the calibre of the applicants. Due to the timing of the final stage of the process, the outcome of the recruitment will be reported verbally to the Council with a recommendation regarding the appointment.

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well-led
	NHS Improvement	**Y**	**Details:** links to governance framework
	Other	**N**	**Details:**
ACTION REQUIRED OF COUNCIL:			

Decision	Approval	Discussion	Information
	Y		Y

ACTIONS FOR COUNCIL

1) To note the annual members meeting date will take place in July 2018 and that a separate service show case event will be taking place linked to NHS 70.

2) To note the returned Governors from the recent elections.

3) To receive the verbal update on the recruitment and approve any recommendation made by the Appointment and Remuneration Committee convened on the 5th March.

The Dudley Group NHS Foundation Trust

Paper for submission to the Council of Governors
Thursday 8 March 2018

TITLE:	**Foundation Trust Membership report Q3 2017/18**		
AUTHOR:	**Helen Board, Patient and Governor Engagement Lead** **Phil Robinson, PALS and Patient Experience Administration Assistant**	**PRESENTER:**	**Helen Board, Patient and Governor Engagement Lead**
CORPORATE OBJECTIVE: SG06 – to deliver an infrastructure that supports delivery			

SUMMARY OF KEY ISSUES:

This report provides the Trust membership report for quarter three 2017/18.

Membership report

- The Trust continues to maintain a public membership in excess of 13,000 to comply with Trust's Terms of Authorisation and IBP (Integrated Business Plan).
- Our membership continues to be mostly well represented by constituency, age, gender, and ethnicity and across the spectrum of Office of National Statistics (ONS)/Monitor classifications against our population base

Total public membership

Membership	31st March 2015	31st March 2016	31st March 2017	30th June 2017	30th September 2017	31st December 2017
Public	13,770	13,981	13,875	13,920	13,903	13,900

The total number of public members as at 31st December 2017 is 13,900 (including Outside of the West Midlands) representing a decrease of 3 compared to 30th September 2017.

Detailed breakdown reporting is provided for review and action by the Committee as required.

ACTION REQUIRED OF GROUP:

Decision	Approval	Discussion	Other
			X

RECOMMENDATIONS FOR THE COMMITTEE:

The Committee is asked to receive the report and review to identify actions where required.

Membership Report Quarter three

The Trust has continued to maintain a public membership that is reflective of the socio-economic and demographic characteristics of the population we serve.

Total public membership

Membership	31st March 2015	31st March 2016	31st March 2017	30th June 2017	30th September 2017	31st December 2017
Public	13,770	13,981	13,875	13,920	13,903	13,900

The total number of public members as at 31st December 2017 is 13,900 (including Outside of the West Midlands) representing a decrease of 3 compared to 30th September 2017. The provisional number of staff members is 4,261 giving a total membership of 18,161.

In-year data base cleansing removes members who are deceased. Data base cleansing also identifies members who may have moved away. These are initially recorded as 'possible address change' and work has recently completed to validate their new addresses wherever possible and remove those members where this was not possible.

Our membership continues to be mostly well represented by constituency, age, gender, and ethnicity and across the spectrum of Office of National Statistics (ONS)/Monitor classifications against our population base.

To comply with the diversity requirements of the Equality Act 2010, all membership recruitment and engagement activities are open to all Trust members, patients, their families and carers as well as members of the wider community. Any person residing in the area served by the Trust and beyond is eligible to become a member of our Trust regardless of age, gender, ethnicity, religion or belief, gender reassignment, disability, marital status, pregnancy or nursing, or sexual orientation. Our Constitution stipulates (annex 9, item 10) that the minimum age for membership is 14 years old. There is no upper age limit.

The Trust will continue to work with governors to develop effective engagement opportunities and continue to target our recruitment activities around our underrepresented groups against our population base and ensure we develop and maintain a representative membership.

Target groups for recruitment purposes consist of the age group, 22–39 year olds, and some ethnic groups. Working closely with governors, we will continue to attend community and support groups as well as develop other recruitment and engagement opportunities.

The governors 'Out there' project is continuing to support a wide range of opportunities for both governors and the Trust to achieve the following key objectives;

- Raise awareness and promote the activities of the Trust
- Develop relationships with our local communities
- Seek views of Trust members and those of the wider public
- Recruit new members

Membership constituency breakdown report as at 31st December 2017

(numbers in bracket indicate previous quarter figures)

Public Constituencies	Number of Members
Brierley Hill	1,774 (1,776)
Central Dudley	2,417 (2,417)
Halesowen	1,154 (1,153)
North Dudley	1,386 (1,390)
Outside of the West Midlands	365 (363)
Rest of the West Midlands	1,768 (1,766)
South Staffordshire and Wyre Forest	1,188 (1,191)
Stourbridge	1,716 (1,713)
Tipton and Rowley Regis	2,132 (2,134)

Public membership breakdown by age, gender and ethnicity		Number of Members
Age	0-16 years	10 (11)
	17-21 years	872 (948)
	22+ years	12,570 (12,510)
Gender	Male	4,638 (4,645)
	Female	9,172 (9,169)
	Unspecified	90 (89)
Ethnicity	White	11,368 (11,198)
	Mixed	402 (402)
	Asian or Asian British	1,232 (1,228)
	Black or Black British	423 (424)
	Other	71 (71)
	Not stated	404 (389)

Staff Constituencies	Number of Members
Allied Health Professionals and Healthcare Scientists	409 (818)
Medical and Dental	462 (508)
Nursing and Midwifery	1,401 (2,455)
Non Clinical	958 (906)
Partner Organisations	632 (621)
Total Staff Members	**3,862**