The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 5 November, 2015 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		D Badger	To Note	9.30
2.	**Declarations of Interest**		D Badger	To Note	9.30
3.	**Announcements**		D Badger	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 1 October 2015	Enclosure 1	D Badger	To Approve	9.30
	4.2 Action Sheet 1 October 2015	Enclosure 2	D Badger	To Action	9.30
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	D Wardell	To Note & Discuss	10.00
	7.2 Nurse Staffing Report	Enclosure 5	D Wardell	To Note & Discuss	10.10
	7.3 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 6	D Wulff	To Note & Discuss	10.20
	7.4 Integrated Dashboard	Enclosure 7	A Baines	To Note & Discuss	10.30
	7.5 Black Country Alliance Report	Enclosure 8	P Clark	To Note	10.40
	7.6 Revalidation Report	Enclosure 9	P Harrison	To Note	10.50
	7.7 Audit Committee Exception Report	Enclosure 10	R Miner	To Note	11.00
	7.8 Corporate Risk Register/Assurance Framework	Enclosure 11	G Palethorpe	To Note	11.10
	7.9 Complaints Report	Enclosure 12	G Palethorpe	To Note	11.20
	7.10 Nurse/Midwife Revalidation Report	Enclosure 13	D Wardell	To Note	11.30
	7.11 End of Life Care Report	Enclosure 14	D Wulff	To Note	11.40
8.	**Finance**				
	8.1 Corporate Performance Report	Enclosure 15	J Fellows	To Note & Discuss	11.50
	8.2 Cost Improvement Programme and Transformation Overview Report	Enclosure 16	A Baines	To Note	12.00

	8.3 Annual Plan Quarter 2 Update	Enclosure 17	A Baines	To Note	12.10
9.	**Any other Business**				12.20
10.	**Date of Next Board of Directors Meeting** 9.30am 3 December 2015, Clinical Education Centre		D Badger		12.20
11.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		D Badger		12.20

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 3rd September, 2015 at 9:30am in the Clinical Education Centre.

Present:

David Badger, Chairman
Richard Miner, Non Executive Director
Jonathan Fellows, Non Executive Director
Paul Taylor, Director of Finance and Information
Ann Becke, Non Executive Director
Paula Clark, Chief Executive
Paul Bytheway, Chief Operating Officer
Dawn Wardell, Chief Nurse
Doug Wulff, Non Executive Director
Paul Harrison, Medical Director
Jenni Ord, Associate Non Executive Director

In Attendance:

Helen Forrester, PA
Liz Abbiss, Head of Communications and Patient Experience
Julie Bacon, Chief HR Advisor
Glen Palethorpe, Director of Governance/Board Secretary
Anne Baines, Director of Strategy and Performance

15/095 Note of Apologies and Welcome

Apologies were received from David Bland. The Chairman welcomed Jenni Ord, Associate Non Executive Director and Chair Designate and Dr Richard Bramble shawdowing Paul Harrison, to the meeting.

15/096 Declarations of Interest

There were no declarations of interest.

15/097 Announcements

No announcements made.

15/098 Minutes of the previous Board meeting held on 3rd September, 2015 (Enclosure 1)

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

15/099 Action Sheet, 3rd September, 2015 (Enclosure 2)

All items appearing on the action sheet were noted to be complete, for update at a future Board meeting or appeared on the Board agenda.

15/100 Patient Story

Liz Abbiss, Head of Communications and Patient Experience presented the patient story. The story related to a patient who was receiving treatment for Parkinsons Disease. The patient had been very happy with the care received during the previous 10 years but raised one concern regarding a new drug regime. Liz confirmed that since the video the drug issue had been resolved and treatment had commenced.

The Chairman confirmed that it was pleasing to hear the overall message but was concerned to hear about the communication issues.

Mrs Becke, Non Executive Director, stated that patients have a 'fear factor' element and that it why it is so important to monitor staff attitude.

The Director of Strategy and Performance confirmed that this was an excellent example of a patient whose care should be picked up through the Vanguard.

The Chairman and Board noted the patient story. The Chairman asked how the information is shared with the providers of the different elements of care. Liz confirmed that all Board stories are shared by a link on the Hub.

15/101 Chief Executive's Overview Report (Enclosure 3)

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

- **Friends and Family:** The Trust continues to struggle with the community response rate and is also undertaking further work around specialist services. The Chief Executive is raising inpatient responses through the Chief Executive briefings. A&E feedback is positive and the online App is now live. Maternity continues to be highly recommended and the Trust continues to push the response rate in this area. Outpatients also remains an issue regarding the target the for monthly score and the Trust is undertaking work on patients gowns and improving signage to improve feedback. Mr Miner, Non Executive Director, asked when looking at comparative local Trusts, what drives percentages when considering performance such as ED wait scores. The Chief Nurse confirmed that it is not a reflection of the care but can be down to response rate. The Chairman asked about response rates and how we maintain consistency. Liz Abbiss confirmed that Day Case has been included so the denominator is much larger. The Chief Nurse confirmed that this had been discussed at the Governance meeting and the team had requested a pile of cards so they could see how many responses they needed in a week.

- **Update on Monitor:** A review meeting took place on 21st September, 2015. The Trust was disappointed that will not be taken out of breach at the present time.

Monitor will visit the Trust in November to look further at the plans for next year and beyond, they will then consider taking the Trust out of breach in the New Year. The Director of Finance and Information stated that the Trust needs to progress documentation around the 2016/17 plans and bring the process forward.

- **Health and Social Care Economy Summit:** The Trust had previously attended a Summit in January. It had recently been agreed at a Partnership Board meeting to hold a further Summit during December, 2015.

- **Black Country Alliance Update:** The first Black Country Alliance Board meeting had taken place the previous day. A joint response is being prepared in relation to the future of Stroke Services. Work is progressing around Rheumatology and Histology and there is good vision around Urology and Interventional Radiology. The Trust was very pleased with the overall progress.

- **Staff Survey:** Communications making considerable efforts on encouraging staff to complete the survey. The Trust has received over 400 responses so far in 3 days.

- **Accident Outside BHHSCC:** Jan Beddows, Community Nurse was a first responder at an incident outside Brierley Hill Health and Social Care Centre and went over and above the call of duty in her actions. The Board wanted to publically recognise her efforts and the Chairman will write to Jan on behalf of the Board. The Chief Operating Officer suggested that the Trust should nominate its staff who have gone above and beyond the call of duty for awards. The Chief Executive confirmed that staff can also make nominations for the Excellence Awards taking place on 3rd March, 2015.

- **HSJ Awards** – The Board noted that A&E had been nominated for an award. The Chairman confirmed that the Chief Executive had also been nominated for the Chief Executive of the Year Award. The Board wished Paula and the ED Team good luck for the judging.

The Chairman and Board noted the report and the work done on Friends and Family and particularly in relation to Outpatients. The Chairman noted the Monitor update and the planned Health Economy Summit and requested that modelling be available for the event in December. The progress on Black Country Alliance was noted and the Board supported the idea of surveying all Trust staff. The Chair confirmed that he would write a letter of thanks to Jan Beddows on behalf of the Board.

The Chairman to write a letter of thanks to Jan Beddows on behalf of the Board.

15/102 Patient Safety and Quality

15/102.1 Infection Prevention and Control Exception Report (Enclosure 4)

The Chief Nurse presented the Infection Prevention and Control Exception Report given as Enclosure 4, including the following points to note:

MRSA: 1 case noted. The Chief Nurse confirmed that it was very disappointing to have experienced the first case in almost 2 years. The Trust is currently undertaking the RCA.

C.Diff: 20 cases noted, which is over trajectory. The Chief Nurse confirmed that there had been a 6% increase in C.Diff nationally. The Board are aware of the very challenging target for the Trust. Actions are being undertaken by a Trust multidisciplinary team and a clear action plan is being monitored on a weekly bases. Improvement noted around lapses in care. A learning event was taking place the following day. Several meetings had been held with Matrons and Lead Nurses and the Medical Teams are also focussing on infection prevention.

Dr Wulff, Non Executive Director, asked if there was an issue regarding the lack of information on patients being transferred being from other organisations. The Chief Nurse confirmed that this had been raised with the organisation in question. Dr Wulff asked about assurance that the Trust also shares information with other care givers. Mrs Becke, Non Executive Director, asked if there is a flag on Oasis, the Chief Nurse confirmed that she would check.

The Chairman and Board noted the report and noted with concern the position and actions around C.Diff and MRSA. The Board confirmed that it was content with the mitigating actions described. The Director of Strategy and Performance confirmed that Infection Prevention and Control is also monitored through the performance reporting process.

15/102.2 Nurse Staffing Report (Enclosure 5)

The Chief Nurse presented the Nurse Staffing report given as Enclosure 5.

The Board noted the position for August. There were no red shifts reported and an increase in amber shifts to 70 and this was noted to be mainly from 4 areas of the Trust. No safety issues had been identified in any areas.

The Chief Nurse confirmed that 14 new Midwives were coming into post the following week.

Recruitment remains a national challenge. 30 registered nurses had commenced on Monday of that week and rolling adverts were appearing on NHS jobs. A further 7 candidates were being interviewed on 8th October and recruitment open days were planned for 30th and 31st October. 25 new qualified nurses had expressed an interest to stay where they had trained.

The Chairman asked about the overall position. The Chief Nurse confirmed that the figures were not yet available but the Trust was running at 60 vacancies. The Trust has seen an improvement in the agency position.

The Chief Executive confirmed that there was an issue with retention and the Chief HR Adviser and her team were looking at the hard to recruit to areas and action was currently being taken to address this in Pathology. The Trust was looking at why nurses and what differences might retain them. The Trust is also investigation the concept of a senior staff nurse post.

The Chief HR Advisor confirmed that the Trust was experiencing significantly better performance around on and off framework usage and had identified all framework agencies that can be used to ensure that they are prioritised. The Trust had made one application to Monitor to use an off framework agency who provide the Trust with very competitive rates. The Trust should start to see a reduction in cost. The Chief Executive confirmed that we need to look at longer term planning and how the Trust uses its workforce more effectively.

The Chief HR Advisor confirmed that the Trust is also looking at Medical locums.

The Chairman and Board noted the report, graph, red shifts and list of mitigations. The Board confirmed that they were assured by the mitigations detailed in the paper. The Chairman noted the work around on and off framework agencies and the Chief Nurses update on nurse recruitment.

15/102.3 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6)

Dr Wulff, Committee Chair, presented the Clinical Quality Safety Patient Experience Committee Exception Report, given as Enclosure 6. The Board noted the following key areas from the previous meeting:

- Positive assurances were received around the increase in number of VTEs reported. Performance assurance will be covered under the performance report. In relation to the mortality review process, a tracker system was in place and the Committee noted that an independent review of tracker sytem will be undertaken. The Trust is approaching Birminghham University to do this. A report will provided back to the Committee. Assurance was received via the Quality and Safety Group that the Transfusion Group meeting was quorate and did undertake a robust review of incidents. Assurance was also received that the Stroke Ward co-location was single sex compliant and no concerns had been identified. The Committee had requested feedback on outcomes from patients.

- Decisions Made/Items Approved: Approval of 3 policies and 9 procedures and 24 RCA action plans had been closed.

- A number of actions were scheduled to be presented to the Committee and these were also noted by the Board, including monitoring issues around C.diff, MRSA and the Flu Plan. Update on the co-location of the Stroke Ward and National Care of the Dying Audit. The Safeguarding Board will monitor issues around patients who are fit for discharge. The Board was asked to note the good presentation from Dr Jo Bowen on end of life care and take great assurance from the improvements made.

The Chairman and Board noted the report and assurances received, decisions made, items approved and actions back to Committee. The Board also noted with assurance the presentation by Dr Bowen on end of life care.

15/102.4 Integrated Performance Report (Enclosure 7)

The Director of Strategy and Performance presented the Integrated Performance Report given as Enclosure 7.

The report covered the Trust's performance to August 2015.

A number of performance items had already been covered on the Board agenda but other areas for the Board's attention included:

- Overall performance to end of August continues to be good.

- Emergency Access Target: The Trust is amongst the best in the country on a consistent basis.

- 18 Week Standard: Achieving very well with the exception of Urology where an action plan is in place and the specialty will be back on target towards end of year.

- Cancer: The Trust is expected to miss quarter 2 as anticipated and discussed at the previous Board meeting. The Trust is hopeful of very few breaches in quarter 3 and anticipates being back on target. The Trust continues to work closely with divisions.

- Infection Control: There was an emerging risk around health acquired infections. The reduced threshold for the Trust was always going to be very challenging but the Trust now sits on the wrong side of the threshold. Failing the meet the target will provide a financial issue. The Chief Nurse has met with the CCG as C.Diff is a health economy issue. The Chief Executive agreed that this is a whole Health Economy problem and debate is needed around the apportionment of blame in the Economy. The Chairman confirmed that he had previously discussed this with Dr Hegarty and will raise again at their next meeting.

- Stroke: Picked up with divisions and a broader action plan will be produced for the next performance meeting.

- Activity: Community and Outpatients are below target. There are issues around recruitment and vacancies.

The Chairman asked whether nursing homes are an issue in relation to infection control. The Chief Nurse confirmed that the CCG are looking at this. Dr Wulff, Non Executive Director asked if the CCG are also looking at antibiotic prescribing and PPIs. The Chief Nurse confirmed that they are and further information will be provided at the next Board meeting.

The Chairman and Board noted the report, key issues and the attention given to Cancer performance.

Chairman to raise infection control as a whole Health Economy issue at his next meeting with David Hegarty.

15/103 Finance

15/103.1 Finance and Performance Report (Enclosure 8)

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

The report provided a summary of the September Committee meeting.

The Board noted that key highlights as follows:

Assurances Received :

- IT scoping undertake and off to a good start. Soarian will be upgraded so it will be supported until January 2018.

- Month 5 deficit is £1.6m which is £1.6m better than the planned £3.1m deficit.

- £18.7m cash at the end of August with a forecast at year end to have £18m cash in the bank. It is no longer a Foundation Trust requirement to have a working capital facility and the Committee proposed to let the facility lapse.

The Chairman and Board noted the report and current position. The Chairman asked if there is any potential to improve the position further for the Monitor visit in November. The Director of Finance and Information stated that the Trust is currently in a tight position due to activity and vacancy costs. Monitor have more concern around the 2016/17 position. The Chairman noted the update on Soarian and C.Diff and that the Finance and Performance Committee would continue to monitor infection control performance.

15/104 Any Other Business

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

15/105 Date of Next Meeting

The next Board meeting will be held on Thursday, 5th November, 2015, at 9.30am in the Clinical Education Centre.

Signed ……

Date …….....

Enclosure 2

The Dudley Group NHS
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Action Sheet
Minutes of the Board of Directors Public Session
Held on 3 September 2015

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
15/101	Chief Executive's Overview Report	The Chairman to write a letter of thanks to Jan Beddows on behalf of the Board.	C	5/11/15	Done
15/102.4	Integrated Performance Report	Chairman to raise infection control as a whole Health Economy issue at his next meeting with David Hegarty.	C	10/11/15	
15/091.10	Annual Plan Quarter 1 Updates	Review of the work around the Clinical Strategy to be presented at the Board Workshop in November.	AB	19/11/15	
15/080.9	Research and Development Report	The Board to receive an update on the availability of case notes at its September meeting.	PH	7/1/16	Update to January Board

Enclosure 3

The Dudley Group NHS
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Paper for submission to the Public Board Meeting – 5th November 2015

TITLE:	**Chief Executive Board Report**		
AUTHOR:	**Paula Clark, CEO**	**PRESENTER**	**Paula Clark, CEO**
CORPORATE OBJECTIVE: SO1, SO2, SO3, SO4, SO5, SO6			

SUMMARY OF KEY ISSUES:

- Friends and Family
- Forget Me Not Unit Update
- Never Events
- Safe Effective Quality Occupational Health Standards and Accreditation (SEQOHS):

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 / COMMITTEE / GROUP: ***(Please tick or enter Y/N below)***

Decision	Approval	Discussion	Other

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

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

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

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

The Dudley Group NHS
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Chief Executive's Report – Public Board – November 2015

Friends and Family Test - Update:

Community FFT (September 2015)

The number of responses has risen from 82 in August to 125 in September. Based on the latest published NHS figures (August '15) the Trust continues to achieve the quality priority target of monthly scores that are equal to or better than the national average for the percentage who would recommend the service to friends and family members.

Date range	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15
Community Nursing Services – percentage recommended	100 %	100 %	95%	83%	94 %	94 %
Number of responses	5	24	58	24	33	65
Rehab and Therapy services – percentage recommended	100 %	100 %	100 %	100 %	96 %	92 %
Number of responses	9	11	20	47	45	48
Specialist Services – percentage recommended	95%	95%	95%	100 %	75 %	92 %
Number of responses	22	20 38	19		4	12
Combined score – percentage recommended	97%	98%	96%	96%	94 %	93 %
Total number of responses	36	55	116	90	82	125
National average percentage recommended	96%	95%	95%	95%	94 %	n/a*

**national data not published at time of writing this report*

Inpatient FFT (01.10.15 – 18.10.15 provisional)

The Trust continues to achieve the quality priority target of monthly scores that are equal to or better than the national average for the percentage who would recommend the service to friends and family members.

Date range	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015 provisional
Ward FFT percentage recommended	96%	97%	98%	97%	99%	97%	97%
Ward response rate	16%	16%	14%	15%	20%	20%	14%
National average percentage recommended	95%	96%	96%	97%	99%	n/a*	

**national data not published at time of writing this report*

Key for inpatient RAG rating

% of footfall (response rate)	*<25%*	*25-30%*	*30-40% +*	*40%+*
FFT percentage recommended	*<95%*	*96%+*	*97%+*	
FFT scores based on Nov 14 national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*	

A&E FFT (01.10.15 – 18.10.15 provisional)

The percentage of patients who would recommend the Trust's A&E to friends and family during the period 1st – 18th October increased to 95% compared to 90% for September. The latest published NHS England figures (August '15) show The Dudley Group scored 95% which is equal to the national average of 95%. This puts us in the top 20% of trusts nationally. Locally, this puts us top of the list ahead of Walsall Healthcare and Worcester Acute (92%) and Royal Wolverhampton and Sandwell and West Birmingham (83%) for August '15.

Date range	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015 provisional
A&E FFT recommended percentage	90%	90%	92%	90%	95%	90%	95%
A&E response rate	8%	15%	12%	7%	6%	3%	6%
National average percentage recommended	88%	88%	88%	88%	95%	n/a*	

**national data not published at time of writing this report*

Key for A&E RAG rating

% of footfall (response rate)	*<15%*	*15-20%*	*20%+*
FFT percentage recommended	*<94%*	*94%*	*95%+*
FFT scores based on Nov 14 national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*

Maternity FFT (01.10.15 – 15.10.15 provisional)

The Trust continues to score well and remains in the top 30% of trusts nationally with those who say they are extremely likely or likely to recommend our maternity services to friends and family.

Maternity Area	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015 provisional
Antenatal , percentage recommended	95%	96%	98%	99%	99%	97%	94%
Response rate	30%	39%	24%	37%	38%	36%	49%
Birth, percentage recommended	100%	100%	100%	100%	99%	100%	98%
Response rate	26%	20%	14%	21%	25%	27%	30%
Postnatal ward, percentage recommended	100%	100%	98%	99%	99%	100%	100%
Response rate	26%	20%	14%	21%	25%	28%	4%
Postnatal community, percentage recommended	100%	100%	93%	96%	92%	100%	100%
Response rate	8%	10%	12%	8%	4%	6%	30%

Key for maternity RAG rating

% of footfall (response rate)	*<15%*	*15%+*	
Antenatal	*100%*	*96-99*	*<95*
Birth	*100%*	*97-99*	*<96*
Postnatal ward	*98+%*	*93-97*	*<92*
Postnatal community	*100%*	*97-99*	*<96*

FFT scores based on Jan 15 national scores	*Below top 30% of trusts*	*Top 30% of trusts*	*Top 20% trusts*

Outpatients FFT

Whilst we are seeing an increase in the percentage of those who would recommend the outpatient services, the Trust has not met the quality priority target of monthly scores that are equal to or better than the national average for the percentage of patients who would recommend the service to friends and family members.

The Patient Experience Team is working closely with managers to address 'You said, we have' actions to improve the patient experience in response to feedback received. Recent actions include:

- Installation of large screen to display waiting times and next number to be called in Corbett blood test clinic
- 'You, said we have' boards being deployed in all patient waiting areas across the Trusts' outpatient departments to update patients about the actions we have taken in response to their feedback

FFT Outpatients Services	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015
Number of respondents	49	93	82	66	67	742
Outpatients recommended percentage	84%	82%	82%	88%	90%	89%
National average percentage recommended	92%	92%	92%	92%	92%	n/a*

**national data not published at time of writing this report.*

Improving the FFT response rates

To support response rate growth, several initiatives that will be rolled out during the next two quarters include;

- Friends and Family App launched September 2015 and is seeing a growing number of responses
- Trust FFT webpage refreshed September 2015
- Proposed introduction of FFT SMS response option for A&E in Q3 and then phased roll out to other areas across the Trust by end of 2015/16.

Forget Me Not Unit Update:

The Forget-me-not unit opened on the 26th June 2015, since then we have made a number of small but effective changes with plans for further improvements. The unit has a higher staff ratio with additional support workers to provide safe, individualised, patient centred care directed to the needs of patients with dementia or acute confusion. The unit has been heavily supported by the wellbeing workers and acute confusion teams who also bring specialist knowledge and experience with them to support the patients care plan and discharge pathway. With the cohorting of the patients with additional support needs into one unit, and the access to the additional staff groups, this has enabled us to manage the use of temporary workers more effectively on C3 resulting in a reduction in spend in the last three months.

The Older People's Mental Health team have a heavy presence within the unit being integral to the whiteboard multidisciplinary meetings assisting and supporting the review of patients support needs and sharing of information and expertise with the patients, their families and the wider MDT. A new dementia bundle has been developed and is currently being trialled in the Forget-me-not unit, B2 Hip and C8. This bundle works alongside the meet and greet and take the time questionnaires that the nursing staff complete with the patient and their families so to gain additional information about the patient and their likes and dislikes.

Opening the unit has allowed us to concentrate on a particularly vulnerable group of patients with high risk areas such as falls and nutrition. The unit offers open visiting to the patient's friends and families which have improved the ability to provide additional support and encouragement to the patients at mealtimes, the families are assisting with feeding and are able to support the patient in choosing food that they like to ensure sufficient calorie intake is maintained. Together with the newly purchased red cutlery and plates and the offer of afternoon tea and snacks the patient's nutritional intake has improved. The open visiting policy has also developed close working relationships with the patient's families enabling any issues or concerns to be dealt with promptly, reducing the number of formal complaints made and assisting with reducing the patient's length of stay.

The environment remains our biggest challenge; we are waiting for work to be carried out with the replacement of flooring to the seminar room on C3 so that a dining area can be created for the patients to eat and join in activities together. We do however now have an activity area within the unit where there is a window view (transfer) for the patients to look at – this can be a very calming area for the patients to sit. There are notices on each bathroom/toilet door to assist the patients. The patients have access to a beautiful tea room on Ward C8 where there are activities, a place to sit and have a drink with a snack. The room is decorated with items from the 1950s and even has items such as carbolic soap for the patients to see and smell.

We have recently had a peer review form WMQRS looking into our dementia services, the feedback was extremely positive.

Further improvements for the unit:

- Red toilet seats
- Blue pillow cases (a method that can be used for all dementia/acutely confused patients in the Trust)
- Additional pictorial transfers for doors so to maintain the patient's independence/mobility but to ensure safety i.e. bookcase transfer or the doors the same colour as the walls.
- There is work on-going looking at the removal of the Arjo baths. Once the bath has been removed we are planning to replace the flooring and furnish as a dementia/acute confusion discharge lounge.
- Blinds to be sourced and financed for the windows.
- Patient/family feedback has been that the unit could be a bit more homely, this is proving a little difficult with adhering to infection control and health and safety guidelines but we are looking to place more pictures and photographs up on the walls (with the relevant permissions).
- Ongoing improvement and resources for the room on C8 and ongoing encouragement of staff to use the facility and obtaining patient feedback
- Carer support groups to be facilitated by the OPMHT and dementia advisor

Never Events:
The Trust has had two serious incidents which have been classified as never events until the final results of the investigations are known when their status will be confirmed or reviewed. A full investigation is underway for both of the incidents to identify root causes and further learning. Once this is established it is anticipated these will be an item for our learning events. In both cases the patients involved were treated and both are well. The Duty of Candour requirement was also implemented.

Safe Effective Quality Occupational Health Standards and Accreditation (SEQOHS):
The OH (occupational health) service accreditation assessment, for which we have just received accreditation, is based on the Safe Effective Quality Occupational Health Standards 2010. These standards are in the public domain and serve to ensure that providers, purchasers and workers understand the standards that they should expect from an OH Service.
Any provider of OH Services can apply for SEQOHS accreditation, e.g. in-house services in both the public and private sectors and commercial occupational health providers from the single-handed provider to large organisations. The Standards and minimum requirements reflect existing ethical and professional guidance and consensus and are intended to help OH Services achieve uniform good practice.
Eligibility for the award of SEQOHS Accreditation has been assessed on the basis of the collection and presentation of suitable documentary evidence and on observation.
It is particularly pleasing for the Trust to receive this accreditation given we have a nurse led service under Maudie McHardy's excellent leadership and not a medical model, and operate the service for less than half the cost per head of other local providers.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors November 2015 - PUBLIC

TITLE:	Infection Prevention and Control Forum		
AUTHOR:	Dr E Rees Director of Infection Prevention and Control	**PRESENTER:**	Dawn Wardell Chief Nurse

CORPORATE OBJECTIVE:

SO1 – Deliver a great patient experience
SO2 – Safe and caring services
SO3 – Drive service improvements, innovation and transformation
SO4 – Be the place people chose to work
SO6 – Plan for a viable future

SUMMARY OF KEY ISSUES:

For the month of October (As of 22nd October 2015)

- A post 48 hr MRSA bacteraemia and a pre-48 hour case
- No Norovirus cases
- A period of increased incidence of C. difficile on B3
- At end of month 7 the Trust is 8 cases over trajectory for this point in the year of 15 cases of post 48 hr C. difficile

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

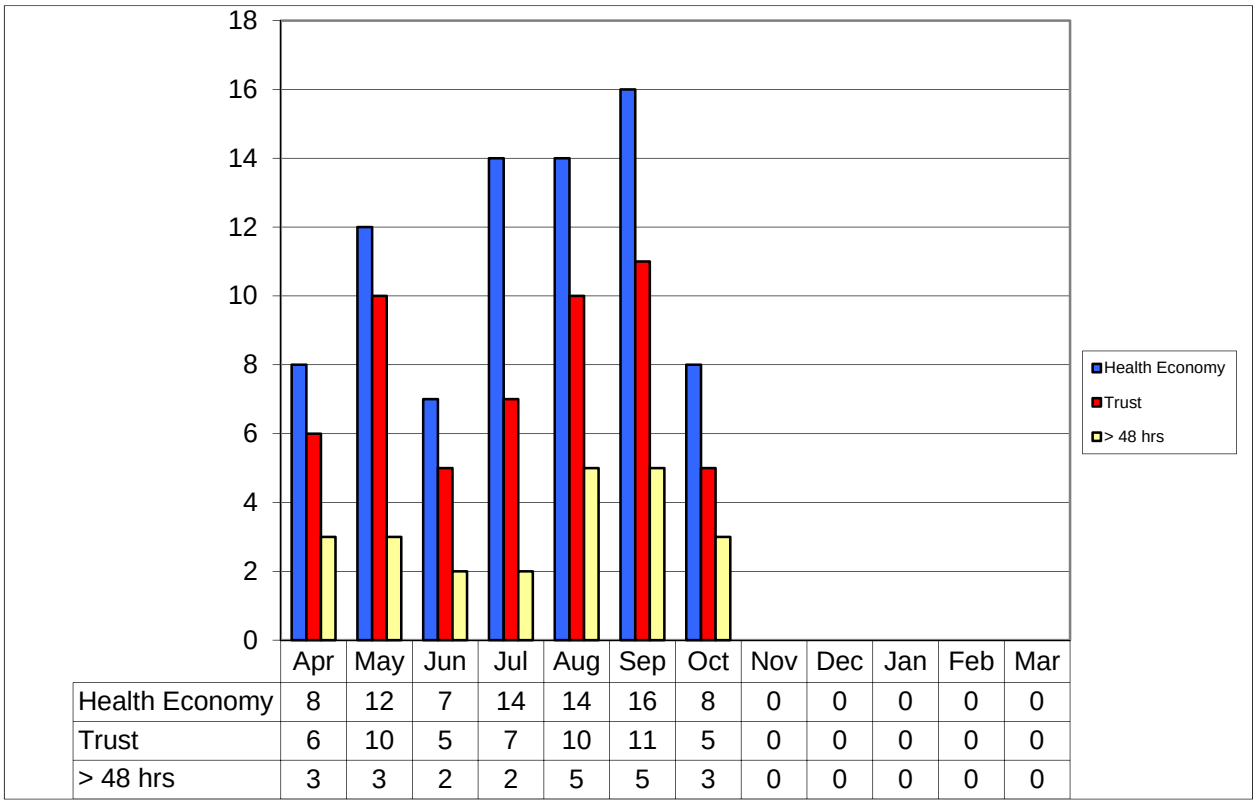
Decision	Approval	Discussion	Other
		√	

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

Summary:

Clostridium Difficile – The target for 2015/16 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. At the time of writing (22.10.15) we have 3 post 48 hour cases recorded October 2015.

C. DIFFICILE CASES 2015/16



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	12	7	14	14	16	8	0	0	0	0	0
Trust	6	10	5	7	10	11	5	0	0	0	0	0
> 48 hrs	3	3	2	2	5	5	3	0	0	0	0	0

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], continues. Of the 23 post 48 hour cases identified since 1st April 2015, 11 cases have so far been reviewed by the apportionment panel and 6 of these were deemed as avoidable. The main themes identified are: delay in sending sample, delay in isolation, poor documentation and incomplete stool charts.

There has been a period of increased incidence (PII) of post 48 hr C. difficile on B3 with 2 cases being identified – ribotyping has been requested and a 72 hour meeting is being held 22nd October 2015.

MRSA bacteraemia (Post 48 hrs) – There have been 2 post 48 hour MRSA bacteraemia cases identified year to date. They will be subject to the national PIR process.

Norovirus - no further cases.

Reference

1. *Clostridium difficile* infection objectives for NHS organisations in 2014/15 and guidance on sanction implementation, Public Health England.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th November 2015

TITLE:	**Monthly Nurse/Midwife Staffing Position – September 2015**		
AUTHOR:	Derek Eaves, Professional Lead for Quality Yvonne O'Connor, Deputy Chief Nurse	**PRESENTER:**	Dawn Wardell Chief Nurse

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

SUMMARY OF KEY ISSUES:
Attached is the latest monthly information on nurse/midwife staffing. As previously stated, there is no set template for this information and so the intention behind the format of the attached has been to make potentially complex information as clear and easily understandable as possible. It is worth noting that a new electronic system of collecting this data was commenced in June 2015 and to ensure consistency the same data is now used to source the monthly UNIFY return which results in the information on fill rates that is published on NHS Choices. Also, discussions with the company that provides the Allocate system to the Trust indicates that new enhanced software will mean that we should be able to produce this data from that system in the near future.

The paper indicates for the month of September 2015 when day and night shifts on all wards were staffed to planned levels (green) and were not staffed to the planned levels for both registered (amber) and unregistered staff (blue), with the day shift registered figures also taking into consideration the nationally recommended 1:8 nurse to patient ratio for general wards. It also indicates if planned levels were not reached for registered and unregistered staff but the dependency or number of patients was such that the extra staff needed was not available and when levels were below agreed numbers. The total number of shortfall shifts was 62 in September, a reduction from August.

With regards to the 1:8 ratio, it is worth noting that this month the Trust received a national joint letter from the TDA, Monitor, NHS England and the CQC indicating that the 1:8 RN to patient ratio should only be seen as guidance. The Trust is assessing the contents of the letter and will include the outcome of this assessment in next month's report.

The planned levels for each ward vary dependent on the types of patients and their medical specialities and national ratios apply to specialist areas such as intensive care, midwifery and paediatric areas. When shortfalls occurred the reasons for gaps and the actions being taken to address these are outlined.

IMPLICATIONS OF PAPER:

RISK	**Y** **Risk Register: Y**		**Risk Score and Description:** Nurse staffing levels are sub-optimal (20) Loss of experienced midwives (15)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** 13: Staffing
	Monitor	**Y**	**Details:** Compliance with the Risk Assessment Framework
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:
To discuss and review the staffing situation and actions being taken and agree to the publication of the paper.

THE DUDLEY GROUP NHS FOUNDATION TRUST

Monthly Nurse/Midwife Staffing Position

September 2015

One of the requirements set out in the National Quality Board Report 'How to ensure the right people, with the right skills, are in the right place at the right time' and the Government's commitments set out in 'Hard Truths', is the need for the Board to receive monthly updates on staffing information.

The paper endeavours to give the Board a view of the frequency when Registered Nurse to patient ratios do not meet the recommended ratio on general wards of 1:8 on day shifts (there is no recommended ratio for night shifts) and also the number of occurrences when staffing levels have fallen below the planned levels for both registered and unregistered staff. It should be noted that these occurrences will not necessarily have a negative impact on patient care

The attached charts follow the same format as previously. They indicate for this month when day and night shifts on all wards fell below the optimum, or when the 1:8 nurse to patient ratio for general wards on day shifts was not achieved.

In line with the recently published NICE (2014) guideline on safe staffing:

1) An establishment (an allocated number of registered and care support workers) is calculated for general wards based on a combination of the results of the six monthly Safer Nursing Care Tool exercise and senior nurse professional judgement both based on the number and types of patients on that ward (with the Board receiving a six monthly paper on this). For areas such as midwifery, critical care and paediatrics other specialist tools are used. The establishment forms a planned number of registered and care support workers each shift.
2) Each six weeks the Lead Nurse/Midwife draws up a duty rota aimed at achieving those planned numbers.
3) Each shift the nurse/midwife in charge assesses if the staff available meet the patients' nursing/midwifery needs.

If, at anytime, there is a shortfall between the planned for that shift and the staff available a clear escalation process is in place.

Starting in June 2015, following each shift, the nurse/midwife in charge now completes a spreadsheet indicating the planned and actual numbers and, if the actual doesn't meet the planned, what actions have been taken, if any is needed, for the patients on that shift. Each month the completed spreadsheet is checked by the Matron then staff in the Nursing Division analyse the data and the attached charts are compiled. In addition, for consistency purposes the data from the spreadsheet is now used for the UNIFY return from which the fill rates are published on NHS Choices.

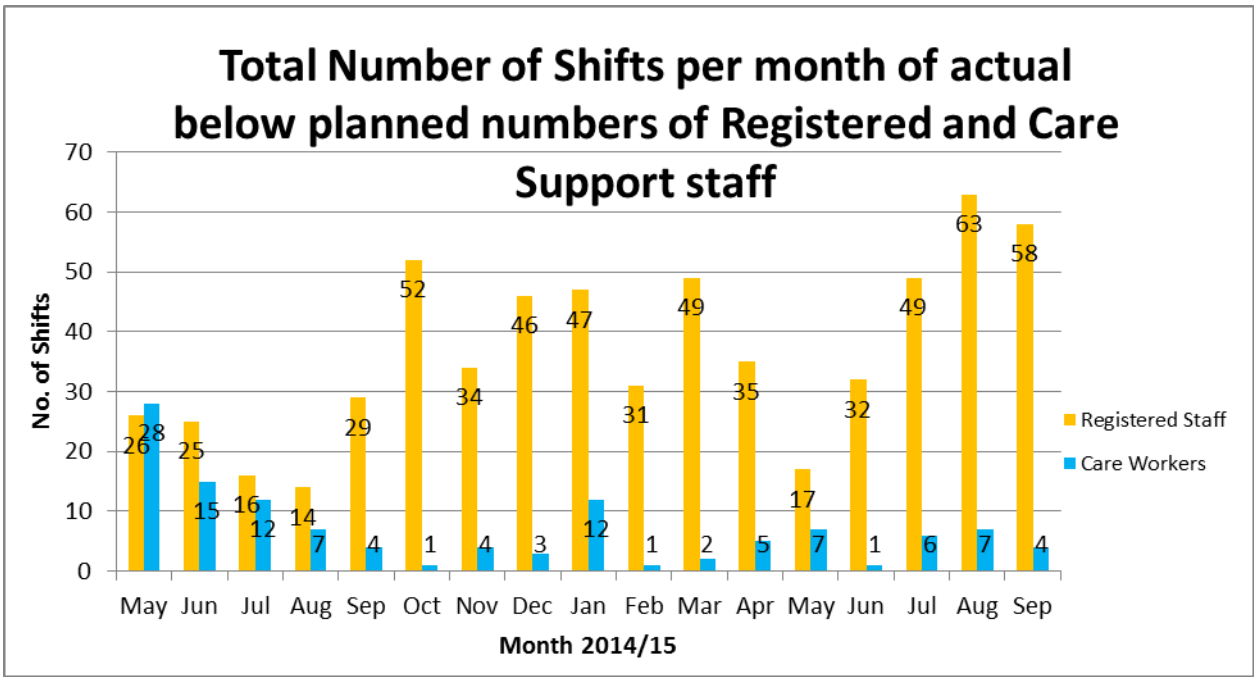
It can be seen from the accompanying chart that the number of shifts identified as amber (shortfall of registered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available), blue (shortfall of unregistered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available) or red (serious shortfall) is 62. This figure can be compared with previous months (see Table 1) and a reduction from the high figure of last month can be seen. In particular, the situation in maternity has vastly improved (2 shifts compared to 10 last month). This month the shifts occur mainly on three wards. As with last month, staff on ward A3 (11 shifts – 13 last month) have had to assist with the opening of the eight beds on A1 which has occurred due to capacity issues. As reported last month, the second area is C1 (14 shifts – 10 shifts last

month) still has 10 vacancies although some new staff commenced in October. Finally, on ward B4 (12 shifts – 7 shifts last month) maternity leave and sickness have added to the long term vacancies some of which have been filled in October. There has been one shift this month with a serious shortfall. With only 10 patients on the 26 bed ward, all patients were moved to one station for the night shift. The nurse in charge assessed there was a safe level of staffing for the patients on that shift. No safety issues occurred on this shift or any of the other shifts with shortfalls.

Returning to the complete Trust picture, the staffing available met the patients' nursing needs in all cases. When shortfalls in the 1:8 RN to patient ratio for day shifts on general wards or when shifts have been identified as below optimum; the reasons for the gaps and the actions being taken to address these in the future are outlined below. The Trust this month received a joint letter from the TDA, Monitor, NHS England and the CQC indicating that the 1:8 RN to patient ratio should only be seen as guidance. The Trust is assessing the contents of the letter and will include the outcome of this assessment in next month's report.

An assessment of any impact on key quality indicators is undertaken each month. From as far as possible as it is to ascertain, these shortfalls have not affected the results of any of the nursing care indicator measures or other quality measures such as the number of infections. In addition, there is no evidence that they have affected patient feedback in terms of the answers to the real time surveys or in the number of concerns or complaints received.

Table 1



Nice (2014) Safe Staffing for nursing in adult in-patient wards in acute hospitals (London: July 2014)

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS SEPTEMBER 2015

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A2	1	RN	Vacancy	The bank was unable to fill the vacant posts. To assist an extra CSW was employed. Floating Band 6 staff also helped on the stations. There were no safety issues.
A3	11	RN	Staffing A1, Vacancy, Sickness	Bank and agency did not fill. Due to patient numbers (capacity), Ward A1 has been opening during this month as and when required. Staff from A3 also staff that ward when it has to open. Risk assessment of patient caseload is always undertaken and the nurse in charge takes a caseload of patients on many shifts. No patient safety issues are occurring. On one occasion lead nurse from C3 assisted.
B1	1	RN	Staff sickness	With only 10 patients on the 26 bed ward, all patients were moved to one station. The Nurse in Charge assessed there was a safe level of staffing for the patients on that shift. No safety concerns occurred.
B2H	2	RN	Sickness and staff moved to another ward	On the day shift, the bank/agency were unable to cover leading to a ratio of 1:10 but with the patients on the ward the lead nurse on for weekend cover assessed the are as safe. On the night shift, the employed bank nurse was moved to an area of greater need with the ward being assessed as safe by the night co-ordinator
B2T	1	RN	Vacancy	The booked agency staff did not turn up for the shift, leaving a ratio of 1:12. With the patients on the ward, care was prioritised to ensure safety was maintained
B3	3	RN	Vacancy x2, Maternity Leave	The bank was unable to fill the shifts. On all three occasions, there were 6 empty beds and on one shift VASCU was empty. On two occasions the Lead Nurse assisted. Patient safety was maintained.
B4	9 3	RN CSW	Vacancy x4 , Maternity Leave x5, Sickness x3	Bank/agency unable to fill all of these shifts but with the dependency of the patients present on the ward safety was maintained with an RN ratio of 1:9.6 on 7 day time occasions. Staff training was cancelled for one shift also. On one of the night RN shifts a nurse from another ward assisted. For the three CSW shifts assistance was given by other wards or the lead nurse working clinically.
B5	1	RN	Vacancy	The bed manager supported the ward and GAU patients were accommodated in SAU
C1	14	RN	Vacancy x12, Sickness x2	On all occasions the lead nurse or nurse in charge assisted, assessed the situation and delegated staff appropriately to maintain patient safety.
C3	2	RN	Vacancy x2	Bank and agency were unable to fill. On one occasion two extra CSWs were employed an on one occasion a nurse from A3 assisted. Patient safety maintained.
C5	3	RN	Vacancy, Sickness and Emergency A/L	Bank unable to fill. On two occasions extra CSWs employed. Safety maintained.
C6	4	RN	Vacancy x2, Staff moved x2	On two occasions staff were moved to assist elsewhere with the remaining staff being able to provide the required care to patients. There were no safety issues on all four shifts.

C7	1 1	RN CSW	Sickness and Vacancy	Bank/agency unable to fill. Staff redeployed appropriately. Some care was delayed but no patient safety issues.
C8	2	RN	Sickness Vacancy	On both occasions a nurse was moved from HASU to main ward so that the workload was effectively distributed. The CNS and lead nurse provided support.
CCU/ PCCU	1	RN	Sickness Vacancy	Bank and agency unable to fill. Matron assisted to ensure safety.
Maternity	2	RM	Vacancy Maternity leave	Escalation policy enacted on both occasions. Staff from tongue tie clinic and specialist midwives from ante natal clinic assisted. No patient safety issues occurred. On both occasions there was a delayed induction of labour.

Sep-15		SHIFT																																																													
		1		2		3		4		5		6		7		8		9		10		11		12		13		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30		31	
WARD	STAFF	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N	D	N
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EAU	Reg																																																												
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MHDU	Reg																																																												
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NEONATAL**	Reg																																																												
MATERNITY ****	Reg							19/15																																						19/16																	
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Key

Serious Shortfall (red)

Registered nurse/midwife shortfall (amber)

Care Support Worker shortfall (blue)

* Critical Care has 6 ITU beds and 8 HDU beds

** Neonatal Unit has 3 ITU cots, 2 HDU cots and 18 Special care cots. Ratios reflect BAPM guidance and include a single figure for registered and non registered staf

*** Children's ward accommodates children needing direct supervision care, HDU care 2 beds, under 2 years of age care and general paediatric care. There are no designated beds for these categories, other than HDU and the beds are utilised for whatever category of patient requires car

**** Midwifery registered staffing levels are assessed as the midwife: birth ratio and is compliant with the 'Birthrate +' staffing assessment

Any coloured shifts without numbers indicate that the planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 5 November 2015

TITLE:	**27 October 2015 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES

SO 1 – Deliver a great patient experience
SO 2 – Safe and caring services

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	27 October 2015	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- Operational Management assurance was provided over the performance of the Trust in respect of key quality indicators. The Committee were informed that the Chief Operating Officer is seeking clarity from the CCG in respect of Stoke performance measures as the local ones reported are not the same as the national Stroke targets. The report contained information by exception on a deterioration in performance in relation to Critical Care and Reducing Ventilation Associated Pneumonia and it was agreed that this indicator would be tracked for a few months to see improved performance or to seek in the event of a continued issue a separate report on this indicator (see below for items to come back to the Committee);
- Executive Management assurance was provided over the Trust's progress with reviewing its Policies, whilst improvement is being made the Committee asked for a further update before the year end (see below for items to come back to the Committee);
- Executive Management assurance was provided over compliance with the Trust's contractual requirements for dealing with SIs;
- The "Picker" patient experience survey results were provided in respect of maternity. One question had an improved score over that of last year all the other 42 questions remained the same (only 43 questions remained the same as last year others were new). When comparing to peers, the Trust scored better in 5 questions, worse in 2 and the same in the remaining 44. The delivery of actions to deliver improvements in this area will be monitored by the Patient Experience Group which will report to the Committee later in the year;
- Executive Management assurance was received via the Quality and Safety Group in respect of the Trust's improved visiting policy, agency staff usage monitoring and the monitoring of medication incidents;
- Executive Management assurance was received via the Internal Safeguarding Board in respect of training within this area;
- Executive Management Assurance was received in respect of the Trust Learning Disability Action Plan delivery;
- Executive Management Assurance was provided on the Trust's performance against the Quality Priorities for 2015/16 as set in the Trust's Quality Account; and
- Operational Management assurance was provided on the benefit of the quarterly learning event and how this supports the Trust's aim to learn from events.

Decisions Made / Items Approved

- Approval of 10 Policies, 5 guidelines and 24 procedures that had all been considered by Policy Group in October 2015; and
- Approval to close 38 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, actions plans completed had been evidenced;
- The Committee asked that the Divisions through their performance management framework be reminded of the need to provide assurance that actions are closed timely given the increase in open actions that have passed their agreed implementation dates.

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

- The Committee will receive a report on the Never Events if further learning is identified at the next meeting;
- The Committee is to receive the Trust infection control action plan and a note of the Health Economy *C diff* action plan at the next meeting;
- The Committee will receive a further update on progress with Policy updates and reviews in February; and
- The Committee will receive an update from the Patient Experience Committee on the actions taken as a result of the maternity patient experience survey run by Picker (this will be towards the end of the financial year).

Items referred to the Board for decision or action

The Board is asked to note that the Patient Experience Group will be monitoring on behalf of the Clinical Quality, Safety and Patient Experience Committee the development and tracking of the action plan in respect of the Picker Maternity Survey

Enclosure 7

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 5th November 2015

TITLE:	**Integrated Performance Report**		
AUTHOR:	**Anne Baines, Director of Strategy and Performance**	**PRESENTER**	**Anne Baines, Director of Strategy and Performance**

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

Attached is the Integrated Performance Report for the period to September 2015.

Overall performance continues to be good, particularly with regard to the Emergenc y Access target (4 hours) where we remain amongst the best organisations in the country. We are also performing well against the nation al 18 week standard f or Referral to Treatment Times although changes to this indicator will impact on future levels of performance.

Provisional performance for the cancer 62 day target for GP referral will fall below t arget and will breach the Quarter 2 standards. This is predominantly as a result of the activity at Royal Wolverhampton Trust where the backlog acti vity is being undertake n and we share the breach for the overall pathway performance. Continued pe rformance management has been with weekly meetings for the Division with Directors

In September Healthcare Acquired Infections of Clostridium Difficile continued at a high rate higher than the thresh old figure a t 5. The Ch ief Nurse h as developed an act ion plan, to address the issues. It is however unknown whether recovery to achieve the end of year target will be possible given the target number of 2 9. This targ et was signi ficantly lower than the total number which occurred in 14/15 (38).

The Trust also had 2 cases of MRSA (the first cases in more than 18 months). A Never Event has also be en reported in Septemb er in Matern ity Services with a second in October. Both are currently under investigation.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: Y/N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:** ***(Please select from the list on the reverse of sheet)***
	Monitor	**Y**	**Details:** Poor performance would result in the Trust being in breach of licence
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD

Board of Directors is asked to not e the contents of the Integrated Performance Report for September 2015

The Dudley Group NHS
NHS Foundation Trust

Trust Board of Directors 5th November 2015

Integrated Performance Report - September 2015

1. Introduction

This paper aims to present to the B oard of Directors per formance against the key areas, highlighting areas of good performance and identifying areas of exception together with the actions in place to address them.

2. Integrated Performance Report

The report for the period April 2015 to September 2015 is enclosed f or consideration at Appendix 1. This month we have included a comparison with the last years out-turn (LYO) position.

Overall the Trust continues t o perform well against the majority of key indicators. Areas to highlight include

- Delivery of the emergency acc ess target (4hrs) where the Trust is consistently performing amongst the top organisations in the country
- Achievement of all three Referral to Treatment (RTT) 18 week targets
- Level of sickness is below target for third consecutive month

Those areas requiring further attention include

- Delivery of Clostridium Difficile (C-Diff) target - see below
- MRSA – 2 cases have occurred in September
- Never events – 1 event has occurred in September
- The Friends & Family measure of how many responses are collected (the footfall) remains below that r equired in some areas, particularly ED. Further work is underway to ens ure that the data included is relevant to the key area. The proposed solution to increasing the response rate is the introduction of a two way texting system which is being scoped

- Outpatient activity – follow-up ou tpatients and outpat ient procedures continue to under-perform. This has continued in September followin g the expected lower numbers in August. The Div isions have been tasked to determine the reasons for this and produ ce a plan for improving the level of activity over the remainder of the year.

- Community activity continues to be below target due to vacant community nursing posts. Recruitment into these posts continues although is not expec ted that this will recover the under-performance by the year end.

3. **Cancer**

The Board have previously been updated on concerns about achieving the 62 day urgent GP referral to treatment.

Data for this indicator is provisional for 2 months following the month end given the level of validation required for each patient pathway. It is therefore only possible to report an interim forecast for August and September based on the internal assessment. The treatment following GP referral is provisionally 85.1% for August, 83.3% for September and 84.2% for Q2.

4. **Clostridium Difficile (CDiff)**

Historical performance of the Trust against this target is good. This resulted in a target being set nationally of no more than 29 cases in 15/16 (compared with performance of 38 in 14/15).

September had a further 5 cases following the same number in August. The Chief Nurse has produced an action plan and work to date has not identified a systematic failure in the system. The issue has been discussed at Clinical Quality, Safety and Patient Experience Committee and Performance and Finance Committee, where it was agreed a detailed report be presented, if necessary, in December 2015 based on performance at that time.

5. **MRSA**

2 cases of post 48 hrs MRSA have occur which are currently being investigated. This target has a zero tolerance.

6. **Never Events**

One never event has been reported in September within Maternity services with a second in October. Investigations as to the key issues and causes are underway.

Recommendation

Trust Board of Directors is asked to:

a. Note the contents of the report

Anne Baines
Director of Strategy and Performance

The Dudley Group NHS
NHS Foundation Trust

Appendix 1

Integrated Performance Dashboard 2015/16

2015/16 | All Divisions | All Directorates | Indicators - Key Only

Quality And Risk

Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target	YEF
Friends & Family – Community – Footfall	-	0%	0%	1%	1%	1%	1%	-	-	-	-	-	-	1%	%	
Friends & Family – Community – Recommended %	-	97%	98%	96%	96%	94%	93%	-	-	-	-	-	-	95%	%	
Friends & Family – ED – Footfall	20%	8%	15%	12%	7%	6%	3%	-	-	-	-	-	-	9%	15%	
Friends & Family – ED – Recommended %	89%	90%	90%	92%	90%	95%	91%	-	-	-	-	-	-	91%	95%	
Friends & Family – Maternity – Footfall	23%	23%	22%	21%	20%	22%	23%	-	-	-	-	-	-	22%	15%	
Friends & Family – Maternity – Recommended %	99%	99%	99%	99%	97%	99%	99%	-	-	-	-	-	-	99%	84%	
Friends & Family – Outpatients – Recommended %	-	84%	82%	82%	88%	90%	89%	-	-	-	-	-	-	88%	%	
Friends & Family – Ward – Footfall	32%	16%	16%	14%	15%	20%	20%	-	-	-	-	-	-	17%	25%	
Friends & Family – Ward – Recommended %	98%	96%	97%	98%	97%	99%	97%	-	-	-	-	-	-	97%	95%	
Incidents - Patient Falls, Injuries or Accidents	1,399	127	116	116	103	97	119	-	-	-	-	-	-	678		
Incidents - Pressure Ulcer	2,091	187	163	182	150	120	132	-	-	-	-	-	-	934		
Never Events	1	0	0	0	0	0	1	-	-	-	-	-	-	1	0	
Rates of Clostridium Difficile	38	3	3	2	2	5	5	-	-	-	-	-	-	20	13	
Serious Incidents - Action Plan overdue	-	46	31	37	24	32	42	-	-	-	-	-	-	212		
Serious Incidents – Not Pressure Ulcer	108	6	9	9	10	7	11	-	-	-	-	-	-	52		
Serious Incidents - Pressure Ulcer	197	21	20	21	17	17	10	-	-	-	-	-	-	106		
Stroke - Suspected TIA Scanned < 24hrs of Presentation	85.47%	95%	100%	91.3%	88.89%	92.31%	-	-	-	-	-	-	-	94.06%	60%	
Stroke Admissions : Swallowing Assessment	78.46%	81.25%	83.33%	72.09%	80%	74.07%	72.73%	-	-	-	-	-	-	77.04%	80%	
Stroke Admissions to Thrombolysis Time	80%	69.23%	61.54%	42.86%	75%	61.54%	71.43%	-	-	-	-	-	-	71.43%	%	
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)	88.84%	94.23%	92%	92.86%	94.34%	88.24%	92.86%	-	-	-	-	-	-	92.41%	80%	
Zero Tolerance MRSA	0	0	0	0	0	0	2	-	-	-	-	-	-	2	0	

Finance

Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target	YEF
Budgetary Performance	(£2,722)k	£224k	£436k	£135k	£16k	£611k	£232k	-	-	-	-	-	-	£1,655k	£0k	
Capital v Forecast	87.8%	100%	98.6%	99.7%	93.7%	74.5%	66.2%	-	-	-	-	-	-	66.2%	95%	
Cash v Forecast	109%	97.9%	104.9%	108.1%	87%	93.5%	84.8%	-	-	-	-	-	-	84.8%	95%	
CIP - Actual Performance	(£2,129)k	£1,773k	£1,218k	£1,298k	£1,516k	£1,743k	£1,002k	-	-	-	-	-	-	£8,550k	£8,105k	
Debt Service Cover	0.85	0.72	0.93	1.05	1.13	1.01	1.08	-	-	-	-	-	-	1.08	2.5	
EBITDA	£15,817k	£1,138k	£1,814k	£2,079k	£2,145k	£829k	£2,283k	-	-	-	-	-	-	£10,288k	£8,529k	
I&E (After Financing)	(£8,033)k	(£783)k	(£123)k	£183k	£201k	(£1,124)k	£346k	-	-	-	-	-	-	(£1,300)k	(£3,085)k	
Liquidity	7.22	6.1	5.76	5.41	6.28	5.16	6.03	-	-	-	-	-	-	6.03	0	
SLA Performance	£6,271k	£1,009k	£522k	£504k	(£729)k	(£297)k	(£852)k	-	-	-	-	-	-	£156k	£0k	
SLR Performance	(£8,032)k	(£782)k	(£123)k	£184k	£201k	(£1,124)k	£337k	-	-	-	-	-	-	(£1,308)k	£0k	

The Dudley Group NHS
NHS Foundation Trust

Appendix 1 (contd)

Integrated Performance Dashboard 2015/16

Performance

Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target	YEF
A&E - A&E Attendances Seen Within 4 Hours (%)	94.7%	98.6%	98.8%	99.1%	99.3%	98.5%	97.6%	-	-	-	-	-	-	98.6%	95%	
Activity - A&E Attendances	99,928	7,895	7,940	8,137	8,052	7,711	7,986	-	-	-	-	-	-	47,721	39,512	
Activity - Community Attendances	415,662	34,397	33,050	35,066	36,362	32,368	34,066	-	-	-	-	-	-	205,309	217,463	
Activity - Elective Day Case Spells	44,639	3,620	3,418	3,979	3,925	3,418	3,679	-	-	-	-	-	-	22,039	22,012	
Activity - Elective Inpatients Spells	6,953	482	525	580	580	509	537	-	-	-	-	-	-	3,213	3,561	
Activity - Emergency Inpatient Spells	50,876	4,425	4,282	4,183	4,205	4,080	4,123	-	-	-	-	-	-	25,298	24,203	
Activity - Outpatient First Attendances	125,382	10,390	10,110	11,464	11,531	10,166	12,114	-	-	-	-	-	-	65,775	60,794	
Activity - Outpatient Follow Up Attendances	320,876	25,984	24,530	28,014	27,363	23,344	26,736	-	-	-	-	-	-	155,971	162,750	
Activity - Outpatient Procedure Attendances	57,196	4,308	3,957	4,833	4,528	4,056	3,411	-	-	-	-	-	-	25,093	29,070	
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	96.7%	97.7%	96.4%	95.5%	95.4%	93.8%	94.1%	-	-	-	-	-	-	95.5%	93%	
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	96%	100%	98.7%	100%	97%	96.8%	95.9%	-	-	-	-	-	-	98.2%	93%	
Cancer - 31 day - from diagnosis to treatment for all cancers	99.7%	100%	100%	100%	100%	100%	99.2%	-	-	-	-	-	-	99.9%	96%	
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	100%	100%	100%	100%	100%	-	-	-	-	-	-	100%	98%	
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	99.6%	100%	100%	100%	100%	100%	100%	-	-	-	-	-	-	100%	94%	
Cancer - 62 day - From Referral for Treatment following national screening referral	97.3%	82.4%	91.3%	95.2%	100%	93.3%	96.2%	-	-	-	-	-	-	93%	90%	
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	87%	83.6%	81.9%	88.5%	83.8%	85.1%	83.3%	-	-	-	-	-	-	84.7%	85%	
RTT - Admitted Pathways within 18 weeks %	91.6%	95.2%	95.3%	96.1%	95.6%	96.1%	94.3%	-	-	-	-	-	-	95.4%	90%	
RTT - Incomplete Waits within 18 weeks %	95.4%	95%	95.2%	95.2%	95.6%	94.9%	95.1%	-	-	-	-	-	-	95.2%	92%	
RTT - Non-Admitted Pathways within 18 weeks %	98.7%	97.7%	97%	98%	98.3%	98.1%	98.3%	-	-	-	-	-	-	98%	95%	

Staff/HR

Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target	YEF
Appraisals	87.2%	88%	80.6%	81.5%	80.8%	80.3%	80.1%	-	-	-	-	-	-	80.1%	90%	
Mandatory Training (Substantive)	80.68%	81.53%	82.13%	82.8%	82.35%	83.51%	83.16%	-	-	-	-	-	-	83.16%	90%	
Sickness Rate (Performance Dashboard)	3.81%	3.49%	3.69%	3.66%	3.48%	3.17%	3.27%	-	-	-	-	-	-	3.46%	3.50%	
Staff In Post (Contracted WTE)	4,181.19	3,758.05	3,744.65	3,722.43	3,698.92	3,699.94	3,716.38	-	-	-	-	-	-	3,716.38		
Vacancy Rate	9.42%	9.04%	9.34%	10.00%	10.60%	10.79%	10.46%	-	-	-	-	-	-	10.46%	%	

Glossary

LYO – Last Year Out-turn
YEF – Year End Forecast

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 5 November 2015

TITLE:	**Black Country Alliance Update**		
AUTHOR:	Terry Whalley, BCA Programme Director	**PRESENTER**	Paula Clark, Chief Executive

CORPORATE OBJECTIVES

ALL

SUMMARY OF KEY ISSUES:

Following the first meeting the attached communication document was produced providing an update on the specific projects.

Moving forward the Black Country Alliance Partnership Board is to meet in public with their first public meeting being held in Walsall on the 30th October.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

To note the progress being made by the BCA on the main projects.

Black Country Alliance
Better Care for All

NHS

The Black Country Alliance CAN – news from Sept Board

Welcome to the first Black Country Alliance CAN. Your monthly update on news from across the alliance. The Alliance was launched on Black Country day back in July by the three chief executives from Walsall Healthcare, Sandwell and West Birmingham Hospitals and The Dudley Group Trusts. The BCA Board met for the first time on September 30 and meets again on October 30th.

Some exciting work has already taken place across the specialities getting colleagues together to talk about the future and any possibilities of working more closely together to provide better outcomes.

Rheumatology

The Board agreed to recruit to new joint consultant posts in rheumatology to help sustain quality services at Walsall Manor in the short term. These are important local, but also regional, services, with key research portfolios built around rheumatology. Partners agreed to make staff time available from within existing teams and to recruit to new posts to provide long term resilience. In 2016-17 we would expect to change the shape of some sub-specialist rheumatology services, but will consistently support local services on each Trust's sites. Richard Kirby, Chief Executive of Walsall Healthcare, can provide further details of the arrangements.

Interventional Radiology

There is a joint proposal to develop a single interventional radiology service commencing a pilot in early 2016. As BCA we have a group of expert clinicians, whereas in individual Trusts we have staffing gaps and recruitment issues. Nationally interventional radiology is a growing discipline which lends itself to a clinical network model of care. If you want to know more about the options, get in touch with Anne Baines, Director of Strategy at DG, who is sponsoring this work.

Oncology Services

Although not on the original list of services to consider, each of the three trusts have expressed a desire to investigate further this as an option for a Black Country Alliance Oncology Service. Each Trust currently 'buys in' oncology time. These arrangements can be fragile. We are exploring, given a one million population, how a single service might be recruited to, either together, or together with other partners, to create a local service on the patch. Such a development would have positive implications for our ability to meet cancer peer review standards, and could help us to 'repatriate' some cancer surgery in key tumour groups into the Alliance. Get in touch with Roger Stedman, Medical Director at SWBH, who is leading the development of these ideas.

Urology, Histopathology and Stroke

The teams in these three areas are developing ideas about how the BCA may be able to improve outcomes for patients and recruitment of staff. Either to meet short term needs or to address longer term sub-specialist interests, there seems to be potential to work better together in these fields. The BCA Board examined initial papers arising from clinicians' discussions and set timetables for fuller

documents to be developed over the next three months. Terry Whalley, BCA Programme Director, is best placed to advise you on these discussions to date.

How to get involved

The Black Country Alliance is your opportunity to think big about the future plans for your service, and how working in alliance with the other Trusts may enable you to solve a problem or realise an opportunity or ambition. We're keen to hear your ideas, and the BCA Board will consider options for the next phase of projects in March, with expressions of interest asked for from January. Further details of how to submit your ideas will follow, but in the meantime contact Terry Whalley.

Whether you want to propose plans for your service or keep your commitment small and help test out ideas - the Black Country Alliance want to hear from you. We will be launching a network for those among you who would like to get more closely involved in the Black Country Alliance.

Getting involved could mean any or all of the following:-

- Involvement in testing early thoughts
- Get insights into proposals to help ensure the details make sense and are well thought through
- Help tell the story of why the Black Country Alliance is a great opportunity for us to improve health outcomes and experience for the million plus people we serve,
- Help show why the Black Country Alliance will make this a better place to work for all of us Contact Terry Whalley for more info.

More news

Clinical conference - the BCA will host a clinical conference in January – invitations will be sent out shortly.

Midland Met – the new Midland Met hospital will have an impact upon patient pathways across the Black Country so the BCA will be finding out more about how this is being mapped across the region early in the new year.

Find out more about the Black Country Alliance at www.blackcountryalliance.org or follow us on twitter @TheBCAlliance

Paula Clark	**Toby Lewis**	**Richard Kirby**
Chief Executive	Chief Executive	Chief Executive
The Dudley Group	Sandwell and West Birmingham	Walsall Healthcare

Enclosure 9

Paper for submission to the Board of Directors 5th November 2015

TITLE:	**Revalidation Update Report**		
AUTHOR:	Teekai Beach, Directorate Manager to Medical Director	**PRESENTER**	Paul Harrison, Medical Director

CORPORATE OBJECTIVE: SO2 SO4

SUMMARY OF KEY ISSUES:

Revalidation for medical staff commenced in December 2012 and is required by all doctors to be given a licence to practice every five years. In order to be revalidated doctors require five satisfactory annual strengthened appraisals (although initial revalidation requires less). Revalidation arrangements have been in place within the Trust since December 2012. This report briefly outlines the progress made in Q2 2015/2016 and highlights any issues.

- The Trust maintains a high appraisal rate with generally positive feedback on the quality of appraisals.

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	Well Led
	NHSLA	**Yes**	**Details:** 1.9 Professional Clinical Requirements
	Monitor	**Yes**	**Details:**
	Equality Assured	**Yes**	**Details: Better Outcomes for All**
	Other: GMC		**Details: 'Good Medical Practice'**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
			Information

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

The board is asked to note the content of this report.

REPORT OF THE MEDICAL DIRECTOR TO THE BOARD OF DIRECTORS

October 2015

Quarterly Revalidation Report

1. Introduction

This report provides an update to the Board on Medical Revalidation further to the Annual Report presented to board in July 2015

.

Medical revalidation is a legislative requirement governing the competence of doctors outlined in the Good Medical Practice Framework for Appraisal and Revalidation (GMC March 2011). The Responsible Officer's role was set out in The Medical Profession (Responsible Officers) Regulations 2010. The background to Revalidation has been outlined in previous papers to the board.

Revalidation arrangements have been in place in the Trust since the requirement to revalidate doctors every five years commenced in December 2012.

This paper will outline the progress against plan for Medical Revalidation in the last quarter, against the issues set out in the previous report.

2. Governance Arrangements

The Trust continues to be compliant with the Framework for Quality Assurance (FQA) presented in July 2014. Compliance is Monitored against the Core Standards set out in the FQA and are reported by exception as part of the development plan below.

The Trust is achieving the majority of the mandatory and good practice standards set by NHS England in April 2014. The table below shows progress against areas of concern as of October 2015. A more detailed report will be provided internally to the Workforce and Engagement Committee. Key areas for improvement are the implementation of learning and development programmes for medical appraisers, case investigators and case managers.

Core Standards Development Plan- Progress October 2015

	Core Standard	June 2015	October 2015
2.2.9	The responsible officer ensures that there is an initial review of performance for appraisers covering the first three appraisals followed by an initial review.		
2.2.11	The responsible officer ensures that there is a written role description, person specification and terms of engagement for medical appraisers		
2.2.12	The responsible officer ensures that appraisers have access to regular appraiser assurance groups or networks, which will include agreement about expectations of attendance.		
3.1.28	The responsible officer co ordinates a quality assurance look back process of cases.		
3.1.29	The responsible officer ensures that there are mechanisms are in place to define the success criteria for interventions and processes and to demonstrate that the organisation learns from experience.		
3.2.4	The responsible officer ensures that individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (ref RST guidance)		
3.2.7	The responsible officer ensures that case investigators and case managers undertake quality assurance of their roles and receive feedback on their performance.		
3.2.8	The responsible officer ensures that case investigators and case managers participate in peer networks to learn and share good practice.		

2.1

In accordance with the Framework of Quality Assurance (FQA) a nd the Independent Verification process, the NHS England Midlands & East Revalidation Team has arranged to review the Trust in Fe bruary 2015. The purpose of this visit is to discuss systems and processes for revalidation based on the core standards as identified above. All Trusts will be participating in this process over th e next 12 months. A d etailed outline of the vi sit and a preparation plan will be reported to the Workforce and Engagement committee in Novembe r 2015.

As a result of the above Revalidation has be en removed from the 2015/2016 audit plan a s the review by NHS England will fulfil the requirement for annual independent verification.

3. Appraisal and Revalidation Performance Data Q2 2015/2016

A standardised quarterly return will be provided to NHS England on 11th November 2015

- 306 doctors had a prescribed connection to The Dudley Group NHS Foundation Trust for the period between 1st July and 30th September 2015
- 74 doctors were due to hold an appraisal meeting within the reporting period of that number, 12 doctors have not held an appraisal meeting within that period.
    - 8 of the 12 appraisals have not yet breached 15 months, the maximum time allowed by the GMC to complete annual appraisal.
    - 3 of 12 appraisals were not completed due to special circumstances such as sick leave, or moving to another jurisdiction and were acceptable to the Responsible Officer.
    - The remaining doctor has been escalated to the Revalidation Lead to provide support to complete their appraisals. Further non-engagement will result in escalation to the Responsible Officer.

A copy of the NHS England return is enclosed within the Appendices.

4.1 Appraisers

At present the number of trained doctors who have volunteered to carry out medical appraisers (52) means that we continue to maintain an acceptable ratio of appraisers to appraisees as set out in the NHS England Medical Appraisal Policy as well as the Trust's own policy.

4.2 Revalidation Recommendations

The responsible officer made 33 recommendations for revalidation for the reporting period. All recommendations were made by the due date. 31 were positive and there were two deferrals.

Both recommendations have been deferred due to a lack of sufficient evidence contained within the medical appraisal for the Responsible Officer to make a positive recommendation.

APPENDIX 1

	Indicator	Q1 (1 Apr to 30 Jun)	Q2 (1 July to 30 Sep)	Q3 (1 Oct to 31 Dec)
1	**Name of designated body** (or NHS England Area Team or Region) Note: Please ensure your organisation's name is written exactly as it is recorded on GMC Connect	The Dudley Group NHS Foundation Trust		
2	Number of doctors with whom the designated body has a **prescribed connection**	313		
3	**Number of doctors[1] due to hold an appraisal meeting** in the reporting period Note: This is to include appraisals where the appraisal due date falls in the reporting period or where the appraisal has been re-scheduled from previous reporting periods (for whatever reason). The appraisal due date is 12 months from the date of the last completed annual appraisal or 28 days from the end of the doctor's agreed appraisal month, whichever is the sooner.	41	74	
3.1	Number of those within #3 above who **held an appraisal meeting** in the reporting period	30	62	
3.2	Number of those within #3 above who **did <u>not</u> hold an appraisal meeting** in the reporting period **[These to be carried forward to next reporting period]**	11	12	
	Data entry checker			
3.2.1	Number of doctors[1] in 3.2 above for whom **the reason is both understood and accepted by the RO**	6	11	
3.2.2	Number of doctors[1] in 3.2 above for whom **the reason is either <u>not</u> understood or accepted by the RO**	5	1	
	Data entry checker			
4	**Any Comments** you wish to raise (e.g. new RO, new appraisal lead etc.):			

APPENDIX 2

Audit of revalidation recommendations

Revalidation recommendations between 1 April 2014 to 30th June 2014	
Recommendations completed on time (within the GMC recommendation window)	33
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
Deferrals	2

Enclosure 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5 November 2015

TITLE:	**Summary of 20 October 2015 Audit Committee Meeting**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Richard Miner – Audit Committee Chair

CORPORATE OBJECTIVES

ALL

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

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

The Board is asked ratify the minor changes to the Audit Committee's terms of reference, note the actions of the Committee in respect of the Risk and Assurance Register and the oversees visitor bad debt.

Audit Committee highlights report to Board of Director 5 November 2015

Meeting	Meeting Date	Chair	Quorate	
Audit Committee	20/10/2015	Richard Miner	yes	no
			x	

Declarations of Interest Made

None

Assurances Received

A Research and Development Directorate turnaround plan to increase recruitment and income is being implemented and progress made.

The Internal Audit Progress Report confirmed that the 2015/16 audit plan is on track with some further work on safeguarding and data quality being undertaken.

That LCFS work is proceeding satisfactorily and on track except for one matter which is referred to below.

That the work of the Risk and Assurance Group (an executive group) support the risk assessments made by the Executive Team.

That the Caldicott and Information Governance Group continues to fulfil its role and keep the required areas under review, noting there had been no Information Commissioners Office reportable IG incidents.

Decisions Made / Items Approved

The external audit plan for 2015/16 was approved. The Audit Committee is to write to the external auditors setting out its approach to dealing with fraud.

Minor changes to internal audit plan approved mainly in respect of timing of a small number of their audits for the remaining part of the year along with follow up audits on safeguarding and safer staffing data quality.

The Audit Committee has agreed to write to NHS Protect in respect of certain fraud allegations concerning an external party.

Clinical Audit Plan 2015/16 – 4 additional clinical audits were approved for inclusion in the plan with the agreement to two local clinical audits relating to obstetric waiting times being removed from the Clinical Audit Plan.

To ratify the Policy Group Recommendations which are really that proper procedures are being followed for the implementation of new policies and guidelines.

To approve a small number of minor amendments to the Audit Committee terms of reference, job titles, the regular attendance at meeting by the Director of Governance and that the Committee would use the HFMA self-assessment checklist for Audit Committees.

Audit Committee highlights report to Board of Director 5 November 2015

Actions to come back to Committee

Further analysis on Overseas Visitor debts.

A response from NHS Protect and the follow up actions necessary should this matter need to be escalated further.

Items referred to the Board for decision or action

A new style Risk Register and Assurance Register is recommended for acceptance and is to be presented to the November Board.

That losses and special payments up to 30 September 2015, which were originally reported directly to the Board are now being monitored by the Audit Committee. The largest items are debts due from overseas visitors although this has been affected by recent changes to recording. Some further work is being done in this area. The Board is asked to note the actions.

Ratification of the minor revisions to the Audit Committee Terms of Reference (see appendix A)

APPENDIX A

The Dudley Group NHS
NHS Foundation Trust

AUDIT COMMITTEE

TERMS OF REFERENCE

1. Constitution

1.1 The Board of Directors resolves to establish a Committee of the Board to be known as the Audit Committee. The Audit Committee in its workings will be required to adhere to the Constitution of The Dudley Group NHS Foundation Trust, the Terms of Authorisation and Code of Governance issued by the Independent Regulator for NHS Foundation Trusts. As a committee of the Board of Directors, the Standing Orders of the Trust shall apply to the conduct of the working of the Audit Committee. The Committee is a Non Executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2. Membership

The Committee shall be appointed by the Board from amongst the Non Executive directors of the Trust and shall consist of not less than three members. One of the members will be appointed Chair of the Committee by the Board. The Chair of the Trust shall not be a member of the Committee.

3. Attendance

3.1 The following members of staff and partners would usually be in attendance at every meeting:

Director of Finance and Information
Director of Governance/Board Secretary
Internal Auditors
External Auditors

Attendance at the Committee will be monitored and reported in the Annual Report.

3.2 The Chief Executive should be invited to attend and should discuss at least annually with the Audit Committee, the process for assurance that supports the Annual Governance Statement. He/she should also attend when the Committee considers the draft Internal Audit Plan and the Annual Accounts. All other Executive Directors should be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

3.3 Other managers/staff may be invited to attend meetings depending upon issues under discussion. The Committee has the power to co-opt, or to require to attend, any member of Trust staff, as felt necessary.

3.4 The Committee will exclude the Director of Finance and Information and any other Trust employee from its meeting with Internal and External Auditors for a minimum of one meeting per year.

3.5 The Trust Secretary will ensure that an efficient secretariat service is provided to the Committee.

4. Quorum

4.1 A quorum shall be two Non Executive Directors.

5. Frequency of meetings

5.1 The Committee will meet at least four times per year. The Agenda will be circulated with papers 7 days before the meeting.

5.2 Ad hoc meetings can be called by the Chair or as a result of a request from at least two members of the Committee. The request is to be made to the Chair. Ad hoc meetings will be arranged within 28 days of the Chair's decision or the request from at least two members of the Committee. Additional meetings may be held at the discretion of the Chairman of the Committee.

6. Authority

6.1 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

7. Duties

The duties of the Committee can be categorised as follows:

7.1 Governance Risk Management and Internal Control

7.1.1 The Committee will review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control-related disclosure statements (in particular the Annual Governance Statement), together with an accompanying Head of Internal Audit statement, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors.
- The underlying assurance processes that indicate the degree of achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self certification. The policies and procedures for all work related to fraud and corruption as set out in Secretary of State's Directions and as required by the NHS Protect (formerly NHS CFSMS).

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

7.2 **Internal Audit**

7.2.1 The Committee shall ensure that there is an effective Internal Audit function that meets Government Internal Audit Standards and provide appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal.
- Review and approval of the Internal Audit Strategy , Operational Plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Assurance Framework.
- Considering the major findings of Internal Audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- An annual review of the effectiveness of Internal Audit.

7.3 **External Audit**

7.3.1 The Committee shall review the work and findings of the External Auditors and consider the implications and management's reponses to their work. This will be achieved by:

- Consideration of the appointment and performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee
- Review of all external audit reports, including the Report to those charged with Governance and any work undertaken outside the Annual Audit Plan, together with the appropriateness of management responses.
- Review of the report on Quality Accounts.

7.4 Other Assurance Functions

7.4.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust and consider the implications for the governance of the organisation.

7.4.2 These will include, but will not be limited to, any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, Monitor, the Care Quality Commission, NHSLA etc) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies etc.).

In addition, the Committee will review the work of other committees within the Trust whose work can provide assurance to the Audit Committee's own scope of work. In particular , this will include the Clinical Quality, Patient Safety and Experience Committee and risk management groups established as reporting groups at 8.5 below.

7.5 Counter Fraud

7.5.1 The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work.

7.6 Management

7.6.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

7.6.2 The Committee may also request specific reports from individual functions within the organisation (for example, clinical audit) as they may be appropriate to the overall arrangements.

7.7 Financial Reporting

7.7.1 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

7.7.2 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

7.7.3 The Audit Committee shall review the Annual Report, Quality Accounts and financial statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee.
- Changes in, and compliance with, accounting policies, practices and estimation techniques.
- Unadjusted mis-statements in the financial statements.
- Significant judgements in preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Letter of representation.
- Qualitative aspects of financial reporting.
- Contents of Quality Accounts

8. Reporting

8.1 The Audit Committee reports to the Board of Directors. The minutes of Audit Committee meetings shall be formally recorded and a summary of key issues, and if required, the minutes, submitted to the Board. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

8.2 The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and 'embeddedness' of risk management in the organisation, the integration of governance arrangements, the appropriateness of the evidence compiled to demonstrate fitness to register with the CQC and the robustness of the processes behind the Quality Accounts.

8.3 The Committee will review the work of other committees/groups within the Trust whose work can provide assurance to the Audit Committee's own scope of work. In particular this will include the Board Committees. In reviewing the work of these Committees and issues around clinical risk management, the Audit Committee will wish to satisfy itself on the assurance that can be gained from the Clinical Audit function.

8.4 The Committee will approve the Clinical Audit Annual Plan and will monitor progress against this, receiving regular reports on audi t activity and t aking assurance on related matters.

8.5 The following groups report directly into this Committee:

- Clinical Audit Leads Group
- Research and Development Group
- Caldicott and Information Group
- Risk and Assurance Group

9. Policies

The committee will approve policies on subjects related to the committee terms of reference on recommendation from the Policy Group.

10. Review

10.1 The Committee shall formally consider its effectiveness utilising any tools within the HFMA NHS Audit Committee handbook.

10.2 The Terms of Reference of the Committee shall be reviewed by the Board of Directors at least annually.

Enclosure 11

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5 November 2015

TITLE:	**Corporate Risk Register and Assurance Report**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary
CORPORATE OBJECTIVES ALL			

Background

The Corporate Risk Register along with the Divisional and Directorate Risk Registers were considered at the Risk and Assurance Committee on the 10 September. This meeting considered, if risks needed escalating to the Corporate Risk Register, the level of assurance in respect of the Corporate Risks and how this impacted on the scoring of those risks and if any risks could be deescalated from the Corporate Risk Register. The output from this meeting was then presented to the Audit Committee on the 20 October specifically focusing on the assurances received and how they support the current risk assessments of each of the Corporate Risks and support their movement from the last quarter's report.

Changes to the Corporate Risk Register (Appendix A)

The Corporate Risk Register records the Trust's key risks linked to each of the Trust's six objectives. The Register includes those key risks to the Trust's objectives as recorded with the Trust's annual plan (these are seen as the top down risks), it also includes those risks that have been escalated from the Trust's Divisions / Directorates (these are seen as bottom up risks). As an appendix to the Corporate Risk Register is a list of the key Division / Directorate risks which have not been escalated.

The Corporate Risk Register along with the Assurance Register was reviewed at the Executive Risk and Assurance Group on the 10 September. At this meeting the following changes to the previous Register were agreed.

<u>New risks / Escalated risks</u>
There have been **three additional risks** since the last report –
COR092 - Failure to deliver successful best practice cEPMA.
This risk has been escalated through the Quality and Safety Group meeting in August

COR093 - Management of young people requiring section under the mental health act (Tier 4)
This risk has been escalated from the nursing division's risk register

COR094 - The Biochemistry analyzers are prone to failure which has a detrimental impact across the Trust
This risk has been escalated from the medicine and integrated care division's risk

register

Increased risks
There has been **one increased risk** since the last report - **COR084** - Failure to embed the improvements from our last CQC inspection
This has increased due to the level of polices that require review to ensure they remain up to date and the gap in assurance over compliance with NICE guidance (see assurance register showing negative assurance relating to this gap)

Reduced risks
There have been **eight risks which have reduced** in their severity
COR079 Failure to continue to deliver the key contractual / monitor delivery targets (18wks / ED / Cancer)
This has reduced in this period due to the assurance over the work undertaken to track patients and the Trust's improved performance in Q1. However, *Executive Management assurance has shown that whilst our internal control system is operating due to delays in the wider system the cancer target will be missed for Q2 and therefore this has been registered as a negative outcome over the whole system of internal control but work is being undertaken with our partners on the achievement to the target.*

COR072 The Trust does not consistently send discharge information to the GP
Archived risks
This has reduced based on the assurance gained from the management audit of the JAC system

COR081 Nurse / Midwifery revalidation fails
This has reduced based on the assurance obtained over the work undertaken in this area

COR086 Patients' nutritional needs are not fully met during their hospital stay
This has reduced based on the assurance obtained over the work undertaken in this area
(see assurance register showing that negative assurance in respect of the outcome of NCI audits in some wards. Whilst there has been this negative assurance the same NCI audits do provide positive assurance for some wards, as action plans and escalation processes exit for wards with poor NCI scores this negative assurance is felt not to negate the reduction in the current risk score to 8 from the previously assessed score of 16 (the previous score was the uncontrolled score as it was a new risk)

COR089 IT Strategy does not deliver
This has reduced as the project is now underway and the consultants have been appointed and commenced with the Trust

COR077 Workforce reduction programme will adversely affect patient care and trust performance
This risk has reduced as the magnitude of workforce reduction has reduced outside of transformation schemes

COR091 The IT DR arrangements are not effective
This has reduced as work has commenced as per the report taken to F&P and the Board

COR080 Failure to deliver our CIP programme
This has reduced as the impact of the residual element of the undelivered CIP reduces

Corporate Assurance register (Appendix B)

The corporate assurance register shows the details of the assurances received to date, noting that this relates to assurances received in five months of the year. The assurance register also records the origin of the assurance, operational management through to an external source. As this assurance is collated across the year, Management and the Board are able to see the relative strength of assurance against each risk underpinning each objective.

Assurance gaps
There have been no assurances logged against the risks within Strategic Objective 4 (Be the place to people chose to work). However it is worth noting that the workforce reduction risk (COR077) has reduced to 6 due to the significance of the actual reductions required now being delivered through transformation schemes. Also that the other risk in the area relates to the separation of the RO and MD roles for which no further progress has been made since the last update and thus no assurance would be available. The Audit Committee asked the Workforce Committee to ensure assurances were obtained for the next update of the risk register in December 2016

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description: ALL**
	Risk Register: ALL		**Risk Score: ALL**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains but particularly well led**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE

Decision	**Approval**	**Discussion**	**Other**
Y		**Y**	

ACTIONS FOR THE AUDIT COMMITTEE

To understand and agree the Trust's corporate risks as at the end of August.

The Dudley Group NHS
NHS Foundation Trust

Appendix A

CORPORATE RISK REGISTER – AUGUST 2015

Risk Dashboard – rolling risk score trend

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Current Score								Trend	Target Risk Score
					09/09/14	09/12/14	17/03/15	05/06/15	26/08/15					
SO1	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer) *	20	20	20	15	20	15				↓	8
	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	25	25	16	16	16	16				→	8
	DG	COR084	Failure to embed the improvements from our last CQC inspection	12			new	8	12				↑	6
	COO	COR092	Failure to deliver successful best practice cEPMA	25				new	15					8
S02	MD	COR072	The Trust does not consistently send discharge information to the GP	20	20	20	20	20	8				↓	4
	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	8	15	15	15	15				→	10
	CN	COR085	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing	20	esc	20	20	20	20				→	15
	CN	COR081	Nurse / Midwifery revalidation fails	12			new	16	8				↓	8
	CN	COR082	Failure to deliver the significantly reduced C.Diff target of just 29 cases within 2015/16	20			new	20	20				→	10
	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16			new	16	8				↓	8
	CN	COR087	The number of grade 3 and 4 pressure ulcers potentially increase	12			esc	12	12				→	12
	CN	COR093	Management of young people requiring section under the mental health act (Tier 4)	20				new	12					8
	COO	COR094	The Biochemistry analyzers are prone to failure which has a detrimental impact across the Trust	20				new	16					0
S03	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20			new	20	20				→	15
	DIT	COR089	IT Strategy does not deliver	16			new	16	12				↓	16

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Current Score								Trend	Target Risk Score
					09/09/14	09/12/14	17/03/15	05/06/15	26/08/15					
	MD	COR044	The need for a medical workforce plan that is fit for purpose	12	new	12	12	arc						4
S04	CHR	COR077	Workforce reduction programme will adverselty affect patient care and trust performance	20		esc	9	16	6				↓	9
	MD	COR090	Failure to separate the role of Responsible Officer for Medical Revalidation from that of the Medical Director	8			new	8	8				→	4
S05	DG	COR088	Failure of DATIX system to support the business	16			esc	16	16				→	6
	DIT	COR091	The IT DR arrangements are not effective	20			esc	20	15				↓	12
	DSP	COR080	Failure to deliver our CIP programme **	20	20	20	20	12	9				↓	9
SO6	DF	COR061	Failure to maintian financial sustainability	20	20	20	20	16	16				→	5

* merged from three previous risks – prior period is highest risk score from each of the three indicators
** a similar risk was in the prior year (COR065) so this has been used for the past trend

Key for Risk Lead		Key for Strategic Objectives		Key for risk	
CE	Chief Executive	**SO1:**	Deliver a great patient experience	**New**	New risk identifed
MD	Medical Director	**SO2:**	Safe and Caring Services	**Esc**	Risk esculated from lower division / directorate etc
CN	Chief Nurse	**SO3:**	Drive service improvements, innovation and transformation	**De-esc**	Risk de-esculated to the lower division / directorate to manage
DF	Director of Finance and Information	**SO4:**	Be the place people choose to work	**Arc**	Risk no longer valid
COO	Chief Operating officer	**SO5:**	Make the best use of what we have		
DSP	Director of Strategy and Performance	**SO6:**	Plan for a viable future		
DG	Director of Governance				
CHR	Chief HR Advisor				
DIT	Director of IT				

NOTE when a risk is esculated it is recalibrated against the impact and liklihood at a corporate level and vice versa when a risk is de-esculated to the division / directorate. Therefore a risk at a divisonal level scoring 20 (4 liklihood x 5 impact) may score on a 12 (4 liklihood x 3 impact) as a corporate level.

DIVISIONAL / DIRECTORATE KEY RISKS – SEPTEMBER 2015

DIVISIONAL / DIRECTORATE KEY RISKS – SEPTEMBER 2015

Division	ID	Risk Description	Current Score						Trend	Target Risk Score
			30/04/15	31/05/15	26/08/15					
Medicine and Integrated Care	DMC009	Radiology capacity is insufficient to provide a safe, robust, fit for purpose service that meets the needs of the Trust. This could potentially delay diagnostic imaging and reporting, thus impacting on the quality of patient care	15	15	15				→	10
	DMC002	Failure to control Directorate overspend	20	16	16				→	4
	DMC006	Dudley Group NHS Foundation Trust is not meeting the needs of patients at the end of their life and is therefore providing a poor quality service (as shown with the failure of 6 out of 7 KPIs associated with The National Care of the Dying Audit for Hospitals)	20	16	16				→	4
	DMC003	Foreign objects may be retained post procedure	15	15	15				→	10
	DO37	There is a risk that a Clinical Biochemistry service cannot be maintained at The Dudley Group NHS Foundation Trust due to poor retention and recruitment of qualified staff which will adversely impact on patient care.	esc	15	15				→	8
Surgery	new	Utlisation of the emergency obstetirc threate team		new	20					new
	new	Inadequate number of staff undertaking training in Theatre and Critical Care		new	15					new
	OSS004	Inappropriate delay in patients having their follow up appointments (opthalmology)		esc	20				↑	16
	NP035	Lack of peadiatric medical workforce capacity to meet service demainds, service standards and recommendations	16	16	16				→	9
	SUV005	Limited outpaitent elective theatre in Urology.	15	15	15				→	12
	SUV006	The Trust is unable to guarentee the availaibity of BCG supplies for treatment of high risk non muscle invasive bladder cancer	15	15	15				→	15
	OSS006	The demand for the Paediatric Orthopeadic Service currently exceeds the capacity we are able to provide	15	15	16				↑	10
Nursing	N013	Catering trolleys are taken into the 4 bedded bays on peediatric ward	16	16	arc					4
	N009	Staffing estbalishment level on B2 does not support full care requirments for demientia / acutely confused patients	15	15	arc					6
	N020	Paediatric Speech and Language Therapy Dysphasia Service	15	15	15				→	6

Division	ID	Risk Description	Current Score						Trend	Target Risk Score
			30/04/15	31/05/15	26/08/15					
	new (N021)	Multi-disciplinary notes are not immediately filed whilst waiting for case notes to be delivered from medical records resulting in potential for a breach of confidentiality		new	To be assessed					
	new (N016)	Paediatric Capacity		new	To be assessed					
Corp Depts	CE002	Insufficient resources in the Governance Team does not support the organisation	new	16	12				↓	4
	ST001	Lack of progress on major service and cost improvement change leadign to delays in qulaity and efficency gains. Skill levels of Lean Practicioners not up to the level required to lead major change projects	16	16	16				→	12
	FE004	Failure to establish accountability for the prevention of legionella within PFI buildings	15	15	arc					10
	PA009	Poor Clinic Utilisation and Management		new	15					6
	PO12	An error could occur in prescribing, prepartion or administration of an injectable medicine		new	15					10

Appendix B

CORPORATE RISK ASSURNACE SUMMARY – AUGUST 2015

Risk Dashboard – rolling risk score trend

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Target Risk Score
					05/06/15	Level 1	Level 2	Level 3	26/08/15	Level 1	Level 2	Level 3	
SO1	COO	COR079	Failure to continue to deliver the key contracual / monitor deliery targets (18wks / ED / Cancer) *	20	20	G	A		15	G	A		
	COO	COR069	Diagnositc standard is at risk if the demand rises to a level above capacity	25	16				16	G	G		
	DG	COR084	Failure to embed the improvements from our last CQC inspection	12	8		G	R	12	R	R		
	COO	COR092	Failure to deliver successful best practice cEPMA	25					15	new			
S02	MD	COR072	The Trust does not consistently send discharge information to the GP	20	20	R			8	G	G		4
	COO	COR032	The Trust is required to have an up to date plan to manage major incidents and business continuity.	15	15				15	G	G	G	10
	CN	COR085	Failure to maintain the delivery of safer staffing levels in relation to ward nurse staffing	20	20	G	G		20	G	G	R	15
	CN	COR081	Nurse / Midwifery revalidation fails	12	16	G	G		8	G	G		8
	CN	COR082	Failure to deliver the significantly reduced C.Diff target of just 29 cases within 2015/16	20	20	G	G		20	G	G		10
	CN	COR086	Patients' nutritional needs are not fully met during their hospital stay	16	16	G			8	G	A		8
	CN	COR087	The number of grade 3 and 4 pressure ulcers potentially increase	12	12	G	G		12	G	G		12
	CN	COR093	Management of young people requiring section under the mental health act (Tier 4)	20					12	new			8
	COO	COR094	The Biochemistry analyzers are prone to failure which has a detrimental impact across the Trust	20					16	new			9
S03	COO	COR083	Failure to have a workforce / infrastructure that supports the delivery of 7 day working	20	20				20	G			15
	DIT	COR089	IT Strategy does not deliver	16	16				12		G		16

Strat Obj	Risk Lead	ID	Risk Description	Inherent risk score	Q1 Asssurance				Q2 Asssurance				Target Risk Score
					05/06/15	Level 1	Level 2	Level 3	26/08/15	Level 1	Level 2	Level 3	
S04	CHR	COR077	Workforce reduction programme will adverselty affect patient care and trust performance	20	16		A		6				9
	MD	COR090	Failure to separate the role of Responsible Officer for Medical Revalidation from that of the Medical Director	8	8				8				4
S05	DG	COR088	Failure of DATIX system to support the business	16	16				16	G			6
	DIT	COR091	The IT DR arrangements are not effective	20	20				15		G		12
	DSP	COR080	Failure to deliver our CIP programme **	20	12				9	G	G		9
SO6	DF	COR061	Failure to maintian financial sustainability	20	16				16	G	G	G	5

* merged from three previous risks – prior period is highest risk score from each of the three indicators
** a similar risk was in the prior year (COR065) so this has been used for the past trend

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 Performance	**SO6:**	Plan for a viable future		
DG	Director of Governance				
CHR	Chief HR Advisor				
DIT	Director of IT				

Paper for submission to the Board of Directors 5 November 2015

TITLE:	Complaints and Claims Q2 report (1 July to 30 September 2015)		
AUTHOR:	Maria Smith (Complaints & litigation manager)	**PRESENTER:**	Glen Palethorpe Director of Governance / Board Secretary

CORPORATE OBJECTIVE: SO1 – Deliver a great patient experience

SUMMARY OF KEY ISSUES:

Complaints report for Q2 ending 30 September 2015

There has been an increase in activity this quarter with 86 complaints being registered this quarter when compared to the 70 in quarter.

Figures in brackets [ ] below relate to the previous quarter.

100% [100%] of complaints received during quarter were acknowledged within 3 working days
44% [44%] of complaints received and closed during quarter answered within 40 working days
65% [49%] of complaints closed during quarter were upheld/partially upheld
1 [6] complainants expressed dissatisfaction with their response (received and investigated)
17 [19] meetings held with complainants
5 [4] Inquests held and closed during quarter
0 [1] rule 28 - reports on 'Action to Prevent Future Deaths' received from Senior Coroner

Claims for Q2

12 [6] CNST claims closed of which 80% [30%] were closed with no settlement costs attributed to the Trust
2 [0] Employer's liability claim closed, of which 50% [0%] had no settlement costs attributed to Trust
3 [5] new Employer's liability claim received
18 [15] new CNST claims received

IMPLICATIONS OF PAPER:			
RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Domains** **Safe, effective and caring**
	Monitor	**Y**	**Details: supports effective governance**
	Other **Ombudsman**	**Y**	**The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 No. 309** **0 complaints accepted for investigation by Ombudsman during the quarter**

ACTION REQUIRED OF COUNCIL:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS:

To note details of complaints and claims activity during the quarter ending 30 September 2015.

Key Facts – Complaints, Inquests & Ombudsman

Key facts	Qtr 2 ending 30/09/14	Qtr 3 ending 31/12/14	Qtr 4 ending 31/03/15	Year ending 31 March 2015	Qtr 1 ending 30/06/15	Qtr 2 Ending 30/09/15
Total number of complaints received during Qtr	**92** 4 - high 58 - med 30 - low	**64** 2 – high 39 – med 23 - low	**94** 4 - high 48 - med 42 - low	**313** 12 – high 179 – med 122 - low	**70** 5– high 32 – med 33 - low	**86** 3 – High 42 – Med 41 - Low
% Complaints acknowledged within 3 working days	100%	100%	100%	100%	100%	100%
% Complaints received and answered within 40 working days	50%	68%	45%	61% (incl complaints C/fwd from yr ending 31/3/14	44%	44%
Number of upheld/partially upheld complaints received & answered during Qtr	**33** during qtr	**15** during qtr	**20** during qtr	**143* (46%)** (*includes C/fwd from yr ending 31/3/14)	34 during qtr	60 during qtr
Complaints accepted for investigation by Ombudsman during Qtr	3	1	2	9	0	2
Privacy/dignity included as a concern in complaint	1	0	4	6	0	0
Complaints referring to shared accommodation	0	0	0	0	0	0
Complaints including safeguarding concern	1	0	0	1	0	0
Number of meetings held with complainants during Qtr	23	19	15	71 (23% of complaints rec'd)	19 (27% of complaints rec'd in qtr)	17 (20% of complaints rec'd in qtr)
Total number of dissatisfied complaints received during Qtr	6	3	6	20 (6% of complaints rec'd)	6	1
Total CCG/CSU led complaints received in Qtr	2	1	3	8	3	0
New Coroner's cases opened during Qtr	3	1	1	7	7	1
Coroner's Inquests held/closed during Qtr	7	4	2	18	4	5
Coroner's Rule 28 (was rule 43) received during Qtr	0	0	0	1	1	0

Category **	Qtr 2 Ending 30/9/14	Q3 Ending 31/12/14	Qtr 4 Ending 31/3/15	Trust yr ending 31/03/15	National Yr ending 31/03/15	Qtr 1 Ending 30/06/15	Qtr 2 Ending 30/09/15
Clinical Care (Assessment/Monitoring)	34 (37%)	20 (31%)	50 (53%)	**134 (43%)**	45%	38 (54%)	43 (50%)
Diagnosis & Tests	25 (27%)	8 (13%)	20 (22%)	**56 (18%)**	NA	12 (17%)	7 (8%)
Records, Communication, Information & appts	3 (3%)	6 (9%)	1(1%)	**17 (5%)**	22%	4 (6%)	17 (20%)
Admission, discharge & transfers	9 (10%)	10 (16%)	6 (6%)	**33 (11%)**	5%	6 (9%)	7 (8%)
Values & behaviour of staff (prev 'staff attitude')	8 (9%)	3 (5%)	6 (6%)	**20 (6%)**	11%	6 (9%)	2 (2%)
Obstetrics	3 (3%)	4 (6%)	2 (2%)	**12 (4%)**	3%	3 (4%)	3 (4%)
Nursing care (District Nurses)	0	0	0	**2 1%)**	NA	0	0
Medication	5 (6%)	6 (10%)	1 (1%)	**13 (4%)**	NA	0	3 (4%)
Patient Falls, Injuries or Accidents	1 (1%)	2 (3%)	2 (2%)	**5 (1%)**	NA	1 (1%)	2 (2%)
Equipment	1 (1%)	2 (3%)	0	**4 (1%)**	1%	0	0
Safeguarding	1 (1%)	0	0	**1 (1%)**	NA	0	0
Theatres	0	2 (3%)	1 (1%)	**4 (1%)**	NA	0	0
Privacy & dignity	1 (1%)	0	4 (5%)	**6 (1%)**	1%	0	0
Pressure Sore	1 (1%)	0	0	**2 (1%)**	NA	0	0
Violence, aggression	0	0	1 (1%)	**2 (1%)**	NA	0	0
Other (security, workforce)	0	1 (1%)	0	**2 (1%)**	4%	0	2 (2%)
Total:	**92 (100%)**	**64 (100%**	**94 (100%)**	**313 (100%)**		**70 (100%)**	**86 (100%)**

*** Note - complaints are allocated to a main category*

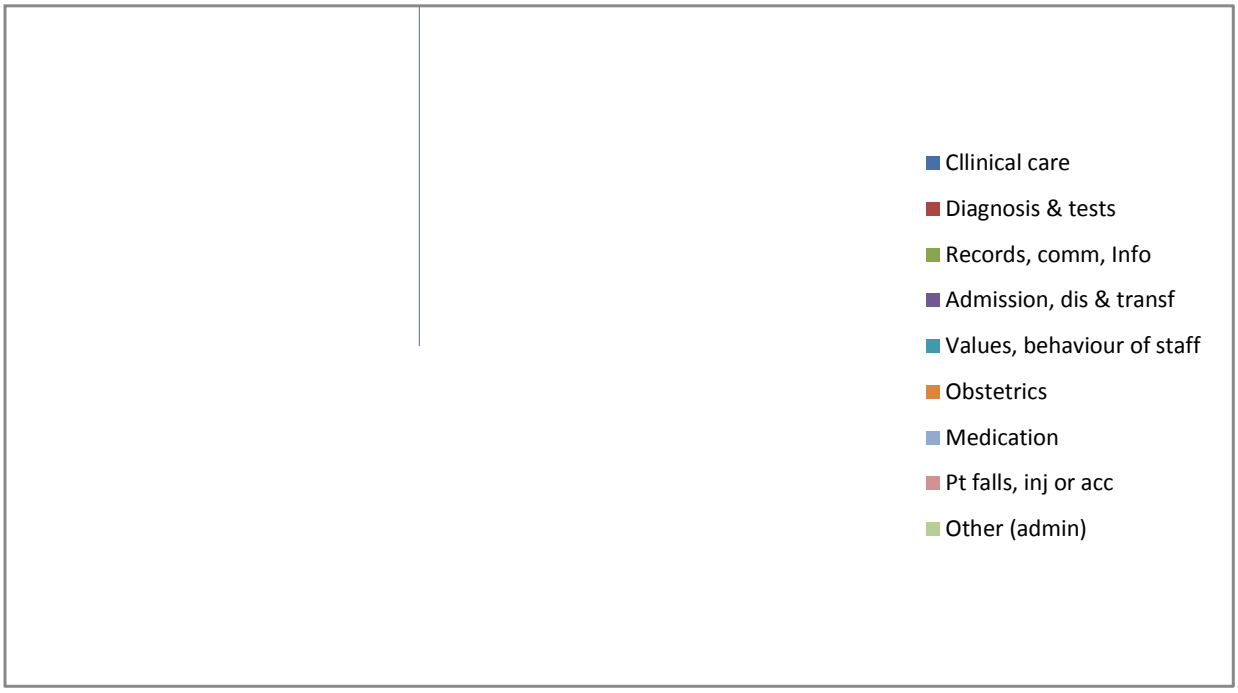
In response to a question from the CCG we have reviewed the Quarter 1 complaints in resp ect of values and behaviour. Our review of these complaints did not identify a specific cause for co ncern with one person. The breakdown of these complaints was as follows -

2 related to consultants – neither had any previous complaint against them
3 related to single instances involving nurses on three separate wards

1 related to a sonographer who had had a previous complaint in this category but the specifics of the complaint were different and un related.

The Quarter 2 report shows a reduction in 'values and behaviour of staff' (including staff attitude), which clearly reflects the message about 'Care, Respect and Responsibility' is being heeded by staff. This message has been included in the Chief Executive's briefings, which all staff are required to attend and have been attending during the end of quarter 1 and into quarter 2.

Analysis of complaints received by category - Q2



Benchmarking – Birmingham & Black Country – Year ending 31/3/2015

	Total yr ending 31/3/15
Birmingham and Solihull Mental Health NHS Foundation Trust	163
Birmingham Children's Hospital NHS Foundation Trust	121
Birmingham Community Healthcare NHS Trust	225
Birmingham Women's NHS Foundation Trust	140
Black Country Partnership NHS Foundation Trust	137
Dudley and Walsall Mental Health Partnership NHS Trust	94
Heart of England NHS Foundation Trust	1,035
Sandwell and West Birmingham Hospitals NHS Trust	837
The Dudley Group NHS Foundation Trust	313
The Royal Orthopaedic Hospital NHS Foundation Trust	105
The Royal Wolverhampton NHS Trust	365
University Hospitals Birmingham NHS Foundation Trust	792
Walsall Healthcare NHS Trust	379
West Midlands Ambulance Service NHS Foundation Trust	522

The above information is from the NHS Litigation Authority

% of complaints received against total hospital activity

ACTIVITY	Total Qtr 2 ending 30/09/14	Total Qtr 3 ending 31/12/14	Total Qtr 4 Ending 31/03/15	TOTAL Year ending 31/03/15	Total Qtr 1 Ending 30/06/15	Total Qtr 2 Ending 30/09/2015
Total patient activity	187,117	184,687	183574	736,510	189260	181895
% Complaints against activity	0.05%	0.03%	0.05%	0.04%	0.03%	0.04%

For information, 1664 complements were received in quarter 2 (0.91% of patient activity)

Senior Coroner – Inquest conclusions during Q2

5 Inquests were held and concluded during the quarter and conclusions were –
No 'rule 28' (formerly 'rule 43') – 'Preventing future deaths'

1 – Natural causes
2 – Narrative
2 – Accidental death

Parliamentary & Health Service Ombudsman (PHSO) – Q2

2 new cases were considered for investigation during the quarter.

- one case relates to care and treatment provided in orthopaedic OPD during 2012/3
- one case relating to care a cancer patient received

CLAIMS

During the quarter, 12 claims were closed –

What should be noted is that in 8/12 (67%) of claims that were closed this quarter, no settlement was awarded.

During the quarter, 21 new claims were opened –

We like most other NHS providers are seeing a continued increase in the number of claims being made against them. We will continue to work with the NHS LA to deal with this swiftly and make payments were appropriate.

Enclosure 13

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors 5th November 2015

TITLE:	**Nurse and Midwife Revalidation**		
AUTHOR:	D Eaves, Quality Manager	**PRESENTER:**	D Wardell, Chief Nurse

CORPORATE OBJECTIVE:

SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.
SGO2: Patient experience - To provide the best possible patient experience
SGO5: Staff Commitment - To create a high commitment culture from our staff with positive morale and a "can do" attitude
SGO6: Enabling Objectives - To deliver an infrastructure that supports delivery

SUMMARY OF KEY ISSUES:

The Nursing and Midwifery Council (NMC) has now decided in early October the final system for revalidation that will commence in April 2016.

Following the first paper to the Board of Directors in May which outlined the published proposals at the time, this paper outlines the changes that have now been made for the final system.

In more detail, the paper describes the work being done to support nurses and midwives at the Trust to ensure that they comply with the revalidation requirements.

IMPLICATIONS OF PAPER:

RISK			**Risk Description: Nurse/Midwife Revalidation**
	Risk Register		**Risk Score: 20**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details**:
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:**
	Equality Assured:	**Y**	**Details:**
	Other	**Y**	**Details**: NMC Statutory Requirement

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to consider the work being undertaken and to make any suggestions that are thought appropriate to the support to nurse/midwives that already being given.

THE DUDLEY GROUP NHS FOUNDATION TRUST

NURSE/MIDWIFE REVALIDATION

Introduction

Following pilot sites in early 2015, the NMC finally announced at the beginning of October the definitive revalidation system that will commence in April 2016 for those nurses/midwives who are due that month to declare their regular compliance with PREP (post registration education and practice) requirements. The Trust has been preparing for its introduction since early in the financial year, based on the draft NMC information of what it initially thought the system would entail. It launched 'Revalidation' awareness on May 5th International Midwives day and on May 12th International Nurses Day when representatives of the RCN (Royal College of Nursing) were present. The recent announcement is that the final system is generally the same as that in the initial draft information except for three new or clarified key issues:

- The requirement for continuous practice development has been reduced from 40 to 35 hours
- A number of the evidence forms are now mandatory
- Applications for revalidation have to be undertaken by the first of the month that revalidation is due (not the date of renewal which is the end of the month).

Actions taken at the Trust

The following actions have been taken:

1. An active co-ordinating group has been meeting regularly to assess any information coming from the centre, publicise this across the Trust and undertake awareness sessions for all Trust staff to which CCG and some nursing home nurses have been invited. A representative also attends the West Midlands Revalidation Group.
2. Commenced a page on the Hub on revalidation and published this in the news section of the Hub. Front page screenshot below:

3. All documents on the Hub have been updated to take into consideration the new final requirements
4. Risk assessment undertaken and added to the risk register
5. A rolling programme of hourly open invite awareness sessions every week has been occurring. These have been scheduled up to the end of January 2016. Nurses from the CCG invited to these via the CCG Chief Nurse
6. Amended the nursing appraisal documents to cover revalidation requirements
7. Developed a template portfolio outline that all nurses can use
8. Two side A4 'Your Guide to Revalidation' produced
9. One side A4 flowchart outlining the timetable for an individual nurse revalidation
10. Contacted senior managers of all areas outside the Nursing Division about the need for confirmers of evidence to be arranged and that senior nurses within the Nursing Division can act as confirmers for any staff who need that facility
11. All bank staff contacted and offered confirmers for their evidence
12. Identified those staff who will need to revalidate in the first four months and wrote to their confirmers to ensure these staff are aware of their responsibilities
13. Liaised with the Head of Organisational Development who now has a plan to enter the confirmation date and confirmer into ESR/OLM as a 'course' as we do now with courses for mandatory training and appraisal. This means we will then be able to report on expiry dates and completion dates. The plan is to also populate that information in Allocate to allow both individual and manager access. The plan is to test this in the next couple of months with a view to starting reports in January.
14. Provided submission of progress to Monitor.
15. Completed an assessment of the NMC document 'Preparing for revalidation. A guide for employers and organisations'
16. Liaising with Walsall Hospital staff (who have a small resource for the whole of the Black Country) to hold two Saturday sessions at Russells Hall to which all nurses/midwives in the health economy will be invited – provisional dates 28th November and 23rd January.

Actions ongoing/being planned

1. Co-ordinating group to meet monthly and keep uptodate with any national and regional developments and take action when necessary
2. Agree a system of escalation if there is a dispute between the confirmer and nurse
3. Write and agree local policies now the final definitive system is clear
4. Continue the awareness sessions and arrange separate training as necessary
5. Co-operate with Organisational Development/Human Resources staff to develop and use the information technology support system they are developing

Enclosure 14

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5 November 2015

TITLE:	**13 October 2015 (Health Economy) End of Life and Palliative Care Strategy Group Meeting Summary**		
AUTHOR:	Doug Wulff – Committee Chair	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES

SO 1 – Deliver a great patient experience
SO 2 – Safe and caring services

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Group Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
			yes	no
End of Life and Palliative Care Strategy Group	13 October 2015	Doug Wulff	√	

Declarations of Interest Made

Nil

Assurances received

Reports on the individual work streams provided the following assurances:

1 Macmillan Specialist Care at Home – pending a decision regarding continued funding Mary Stevens Hospice is preparing for the recruitment of a Project Manager.
2 Advance Care Planning – assurance provided on completion of key milestones
3 Rapid Discharge – assurance provided on launch of process in September 2015
4 Priorities for Care – assurance on roll out provided, audits in community and hospice to be conducted to measure impact
5 Education – assurance provided on key milestones. Business plan for Education post has been approved.
6 AMBER Care Bundle – assurance provided on progress though concerns raised in respect of sustainability
7 Bereavement – negative assurance as no progress reported
8 Electronic Palliative Care Coordination System (EPaCCS) – negative assurance provided due to lack of progress and concerns regarding choice of system, funding and implementation.
9 End of Life and Palliative Care LIS – assurance provided that audit demonstrates improvement within General Practice
10 Long Term Conditions and End of Life Care – assurance provided of continued focus on Advance Care Planning in Care Homes.

Decisions Made / Items Approved

Terms of reference approved and Deputy Chair appointed. Agreed that Group will report to the Partnership Board.

Actions to come back to Group

Dudley Joint Commissioning Strategy to be reviewed by members and comments to be feedback to Andrew Hindle together with stocktake of

services (spread sheet to be circulated to all members). Report on the Electronic Palliative Care Coordination System (EPaCCS) to be provided to the next meeting and to include estimate of costs, risks and benefits.
Items referred to the Board for decision or action
The issue relating to the costs of the EPaCCS to be brought to the attention of the individual members Boards and to the Partnership Board.

The Dudley Group NHS
NHS Foundation Trust

ECONOMY WIDE END OF LIFE AND PALLIATIVE CARE STRATEGY GROUP

TERMS OF REFERENCE

1. Constitution

1.2. The purpose of the Group will be to develop a Health Economy wide End of Life and Palliative Care Strategy and as a point of referral and consideration for issues that may impinge on the patients journey to a good death.

2. Membership

Non Executive Director (Dudley Group NHSFT) - Chair
Chief Nurse (Dudley Group NHSFT)
Palliative Medicine Consultant (Dudley Group NHSFT)
Clinical Executive for Integration & Partnerships (Dudley CCG)
Chief Quality & Nursing Officer (Dudley CCG)
Lay Member
Clinical Lead End of Life & Cancer (Dudley CCG)
Commissioner for Integration (Dudley CCG)
Chief Executive Officer (Mary Stevens Hospice)
Associate Director of Adult Social Services (Dudley Metropolitan Borough Council)

If a member is unable to attend a deputy should attend on their behalf.

Deputy chair to be agreed by the Chair based on nomination from the Group

3. Attendance

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

3.3 Dudley Group NHSFT will ensure that an efficient secretariat service is provided to the Group.

4. Quorum

4.1 A quorum shall be 75% of the membership.

If a member is unable to attend a deputy should attend on their behalf.

5. Frequency of meetings

1.1. The End of Life and Palliative Care Strategy Group will meet quarterly

.

5.2 Additional meetings may be held at the discretion of the Chairman of the Group

6. Authority

6.1 The Group is authorised by each constituent or ganisation to investigate any activit y within its terms of reference only.

7. Duties

The duties of the Group can be categorised as follows:

7.1 To develop a strategy for End of Life and Palliative Care services for the borough.

7.2 To inform relevant national guidance for local implementation

7.3 To set priorities in order to deliver the strategy

7.4 To oversee the delivery of the priorities through updates from workstream leads.

7.5 To agree key performance indicators and appropriate outcome measures

7.6 To commission and receive audits to inform future priorities

7.7 To escalation areas of concern to the Partnership Board and individual organisation's governance structure.

8. Reporting

8.1 The End of Life and P alliative Care Strategy Group will report to the Partnership Board and to each constitute org anisation's governance structure. The following working groups report to the End of Life and Palliative Care Strategy Group.

- End of Life Care Plan
- AMBER
- EPaCCS
- Rapid Discharge Home to Die
- Advance Care Planning
- Macmillan Specialist Care at Home Pilot
- End of Life Education
- Bereavement

9. Review

9.1 The Terms of Reference shall be reviewed b y the End of Life and Palliative Care Strategy Group at least annually.

Enclosure 16

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th November 2015

TITLE:	Transformation and Cost Improvement Programme (CIP) Summary Report – September 2015		
AUTHOR:	Alex Claybrook Interim Head of Service Improvement and Programme Management	**PRESENTER**	Paul Taylor Director of Finance

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

The Trust has achieved £8.55m CIP against a year to date plan of £8.11m. However, the Trust is forecasting to achieve £16.13m against a full plan of £16.70m.

Transformation Executive Committee (TEC) met on 22nd October to:

- Review overall CIP delivery status and progress.
- Scrutinise Exception Reports and identify any further mitigating actions for any projects off plan.

The current CIP plan consists of 64 projects (35 in 2015/16 and 29 in 2016/17), of which 39 have been approved by TEC (33 in 2015/16 and six in 2016/17). TEC requested all outstanding 2015/16 PIDs and Project Briefs for 2016/17 are presented at the November TEC meeting.

A number of mechanisms are being used to identify additional schemes for 2016/17 and beyond including service improvement workshops and a survey to all colleagues in the Trust.

In addition, discussion has begun regarding the Transformation and CIP opportunities arising from improved services and processes supported by the new IT systems.

This will provide major opportunity for 2017/18 and beyond. TEC will be debating this further in December when the current IT scoping exercise is completed.

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

RISK	**Y**	**Risk Description:** ST001 – Capability to deliver the Programme of work ST002 – Delivery of the Programme negatively impacting on Quality of Care or Patient Experience Capacity to deliver Programme of work

	Risk Register: Y		**Risk Score:** 12, 12, 16 (respectively)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details: (*Please select from the list on the reverse of sheet)***
	Monitor	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE
Note progress during September, delivery of CIP to date and the current forecast outturn proposal.

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COMMITTEE

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

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

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

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

The Dudley Group NHS
NHS Foundation Trust

Trust Board of Directors

Service Transformation and PMO Update

5th November 2015

Executive Summary

The Trust has an overall Cost Improvement Programme (CIP) target of £16,701k in 2015/16. To support this, the Trust has developed 35 projects to deliver savings in 2015/16. The Trust has identified provisional plans for 2016/17, made up of 29 projects which are forecasted to achieve £12,400k CIP savings.

The projects have been split into four ambitious programmes to deliver the changes and benefits required. These programmes are:

- Value for Money
- Delivering Efficiency & Productivity
- Keeping People Closer to Home
- Workforce

Transformation Executive Committee (TEC) met on 22nd October 2015 to review the current CIP status. A summary of CIP performance as at Month 6 is provided below (with the programme detail provided overleaf):

CIP Project Plans	Full Year Plan	YTD Plan	YTD Actual	YTD Variance	Y/E FOT	Y/E FOT Variance
TOTAL	£16,701k	£8,105k	£8,550k	£445k	£16,126k	-£575k

Based on the month six position, the Trust has achieved 51% of the full year plan and is **£445k** ahead of year to date plan. However, to date the Trust is forecasting under performance of **£575k** against the **£16,701k** CIP plan. TEC reviewed all projects for performance against planned delivery and agreed mitigations for the shortfall that will be reported next month.

Of the 35 projects due to deliver savings in 2015/16, 33 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC). Of which, 27 projects have been approved at a Quality Impact Assessment (QIA) panel, with the remaining 6 projects scheduled for a QIA panel in November.

The Trust has identified 29 projects for delivery in 2016/17. Of these, 6 have been approved by TEC, of which 5 projects have been approved at a QIA panel, with the remaining scheduled for a QIA panel in November.

Executive Summary

Figures reported in £000's

	Planned	Actual	Forecast	Variance
FYE	£16,701	£8,550	£16,126	-£575
YTD	£8,105	£8,550	£8,550	£445

Exec Lead : Paul Taylor			Click for Details
Planned Recurrent	£3,357	Planned Non Recurrent	£645
Forecast Recurrent	£4,409	Forecast Non Recurrent	£645

Value for money Infrastructure

	Planned	Actual	Forecast	Variance against Plan
FYE	£4,002	£2,632	£5,054	£1,052
YTD	£2,001	£2,632	£2,632	£631

Exec Lead : Anne Baines			Click for Details
Planned Recurrent	£0	Planned Non Recurrent	£0
Forecast Recurrent	£0	Forecast Non Recurrent	£0

Keeping People Closer to Home

	Planned	Actual	Forecast	Variance against Plan
FYE	£0	£7	£28	£28
YTD	£0	£7	£7	£7

Exec Lead : Paul Bytheway			Click for Details
Planned Recurrent	£2,873	Planned Non Recurrent	£300
Forecast Recurrent	£3,301	Forecast Non Recurrent	£300

Delivering Efficiency and Productivity

	Planned	Actual	Forecast	Variance against Plan
FYE	£3,173	£2,082	£3,626	£454
YTD	£1,509	£2,082	£2,082	£573

Exec Lead : Julie Bacon			Click for Details
Planned Recurrent	£9,331	Planned Non Recurrent	£125
Forecast Recurrent	£7,356	Forecast Non Recurrent	£63

Workforce

	Planned	Actual	Forecast	Variance against Plan
FYE	£9,526	£3,829	£7,418	-£2,108
YTD	£4,596	£3,829	£3,829	-£766

2015/16 Forecast Non Recurrent	£1,007k	% of Total CIP Forecast as Non Recurrent	6.25%

Enclosure 17

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th November 2015

TITLE:	**Operational Plan 2015/16** **Q2 progress against the annual goals**		
AUTHOR:	Karen Morrey	**PRESENTER**	Anne Baines Director of Strategy & Performance

CORPORATE OBJECTIVE: All

SUMMARY OF KEY ISSUES:

The attached table identifies the progress against the annual goals identified in this year's Operational Plan.

Strategic Objective	RAG rating		
	Red	Amber	Green
Deliver a Great patient experience	1		5
Deliver safe and caring services	2	2	10
Drive service improvement, innovation and transformation		4	3
Be the place people choose to work		1	4
Make the best use of what we have		2	3
Plan for a viable future		2	2
Total			

Where there is slippage identified the lead Executive has outlined the mitigating actions being undertaken.

There are three red rated actions:

- one in Delivering a Great Patient Experience; there is slippage in delivering cancer waits in Urology, because of long waits for surgery at RWHT.
- two relate to delivery of quality improvements, MRSA & C Diff. We will not achieve the MRSA target and are unlikely to achieve the year end target for C Diff. The Chief Nurse has requested increased focus from the clinical teams so that the position does not deteriorate further.

A further review will be carried out at the end of Q3.

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

RISK	**N**		**Risk Description:**
	Risk Register:		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** All
	Monitor	**Y**	**Details:** Operational Plan is submitted to & approved by Monitor

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	x	x	

RECOMMENDATIONS FOR THE BOARD:

- The progress against each of the goals is noted
- Assurance that remedial actions are being taken where appropriate

The Dudley Group NHS
NHS Foundation Trust

Operational Plan 2015/16 Q2 Progress against the Annual Goals

Annual Goal	Measures of Achievement	Timescale	Lead	Q2 Performance	RAG	Remedial Action
Deliver a great patient experience						
➢ Achieve good FFT results/patients survey	✓ Monthly scores equal or better than national average	Monthly	Chief Executive	Achieved better than national average for inpatient, A&E and three out of the four areas measured in maternity (antenatal, birth and postnatal ward) Not achieved for Outpatients, community and postnatal maternity.	G	Meeting to be arranged with Director of Operations for each division and working with local managers to address this
➢ Ensure patients, carers and public fully engaged and involved	✓ Improved National Patient Survey results	Annual	Chief Executive	The 2015 survey will sample 1250 patients who were inpatients during July 2015. Task and Finish Group established and developed detailed action plan to improve those areas where we scored less than the national average. Circulated to staff responsible for delivery of actions, themes identified for improvement relating to communication, environment and process. All actions monitored by Patient Experience Group. Provisional survey results for 2015 survey work expected late 2015.	G	
	✓ Demonstrate engagement through feedback	Ongoing		The Trust is employing a range of communication and engagement mechanisms to inform staff and patients of feedback received. Developed enhanced analysis tool and modified report submitted quarterly to the Patient Experience Group, displaying the 'you said, we have' in wards and clinic areas, publishing results of survey feedback to Trust website and in the Your Trust magazine	G	

➢ Achieve key performance standards	✓ 95% emergency access standard ✓ 18 weeks RTT ✓ Cancer treatment standards	Monthly Monthly Monthly	Chief Operating Officer	Achieved Achieved Long waits for Urology patients at RWHT	G G R	 Plan in place for recovery
Deliver safe and caring services						
➢ Deliver quality improvements	✓ Achievement of nursing care indicators ✓ Zero avoidable stage 4 pressure ulcers ✓ Reduction in stage 3 pressure ulcers from 14/15 ✓ Zero post 48 hour MRSA cases ✓ No more than 29 post 48 hour clostridium difficile ✓ Achievement of improvement trajectory in nutritional audit ending year in all wards green (93%)	Quarterly Monthly March 2016 March 2016 March2016 Monthly/March 2016	Chief Nurse	Review of the NCI process identified suboptimal assessment and escalation process No stage 4 pressure ulcers identified On track to achieve, but time lag in assessment impacts on ability to predict numbers accurately No post 48 hour MRSA cases. Two cases in Sept 15 YTD trajectory exceeded by 8 Cases; Annual limit of 29 cases remains unlikely to be achieved. Unavoidable 5/11 cases reviewed to date The overall Trust score is 97% for the target is presently being met some not yet at green but on target to achieve.	A G G R R G	Review of audit tool and escalation. New tool from November. Improve process of review Increase Focus for teams Review of areas in escalation
➢ Deliver agreed CQUIN requirements	✓ Deliver CQUINs schemes	On-going	Director of Strategy & Performance	Slippage on one CQUIN for Q2, value of £56,000. Others on plan, but require final validation	G	
➢ Maintain good mortality performance	✓ SHMI/HSMR within expected range ✓ 85% of in hospital deaths have multidisciplinary review within 12 weeks	On-going On-going	Medical Director	The latest SHMI published for the period April 2014- March 2015 is 1.02 and is within the expected range. The 15/16 target is 90% of deaths to be reviewed, where applicable, within 12 weeks by March 2016 Q2 data is not available in full until 12 weeks after the end of q1 which would be 31/12/2015 but a calculation to date shows that the trust is on target to achieve 90% by March and exceeds last year's target of 85%	G G	

➢ Improved risk management	✓ Reconfiguration of DATIX system	March 2016	Director of Governance	Since the last update Datix has revised their time line on the delivery on version 14 of the system to January 2016. The rebuild commences now in November and pre planning work has been undertaken regarding the mapping of the data base. There is one issue to resolve with Datix about data migration which will impact on the version 14 launch, if data can be migrated then this should be January 2016 but if not then as we do not want to run two systems we may keep the old version for all 14/15 incidents an then move open cases at 31/3/16 to the new system on midnight of the 1/4/16. Training on the new system is planned for Dec working on the assumption that data migration can be undertaken as we see this as a version upgrade rather than a new system. Once the new system is launched then the improved reporting will be delivered thus allowing the Divisions and the Corporate Governance Team to focus on the "learning" from incidents rather than mechanically on the reporting. As a revised implementation date for the new system is now being planned the rating has been moved to Amber.	G	No additional action required
➢ Deliver requirements from key quality inspections	✓ Deliver CQC action plan ✓ Deliver WMQRS action plans	See action plan See action plans	Chief Executive	An update report was taken to the Board in June providing assurance over the progress with the key actions from the previous inspection. Due to service changes after the inspection 2 areas were deemed to still be open to ensure that actions completed following the service redesign did not cut across the CQC initial actions. As WMQRS reviews are undertaken action plans are developed to address any findings. The action plan in relation to the	G G	Closed/Monitored through CQSPE Closed/Monitored through CQSPE

				Day Theatres review was presented to CQSPE and has been shared with the CCG as part of the regular CQR meetings. Progress against the completion of the final actions where the due dates were after the CQSPE and CQR mtg will be reported to subsequent CQSPE meetings.		
➢ Safe staffing levels	✓ Deliver safe staffing levels	Monthly	Chief Nurse	1:8 ratios in place (day) escalation of red areas on capacity brief. New starters September– 30 staff commenced. 64 Vacancies to fill Midwifery 13 new midwives now started 2 posts out to advert. Increase in Midwife to Birth Ratio Systems to deliver compliance with the new Nurse Agency rules are in place. Off-framework usage has been reduced by around 70% to acceptable numbers of individual shifts	A G	Recruitment
Drive service improvement, innovation & transformation						
➢ Develop integrated services and redesigned community provision	✓ Integrated services across acute and community in place ✓ Redesigned community services in line with Vanguard proposals	Dec 2015 March 2016	Director of Strategy and Performance/ Chief Operating Officer	Structure agreed. Appointments underway. 2nd phase being developed in November	G G	
➢ Increase access to 7 day services	✓ 7 day services in place in diagnostics	TBA	Chief Operating Officer	Self assessment submitted 4th September. National position due to be published shortly.	A	Plans for improved compliance to be included within Divisional annual plans
➢ Continued improvement in key services	✓ Improvements in service performance delivered Stroke Renal Care of the Elderly	Review quarterly	Chief Operating Officer	Stroke reconfiguration completed. Good performance against HASU standards. Issue with swallowing assessment Improvements in efficiency. External Advisor embedded within the tea. Renal consultant of the week in place Driving improvement through clinical engagement and Vanguard	A A G	Recovery plan being developed
➢ Expand Research & Development / Academic Health Sciences Network	✓ Demonstrate greater involvement and engagement	Ongoing	Medical Director	Participated in Innovation Adoption benchmarking process. Trust representation on AHSN advisory groups	A	

role						
Be the place people choose to work						
➢ Continued implementation of Listening into action	✓ Regular events in place	June 2015	Chief Executive	Support, guidance and publicity continues to be provided to teams wishing to use the LiA format to improve services. Events held in Q2	G	
➢ Enhance colleague engagement	✓ Improved scores in National staff Survey ✓ Wider engagement developed	Annually Ongoing	Chief Executive Chief Executive	Plans are being developed to improve the score for National Staff Survey. Engagement activities continue, including CE face-to-face briefings, Long Service Awards and launch of Committed to Excellence. Trust's Facebook site launched in Q1 and we are about to launch 'Team of the Week' on Facebook to highlight the work of teams across the Trust and promote their services. Twitter followers steadily increasing (now stands at 1533 followers). Staff Discounts page on the Hub grows in popularity and positive feedback received.	G	
➢ Improve workforce performance in sickness, mandatory training, appraisal	✓ Sickness a target 3.5% ✓ Mandatory training and appraisal target of 90%	Monthly	Chief Executive	Sickness has been below the 3.5% target for two consecutive months. Corporate Division has achieved the 90% mandatory training target. However, overall (as @ September 2015), the Trust figure is 83.16%. The September figure for appraisals is 80.06%.	G A	
➢ Leadership development/OD	✓ To develop the measure in year	Quarterly	Chief Executive	A new middle management programme has been developed which includes coaching and an action learning set. Handling difficult conversations and job planning training for clinical directors has been rolled out.	G	
Make the best use of what we have						
➢ Develop IT Strategy /EPR	✓ Strategy and plan in place	December 2015	Chief Executive	The Trust has engaged Cymbio, (part of Capita Health), to carry out a process review across the hospital to measure the	G	

				effectiveness of Clinical IT. This work started in August 2015 and will complete in October. This output will enable the development of and detailed output Based Specification for upgrade/replacement of clinical systems. An outline Business case will be submitted to the December 2015 Board.		
➢ Match capacity to demand	✓ Initial improvement achieved	Quarterly	Chief Operating Officer	Further work on capacity and demand to meet access targets in cancer services Imaging plan in support of additional MRI & CT capacity is being developed	A	Will be included in annual plan
➢ Deliver financial (recovery) plan	✓ Effective plans in place and monitored ✓ Financial plans delivered in line with plans	Monthly	Director Finance and IT	Financial sustainability plan submitted to Monitor on time – due for review in December 2015	G	
➢ Delivery Monitor financial requirements	✓ Deliver plan i.e. Deficit of £4.2m, rating of 2	Monthly	Director of Finance and IT	Revised fore-cast out-turn of £3.1m forecast at Month 6 – expenditure maintaining steady run rate position but income projections at risk following 3 months lower than target.	G	
➢ Deliver the CIP	✓ Deliver CIP and financial target	Monthly	Director Strategy and Performance	YTD performance over target by £445,000. Current year end forecast shows £575,000 shortfall	A	Mitigation plans in development
Plan for a viable future						
➢ Revise the current 5 year plan	✓ Revised plans in place	June 2015	Director of Strategy and Performance	Completed & submitted to Monitor.	G	Discussion with Monitor on FRP may result in further amendment
➢ Review the Clinical Strategy	✓ Revised plans in place	June 2015 Revised January 2016	Director of Strategy and Performance	Work underway with Medical Director and Chiefs of Surgery & Medicine. The proposed strategy will go to MDTs in November for review		
➢ Develop an economy wide plan with CCG and other providers in Dudley	✓ Play a full part in this work	July 2015	CEO/ Director of Strategy and Performance	Dudley Health Summit planned for 30th November. CCG taking the lead role	A	

➢ Play a part in the development of the Black Country Alliance	✓ Plan and Programme in place across alliance	July 2015	CEO		G	
➢ Dudley Partnership	✓ Vanguard	TBA	CEO/DSP	Vanguard proposal developed. Partnership meeting in place. Process in place. Trust deliverables not yet identified	A	Discussion on the way forward took place at the Board workshop