The Dudley Group
NHS Foundation Trust

Board of Directors
Thursday 3rd May, 2018 at 8.30am
Clinical Education Centre
AGENDA

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		J Ord	To Note	8.30
2.	**Declarations of Interest** Standing declaration to be reviewed against agenda items.		J Ord	To Note	8.30
3.	**Announcements**		J Ord	To Note	8.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 12 April 2018	Enclosure 1	J Ord	To Approve	8.30
	4.2 Action Sheet 12 April 2018	Enclosure 2	J Ord	To Action	8.35
5.	**Patient Story**		L Abbiss	To Note & Discuss	8.40
6.	**Chief Executive's Overview Report**	Enclosure 3	D Wake	To Discuss	8.50
7.	**Safe and Caring**				
	7.1 Clinical Quality, Safety and Patient Experience Committee Exception Report - including overview report on Service Improvement Plan	Enclosure 4 Enclosure 4a	D Wulff	To note assurances & discuss any actions	9.00
	7.2 Infection Prevention and Control Report	Enclosure 5	E Rees	To note assurances & discuss any actions	9.20
	7.3 Nurse/Midwife Staffing Report	Enclosure 6	S Jordan	To note assurances & discuss any actions	9.30
8.	**Responsive and Effective**				
	8.1 Finance and Performance Committee Exception report	Enclosure 7	J Fellows	To note assurances & discuss any actions	9.40
	8.2 Integrated Performance Dashboard	Enclosure 8	K Kelly	To note assurances & discuss any actions	9.50

	8.3 Cost Improvement Programme and Transformation Overview Report	Enclosure 9	N Younes	To note assurances & discuss any actions	10.00
	8.4 Annual Plan	Enclosure 10	N Younes	To note	10.10
	8.5 Q4 Monitoring of 17/18 Annual Plan	Enclosure 11	N Younes	To note assurances & discuss any actions	10.20
	8.5 Patient Experience Quarterly Report	Enclosure 12	S Jordan	To note assurances & discuss any actions	10.30
9.	**Well Led**				
	9.1 Digital Trust Committee Exception Report	Enclosure 13	M Stanton/ A Becke	To note assurances & discuss any actions	10.40
	9.2 Trust Annual Declarations	Enclosure 14	G Palethorpe	To approve	10.50
	9.3 Workforce Committee Exception Report	Enclosure 15	J Atkins	To note assurances & discuss	11.00
10.	**Any other Business**		J Ord		11.10
11.	**Date of Next Board of Directors Meeting** 8.30am 7th June, 2018 Clinical Education Centre		J Ord		11.10
12.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Ord		11.10

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

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 12th April, 2018 at 8.30am in the Clinical Education Centre.

Present:

Jenni Ord, Chairman
Richard Miner, Non Executive Director
Julian Atkins, Non Executive Director
Doug Wulff, Non Executive Director
Julian Hobbs, Interim Medical Director
Karen Kelly, Chief Operating Officer
Tom Jackson, Director of Finance
Siobhan Jordan, Chief Nurse
Ann Becke, Non Executive Director
Jonathan Fellows, Non Executive Director
Richard Welford, Non Executive Director

In Attendance:

Helen Forrester, EA
Andrew McMenemy, Director of HR
Mark Stanton, Chief Information Officer
Liz Abbiss, Head of Communications
Glen Palethorpe, Director of Governance/Board Secretary
Natalie Younes, Director of Strategy and Business Development
Dr Mark Hopkin, Associate Non Executive Director
Jonathan Hodgkin, Non Executive Director
Liz Rees, Director of Infection Prevention and Control (Item 18/045.2)

18/038 Note of Apologies and Welcome
8.35am

Apologies were received from Diane Wake, Chief Executive.

The Chairman welcomed Jonathan Hodgkin and Richard Welford, Non Executive Directors, to their first Board meeting. Three Anaesthetic Registrars, Catherine Holland and Keith Spencer were also in the public gallery and were subsequently joined by Arthur Brown, Governor.

18/039 Declarations of Interest
8.38am

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

There were no other declarations of interest.

18/040 Announcements
8.41am

No announcements to note.

18/041 Minutes of the previous Board meeting held on 8th March, 2018 (Enclosure 1)
8.42am

The minutes were amended as follows:

Top of page 5 to read "It was confirmed that all guidance is considered and more than 80% of food and drink offerings in the Trust conformed to healthy eating guidelines."

Page 8, 3rd paragraph to read "Mr Miner, Non Executive Director, noted that currently all mortality indices seemed to be within the expected range and he asked for assurance that there was nothing for the Board to be concerned about."

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

18/042 Action Sheet, 8th March, 2018 (Enclosure 2)
8.45am

18/042.1 Patient Experience Report

The Chairman had discussed with Jill Faulkner, Patient Experience Manager, the requirements of the report, so this item was agreed to be closed

18/042.2 Quality Priority Targets

The Grade 3 Pressure Ulcer target now included a percentage reduction. The Chairman asked what the percentage was. It was suggested that the reduction was by 10% and this would be confirmed to the Board.

Grade 3 Pressure Ulcer percentage reduction figure to be confirmed to the Board.

On the basis of the update provided in the report the action progress and closure were noted or agreed.

18/043 Staff Story
8.50am

The Head of Communications presented the staff story which was from three members of staff who work in a Multi-Disciplinary Team on Ward C8.

The story was very positive and the Team had recently been presented with a Healthcare Heroes Award.

The meeting was joined by two members of the team and the Chairman acknowledged their contribution.

Mr Atkins, Non Executive Director, commented that it was impressive to see a desire and passion to continually improve good performance.

Dr Hopkin congratulated the team from a GP perspective. He asked about lessons learnt and whether their approach could be replicated on other wards. The Medical Director stated that the key differentiators are local leadership and ownership of the service. Dr Hopkin commented that he was pleased to see that within the story that staff were focused on doing what is right for the patient.

The Chief Nurse stated that the multi-disciplinary team approach on the ward was outstanding.

The Chairman agreed that all staff have a part to play, and it was pleasing to note the clinical leadership and involvement in their area and service.

The Chairman and Board commended their work and asked that other ward colleagues were thanked and that the Board's comments were communicated to the team.

Ward C8 MDT to be thanked and have the Board's comments communicated to them.

18/044 Chief Executive's Overview Report (Enclosure 3)
9.09am

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

- NHS Lean Programme: The Trust had been accepted on this 3 year programme which will help the Trust develop its lean methodology and support enhanced local service leadership skills.

- Capacity Champions: Wards B4 and C5 had received awards for this new initiative seeking to drive improved discharge management across the wards.

- Neon 5k Colour Dash: This charity run is taking place on 10th June, 2018 and the Trust hopes to see the public and staff support the event.

Mr Miner, Non Executive Director, asked about staff engagement with Digital Trust project. The Chief Information Officer confirmed that a lot of energy had been put into staff engagement and the Chief Nurse was lead sponsor for E.Obs phase of the project. The Trust is monitoring the target for E.Obs training closely and was aiming for a high percentage completion rate by go live.

Mrs Becke, Non Executive Director, confirmed that she was pleased to see the launch of "My Letters". The Chief Information Officer commented that this was just one more step along a journey of improved contact channels with patients and the Trust is moving to the development of a patient portal .

Mr Atkins, Non Executive Director, asked about the Red to Green initiative. The Chief Operating Officer confirmed that it was not fully operational within the organisation and the Trust was looking at undertaking a full launch in May.

Dr Hopkin, Associate Non Executive Director, asked if readmissions were monitored. The Chief Operating Officer confirmed that these were monitored every day. The Medical Director commented that this was discussed at the last Clinical Leads meetings and the Trust always looks at its readmission rates albeit there are no significant issues to report.

The Chairman and Board noted the report

Full launch of Red to Green at the Trust to take place in May 2018.

18/045 Safe and Caring

18/045.1 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 4)
9.18am

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

The Board were asked to note the following key areas from the Committee meeting:

- There had been issues around the transfer of patients between the Trust and specialist service delivered elsewhere, especially Neuro-Surgery. The Committee was pleased to note the improvements in respect of the NORSE pathway for neurosurgical emergencies.

- The Board was asked to note that the Committee had requested improved attendance from the Medical Division at the Committee.

- The Committee had referred a request for the data quality audits to be undertaken by Internal Audit on the Trust's quality measures and metrics to the Audit Committee.

- The Board was asked to endorse the decision to not change the Terms of Reference for the year ahead following the annual review undertaken by the Committee.

Mr Atkins, Non Executive Director, highlighted a typographical error on page 7 where Caesarean Section had been spelt incorrectly.

The Chairman asked how the Trust tests delivery of quality priorities, especially pressure ulcer rates. Dr Wulff confirmed that the Committee had asked for clear assurances. The Chief Nurse confirmed that a number of actions had been taken and the Trust had not had a Grade 4 pressure ulcer reported for nearly 3 months. A review panel meeting is held for every single Grade 4 Pressure Ulcer occurrence.

The Chairman and Board noted the report, assurances received and items to come back to the Committee. The Board recognised that the Terms of Reference were still extant. The Medical Director to ensure that the Medical Division improve their attendance at the Committee and the Board noted that the Audit Committee will consider the Clinical Quality, Safety, Patient Experience Committee request for an internal audit on the validity of quality metrics.

The Chief Operating Officer to ensure appropriate representation from the Medical Division at Committee meetings.

18/045.2 Infection Prevention and Control Update (Enclosure 5)
9.25am

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

There had been 17 C.Diff avoidable lapses of care to date against a target of 29 cases. Whilst there had been a further 2 cases reported in March it would result in the Trust meeting its target for the year.

There had been no post 48 hour MRSA cases.

The Trust was improving its compliance against the Code of Practice (The Health and Social Care Act 2008).

In relation to the NHSI action plan, there had been a further visit by Dr Adams on 20th March, and she had given some very encouraging feedback. There were some actions to still complete. A number of new issues had arisen connected to her visit to the Neonatal Unit and these were now recorded in the Improvement Plan.

Training performance was still currently noted to be green on the dashboard as it currently tracks against the 3 year requirement. The Trust needs to train 1,700 staff in year to move to an annual performance measure. Dr Adams view was it would take approximately 12 months to become compliant with this new measure. The areas with high numbers and large staff groups willl be targeted first to progress this move. Daily sessions will also be offered for a period of 2 weeks to maintain the momentum for change. Those who have not been trained will receive weekly reminder emails to book onto a training event. The Trust was looking to provide a “one click” entry system to online training to make the programme more easily accessible to staff.

The Chairman asked about PFI partner staff. The Board were told that the PFI partner staff have similar training for their roles. The Director of Human Resources commented that PFI partners should have reported KPIs for their staff that were consistent with our own.

The Chairman raised the annual compliance statement and advised of the need for evidence in support. The Director of Infection Prevention and Control confirmed that the Trust should be in a position to declare compliance at the next Board meeting.

Mr Atkins, Non Executive Director, stated that he would like to see the total number of staff that require training and the percentage trained by area. The Director of Human Resources stated that we need to look at stepped compliance and areas of high risk when considering the training numbers.

The Chief Nurse asked for an update on the Isolation Pod for Critical Care. The Director of Infection and Prevention and Control confirmed that the Business Case had been completed and was progressing.

The Chairman and Board noted the report and the work being undertaken to support training compliance.

Total number of staff requiring training and percentage trained by area to be included in the next report and for this to include reference to PFI partner staff groups.

18/045.3 CQC Improvement Plan
9.42am

The Director of Governance/Board Secretary presented the live CQC Improvement Plan.

The Board were provided with an overview of the key elements of the action plan.

Dr Wulff, Non Executive Director, confirmed that actions are also discussed at the Clinical Quality Safety and Patient Experience Committee.

Richard Welford, Non Executive Director, asked about assurance on progress. The Director of Governance/Board Secretary explained how the evidence on the action plan was gathered and reported. The Chairman advised that there had been a request for an overview dashboard; this was under development. She also confirmed that the live action plan was available on the Directors shared drive. The Director of Governance/Board Secretary agreed to ensure all Board members have access to this.

The Chief Operating Officer confirmed that the CQC report should be published on Wednesday, 18th April, 2018.

CQC Improvement Plan Overview Dashboard to be produced for the next reporting cycle to CQSPE Committee and the Board.

Director of Governance/Board Secretary to confirm that all Board members have access to the Directors shared drive.

18/045.4 Monthly Nurse/Midwife Staffing Report (Enclosure 6)
9.55am

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

The Board noted the following key issues:

- The Trust was continuing to achieve its set safe staffing levels.
- The Trust is committed to recruitment and retention of substantive staff so that it can address reliance on Agency staff.

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The Chief Nurse confirmed that the findings from Internal Audit had been extremely helpful in the Trust's review of its staffing systems and processes.

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

18/045.5 Nurse Revalidation Report (Enclosure 7)
9.58am

The Chief Nurse presented the Nurse Revalidation Report given as Enclosure 7 for information.

Dr Wulff, Non Executive Director, asked about percentages of staff completing the process. The Chief Nurse confirmed that she was assured that all appropriate staff had engaged with the revalidation requirement.

The Chairman confirmed that she would also like to see numbers included in future reports and some detail around the quality of evidence relied upon for revalidation.

The Chairman and Board noted the report.

Further detail around numbers and quality of evidence relied upon for revalidation to be included in future reports.

18/046 Responsive and Effective

18/046.1 Finance and Performance Committee Exception Report (Enclosure 8) 10.03am

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

The Board noted the following key issues, in respect of the Trust's performance for February 2018:

- The 2017/18 forecast outturn position was £10.1M at the end of February.
- The forecast for the Trust is a £10.5M deficit for the end of year.
- The 2018/19 revenue and capital budgets were presented to the Committee
- The Trust had accepted its £4.5M control total, but recognised the significant risks and challenge associated with its delivery.
- A stretch CIP target had been set at £25M to achieve the control total.
- The Terms of Reference for the Committee will remain as the year before following their review by the Committee.
- For the year ahead the Committee will focus on the Trust's delivery of its established plans to ensure the future sustainability of the Trust.

The Chairman and Board noted the report and endorsed the approach of the Committee in terms of oversight of the CIP delivery for 2018/19. The Board noted the forecast outturn position, approval of revenue and capital budgets, the Terms of Reference remaining extant following the positive review of Committee's performance and gave delegated authority to the Committee to sign off the Annual Financial Plan submission on behalf of the Board at its April meeting.

The Board gave delegated authority to the Finance and Performance Committee to sign off the Annual Financial Plan submission on its behalf.

18/046.2 Integrated Performance Report (Enclosure 9)
10.11am

The Chief Operating Officer presented the Integrated Performance Report given as Enclosure 9.

The Board noted the following key issues in respect of the Trust's performance for February 2018:

- Emergency Access: The Trust had ended the year at 87% which was below the 95% national target and 90% locally agreed target for patients being seen and admitted or discharged within 4 hours. The Trust was still seeing unprecedented levels of demand. The ambulance handover area has been extended to provide a better environment for patients and ambulance turnround times had vastly improved. The Trust was redesigning the Acute Medical Area and reducing the AMU bed base. Acute Physicians were working in ED and this had been very successful. There was still work to be done on reducing breaches overnight. The Board were reminded that the Trust must be achieving 95% performance by the end of March 2019.

- RTT (referral to treatment): The Trust continues to perform well in providing access to services inside the 18 week target.

- DM01 (diagnostics) : The Trust is performing well against this standard

- Cancer: The Trust's performance for these targets is on track for March and the Trust forecasts to achieve the quarter's required performance.

- Out of Area Delays: The Trust is working closely with NHSI and Sandwell Local Authority to address these delayed discharges.

- Workforce and Appraisals: Appraisal rates had fallen in February and were expected to fall again for March. This was anticipated as staff realign their work for the new appraisal window from 1st April, 2018 to the end of June 2018. Dates are booked for over 70% of staff already. A reduction in absence rates was also reported in month.

Mrs Becke, Non Executive Director, asked about night time patient move data and whether this was the same as discharges. The Chief Operating Officer confirmed that the majority of patient moves are from AMU to wards and patients were not routinely discharged after 8pm, but if they are then this would be where it was safe to do so.

The Medical Director highlighted the position regarding the Trust's Standardised Hospital Mortality Index (SHMI). He advised there had been a 20% increase in crude mortality nationally during January, although our SHMI had remained fairly stable A detailed analysis will be included in the next learning from deaths report to Board on the outcome of our review of the quarter's performance.

Dr Hopkin, Associate Non Executive Director, asked why the Trust was seeing so many ambulances. The Chief Operating Officer replied that there were many reasons for this but the review of conveyances had confirmed that the majority of ambulances were Dudley for patients.

The Medical Director confirmed that there is also an issue with the timing of ambulance arrivals and that continued batching of these puts increased pressure on the Trust. The Trust is developing flexible strategies to react to such peaks in ambulance arrivals.

Mr Welford, Non Executive Director, raised the HR dashboard and fill rates not aligning with other reported information and the upwards trend in reported attrition rate. The Director of HR confirmed that the national average turnover rate is around 10.5% and the Trust was performing at just under 9% until recently. The Trust is looking at the reasons for the increase in turnover. The Chairman suggested that turnover rates need further analysis by the Workforce Committee to be assured that the Trust's retention approaches were being maximised.

The Chairman stated that there were some reconciliation issues with some of the data within the report and she would pick this up with the Chief Operating Officer outside of the meeting.

The Chairman and Board noted the report.

Detailed analysis around crude mortality to be included in the next Learning from Deaths report to Board.

Workforce Committee to look at the reasons for increased staff turnover and retention work.

Chairman to discuss reconciliation of data within the integrated performance report with other reported data with the Chief Operating Officer.

18/046.3 Cost Improvement Programme and Transformation Overview Report (Enclosure 10)
10.35am

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

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

- There was an under delivery of £5.19M against the original CIP target of £12.M.

- In 2018/19 the Trust was increasing the target to account for programme slippage to a CIP totalling some £25M with a view to achieving a CIP of £20.8M. The main reasons for slippage included the lack of delivery against the reduction in nursing bank and agency spend and the medical bank and agency spend. There was also under achievement of the forecast surgery contract income growth. Some slippage had been unavoidable but lessons have been built in to the plans for 2018/19.

Mr Hodgkin, Non Executive Director, asked if this year's slippage was included in next year's plans. The Director of Strategy and Business Development explained that this year's programme has been built up from realistic Divisional plans rather than just a crude roll over from last year. A Financial Improvement Lead had been appointed and will assist the Trust in driving the delivery of its plans. Mr Hodgkin asked about the key lessons learnt from last year's under performance. The Director of Strategy and Business Development stated that it was too early to confirm these. The Chairman asked for detail on lessons learnt and actions taken to mitigate their reoccurrence to be included in the next report to the Board.

The Chief Operating Officer stated that the Divisions have to have tight control on all schemes. Mr Welford, Non Executive Director, asked if Divisions were being held to account. The Chief Operating Officer confirmed that they were held accountable. Mr Welford voiced caution around the narrative used within the Trust regarding such large CIP targets. It was important that such a large target should be broken down into achievable milestones. This would help reduce the impression that the target was unachievable.

The Chairman and Board noted the report and recognised the under delivery in CIP in 2017/18 and the engagement work being undertaken in relation to this year's delivery. Key lessons learnt to be included in the next report to Board to enhance the Trust's likelihood of delivery of the 2018/19 target.

Detail on key lessons learnt to be included in the next report to Board to enhance the Trust's likelihood of delivery of the 2018/19 target.

18/046.4 Annual Plan (Enclosure 11)
10.45am

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

The Director of Strategy and Business Development informed the Board that some of the graphics needed to be changed, along with the Quality Priorities as part of the finalisation of the document.

The Chairman stated that the Board recognised that the report was draft but in order for it to be submitted she asked that the text be thoroughly reviewed to improve its flow, remove those areas of repetition and that the text reflect the full picture of Trust activity and agreed goals, where gaps still existed.

Mr Welford, Non Executive Director, made some observations about consistency of the contents and whether two of the main strategic objectives should be brought together. Mr Hodgkin, Non Executive Director, commented that the main document was about what the Trust was going to do and not how it would achieve it.

There was a need for the text to bridge for the readers on how the actions within the detailed appendix will be achieved and how the public will know this has occurred. Mrs Becke, Non Executive Director, wished to know who the intended audience was. She was also concerned about using the Dudley CCG population number rather than that of the wider catchment area.

Mr Atkins, Non Executive Director, asked about page 21 and the reduction in elective income. The Director of Strategy and Business Development confirmed that she would check the figure.

The Chairman suggested that Mr Hodgkin and Mr Welford assist with the re-working of the document.

The Chairman noted that final plans had to be presented to NHS Improvement before the next Board meeting and therefore would be recommending that the Board delegate the final sign off to the Finance and Performance Committee scheduled for 26th April, 2016.

The Chief Operating Officer agreed that the required work would be completed to allow its final review before submission to NHS Improvement

The Chairman and Board agreed the need for re-work and re-styling and that the revised document would be considered by the Finance and Performance Committee. The Board would receive the final agreed version for endorsement on 3rd May, 2018.

Mr Hodgkin and Mr Welford to support the Director of Strategy and Business Development with the re-working of the Plan.

The Director of Strategy and Business Development to check the information in relation to the reduction in elective income.

Plan to the presented to the April Finance and Performance Committee for final sign and off and then presented back to the May Board.

18/046.5 Audit Committee Exception Report (Enclosure 12)
10.53am

Mr Miner, Committee Chair, presented the Audit Committee Exception Report given as Enclosure 12.

Mr Miner advised the Board that there were a number of outstanding internal audit reports that require management input to support their closure.

The Head of Internal Audit draft opinion for the business year will be impacted if reports were not cleared. This had the potential to distract from the key message that the Trust has, generally, a sound system of control.

At the last meeting the Committee agreed to continue to review the Board Assurance Framework to drive their assurance programme including oversight of risks.

The Committee had reviewed the Board Assurance Framework and agreed it reflected the Trust's current position and should be reported to the Board. This was a separate agenda item later at this meeting.

The Audit Committee has a scheduled meeting on 22nd May, 2018, to consider the Trust's Accounts and associated Reports and asked for delegated authority from the Board to approve these at this meeting. External Auditors reports would support the Committee.

The Chairman and Board noted the report and the Board approved delegated powers to the Audit Committee to approve the Accounts and associated reports at its meeting on 22nd May, 2018.

Board gave delegated authority to the Audit Committee to approve the Accounts at its meeting on 22nd May, 2018.

18/047 Well Lead

18/047.1 Digital Trust Committee Report (Enclosure 13)
10.56am

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

The Board noted the following key highlights from the report:

- The roll-out of E.Obs for the EPR project go live date of 26th April, 2018, was agreed and this will cover ED.

- There were two 'go live blockers' in relation to product defects but these should be rectified by the 26th April, 2018, although close monitoring of the situation would be maintained. The remainder of the roll-out remains scheduled as previously for June and October, 2018.

The Board noted that a lot of effort had been put into staff engagement as discussed previously and the Trust continues to check clinical safety requirements as part of each of its internal checkpoints.

The Chairman asked about e-Obs and its linkage to the CQC's findings. The Chief Information Officer confirmed that the EPR , which would include e-Obs could not go live if the two issues were not resolved but confirmed that the supplier and local team were very focused on providing a solution.

The Chairman requested that Board members are kept informed of the situation by email, including a full analysis of the position if the risks to the 26 April crystalise.

The Medical Director stated that if go live does not happen the Trust will have to deliver another interim solution regarding the Trust's clinical observation tool. The Chief Information Officer confirmed that if the product is not ready it will only mean a very minimal delay and all efforts were being made to deliver on the planned date and thus negate the need for further interim solutions to be developed.

The Chief Information Officer also updated the Board that free patient wi-fi had been launched and he would speak to the Head of Communications regarding communicating the full launch.

The Chairman and Board noted the report and the position regarding go live.

The Chief Information Officer to keep Board members updated on go live by email including a full analysis of the situation.

The Chief Information Officer to discuss communicating the launch of free wi-fi with the Head of Communications.

18/047.2 Board Assurance Framework Report (Enclosure 14)
11.07am

The Director of Governance/Board Secretary presented the Board Assurance Framework (BAF) Report, given as Enclosure 14.

The Board noted the following key highlights:

- The BAF is used to support the published annual governance statement for the year ending 31 March 2018

- There will be a revised BAF structure which is to be presented at the Board Workshop in May, which will give more detail on the controls and mitigation actions being taken in respect of the BAF risks per objective

- The revised BAF Risks will be more transparently linked back to the annual plan goals.

- The BAF is kept under review by the Audit Committee and Executive led Risk and Assurance Group.

The Chairman asked about risks around compliance with new alerts and policies and procedures. The Director of Governance/Board Secretary confirmed those risks and the required actions to address them does appear on the new BAF.

The Chairman asked for assurance that the Audit Committee considers emerging or increasing risks and that there is a process for ensuring they can flow to the corporate risk register and/or BAF. Mr Miner, Committee Chair, confirmed that such assurance would be seen from the Audit Committee minutes. Mr Miner also reminded the Board that each Board Committee sees relevant corporate and BAF risks they have oversight of and this approach should also result in the identification of new or missing risks.

The Director of Governance/Board Secretary confirmed that the Audit Committee also receive all high risks on the Corporate and Divisional Risk Registers allowing them to make similar judgements.

The Chairman and Board noted the report and the work in progress to further develop the BAF for 2018/19.

Revised BAF structure to the presented at the Board Workshop in May.

18/047.3 Charitable Funds Committee Report (Enclosure 15)
11.15am

Mr Atkins, Committee Chair, presented the Charitable Funds Committee Report given as Enclosure 15.

The Board noted the following key highlights:

- The Committee were pleased to note the donation from the Goodyear Fund.
- The total Fund stands at £2.4M.
- Two bids were presented, one of which was approved and one required further information.

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

18/047.4 Fit and Proper Persons Requirement Report (Enclosure 16)
11.16am

The Director of Human Resources presented the Fit and Proper Persons Requirement Report given as Enclosure 16.

The Director of HR confirmed that Mr Welford and Mr Hodgkin, new Non Executive Directors, were also included in the process and had been assessed as meeting requirements but as this report was to the period of 31 March 2018 they would now be included in the next report.

Mr Miner, Non Executive Director, asked about professional registration. The Director of Governance/Board Secretary confirmed that the table recorded this where it was a requirement of the role. It was not a record of all members' qualifications.

The Chairman and Board accepted the report and received assurance that the annual check had been undertaken.

18/048 Any Other Business
11:18am

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

18/049 Date of Next Meeting
11:18am

The next Board meeting will be held on Thursday, 3rd May, 2018, at 9.00am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 12 April 2018

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
17/117	Patient Story	Follow up to the patient story to be presented to the Board.	LA	7/6/18	To June Board.
18/029.8	Action Sheet	Board members perspective of the 6Cs to be presented to the Board in May. Update on Theatre scheduling to be presented to the Clinical Quality, Safety, Patient Experience Committee.	LA KK	5/7/18 24/4/18	To July Board. Presentation from the Surgeryl has been arranged.
18/034.1	Finance and Performance Committee Exception Report	Paper to be presented to the Workforce Committee and then Board showing the actions being taken in respect of the utilisation and retention of staff.	SJ	24/4/18	Done
18/035.2	Staff Survey Report	Staff Survey action plan to be presented to the Workforce Committee and Board.	JA	24/4/18 & 3/5/18	Done To July Board.
18/045.3	CQC Improvement Plan	CQC Improvement Plan Overview Dashboard to be produced for the next reporting cycle to CQSPE and the Board. Director of Governance/Board Secretary to confirm that all Board members have access to the Directors shared drive.	GP GP	24/4/18 & 3/5/18 3/5/18	On Agenda All Board members, including new NEDs have access to the drive.
18/046.2	Integrated Performance Report	Detailed analysis around crude mortality to be included in the next Leaning from Deaths Report to Board. Workforce Committee to look at the reasons for increased staff turnover and retention work.	JH JA	7/6/18 24/4/18	To June Board. Done and back to June Workforce Committee.

		Chairman to discuss reconciliation of data within the Integrated Performance Report with other reported data with the Chief Operating Officer.	C	3/5/18	Chair discussed with Chief Operating Officer. Report presented at Executive Director Team meeting and required changes being made.
18/046.1	Finance and Performance Committee	The Board gave delegated authority to the Finance and Performance Committee to sign off the Annual Financial Plan submission on its behalf.	JF	26/4/18	On Agenda
18/046.4	Annual Plan	Mr Hodgkin and Mr Welford to support the Director of Strategy and Business Development with the re-working of the Plan.	JH/RW/NY	18/4/18	Done
		The Director of Strategy and Business Development to check the information in relation to the reduction in elective income.	NY	3/5/18	Elective cases are planned to decrease as the Trust plans to convert elective activity into day case activity. Outpatient follow up and emergency activity will decrease as a result of a change in coding. The figures are provisional pending the completion of planning for 2018/19.
		Plan to be presented to the April Finance and Performance Committee for final sign off and then presented back to the May Board.	NY	26/4/18 & 3/5/18	On Agenda
18/042.2	Quality Priority Targets	Grade 3 Pressure Ulcer percentage reduction figure to be confirmed to the Board.	SJ	3/5/18	
18/043	Staff Story	Ward C8 MDT to be thanked and have the Board's comments circulated to them.	LA	3/5/18	Done
18/046.3	Cost Improvement Programme and Transformation Overview	Detail on key lessons learnt to be included in the next report to Board to enhance the Trust's likelihood of delivery of the 2018/19 target.	NY	3/5/18	On Agenda

18/047.1	Digital Trust Committee	The Chief Information Officer to keep Board members updated on go live by email including a full analysis of the situation. The Chief Information Officer to discuss communicating the launch of the free wi-fi with the Head of Communications.	MS MS/LA	26/4/18 3/5/18	Done Done
18/044	Chief Executive's Report	Full launch of Red to Green at Trust to take place in May 2018.	KK	May 18	Deputy Director of Operations to lead on Red to Green in July.
18/045.1	Clinical Quality, Safety, Patient Experience Committee	The Chief Operating Officer to ensure appropriate representation from the Medical Division at Committee meetings.	KK	3/5/18	Done
18/045.2	Infection Prevention and Control	Total number of staff requiring training and percentage trained by area to be included in the next report and for this to include PFI partner staff groups.	ER	3/5/18	On Agenda
18/047.2	Board Assurance Framework	Revised BAF structure to be presented at the Board Workshop in May.	GP	10/5/18	On Board Workshop Agenda
18/046.5	Audit Committee Exception Report	Board gave delegated authority to the Audit Committee to approve the Accounts at its meeting on 22nd May, 2018.	RM	22/5/18	On Audit Committee Agenda
18/033.5	Learning from Deaths Report	NHSI Mortality Dashboard to be included in the next Learning from Deaths report to Board.	JH	7/6/18	To June Board.
18/045.5	Nurse Revalidation Report	Further detail around numbers and quality of evidence relied upon for revalidation to be included in future reports.	SJ	5/7/18	To July Board.

Enclosure 3

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd May 2018

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

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

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

SUMMARY OF KEY ISSUES:

- Visits and Events
- Care Quality Commission Report and Rating
- Black Country Pathology
- Healthcare Heroes
- Committed to Excellence
- National NHS News
- Regional NHS News

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	Y

RECOMMENDATIONS FOR THE BOARD:

The Board are asked to note and comment on the contents of the report

The Dudley Group
NHS Foundation Trust

Chief Executive's Report – Public Board – May 2018

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

Items below are not reported in any order of priority.

Visits and Events

19th April	Patient Opportunity Panel
	Team Brief
20th April	Clinical Summit
30th April	Medical Director Interviews

Care Quality Commission Report and Rating

The Care Quality Commission (CQC) inspected the Trust from 5th December 2017 to 18th January 2018 and they published their report on the services inspected on the 18th April 2018. The CQC inspected five core services at Russells Hall Hospital and community adult services including sexual health services.

Although our overall rating remains Requires Improvement, we are really pleased that our medical care including older people's care retained its good rating across all domains. Our community services were inspected for the first time and received a Good rating overall, as did our maternity services who were also good, and the CQC found examples of outstanding practice.

It is pleasing to see the inspectors found our services to be caring overall, rating the care given as good; however it is disappointing that our overall rating remains Requires Improvement. We are particularly disappointed that ED has been rated Inadequate, especially given how hard our staff have worked in very challenging times. We absolutely recognise there is work to do to ensure our services are the best they can be for our patients and we are supporting staff to make the improvements we need to ensure safe, effective, responsive and well-led services.

ED has an improvement plan in place which will support them to deliver the safe quality care they all aspire too and I know just how hard all staff are working to deliver good care to patients. We have taken some immediate actions with ED to resolve patient safety concerns and are supporting the team to continue to deliver all of the actions in their improvement plan.

The service is now fundamentally different. It feels different in the department we have invested in both nurse and medical staffing to support the teams to deliver good care.

Next Steps

- Re-inspection of the other core services and then areas of concern will take place within 12 months.
- Continuous improvement journey from Requires Improvement to Good then outstanding.

Black Country Pathology

Dr Helen Hibbs, Accountable Officer at Wolverhampton CCG, has been appointed as the next Senior Responsible Officer (SRO) for the Black Country and West Birmingham STP.

As an experienced GP, Helen brings with her extensive knowledge of the national health and care system combined with local experience and strong leadership. Helen will provide executive leadership to the STP with immediate effect and will support our system to deliver the three key accountabilities: to local communities; to the Black Country and West Birmingham as a whole; and to partners across the West Midlands Combined Authority area.

Following Helen's appointment, the Partnership will now begin the search for an Independent Chair and Portfolio Director. Together, these roles aim to support and enable the delivery of integrated place-based care and system-wide collaboration across the Black County and West Birmingham.

Healthcare Heroes

Always a favourite part of my role is our monthly staff recognition awards. This month senior dietitian Cheryl Southall picked up the individual award for striving to ensure the paediatric dietetic service is the best it can be by constantly working hard so that children can receive the multidisciplinary input they need to ensure the best outcomes.

Radiology received the team award for pulling together and responding to ED when they needed extra radiology staff to help cover evening and weekends. The team have constantly supported each other to try and help reduce waiting lists for our patients. Well done all!

Don't forget to nominate your Healthcare Heroes to be in the running for next month's awards!

Committed to Excellence

Nominations for the **new style Committed to Excellence Awards** are now open! This year sees the launch of a brand new category to recognise our Trust volunteers and a separate Patient Choice Award.

If you know a team or individual who has really impressed you with their innovation, leadership and/or dedication to patient care and experience, nominate them now!

The awards celebrate the work of all our staff no matter what role or where they work.

Committed to Excellence recognises individuals and teams who have made an outstanding contribution to their ward or department, and who have, in some way, helped to make a real difference to patients.

Nominate in the following categories:

- Excellence in Patient Care
- Team Excellence
- Excellence in Business Development
- Unsung Hero – Clinical
- Unsung Hero – Non-clinical
- Volunteer Award

All Healthcare Hero winners in the previous 12 months are automatically entered into Committed to Excellence.

The Dudley Group
NHS Foundation Trust

National NHS News

Hunt hints at backing 'NHS levy' to buoy struggling finances
Health and social care secretary Jeremy Hunt has this week suggested plans for a 1p income tax levy to raise money for the NHS would be supported by the public. The health and social care secretary told the Mail on Sunday that it was: "vital to be open to innovative models of taxation." In the past, policies like a 1p income tax hike that would be ring-fenced for health and social care. A 1p levy would raise around £5bn for the struggling NHS, as increasingly organisations find themselves putting long-term funding into plugging short-term funding gaps.
National Health Executive (27.03.18)

NHS no to dandruff and diarrhoea treatment
Thirty-five treatments responsible for £570m of spending have been targeted. All are available over-the-counter in pharmacies. And the restriction will apply only where the ailment is judged to be a minor, short-term problem. NHS bosses says the move could cut spending by a fifth. But experts warned the poorest risked losing out on treatment.
BBC News (29.03.18)

NHS 'winter crisis' will last into August amid unprecedented funding pressure, BMA warns
The British Medical Association (BMA) has said NHS staff now work flat-out all year round and summer months that used to bring extra bed and staff capacity are spent managing the fallout of "massive spikes in demand". After the worst winter in recorded history, where senior doctors warned patients were "dying prematurely" in corridors, BMA council chair Dr Chaand Nagpaul said every year these issues "stretch further into spring". Some hospitals, such as University Hospitals North Midlands, have already committed to extending their winter contingency measures through to summer to cope with the expected demand.
The Independent (01.04.18)

NHS launches cancer 'one-stop shops' to speed up diagnoses
New "one-stop shops" to speed up cancer diagnosis are being trialled across the country for the first time. GPs can refer patients suffering from "vague" symptoms including unexplained weight loss, abdominal pain and fatigue to assessment centres, to undergo multiple tests for different cancers. The initiative aims to ensure a quick diagnosis in those not showing "alarm" signs for a specific type of cancer, NHS England said. Some patients will be able to receive a definitive diagnosis or be given the all-clear on the same day, while others may require further tests but should receive a final result within two weeks.
The Guardian (03.04.18)

NHS sees 18% increase in obesity related admissions in a year, official data shows
The growing toll of weight-related problems on the health service in England and Wales was laid bare in new data published by NHS Digital, which showed there were 617,000 obesity related admissions in 2016-17. Two-thirds of the admissions were women, and the same report reveals that 42 per cent of women had a BMI that placed them in a high or very high health risk group, compared to 35 per cent of men. There were 10,705 cases where obesity was recorded as the primary diagnosis and reason for admission – an increase of eight per cent on 2015-16 – and women accounted for nearly three-quarters of these.
The Independent (04.04.18)

NHS bodies told to boost mental health funds or face sanctions
NHS bodies that put too little money into improving mental health care have been threatened with sanctions in a crackdown intended to ensure more cash reaches the frontline. NHS England has written to all 207 clinical commissioning groups (CCGs) to warn that they must deliver on a key NHS-wide funding pledge in order to meet the rising demand for help. Claire Murdoch, NHS England's national mental health director, has ordered CCGs to ensure they boost spending on mental health by more than the size of their overall annual budget increase. CCGs are the local NHS bodies that hold the health budget for every area and pay hospital trusts to treat patients.
The Guardian (04.04.18)

Third of NHS trusts facing ban of sugary drinks due to failure to comply
Figures released today show that 80 of 232 trusts have not yet signed up to NHS England's initiative, designed to "battle against the bulge" by cutting down the sales of sugary snacks and drinks – SSBs, or sugar-sweetened beverages – in light of the looming 'sugar tax.' They are now at risk of facing an outright ban later this year if they do not comply. Stevens, NHS England's chief executive, said: "We now know that obesity causes 13 different types of cancer as well as heart attacks and strokes, so the NHS has needed to get its own house in order on the epidemic of flab.
National Health Executive (04.04.18)

More than 80 cases of scarlet fever reported in West Midlands within last week
From the start of the year up to April 1, 667 suspected cases of scarlet fever were reported to Public Health England (PHE) in the West Midlands met area. The number of reports is up from 480 cases reported in the same 13 weeks in 2017, and compares to 428 cases reported in 2016 and 318 in 2015. The number of cases appears to still be growing, with 84 cases in the week to April 1, the highest number of any week in 2018 so far, up from 45 cases in the week ending March 25.
Birmingham saw the highest number of reports in the first 13 weeks of the year, with 295, up from 183in the same period in 2017. It was followed by Wolverhampton with 92 cases, up from 57, with 79 cases in Walsall, 55 in Coventry, 51 in Sandwell, 48 in Solihull, and 47 in Dudley
Birmingham Live (04.04.18)

Obesity-related hospital admissions up says NHS Digital
There were 617,000 admissions in 2016/17 compared to 525,000 during 2015/16, NHS Digital has said. Of the latest figures, 10,705 admissions had obesity recorded as the main cause, an increase on 9,929 admissions in 2015/16. The obesity report also revealed that here were 6,760 Finished Consultant Episodes (FCEs) for bariatric surgery in 2016/17, a five per cent increase on 2015/16 (6,438). Of these, 77 per cent of the patients were female, the report said. The figures come as NHS England claimed a victory in its efforts to cut the sales of sugary snacks and drinks in hospitals. ***The Diabetes Times (05.04.18)***

Health Secretary calls for chairman of NHS Tayside to step down
Concerns have been raised about the use of funds donated to the health service for IT improvements. NHS Tayside has a significant funding gap, and has received emergency loans from the Scottish government. It has been claimed the health board used cash from an endowment fund to cover planned expenses including new computer systems in 2014. Politicians say there was an "apparent misuse" of funds, but the health board insists it was "appropriate".
BBC News (06.04.18)

'Sexual safety' review of NHS mental health wards launched
A review of “sexual assault and harassment” on NHS mental health wards has been launched by England’s health and social care watchdog, after a snapshot survey identified 900 incidents or risks reported by staff in a three-month window. It was triggered after Care Quality Commission (CQC) inspectors found “sexual incidents” reported by staff at a trust that was already being investigated for housing men and women on the same ward - a clear breach of guidance.
The Independent (12.04.18)

Doctors and nurses at Gloucestershire hospitals feel more under pressure than NHS staff elsewhere
According to the latest NHS Staff Survey results medical staff across the country are struggling but those the county are feeling the strain more than most. Over half of those who took part in the questionnaire from Gloucestershire do not believe they have enough staff to do their job properly and well over a third said the stress of the job had made them ill. Nursing leaders said the latest results should act as a warning to the government that staff are working under “impossible conditions” and this is not good for patient care. When asked if there was enough staff at the trust for them to do their job properly, 51.5 per cent of staff at Gloucestershire hospitals disagreed, up from 49.2 per cent in 2016. This is higher than the national average of 46.9 per cent.
Gloucestershire Live (12.04.18)

Scale of vaginal mesh problem confirmed by NHS review
The investigation by NHS Digital came after the Guardian revealed last year that the number was far higher than official figures for complication rates suggested. The latest report shows that in each year since 2008, surgeons have performed at least 500 removal operations in England for implants that have been used to treat common complications of childbirth and pregnancy. Over the past decade, there were 5,374 mesh removal operations in women who had initially been treated for stress urinary incontinence. NHS Digital was tasked with collating figures on to help the health service create a “clearer” national picture of the rates of complications linked to the devices.
The Guardian (17.04.18)

NHS given a lashing for lack of action plan one year since WannaCry
Nearly a year has passed since the unprecedented WannaCry cyber attack and the UK's NHS has yet to agree an action plan, according to a report by MPs. Following the incident last June, which caused 20,000 hospital appointments and operations to be cancelled, a Lessons Learned review was published with 22 recommendations for strengthening the NHS's cyber security. However, implementation plans have yet to be agreed, while the Department of Health does not know exactly how much the recommendations will cost or when they will be implemented, the Public Accounts Committee report found.
The Register (18.04.18)

Fresh NHS funding crisis as health board short of £31m
An NHS health board needs £31m to return its services to the same levels it provided last year, MSPs have been told. NHS Lothian is the latest Scottish health board facing financial problems, with its counterpart NHS Tayside under fire for using millions of pounds of charitable donations to fund a new IT system. The fresh funding shortfall was revealed in evidence to Holyrood's health committee. Jacquie Campbell, chief officer of acute services at the health board, added: "Even if we had the funding to return to March 2017 we don't have the overarching capacity either internally or with the external providers in relation to that and there's often a lead in time in starting up capacity."
STV News (24.04.18)

Two-thirds of councils and 90% of NHS trusts have a gender pay gap
In the NHS, Doncaster and Bassetlaw teaching hospitals NHS foundation trust posted a gender pay gap of 26.5%. The Royal Orthopaedic hospital in Birmingham has a gap of 25.9 %, while it is 22.7% at Burton hospitals NHS foundation trust. At Liverpool community health NHS trust, women's median pay is 17.3% higher than men's, while at Bradford district care foundation trust and Sussex community NHS foundation trust it is 4.6% and 3.8% higher for women, respectively. Among the 56 councils with pay gaps favouring women, the largest gaps were at Three Rivers district council (42%) and Pendle borough council (36%), while four councils had gaps in excess of 20%.
The Guardian (27.03.18)

Regional NHS News

West Midlands lags behind in getting children with eating disorders urgent treatment
From April 11, Walsall residents will be taken the few miles to Wolverhampton for treatment because the stroke unit at the town's Manor Hospital is not considered busy enough to keep running. Treatment will be centralized at a unit at New Cross Hospital in Wolverhampton on the basis that it will provide complete and specialised treatment for patients suffering from a stroke. Starting next month all new onset suspected stroke cases in Walsall will be treated at a specialist stroke unit at New Cross Hospital run by Royal Wolverhampton NHS Trust.
Express & Star (28.03.18)

The NHS is wrongly demanding payment for dentistry from thousands of innocent people
Over the past three years the NHS has sent almost 48,000 penalty notices to people in Birmingham and the Black Country demanding payment for their dental treatment plus a penalty of up to £100. However, only a fraction of these notices - some 13,775 in total - have actually been paid, while 11,195 were successfully challenged because the patient was entitled to free care.
Birmingham Live (28.03.18)

Ambulance crews risk burnout with 1,000 posts vacant
Ambulance services have been badly hit by the staffing crisis which runs right across the NHS. An Observer survey of the 10 NHS regions found that the London Ambulance Service had the highest number of unfilled posts – more than 350. It was closely followed by the South East Coast Ambulance Service and the South Central Ambulance Service. The ambulance trusts covering the east Midlands, west Midlands and south-west said they were not experiencing any shortages in frontline staff at all. But the GMB union, which represents 15,000 of the 45,000 ambulance staff in England, said this was "not credible". Kevin Brandstatter, the union's NHS national officer, added: "I do not believe that the three ambulance trusts have no vacancies." Staff were suffering burnout from working long hours and dealing with the growing demand for care, he said.
The Guardian (01.04.18)

Hospital admissions for obesity in West Midlands have soared – again
That's up from 38,096 admissions the year before - an increase of 13% - and in some parts of the region the rise has been even sharper. In Walsall, for example, hospital admissions related to obesity rose by 33%, from 4,763 n 2015/16 to 6,336 a year later. Similarly, Solihull saw admissions increase from 1,939 to 2,510 over the same period - a rise of 29%. Walsall also has the highest rate of hospital admissions due to obesity in the West Midlands - and one of the highest rates in the country. Wolverhampton also has one of the highest rates of hospital admissions for obesity in England, with 5,662 recorded in 2016/17 - up by 12% compared to the 5,041 seen the year before.

Birmingham Live (04.04.18)

Seven held after attempted 'hippy crack' raid on NHS hospital
Seven people have been arrested over a spate of nitrous oxide thefts after an attempted raid on an NHS hospital, police said. A woman and six men, all from Norwich in Norfolk, were held after Cannock Chase Hospital was targeted in the early hours of Friday, Staffordshire Police said. It followed a spate of thefts of nitrous oxide – which is also known as laughing gas or hippy crack – from medical sites in the county. Prior to that, in the early hours of March 31, Cannock Chase had again been the target as three men in dark clothing forced their way into a store room and took 13 bottles of nitrous oxide before making off in a silver Peugeot 307.
Shropshire Star (07.04.18)

The staggering number of FGM cases recorded in Birmingham every single day
Analysis by BirminghamLive of NHS Digital figures reveals that in 2017, there were 620 cases where a woman was newly recorded in the FGM dataset. Overall, the total number of attendances in 2017 where FGM was identified or a procedure for FGM was carried out was 1,010. Birmingham Crosscity CCG area saw the highest number of newly recorded cases in the metropolitan area, 210, with a total of 335 attendances recorded, followed by Birmingham South and Central CCG area, with 70 new cases and 95 attendances recorded.
Birmingham Live (09.04.18)

NHS SOS: Two people in Stoke-on-Trent die needlessly every day due to lack of healthcare
Deaths are considered avoidable if they could have been prevented by public health interventions, or through effective and timely healthcare. They include deaths from various types of cancer, heart disease, alcohol, drugs, and childbirth complications, as well as accidents, suicides and murders. Data from the Office for National Statistics has revealed that 678 people in Stoke-on-Trent died an avoidable death in 2015, the latest figures available. It worked out as 288 avoidable deaths for every 100,000 people living in the city – one of the highest rates in the country.
Stoke-on-Trent Live (10.04.18)

Hospitals in England have bought 600 million disposable cups over the last five years
Some 174 NHS acute, mental health and community trusts responded to Freedom of Information requests by the Press Association. Together, they had purchased 609,830,335 disposable cups over the last five years – the equivalent of more than 334,000 per day, or 11 disposable cups for every person currently living in England. Over five years 14 trusts purchased more than 10 million cups each – with some even reaching this figure in four years or less. Twenty seven trusts – including some large acute hospitals – are yet to respond and 16 said they did not hold the information requested.
I News (11.04.18)

Nearly a third of patients wait more than four hours at Coventry and Warwickshire A&Es
For all A&Es and emergency care run by the trust, 79 per cent of patients waited less than four hours. George Eliot Hospital saw 77 per cent of patients waiting less than four hours in its A&Es in March, the trust's worst performance since the measure began being recorded on a monthly basis in June 2015. At South Warwickshire, 83 per cent of patients waited less than four hours in the trust's major A&Es, with 85 per cent waiting less than four hours in all of its A&Es. Currently the agreed A&E recovery plan is for the majority of NHS trusts to be hitting the 95% A&E waiting time target by March 2019.
Coventry Live (13.04.18)

The devastating effect cocaine abuse is having on Brummies' mental health
Nearly two people a day are admitted to hospital in the West Midlands for mental health problems linked to cocaine. Figures from NHS Digital show that in 2016/17 there were 605 admissions to hospitals in the area for people suffering from mental and behavioural disorders caused by cocaine. At a local level, Heart of England NHS Trust saw the highest number of admissions, with 182 episodes. Sandwell and West Birmingham Hospitals NHS Trust followed with 121 episodes and The Dudley Group NHS Trust came third with 84 episodes.
Birmingham Live (16.04.18)

NHS S.O.S: Fall in community nurse numbers 'is a big concern'
The number of NHS community health nurses has been cut by more than 350 in the West Midlands since the Conservatives came to power. Exclusive figures from NHS Digital show there were 4,568 full-time equivalent community nursing roles in the region in 2010 – but only 4,199 in 2017. That is a fall of more than eight per cent at a time when pressures on the NHS are greater than ever. The government responded to the figures by admitting an 'urgent' need to boost numbers.
Stoke-on-Trent Live (18.04.18)

Hundreds of health workers attacked - but which hospital is worse?
There were 290 attacks on workers at Sandwell and West Birmingham NHS Trust, which runs Sandwell General Hospital and City Hospital in Birmingham, in 2016/17. This was up from 249 the year before. And the number of attacks also rose at The Dudley Group NHS, which runs Russells Hall Hospital, from 132 to 139. But at Walsall Healthcare NHS Trust, which runs Walsall Manor, the number dropped from 202 to 168, as they did at The Royal Wolverhampton, which runs New Cross Hospital, from 140 to 77.
Express & Star (19.04.18)

Midland Met super hospital to open to patients in 2020 after Carillion setback
Toby Lewis, chief executive of the Sandwell and West Birmingham NHS Trust, says any further delay to the Midland Metropolitan Hospital will impact on the quality of care provided by the trust. The hospital was targeted for opening next year, combining acute and emergency services at Sandwell General Hospital and City Hospital in Birmingham Work will remain at a standstill until a contractor is chosen by The Hospital Company, a move which will add £125m to the £350m hospital bill. This week, West Midlands Mayor Andy Street revealed Swedish construction firm Skanska had been identified as the preferred new contractor***.***
Express & Star (22.04.18)

Enclosure 4

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 3 May 2018

TITLE:	**24 April 2018 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe – Director of Governance	**PRESENTER**	Doug Wulff – Committee Chair

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

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

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: covers many risks, nut key are those related to the Trust quality priorities, deteriorating patient and patient experience**
	Risk Register: Y		**Risk Score: numerous across the BAF, CRR and divisional risk registers**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	NHS I	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
Y			**Y**

RECOMMENDATIONS FOR THE BOARD
The Committee requests the Board note the assurances received at the meeting and the decisions made by the Committee.

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Clinical Quality, Safety and Patient Experience Committee	24 April 2018	D Wulff	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances received

- The Committee received a further update report from the Medical Director in respect of VTE. The Committee were updated to the improved performance especially within the in-patient ward areas which were compliant with the 95% performance standard. This had been brought about by increased support and enhanced reporting of patients awaiting assessment. The area where improvement is still required is AMU, and the Medical Director is meeting with the Clinical Lead for this area to support their improvement. Work continues to ensure that the new digital trust solution supports the VTE assessment being a mandatory process which then will remove the need for cumbersome manual data transfers.
- The Committee received a report from the Medical Director looking at the past 5 year's never event activity. The Committee agreed that this did not show any one area of repeated failure. The Committee were reminded of the actions taken as result of each never event incident investigation. The Committee were updated as to how the clinical audit forward plan has been enhanced this year to audit known risk areas for the national never event list. The Committee welcomed this development to proactively consider these risk and looked forward to receiving regular updates on the clinical audit outcomes.
- The Committee received a verbal report from the Risk and Assurance Group as it had only met the Thursday before this meeting. The Committee was updated as to the work undertaken at the Group's meeting in April covering the review of coroners cases, incidents, NPSA alerts and performance issues. The Committee agreed that the now drafted chair's report be circulated to all to ensure efficient reporting of the outcome of this Group's work.
- The Committee reviewed the quality aspects of the Trust Integrated Performance Report. The Committee noted there still remained a number of anomalies had with the information within this report but were reminded that Internal Audit had been asked as part of their data quality work to review the underpinning processes that support the production of the quality measures reported within this report and other complementary dashboards. The Committee was updated in respect of actions being taken and the links to subsequent reports on the agenda where performance was below the Trust's targets, which included VTE, Nutrition, Cleaning, Training

and Friends and Family response rates.

- The Committee received a report on Infection Prevention and Control which included a forecast of the Trust year end position in respect of the Hygiene Code compliance statement for 2017/18. The Committee was informed of the actions being taken to address the challenge to secure the move from three yearly staff training to annual training. The Committee was updated on the actions being taken as a result of both NHS I infection control visits. The Committee was also updated by the Director of Infection Prevention and Control on the work begin undertaken in respect of MRSA screening and asked that the report to the Committee next month contains a date by which the data extraction issues will be resolved to enable the effective follow up of patients requiring screening will be in place. The Director of Infection Prevention and Control confirmed that the Trust annual report on infection control will be presented to the June Board.
- The Committee received a report on actions taken as a result of identified Stage 4 Pressure Ulcers. The Deputy Chief Nurse updated the committee on the work being undertaken along with the CCG on system wide learning for pressure area care which included working and providing training with residential homes within Dudley.
- The Surgery, Women and Children Division provided an update on the actions being taken within ophthalmology to ensure sustainably in the delivery of the service. The Division provided verbal assurance that there continued to be no overdue follow up appointments for urgent or “red” categories of patients. The Division also provided an update on the work being undertaken in respect of paediatric outpatient waiting lists and that the Division was behind its trajectory. The Chief Executive asked that the Division meet with the Chief Operating Officer to discuss the slippage and confirm a final date for the removal of these backlogs. The Committee requested that the Division in their next report provide confirmation of this date. The Division also provided an update on its progress and challenges regarding the action plan in relation to the Children and Young People service improvement plan.
- The Committee received an update from the Medical Director on the work being undertaken in respect of the deteriorating patient. This report contained an update on the delivery of the action plan in respect of the delivery of a deteriorating patient strategy for the Trust which was presented that the last Committee meeting in March 2018. The Committee was updated as to the actions being taken to cascade this learning to the Junior Doctors as well as the Consultants and Trust Grade doctors.
- The Committee was presented with the Maternity Dashboard report and updated on the improved performance across a range of areas since last month’s report. The Committee’s attention was drawn to the improvement made in respect of screening performance.
- An update was provided in respect of the Maternity Service Improvement Plan, the Committee had tabled the most up to date version of the plan. The report provided assurance of progress and the continued executive oversight of the action tracking process which has and will continue to take place within the Division and the Directorate.

- The Committee was presented with a report covering the review of Caesarian activity during December by the Clinical Service Lead and the high level findings from this review.
- The Committee received reports from the divisions of Medicine & Integrated Care, Surgery and Clinical Support Services. The Committee asked that for the next meeting of the Committee that a plan is presented in respect of the consultant cover being provided on a substantive basis.
- The Committee received a report on the progress against the agreed action plans following the CQC service inspections of Urgent and Emergency Care, Critical Care, Children and Young People, Maternity, Medicine and Community Services. The Committee was updated as to the work to provide assurance over the actions within the improvement plan. The plans showed progress made across each of the services. The Committee received feedback from the Emergency Department and endorsed the actions being taken by the Executive in respect of enhanced oversight of this action plan.
- The Committee received both the Clinical Audit annual report for 2017/18 and the Clinical Audit forward plan for 2018/19. Both of these documents had been subject to discussion at the new Clinical Effectiveness Group and the forward plan had been provided to the Risk and Assurance Group to ensure a wider understanding of the assurance this activity will provide over the forthcoming year, noting that the clinical audit plan for 2018/19 is much broader than in previous years. The Committee endorsed the improved breadth of the clinical audit plan for 2018/19. The Committee asked that in progress reports to the Committee as the plan is delivered that the activity of the junior doctors be highlighted as they make a valuable contribution to audit activity across the Trust.
- The Committee received a report on incident management. The report provided assurance on the Serious Incident process being applied and included information on the Trust position in respect of wider incidents. The Trust had seen a decrease in reported incidents in the month of March and given the Trust's quality priority the central governance team continues to encourage Divisions to push the message for staff to report all incidents including the commencement of positive incidents (where good practice was identified and can be shared). The Committee was updated on the actions being taken to close investigations in a timely manner and was informed that in 2 cases no assurance had been provided that the actions had been taken in line within the agreed timescales. These two cases have been referred to the Division.
- The Committee received a summary report of quality metrics. The Committee was updated as to the action being taken as a result of both positive and poor performance.
- The Committee received a patient experience report for the month of March. The report provided an update on compliments, friends and family feedback, concerns and complaints activity. The Committee was updated on the number of open complaints and the actions required of the respective Divisions to better manage these. The Committee was updated as to the short term actions being taken to address the back log in responding to complaints across the Trust.
- The Committee received a report on the qualitative aspects of the estates contract

management processes in respect of both estates and facilities. The report provided information on actions taken in respect of water safety, decontamination and cleaning.

- The Committee received a report from the and a wider report on Safeguarding developments, activities and challenges across the Trust. The Head of Safeguarding took the Committee through the developed improvement plan and the associated timescales for delivery of the identified actions.
- The Committee received reports from the Internal Safeguarding Board, Quality and Safety Group, Medicines Management Group, Infection Prevention and Control Forum and the Mortality Surveillance Group. These reports confirmed that the groups were quorate when meeting and were working in accordance with their terms of reference.

Decisions Made/Items Approved

- The Committee agreed that the now drafted Risk and Assurance chair's report be circulated to all to ensure efficient reporting of the outcome of this Group's work.
- The Committee endorsed the clinical audit plan, which would be formally approved by the Audit Committee.
- The Committee ratified three policies, two new polices and one subject to a minor revision based on the recommendations of the Policy Group. The Committee noted that the Divisions had reviewed and approved 33 guidelines / standard operating procedures during the month of March, recognising there were still 74 due to for review.

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

The Committee asked that the Infection Prevention and Control Report for next month contains a date by which the data extraction issues will be resolved to enable the effective follow up of patients requiring screening will be in place.

The next report from the Surgery division to include the revised date by which the backlog of ophthalmology and paediatric outpatient waits will be removed

The Medicine Division to provide a plan in respect of the consultant cover being provided on a substantive basis for ED at the next committee meeting.

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

Items referred to the Board for decision or action

There were no specific matter requiring referral to the Board, but the Committee requests the Board note the assurances received at the meeting and the decisions made by the Committee.

Enclosure 5

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board on 3rd May 2018

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

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

- Update of statement against the Hygiene Code for 2017/18.
- Mandatory Infection Control training - during the current 3 month implementation phase (January – March 2018) the Trust is green for March. The numbers for April will be gathered on the 10th May and will be provided for the June Board report.
- Update on NHSi action plan – a further visit by Dr Adams was conducted on 20th March 2018. Improvements were noted in the general ward areas, however, concerns were raised against specific issues on the NNU. The action plan has been updated to reflect these.
- For 2017/18 there have been 30 post 48 hr case with 2 cases in March. Of these 17 were associated with a lapse in care, 11 were associated with 'no lapse in care' and 2 remain under review. The Trust will meet its trajectory of less than 29 cases associated with a lapse in care for 2017/18.
- No post 48 hr MRSA bacteraemia cases since September 2015

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		√	

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

Introduction:

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

Compliance Criterion	What the registered provider will need to demonstrate	RAG rating
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may post to them.	
Assurance: A risk log of all infection prevention risks identified across the Trust is maintained and updated regularly.		
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Mitigation of all issues identified by the recent NHSi visit in place. Confirmation of permanent solutions awaited.
Assurance: A Cleaning Policy and associated environmental audits provide assurance that a clean and appropriate environment is maintained. A recent business case has been introduced to ensure a more robust HPV fogging programme.		
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse event and antimicrobial resistance.	Internal data confirms compliance with the antimicrobial targeted reductions.
Assurance: There is an Antimicrobial Policy in place with appropriate stewardship recommendations. Audits demonstrate compliance with policy. The new lead antimicrobial pharmacist has now taken up post.		
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion.	
Assurance: Patient and visitor information is available for a variety of healthcare associated infection issues on the website. Patients identified with infections in hospital are visited and provided with information leaflets including contact information for further support.		
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Final work to address compliance against MRSA screening is on target to be delivered by end of April 2018.
Assurance: Patient records are flagged with information about previous healthcare associated infections. Patient admission documentation includes screening questions to identify patients at risk.		
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Mandatory IC training is moving to an annual programme for clinical staff. Compliant at 90% for clinical staff based on current criteria at year end as agreed with NHSi. A

		phased approach to reach 90% compliance with annual training by March 2019 will be established from April 2018.
Assurance: Staff are provided with mandatory infection control training to ensure they are aware of their responsibilities for the prevention and control of infection.		
7	Provide or secure adequate isolation facilities.	Funding has been secured for a Pod for ITU.
Assurance: There is a policy in place to ensure that patients are isolated appropriately. 25% of the inpatient beds take the form of single ensuite rooms.		
8	Secure adequate access to laboratory support as appropriate.	
Assurance: The Trust has access to a CPA/UKAS accredited Microbiology and Virology laboratory.		
9	Have adherence to policies, designed for the individuals' care and provider organisations that will help to prevent and control infections.	Trustwide scores all green during last quarter of 2017/18.
Assurance: All policies, as recommended in the Hygiene Code, are in place. Audit data confirms compliance with policies and identifies areas for improvement.		
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	
Assurance: There is in house provision of Staff Health and Wellbeing. There are regular reports to the Infection Prevention and Control Forum detailing any issues raised within this system.		

Summary of alert organism surveillance:

Clostridium Difficile – The target for 2017/18 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. The cases that count within this dataset are patients identified after 48 hrs admission with C. difficile in whom a lapse in care has been recognised using the national apportionment tool [1]. For 2017/18 there have been 30 post 48 hr cases to the end of February, of these 17 were associated with a lapse in care, 11 were associated with 'no lapse in care' and 2 under review. For March 2018 2 post 48 hr cases have been reported.

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

A period of increased incidence (PII) has been identified on ward C1. RCAs have been requested. A 72 hour meeting has been arranged for 24th April and ribotyping requested.

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

MSSA bacteraemia (Post 48 hrs) - For March 2018, 2 cases of post 48 hr MSSA bacteraemia were reported.

MRSA screening – There is no external compliance target for MRSA screening. The internal target is to achieve 95% compliance with the policy. The percentage of

emergency admissions screened for March 2018 is 89.4%. Data is available locally to the units to enable them to identify patients missing from the dataset.

The percentage of elective admissions screened for March 2018 is 94%. As above data is available locally to all units to enable them to identify patients missing from the dataset.

The Task and Finish Group has completed the work on elective admissions and we anticipate compliance for April. The data is now sufficiently reliable that work to develop a daily ward list for patients who require screening is ongoing in order to bring the emergency screening compliance up to the internal target.

E. coli bacteraemia – For the post 48 hr cases an enhanced surveillance module has been commenced in April 2017 in order to ascertain themes and trends within the acute Trust to see where lessons may be learnt. For March 2018, 2 cases of post 48 hr E. coli bacteraemia were reported.

Klebsiella* and Pseudomonas* bacteraemias – For March 2018 there was 1 post 48 hr Trust identified Klebsiella bacteraemia case and 0 post 48 hr Pseudomonas bacteraemia cases.

Norovirus – Between 9th and 17th April a total of 8 patients developed symptoms of diarrhoea and/or vomiting on ward B6. Norovirus was confirmed on the ward. Infection prevention control precautions were implemented and maintained throughout this period. The incident was declared over and the ward reopened on 17th April 2018.

Infection Control Mandatory Training – The revised mandatory requirement is to update Infection Control training annually for clinical staff. During the implementation phase (ie, until March 2018) the data will continue to be presented based on the historical 3 yearly cycle. The percentage compliance as at 31.3.18 (target 90%):

Area	Total
Corporate/Management	91%
Medicine and Integrated Care	91%
Surgery	93%
Clinical Support	91%

To achieve compliance at 90% of clinical staff by the end of March 2019 there are approximately 1700 clinical staff who require training.

The following measures are being introduced:

- Targeting training at the top 10 non-compliant areas over the next 2 months (this will incorporate approximately 25% of those staff requiring training).
- Target the 2 largest groups of staff requiring training (this being registered nurses and clinical support workers) by offering face to face training sessions within the clinical areas.
- A targeted email to all those staff who are currently not compliant or will become non-compliant within the next 3 months was sent out on Friday 13th April.
- An IT solution to enable staff to click directly onto a link for the mandatory IC training rather than log into the web based portal is being developed.
- Work is ongoing to detail individual training trajectories for the clinical areas.

Infection Prevention and Control Group – It has previously been agreed to increase the frequency of the meetings to 10 per annum and to introduce a cycle of reporting to ensure adequate time for discussion of agenda items. The membership was also reviewed and approved to reflect the revised divisional structures whilst maintaining membership of external agencies including the CCG, Office of Public Health and Public Health England. A number of sub-groups report into the meeting including the Water Safety Group and Antimicrobial Steering Group.

The next Infection Prevention and Control Group meeting will be held on Thursday 26th April 2018.

NHSi visit – 20th March 2018

The action plan following the NHSi visit in March has been updated to reflect the work done to address the laundry being undertaken on the Neonatal Unit and the other issues highlighted.

GLOSSARY OF TERMS

MSSA

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

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

MRSA

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

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

E Coli

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

What types of disease does *E. coli* cause?
The commonest infection caused by *E. coli* is infection of the urinary tract, the organism normally spreading from the gut to the urinary tract. *E. coli* is also the commonest cause of

cystitis (infection of the bladder), and in a minority of patients the infection may spread up the urinary tract to the kidneys, causing pyelonephritis.

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

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

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

Klebsiella species

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

What types of disease does *Klebsiella species* cause?
These organisms are rarely associated with diseases in the normal host. They are a cause however of nosocomial and opportunistic infection.

Pseudomonas aeruginosa

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

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

C difficile

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

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

How do you catch it?
Another person may acquire C.difficile disease by ingesting the bacteria through contact with the contaminated environment or patient. In most healthy people the

C.difficile will not be able to multiply in the gut and they will not develop disease. In some more vulnerable people, particularly those whose normal gut bacteria have been disrupted by antibiotic treatment, the C.difficile may be able to multiply in the gut and go on to cause disease.

CPA/UKAS

What is CPA/UKAS?

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

RCA

What is RCA?

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

PFI

What is PFI?

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

CCG

What is CCG?

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

RAG

What is RAG?

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

Reference

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

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

ACTION PLAN FOLLOWING NHSi VISIT – 8TH NOVEMBER 2017

The Dudley Group NHS Foundation Trust

Manager/Lead	Dr Elizabeth Rees, Director of Infection Prevention and Control	**Executive Lead**	Ms Siobhan Jordan, Chief Nurse
Associated Staff	Miss A Murray, Matron, Infection Prevention and Control	**Action Plan updated on**	24th April 2018

RAG status	Not started	Underway	Complete

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

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

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

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
12	Criterion 1, 5 and 6	Annual Infection Prevention Training to ensure knowledge is embedded into action.	Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19.	Dr E Rees and Miss A Murray	Completed on 18th January for Matrons.	January 2018	
					The plan is to deliver 90% compliance against the annual programme within the next financial year. A baseline assessment has been performed and a plan has been agreed.	April 2019	
13	Criterion 1	Analytical support to be considered to provide expertise to existing IPC team.	To develop and JD, advert and PS in order to advertise this post.	Miss A Murray	JD and PS developed – awaiting banding. Complete.	January 2018	
14	Criterion 1	To advertise for a substantive Consultant Microbiologist	To advertise post using existing College approved JD and PS.	Dr E Rees	Currently being advertised on NHS Jobs.	December 2017	
15	Criterion 1 and 5	Catheter Care Bundles reflect national guidance but senior nursing staff seemed unaware of all available tools.	As part of the current health economy work around urinary tract infection, protocols around the management of catheters will be reviewed for each participating organisation; DGFT will review its own.	Miss A Murray and Mr B Jones	Working across healthcare economy catheter passport has been created; it will go to ACE panel for approval in March. Report back to IPCF at April meeting. Mr Jones suggested that after approval by ACE this item is included in the HCAI agenda.	April 2018	

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

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

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

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

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
7	Criterion 1 and 2	The Neonatal Unit *Enterobacter cloacae* SI from May 2017 to be signed off.	To sign off SI action plan and move risk assessment regarding sinks to the Trust IC Risk Register.	Dr E Rees	Complete. Risk assessment has been signed off by division.	December 2017	
36 **Added 20.3.18**	Criterion 2	All mattresses not in use to be stored appropriately and correctly labelled with 'I am green' sticker or labelled as 'condemned'.	To review the Trust's Mattress Policy and ensure it's fit for purpose and to evidence by audit.	Mrs J Pain/Mrs J Bree and Mrs K Anderson		June 2018	
37 **Added 20.3.18**	Criterion 2	There were excessive amounts of baby clothes in the clinical area to launder. It is required that the laundry procedures ensures appropriate thermal disinfection.	To review the provision of baby clothes and laundering on Neonatal unit and to agree a process to deliver the recommendation.	Mrs K Anderson	Laundering on the NNU has ceased as of 16th April 2018. A risk assessment is in place to support the laundering of these items by Interserve pending permanent solution to ensuring current laundering standards are met.	June 2018	
38 **Added 20.3.18**	Criterion 2	To confirm the decontamination arrangements for baby incubators.	To review the SOP for incubator decontamination to ensure it is fit for purpose and to evidence by audit.	Infection Prevention and Control Team and Mrs K Anderson		June 2018	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.							
12	Criterion 1, 5 and 6	Annual Infection Prevention Training to ensure knowledge is embedded into action.	Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19.	Dr E Rees and Miss A Murray	Completed on 18th January for Matrons.	January 2018	
					See above.	April 2018	
15	Criterion 1 and 5	Catheter Care Bundles reflect national guidance but senior nursing staff seemed unaware of all available tools.	As part of the current health economy work around urinary tract infection, protocols around the management of catheters will be reviewed for each participating organisation; DGFT will review its own.	Miss A Murray and Mr B Jones	Working across healthcare economy catheter passport has been created; it will go to ACE panel for approval in March. Report back to IPCF at April meeting.	April 2018	
23	Criterion 5	Compliance with MRSA screening target.	Provide action plans to explain how the Trust target (90%) will be achieved.	Miss Murray/Mrs Pain/Mrs Bree	The elective surgery element of MRSA screening is achieving 93.8% during March and is set to be compliant by end April. The emergency screening is showing compliance at 90% - work to develop a daily list to identify patients who have outstanding screens is being undertaken with a completion date of end April.	May 2018	

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

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
32 **Added 13.2.18**	Criterion 6	Assurance to IPCF that junior medical staff undertake appropriate skills training during their time at DGFT (junior doctor witnessed carrying syringe of blood by hand).	To enquire with Post Graduate centre regarding training.	Dr Rees	Clinical skills have developed a self declaration tool to confirm that non-training grades have had appropriate training including IC elements required.	April 2018	
12	Criterion 1, 5 and 6	Annual Infection Prevention Training to ensure knowledge is embedded into action.	Currently on a 3 yearly cycle. Move to yearly updates with full year effect 2018/19.	Dr E Rees and Miss A Murray	a) Training delivered by Dr Adams on 18th January.	December 2017	
					b) See above.	April 2018	
Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.							
21	Criterion 9	MRSA Screening Policy has 'meticillin' spelled with an 'h' ie, 'methicillin'.	Amend policy.	Dr E Rees		Immediate	
22	Criterion 9	The Management of Patients and Staff with Diarrhoea policy to reflect national guidance relating to stool type.	Review policy to ensure compliance.	Dr E Rees		Immediate	
39 **Added 20.3.18**	Patient Safety Issue	To confirm the security arrangements around the storage of breast milk to ensure expressed breast milk cannot be tampered with/contaminated.	To review the arrangements for safe storage of expressed breast milk.	Mrs K Anderson	A review of NNU, C2 and maternity milk storage has been undertaken. Digilocks have been requested via a variation with Interserve and these have been signed off and request issued.	May 2018	

Action No.	Code of Practice compliance criterions*	Recommendations	Actions Required	By Whom	Progress to date	Agreed completion date	Status (RAG)
40 **Added 20.3.18**	Patient Safety Issue	To confirm the temperature and 'use by' dates applied to stored expressed breast milk to ensure that it is safe to use.	To review SOP for monitoring temperatures in the fridge and freezers used for milk storage.	Mrs K Anderson/Mrs J Pain	All milk was held within date during the audit held on 21.3.18. temp monitoring was in place.	April 2018	
41 **Added 20.3.18**	Criterion 2	To establish a cleaning schedule for toys on the NNU and to ensure that there are no soft toys.	To remove soft toys and to review toy cleaning SOP.	Mrs K Anderson/Mrs J Pain	The soft toys present have been removed. All toys have been decontaminated according to the agreed policy and all toys have been HPV fogged.	April 2018	

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

Enclosure 6

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd May 2018

TITLE:	**Monthly Nurse/Midwife Staffing Position – May 2018 report containing March 2018 data**		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER**	Siobhan Jordan Chief Nurse

CLINICAL STRATEGIC AIMS

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

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

SUMMARY OF KEY ISSUES:

The attached paper contains the actual and planned hours for qualified and unqualified staff for both day and night shifts. This is against the historic establishments as agreed by the previous Chief Nurse. There is a continuing significant reliance on temporary staff (bank and agency). The fill rates and the Care Hours Per Patient Day (CHPPD) are also tabled. It can be seen that in general the fill rates are close to but less that 100 percent of the historic establishment. There has been some increase in the fill rates as 2017 progressed although a reduction has occurred from November/December onwards into the new year. Following the issue raised in the last and previous months reports, regarding making straightforward comparisons between the Trustwide CHPPD and that of its peers and the national figure, information has been received from experts in the field and changes to the report have been made on that advice.

Under the guidance of the new Chief Nurse, the Trust has been undertaking a detailed, extensive staffing review of each of the wards and departments. To date all of the medical and surgical wards have been reviewed as have some of the specialist areas. The new templates for the medical and surgical wards took effect from April 8th with clear rules on the use of temporary staff. The community and the remaining other specialist areas of the Trust are in the process of being presented to the Directors.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD: To note and consider the safe staffing data for March.

Monthly Nurse/Midwife Staffing Position

May 2018 Report containing March 2018 data

The attached Safer Staffing Summary (Appendix1) shows the actual and planned hours for four categories of staff, qualified and unqualified staff for both day and night shifts, for each area of the Trust for March 2018 (wards that have been fully or partially closed in the month are omitted). As well as showing the actual and planned hours the report shows the fill rate for each of the four categories. The totals for the Trust are also indicated. In addition, the last four columns show the actual Care Hours Per Patient Day (CHPPD). We provide this information to NHS Improvement and part of it is utilised in the National Model Hospital dataset.

The report shows that the overall fill rates for the Trust is less than 100% but this has been achieved by using the historic establishments with a significant reliance on temporary staff (bank and agency). A number of factors make it unlikely that a full fill rate will always be achieved although this is the aim. These factors include long term issues such as vacancies, short term issues such as sickness and maternity leave, the unavailability of temporary staff and unexpected numbers of patients requiring enhanced care.

Table 1 shows there was some improvement as 2017 progressed although the overall fill rates of both qualified and unqualified staff have reduced from November/December 2017 onwards. This is a result of opening extra capacity and the need to move staff to support these areas.

- On occasion, the fill rate is over 100%. This tends to occur with C2, the paediatric ward, and NNU (neonatal unit) as the planned hours are derived from the dependency tools used for each shift. Each shift the planned hours are determined by the acuity of the children/neonates actually on the ward/unit.
- Also, sometimes there are occasions when the fill rate of unqualified staff exceeds 100%. This occurs when it is recognised that there will be a reduction in qualified staff (e.g. C1 (Renal/Endocrinology), C3 (Care of the Elderly) and C8 (Stroke Unit)).
- The low fill rate during the days in a) Coronary Care Unit/Post Coronary Care Unit reflects the problems in recruiting staff to this particular area and b) EAU reflects the winter pressures and opening the new larger EAU.
- The low fill rates for B3 (Vascular Unit) are working otdue to that ward already using the new planned levels following the recent staffing review and the need to increase staffing levels as a priority.

Table 1. Percentage fill rates January 2017 to the present

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

With regards to the CHPPD, as has been explained in previous monthly reports this is the national indicator that is intended to be utilised to benchmark the Trust. This is outlined in Table 2 (on page 6).

Following the issue raised in the last and previous months reports, regarding making straightforward comparisons between the Trustwide CHPPD and that of its peers and the national figure, information has been received from experts in the field. The difficulties in such comparisons is that all Trusts have a combination of different specialities of different size. Comparisons by individual wards/units is seen to be more useful, however, this exercise brings with it other problems that need to be noted.

Table 2 includes the CHPPD of the Trust's wards/units with comparative values for the nearest specialties that are included in the Model Hospital. The Model Hospital has a restricted number of specialities which necessitates interpreting this data with caution. For instance the Model Hospital has only one speciality for children areas called 'Paediatrics' which covers general wards (such as C2) and specialist paediatric areas (such as the Trust's NNU). A neonatal unit obviously requires more intensive nurse staffing than a general paediatric ward (as the Trust's own figures indicate), however, the Model Hospital comparator figures are the same for both these areas and so any sensible comparison cannot be made.

Looking at the other different Model Hospital specialities in turn:

1) General Medicine.

General Medicine covers a wide range of areas from general wards to busy acute admission units. It can be seen from the table that at the Trust there are two areas with this speciality (A2 and EAU). These are the areas that take newly arrived sick patients and one would expect them to be at the high end of dependency for this range of wards which is the case.

2) Trauma and Orthopaedics

This speciality covers a diverse range of types of wards. It can be seen that the general T&O ward (B1) is below the national/peer averages which B2 (Trauma) is similar to the comparators with the B2 Hip being above the comparators which would be expected as it

has highly dependent patients with hip fractures who are generally elderly with associated medical problems.

3) General Surgery

The Trust has three wards with this speciality [B3 (Vascular), B4(Colorectal), B5(General Surgery)] which have varying CHPPD's as expected by the patient base of these areas with the vascular ward which has a vascular unit being above the national average.

4) Specialist Medical Areas – Nephrology (C1), Clinical Haematology (C4), Respiratory(C5), Gastroenterology (C7)

The CHPPD of Wards C1, C4 and C5 are between the national and peer medians while the CHPPD is slightly higher than the national median.

5) Paediatrics

As discussed above.

6) Geriatric Medicine/Rehabilitation

The CHPPDs of C8 (Stroke) and C3 (Care of the Elderly) are quite high compared to the peer/national medians. A breakdown of the separate Qualified and Unqualified CHPPDs are shown in the chart below.

	CHPPD COMPARISONS		
	QUALIFIED STAFF	UNQUALIFIED STAFF	TOTAL STAFF
C3	2.69	5.63	8.32
Peer	2.99	3.03	6.03
National	3.00	3.41	6.50
C8	3.34	4.70	8.04
Peer	3.16	3.25	5.78
National	3.17	3.54	6.64

For C3 it can be seen that the qualified CHPPD is below the peer/national figures but the total CHPPD is higher due to the high unqualified CHPPD. For C8 both qualified and unqualified CHPPDs are above the peer/national figures. The high unqualified figures can be explained by the high number of patients requiring 1:1 care but one would expect that to be reflected in the peer/national figures also. A further exploration of this situation will be undertaken.

7) Cardiology

The Trust CHPPD is the same as the national picture both of which are above the peer comparator.

8) Critical Care Medicine

The Model Hospital has a single speciality for all of the Level 2 and Level 3 critical care areas. As expected the Level 2 area of MHDU is significantly lower than peer/national medians which will include all Trusts' level 3 areas. The Trust's critical care CHPPD is a lot higher than the peer/national medians. While a figure over the peer/national medians would be expected as they contain all Trusts' Level 2 areas the critical care CHPPD is significantly higher, so this is worth further analysis.

9) Obstetrics

The Trust's unusual Maternity format explains the differences between the Trust's CHPPD and the peer/national medians. The majority of Trusts retain the tripartite breakdown of Antenatal Ward, Delivery Suite and Postnatal Ward so direct comparisons cannot be made for this speciality.

Conclusion

This report demonstrates that we are achieving nearly 100% fill rate using the historic establishments with a significant reliance on temporary staff (bank and agency). The reduction in the figures from November/December reflect the need to move staff to support additional capacity.

Benchmarking the Trust workforce data using the CHPPD can be informative but needs to be undertaken with caution as exact like for like comparisons cannot always be made.

The staffing review which commenced in 2017 has used data from a wide variety of sources to inform and ensure the required outcome. As well as considering the above data, the review has been structured discussions with Matrons and senior nurses from each area together with their managers using information on establishments, staffing ratios and vacancy, sickness and temporary staffing rates. It also considered the outcome of the most recent Safer Nursing Tool exercise and patient acuity.

Both the main medical and surgical ward area, NNU and Critical Care reviews have been completed and decisions made following discussion and approval at Director level and the Finance and Performance Committee. The NNU staffing review took place in August 2017 and it was noted at the time that that the Trust's overall staffing compliance with the British Association of Perinatal Medicine (BAPM) Service Standards was 28.9% compared to the national average of 57.37%. The review detailed what action would be required to be compliant. The executives agreed to increase staffing incrementally to reach 66% compliance with a further review. The NNU Peer Review took place in January of this year and nurse staffing was raised as a concern. The initial phase of further recruitment of nursing staff has been completed. In September 2018 an intake of three Trainee Nursing Associates (TNAs) is planned. When this has occurred a further nursing review of the compliance with the BAPM standards will be undertaken.

Reports have been produced on a number of specialist areas which include Main Out Patients Department (OPD), Renal Unit, Emergency Department, Emergency Assessment Unit and Medical Day Case, a number of which are with Directors for consideration. They will be presented to the Finance and Performance Committee in May and June. The review of the Community services is now in its initial draft and is in the process of being presented to Directors.

Table 2. Ward/Area CHPPDs for March compared to nearest speciality latest comparators in Model Hospital from January 2018

MARCH 2018										
Ward	Beds	Speciality	Fill Rates				Care Hours Per Patient Day			
			Qual D	Unqual D	Qual N	Unqual N	Trust	Peer (Jan18)	National (Jan 18)	Peer/National Speciality
A2	42	Acute Medicine	89%	89%	97%	95%	7.13	6.26	6.88	General Medicine
B1	26	T&O	87%	90%	96%	91%	5.64	6.53	6.74	T and O
B2(H)	30	T&O – Hip #	94%	98%	100%	94%	8.68	6.53	6.74	T and O
B2(T)	24	T&O – Trauma	92%	99%	100%	95%	6.40	6.53	6.74	T and O
B3	42	Vascular Surgery	75%	91%	89%	93%	7.54	6.30	6.80	General Surgery
B4	48	Colorectal Surgery	92%	92%	94%	98%	6.32	6.30	6.80	General Surgery
B5	30	General Surgery	96%	94%	102%	97%	5.76	6.30	6.80	General Surgery
C1	48	Renal/Endocrinology Med	88%	94%	91%	103%	6.37	6.17	6.44	Nephrology
C2	41	Paediatrics	114%	95%	91%	100%	7.45	9.52	12.05	Paediatrics
C3	52	Elderly Medicine	91%	101%	84%	101%	8.32	6.03	6.50	Geriatric Medicine
C4	22	Oncology	96%	95%	100%	94%	6.85	5.85	7.08	Clin. Haematology
C5	48	Respiratory Med	90%	100%	88%	104%	5.75	5.66	6.31	Respiratory
C6	20	Urology Surgery	85%	102%	95%	99%	6.11	5.83	6.42	Urology
C7	36	Gastro Medicine	86%	81%	96%	88%	6.16	5.73	6.14	Gastroenterology
C8	44	Stroke	93%	98%	98%	100%	8.04	5.78	6.64	Rehabilitation
CCU/PCCU	26	Cardiology	83%	102%	99%		7.65	7.13	7.65	Cardiology
Critical Care	17	Critical Care - Surgery	100%	82%	99%		32.74	24.61	24.45	Crit Care Medicine
EAU	35	Acute Medicine	88%	77%	96%	84%	8.23	6.26	6.88	General Medicine
Maternity		Obstetrics	97%	88%	98%	92%	30.22	12.22	15.65	Obstetrics
MHDU	10	Crit Care – Med	88%	83%	95%	80%	12.86	24.61	24.46	Crit Care Medicine
NNU	22	Neonates	110%		108%		9.38	9.52	12.05	Paediatrics

APPENDIX 1

Safer Staffing Summary	Mar		Days in Month	31											
	Day RN Day RM	Day RN Day RM	Day CSW Day MSW	Day CSW Day MSW	Night RN Night RM	Night RN Night RM	Night CSW Night MSW	Night CSW Night MSW					Actual CHPPD			
Ward	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Qual Day	UnQual Day	Qual N	UnQual N	Sum 24:00 Occ	Registered	Care staff	Total
Evergreen																
A2	248	221	221	197	155	150	188	178	89%	89%	97%	95%	1,256	3.54	3.58	7.13
A3																
A4																
B1	119	104	65	59	73	70	57	52	87%	90%	96%	91%	582	3.40	2.24	5.64
B2(H)	124	117	226	222	93	93	193	181	94%	98%	100%	94%	847	2.98	5.71	8.68
B2(T)	93	86	125	124	62	62	94	89	92%	99%	100%	95%	670	2.59	3.81	6.40
B3	276	208	181	164	186	165	168	157	75%	91%	89%	93%	1,080	4.05	3.49	7.54
B4	186	171	243	223	155	146	178	174	92%	92%	94%	98%	1,343	2.77	3.55	6.32
B5	187	179	126	118	157	160	93	90	96%	94%	102%	97%	1,125	3.54	2.22	5.76
B6																
C1	186	164	308	290	155	141	180	186	88%	94%	91%	103%	1,457	2.45	3.92	6.37
C2	203	231	74	70	213	194	46	46	114%	95%	91%	100%	837	5.96	1.50	7.45
C3	217	198	366	370	186	156	366	371	91%	101%	84%	101%	1,580	2.69	5.63	8.32
C4	155	149	65	62	93	93	93	87	96%	95%	100%	94%	663	4.16	2.70	6.85
C5	186	168	229	230	155	136	170	176	90%	100%	88%	104%	1,451	2.39	3.35	5.75
C6	93	79	66	67	62	59	70	69	85%	102%	95%	99%	538	3.08	3.03	6.11
C7	190	163	164	133	129	124	164	144	86%	81%	96%	88%	1,073	3.13	3.03	6.16
C8	203	189	240	235	186	182	277	276	93%	98%	98%	100%	1,305	3.34	4.70	8.04
CCU_PCCU	217	181	43	44	155	154	-	2	83%	102%	99%		583	6.74	0.91	7.65
Critical Care	320	320	65	53	321	318	-	-	100%	82%	99%		246	30.47	2.26	32.74
EAU	279	245	341	264	279	268	341	286	88%	77%	96%	84%	1,533	4.02	4.22	8.23
Maternity	571	554	217	192	527	518	155	143	97%	88%	98%	92%	473	21.93	8.30	30.22
MHDU	117	103	38	32	115	109	5	4	88%	83%	95%	80%	227	10.98	1.88	12.86
NNU	154	170	-	-	153	166	-	-	110%		108%		411	9.38	0.00	9.38
TOTAL	**4,324**	**3,998**	**3,403**	**3,148**	**3,610**	**3,464**	**2,838**	**2,711**	**92%**	**92%**	**96%**	**96%**	**19,280**	**4.43**	**3.61**	**8.05**

Enclosure 7

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 3 May 2018

TITLE:	**Finance and Performance Committee Exception Report**		
AUTHOR:	Chris Walker - Deputy Director of Finance	**PRESENTER**	Jonathan Fellows Non-Executive Director

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

CORPORATE OBJECTIVE: S06 Plan for a viable future

SUMMARY OF KEY ISSUES:

Summary report from the Finance and Performance Committee meeting held on 26 April 2018.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** Achievement of Finance Goals
	Risk Register: Y		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Well led
	NHSI	**Y**	**Details:** Achievement of all Terms of Authorisation
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
		X	X

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the contents of the report and in particular the items referred to the Board for decision or action.

Meeting	Meeting Date	Chair	Quorate	
Finance & Performance Committee	**26 April 2018**	**Jonathan Fellows**	**yes**	**no**
			Yes	

Declarations of Interest Made

None

Assurances Received

- The financial position as at 31st March 2018 was discussed in detail. The final year end position was a £10.495m deficit before impairments and technical adjustments. This meant the Trust ended the year £13.025m short of our control total set by NHSI. Performance in March deteriorated against forecast mainly as a result of the pay costs the Trust incurred. The pay spend in March was the highest incurred by the Trust all financial year, characterised by the highest staff numbers, highest bank spend and an agency spend that was similar in magnitude to the previous two months.
- The new control total for 2018-19 was discussed and accepted by the Committee.
- The balance sheet, cash and capital position at 31st March 2018 was discussed in detail. This included an improved cash position against forecast due to the timing of receipts from NHS bodies and a slippage in capital payments. The 2018-19 cash flow had been updated for the final year end position and additions to the capital programme had resulted in a £631k movement against the approved plan last month.
- The transformation and CIP position was debated. The full year programme delivery was £8.9m which is below the plan. The lessons learnt from the 2017-18 CIP programme were discussed including the terms of reference of the new Financial Improvement Group.
- The Trust Operating Plan for 2018-19 was reviewed and minor changes requested.
- Performance in March against key performance targets was discussed. The March ED performance was debated. All other key targets were reviewed and assurance provided on achievement. The Committee requested clear sight of all key performance target trajectories for 2018-19 for the next meeting.
- A nursing and midwifery workforce report was discussed. This reviewed safer staffing, agency usage and recruitment. Concern was raised around the current control around wards/departments exceeding their establishment.
- Medical agency expenditure and the reduction in expenditure due to substantive recruitment and agency caps were discussed.
- Performance of the PFI contract in March was reviewed which included the Theatre Ultra Clean Canopy contract non-compliance and a slight improvement in overall service performance in the month.

Decisions Made / Items Approved

- 2018-19 revised control total

Actions to come back to Committee

- Detailed 2018-19 financial plan which includes the phasing by month.
- Further work on the business plan for the ‘Terafirma’ IT service provider to include profit/loss by contract and future business risk assessments.

• Report detailing status of budget holder/manager sign off of 2018-19 budgets and on-going accountability.
Performance Issues to be referred into Executive Performance Management Process
• Accountability of budget managers and budget holders in relation to management of budgets in 2018-19.
Areas of Risk to be escalated onto the Corporate or Divisional Risk Register
None
Items referred to the Board for decision or action
None

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd May 2018

TITLE:	Integrated Performance Report for Month 12 (March) 2018		
AUTHOR:	Andy Troth Head of Informatics	**PRESENTER:**	Karen Kelly Chief Operating Officer

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD:

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

The Dudley Group
NHS Foundation Trust

Integrated Performance Report - Board




March 2018

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

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

The Dudley Group NHS Foundation Trust

Quality Dashboard

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Complaints	-	20	25	28	29	43	33	36	35	29	51	28	42	399
Compliments	-	659	399	315	324	384	492	579	525	862	851	522	457	6,369
Friends & Family – Community – Footfall	1.20%	1.10%	0.90%	2.10%	3.30%	3.20%	1.90%	4.90%	5.20%	4.30%	3.30%	4%	3.40%	3.10%
Friends & Family – Community – Recommended %	95.80%	94%	96%	97.40%	98%	98.20%	97.10%	95.10%	95.90%	95.70%	96.30%	97.20%	97.40%	96.60%
Friends & Family – ED – Footfall	7.90%	15.40%	13.70%	17.10%	15.30%	16%	19.60%	28.50%	24.70%	17%	21.20%	22.60%	19.50%	19.10%
Friends & Family – ED – Recommended %	85.10%	75%	76.10%	78.70%	77.40%	72.50%	75.90%	83.60%	80.30%	77.40%	74.40%	75.50%	74.50%	77.30%
Friends & Family – Inpatients – Footfall	17.80%	28.70%	30.80%	32.80%	34.20%	32.30%	27.80%	33.90%	33.90%	30.90%	30.10%	34.60%	34.90%	32.10%
Friends & Family – Inpatients – Not Recommended %	-	0.60%	1.10%	0.70%	0.90%	1.40%	1.50%	2%	1.50%	2.60%	1.80%	1.90%	2.30%	1.50%
Friends & Family – Inpatients – Recommended %	96.60%	96.40%	95.60%	96.50%	96.40%	96.30%	95.90%	95.10%	95.30%	95.10%	94.10%	95.10%	93.70%	95.40%
Friends & Family – Maternity – Footfall	30.10%	30.90%	48.90%	40.40%	48.60%	56.30%	39.60%	34.80%	45.10%	23.60%	38.40%	35.90%	36.30%	40.30%
Friends & Family – Maternity – Not Recommended %	-	0.50%	0.70%	0.50%	0.80%	1%	0.80%	0.60%	0.70%	0%	0.20%	0.50%	0%	0.60%
Friends & Family – Maternity – Recommended %	98.30%	98.80%	97.80%	98.20%	98.60%	97.60%	97.80%	98.60%	95%	98.40%	97.20%	97.90%	97.80%	97.80%
Friends & Family – Outpatients – Footfall	1.60%	1.50%	1.90%	2.30%	2.60%	4.80%	2.90%	10.90%	5.90%	3.50%	5.90%	4.40%	4.60%	4.30%
Friends & Family – Outpatients – Recommended %	92.60%	95.30%	95.20%	91.60%	95.30%	93.40%	92.30%	90.80%	89.80%	92.80%	91.70%	89.30%	91.60%	91.80%
HCAI – Post 48 hour MRSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
HCAI CDIFF – Due To Lapses In Care	13	2	1	1	4	1	5	0	1	0	2	0	0	17
HCAI CDIFF – Not Due To Lapses In Care	20	0	0	1	0	0	1	1	4	1	3	0	0	11
HCAI CDIFF – Total Number Of Cases	33	2	1	2	4	1	6	1	5	1	5	0	2	30
HCAI CDIFF – Under Review	0	0	0	0	0	0	0	0	0	0	0	0	2	2
Incidents - Appointments, Discharge & Transfers	724	58	71	65	90	93	90	95	78	82	99	94	113	1,028
Incidents - Blood Transfusions	128	4	13	6	8	4	5	10	11	5	5	11	6	88
Incidents - Clinical Care (Assessment/Monitoring)	898	80	98	86	99	108	114	112	160	129	125	114	150	1,375
Incidents - Diagnosis & Tests	350	33	31	24	35	39	37	32	31	30	32	37	36	397
Incidents - Equipment	228	32	23	29	23	33	15	21	15	23	25	28	23	290
Incidents - Facilities (Security, Estates, Transport, Fire etc.)	401	38	45	65	52	61	37	42	29	39	24	26	33	491
Incidents - Falls, Injuries or Accidents	1,629	133	132	109	130	101	98	130	139	103	133	136	98	1,442
Incidents - Health & Safety	301	17	24	38	27	34	28	26	27	17	39	29	25	331

The Dudley Group NHS Foundation Trust

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Incidents - Infection Control	63	6	5	6	8	9	3	14	12	11	7	12	19	112
Incidents - Medication	4,441	293	334	324	312	226	287	499	608	341	372	260	304	4,160
Incidents - Obstetrics	935	89	73	87	127	102	85	80	78	68	79	64	58	990
Incidents - Pressure Ulcer	2,573	239	253	225	241	315	280	316	302	277	366	315	363	3,492
Incidents - Records, Communication & Information	562	47	52	40	123	64	68	79	68	65	87	65	67	825
Incidents - Safeguarding	638	51	60	63	63	49	78	80	79	76	89	93	85	866
Incidents - Theatres	195	13	11	15	27	18	12	17	10	22	20	20	23	208
Incidents - Venous Thrombo Embolism (VTE)	137	14	17	4	21	11	5	6	11	5	7	11	15	127
Incidents - Violence, Aggression & Self Harm	660	51	91	81	76	62	49	68	73	34	53	43	53	734
Incidents - Workforce	401	30	22	41	58	69	63	54	84	66	47	78	67	679
Maternity : Early Booking KPI: % of women who see midwife/maternity healthcare professional	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Maternity : Increase in breast feeding initiation rates by 2% per year	55.89%	57.45%	60.42%	60.99%	56.98%	53.47%	47.82%	58.39%	61.31%	55.08%	58.43%	59.27%	53.47%	56.85%
Maternity : Smoking In Pregnancy : Reduce to a prevalence of 12.1% across the year	14.75%	17.75%	14.57%	13.66%	12.91%	17.44%	13.69%	14.75%	19.78%	15.80%	17.59%	14.52%	14.66%	15.61%
Medicines Management Audit (Announced)	81%	-	-	86%	84%	-	76%	80%	-	-	-	79%	92%	83%
Medicines Management Audit (Unannounced)	-	-	60%	86%	71%	86%	73%	80%	78%	-	-	93%	-	78%
Mixed Sex Sleeping Accommodation Breaches	62	5	3	0	0	2	6	4	0	10	5	5	11	51
Never Events	1	0	0	1	0	0	0	0	1	0	0	1	0	3
NQA - Matrons Audit	89%	89%	92%	92%	92%	92%	92%	93%	95%	93%	94%	90%	-	92%
NQA - Nutrition Audit	96%	96%	95%	93%	95%	96%	95%	95%	93%	95%	92%	93%	95%	94%
NQA - Paediatric Nutrition Audit	98%	98%	100%	100%	91%	92%	97%	98%	98%	98%	100%	100%	98%	98%
NQA - Safety Thermometer	90	2	11	-	3	-	-	-	-	-	-	-	-	16
NQA - Skin Bundle	96%	93%	97%	94%	96%	95%	96%	93%	95%	96%	94%	96%	95%	95%
NQA - Think Glucose - EAU/SAU	-	83%	47%	82%	89%	65%	66%	80%	93%	100%	100%	100%	90%	77%
NQA - Think Glucose - General Wards	88%	92%	91%	89%	93%	94%	98%	97%	96%	98%	99%	90%	93%	94%
Nursing Care Indicators - Community Childrens	99%	100%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	-	99%
Nursing Care Indicators - Community Neonatal	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Nursing Care Indicators - Critical Care	98%	98%	100%	98%	100%	100%	98%	98%	100%	99%	98%	95%	99%	98%
Nursing Care Indicators - District Nurses	94%	91%	98%	94%	96%	97%	94%	91%	93%	92%	95%	95%	96%	94%

The Dudley Group NHS Foundation Trust

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Nursing Care Indicators - EAU	93%	88%	86%	98%	92%	94%	88%	97%	97%	97%	63%	86%	95%	90%
Nursing Care Indicators - ED	88%	91%	86%	93%	72%	92%	92%	92%	91%	86%	83%	90%	92%	88%
Nursing Care Indicators - Evergreen	90%	98%	91%	83%	97%	89%	85%	82%	-	-	-	-	-	89%
Nursing Care Indicators - General Wards	93%	93%	95%	96%	95%	94%	95%	95%	96%	97%	95%	93%	96%	95%
Nursing Care Indicators - Maternity	92%	100%	94%	97%	95%	95%	95%	95%	97%	94%	97%	96%	96%	96%
Nursing Care Indicators - Neonatal	98%	98%	99%	99%	99%	99%	99%	99%	98%	99%	98%	99%	100%	99%
Nursing Care Indicators - Paediatric	98%	94%	100%	97%	84%	95%	95%	97%	96%	97%	95%	97%	95%	95%
Nursing Care Indicators - Renal	95%	98%	99%	97%	98%	99%	92%	96%	93%	96%	98%	98%	95%	97%
PALS Concerns	-	177	235	234	232	246	189	218	209	197	187	172	205	2,501
Saving Lives - 01a CVC Insertion	98%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	96%	99%
Saving Lives - 01b CVC Ongoing Care	99%	98%	98%	98%	93%	100%	94%	100%	100%	100%	100%	100%	100%	98%
Saving Lives - 02a Peripheral Lines Insertion	97%	97%	96%	99%	99%	99%	99%	97%	98%	98%	98%	99%	100%	98%
Saving Lives - 02b Peripheral Lines Ongoing Care	96%	98%	99%	97%	99%	98%	98%	98%	99%	98%	98%	96%	97%	98%
Saving Lives - 03a Renal Dialysis Insertion	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%	99%
Saving Lives - 03b Renal Dialysis Ongoing Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Saving Lives - 04a Surgical Site Pre Op	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Saving Lives - 04b Surgical Site Intraoperative	100%	100%	100%	100%	100%	100%	100%	100%	90%	53%	96%	100%	100%	95%
Saving Lives - 04c Surgical Site Post Op	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Saving Lives - 05 Reducing Ventilation associated pneumonia	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Saving Lives - 06a Urinary Catheter Insertion	99%	100%	100%	100%	100%	98%	100%	98%	100%	100%	100%	100%	100%	99%
Saving Lives - 06b Urinary Catheter Ongoing Care	99%	99%	100%	98%	99%	98%	100%	100%	100%	99%	98%	99%	97%	99%
Saving Lives - 07 C.difficile	87%	100%	100%	-	75%	100%	88%	75%	75%	75%	100%	100%	100%	89%
Saving Lives - 08a Clinical equipment Decontamination Infected	99%	100%	100%	100%	99%	99%	99%	98%	100%	99%	99%	98%	100%	99%
Saving Lives - 08b Clinical equipment Decontamination Non Infected	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%	100%	99%	98%	99%
Saving Lives - 11 Enteral Feeding (New)	98%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	99%
Serious Incidents - Action Plan overdue	206	4	5	5	9	4	11	10	8	-	5	6	-	67
Serious Incidents - Appointments, Discharge & Transfers	7	-	-	-	-	-	-	-	-	-	-	-	1	1
Serious Incidents - Clinical Care (Assessment/Monitoring)	20	1	2	-	1	-	1	2	3	1	1	5	3	20

NHS
The Dudley Group
NHS Foundation Trust

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Nursing Care Indicators - EAU	93%	88%	86%	98%	92%	94%	88%	97%	97%	97%	63%	86%	95%	90%
Nursing Care Indicators - ED	88%	91%	86%	93%	72%	92%	92%	92%	91%	86%	83%	90%	92%	88%
Nursing Care Indicators - Evergreen	90%	98%	91%	83%	97%	89%	85%	82%	-	-	-	-	-	89%
Nursing Care Indicators - General Wards	93%	93%	95%	96%	95%	94%	95%	95%	96%	97%	95%	93%	96%	95%
Nursing Care Indicators - Maternity	92%	100%	94%	97%	95%	95%	95%	95%	97%	94%	97%	96%	96%	96%
Nursing Care Indicators - Neonatal	98%	98%	99%	99%	99%	99%	99%	99%	98%	99%	98%	99%	100%	99%
Nursing Care Indicators - Paediatric	98%	94%	100%	97%	84%	95%	95%	97%	96%	97%	95%	97%	95%	95%
Nursing Care Indicators - Renal	95%	98%	99%	97%	98%	99%	92%	96%	93%	96%	98%	98%	95%	97%
PALS Concerns	-	177	235	234	232	246	189	218	209	197	187	172	205	2,501
Saving Lives - 01a CVC Insertion	98%	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	100%	96%	99%
Saving Lives - 01b CVC Ongoing Care	99%	98%	98%	98%	93%	100%	94%	100%	100%	100%	100%	100%	100%	98%
Saving Lives - 02a Peripheral Lines Insertion	97%	97%	96%	99%	99%	99%	99%	97%	98%	98%	98%	99%	100%	98%
Saving Lives - 02b Peripheral Lines Ongoing Care	96%	98%	99%	97%	99%	98%	98%	98%	99%	98%	98%	96%	97%	98%
Saving Lives - 03a Renal Dialysis Insertion	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%	99%
Saving Lives - 03b Renal Dialysis Ongoing Care	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Saving Lives - 04a Surgical Site Pre Op	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Saving Lives - 04b Surgical Site Intraoperative	100%	100%	100%	100%	100%	100%	100%	100%	90%	53%	96%	100%	100%	95%
Saving Lives - 04c Surgical Site Post Op	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Saving Lives - 05 Reducing Ventilation associated pneumonia	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Saving Lives - 06a Urinary Catheter Insertion	99%	100%	100%	100%	100%	98%	100%	98%	100%	100%	100%	100%	100%	99%
Saving Lives - 06b Urinary Catheter Ongoing Care	99%	99%	100%	98%	99%	98%	100%	100%	100%	99%	98%	99%	97%	99%
Saving Lives - 07 C.difficile	87%	100%	100%	-	75%	100%	88%	75%	75%	75%	100%	100%	100%	89%
Saving Lives - 08a Clinical equipment Decontamination Infected	99%	100%	100%	100%	99%	99%	99%	98%	100%	99%	99%	98%	100%	99%
Saving Lives - 08b Clinical equipment Decontamination Non Infected	99%	99%	99%	99%	99%	99%	99%	99%	99%	100%	100%	99%	98%	99%
Saving Lives - 11 Enteral Feeding (New)	98%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	99%
Serious Incidents - Action Plan overdue	206	4	5	5	9	4	11	10	8	-	5	6	-	67
Serious Incidents - Appointments, Discharge & Transfers	7	-	-	-	-	-	-	-	-	-	-	-	1	1

The Dudley Group NHS Foundation Trust

Quality And Risk														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Serious Incidents - Clinical Care (Assessment/Monitoring)	20	1	2	-	1	-	1	2	3	1	1	5	3	20
Serious Incidents - Diagnosis & Tests	10	1	1	-	-	-	-	-	-	-	1	-	-	3
Serious Incidents - Facilities (Security, Estates, Transport, ICT, etc.)	-	-	-	-	-	-	-	1	-	-	-	1	-	2
Serious Incidents - Falls, Injuries or Accidents	32	3	-	2	3	-	2	2	3	2	2	1	1	21
Serious Incidents - Infection Control	6	1	-	-	-	-	-	2	2	-	-	-	-	5
Serious Incidents - Medication	1	-	-	-	-	-	-	-	1	-	-	1	-	2
Serious Incidents - Obstetrics	5	-	1	-	-	1	-	-	-	-	-	1	-	3
Serious Incidents - Pressure Ulcer	150	6	13	9	10	13	7	-	5	6	13	11	5	98
Serious Incidents - Records, Communication & Information	6	-	-	-	-	-	-	-	-	-	1	-	-	1
Serious Incidents - Theatres	3	-	-	-	1	-	-	-	-	-	-	1	1	3
Stroke Admissions : Swallowing Screen	77.02%	72.72%	76.27%	82.22%	82.69%	88.09%	90.24%	89.18%	71.79%	80%	78.26%	92.50%	100%	83%
Stroke Admissions to Thrombolysis Time	51.24%	100%	55.55%	0%	63.63%	77.77%	71.42%	71.42%	75%	42.85%	62.50%	0%	25%	57.14%
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)	87.56%	94.23%	96.49%	93.33%	96.22%	92.72%	90.69%	100%	80%	81.08%	98.07%	95.34%	89.79%	92.73%
Suspected High-risk TIA Assessed and Treated < 24hrs from presentation	79.31%	100%	85.71%	100%	81.81%	100%	100%	100%	90%	100%	100%	86.66%	87.50%	94.26%
Time to Surgery - Elective admissions operated on within two days for all procedures	92.81%	91.36%	82.83%	87.81%	92.65%	89.70%	70.68%	93.44%	94.65%	57.44%	92.03%	92.60%	61.17%	84.43%
Time to Surgery : Emergency Procedures (Appendectomy)	94.29%	100%	96.96%	95.45%	97.43%	97.05%	100%	96%	93.33%	90.90%	100%	93.75%	94.44%	96.89%
Time to Surgery : Emergency Procedures (Femur Replacement)	94.92%	94.44%	84.61%	80%	100%	95.23%	94.11%	89.47%	100%	100%	95.23%	85.71%	100%	93.40%
Time to Surgery : Emergency Procedures (Reduction of fracture of bone)	92.80%	94.23%	95.65%	88.09%	95.34%	86%	86.48%	95.34%	94.11%	89.28%	97.56%	88.63%	89.65%	91.89%
Time to Surgery : Emergency Procedures (Upper GI Diagnostic endoscopic)	64.98%	58.33%	70.58%	73.68%	70.37%	63.15%	92.85%	62.50%	57.14%	46.15%	78.78%	50%	80%	66.27%
VTE Assessment Indicator (CQN01)	94.75%	92.24%	91.97%	93.50%	94.08%	94.74%	94.37%	95.05%	93.97%	92.12%	91.72%	92.89%	94.10%	93.34%

The Dudley Group NHS Foundation Trust

Performance Dashboard

Performance														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
A&E - 4 Hour A&E Dept Only % (Type 1)	89.76%	84.93%	86.59%	90.02%	82.74%	80.19%	81.47%	84.94%	73.99%	64.79%	70.21%	67.99%	70.04%	78.38%
A&E - 4 Hour UCC Dept Only % (Type 3)	100%	100%	99.96%	100%	100%	99.41%	99.64%	99.18%	99.88%	98.57%	98.31%	99.48%	98.33%	99.38%
A&E - 4 Hour UCC/A&E Combined % (Type 1+3)	94.16%	91.69%	92.04%	93.52%	89.11%	87.15%	87.73%	90.06%	83.90%	78.92%	81.70%	80.60%	81.55%	86.56%
A&E - Patients who Left Without Being Seen %	1.90%	2.10%	2.20%	2.20%	3.10%	2.80%	2.90%	2.50%	2.90%	3.80%	3.10%	2.30%	1.60%	2.60%
A&E - Time to Initial Assessment (95th Percentile)	9	19	15	21	32	24	21	20	33	50	35	12	9	9
A&E - Time to Treatment Median Wait (Minutes)	65	63	64	70	74	70	72	68	83	92	79	72	70	70
A&E - Total Time in A&E (95th Percentile)	296	406	388	352	474	472	485	432	610	771	662	705	731	731
A&E - Unplanned Re-Attendance Rate %	1.80%	1.80%	2.10%	1.60%	1.80%	1.20%	1.50%	1.60%	1.50%	1.20%	1.30%	1.20%	1%	1.50%
Activity - A&E Attendances	102,696	8,573	9,047	8,867	9,064	8,118	8,565	9,144	8,671	8,425	8,748	7,791	8,413	103,426
Activity - Cancer MDT	5,489	406	479	459	458	392	415	436	423	381	426	445	411	5,131
Activity - Community Attendances	394,381	27,630	33,233	30,929	31,939	31,808	32,404	31,250	34,138	27,169	34,143	30,122	31,783	376,548
Activity - Critical Care Bed Days	8,366	686	649	624	626	607	602	610	648	665	644	671	580	7,612
Activity - Day Care Attendances	6,353	278	343	351	271	242	341	424	434	277	423	420	346	4,150
Activity - Diagnostic Imaging whilst Out-Patient	56,516	3,835	4,285	4,364	4,493	4,575	4,484	4,667	4,752	3,725	5,061	4,206	4,245	52,692
Activity - Direct Access Pathology	1,929,670	143,708	168,459	172,016	164,859	172,090	162,338	174,512	169,262	113,573	184,339	168,847	176,643	1,970,646
Activity - Direct Access Radiology	73,314	5,659	6,678	6,406	6,476	6,449	6,355	6,619	6,874	5,103	6,773	5,947	6,111	75,450
Activity - Elective Day Case Spells	45,982	3,805	4,209	4,170	4,190	4,219	3,916	4,224	4,139	3,596	4,180	3,982	4,052	48,682
Activity - Elective Inpatients Spells	6,029	473	509	479	486	492	493	509	547	411	467	442	520	5,828
Activity - Emergency Inpatient Spells	60,748	4,966	5,202	5,026	5,056	4,888	3,697	3,891	3,542	3,340	3,794	3,260	3,498	50,160
Activity - Evergreen Bed Days	-	1,013	1,186	1,407	1,197	858	1,089	316	0	0	0	0	0	7,066
Activity - Excess Bed Days	18,931	1,285	953	873	1,011	1,308	1,079	870	748	894	962	739	344	11,066
Activity - Maternity Pathway	7,361	613	628	679	572	703	741	654	656	508	811	562	509	7,636
Activity - Neo Natal Bed Days	6,734	532	529	633	655	665	644	585	637	585	624	506	516	7,111
Activity - Outpatient First Attendances	125,869	8,700	11,090	11,297	11,053	11,373	13,572	13,419	13,612	11,361	14,316	13,102	13,351	146,246
Activity - Outpatient Follow Up Attendances	310,607	21,003	25,421	25,593	24,627	24,381	25,456	26,331	26,992	20,360	27,410	23,762	23,965	295,301
Activity - Outpatient Procedure Attendances	59,621	5,013	6,496	6,470	6,155	6,230	5,934	6,395	6,369	4,786	6,081	6,018	5,555	71,502
Activity - Rehab Bed Days	20,228	1,510	1,373	1,854	1,826	1,705	1,872	1,574	1,608	1,668	2,019	1,420	1,650	20,079
Activity - Renal Dialysis	48,418	4,170	4,496	4,129	4,192	4,322	4,342	4,298	4,497	4,606	4,472	3,968	4,578	52,070

The Dudley Group NHS Foundation Trust

Performance														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Ambulance Handover - 30 min – breaches (DGH view)	1,381	252	190	214	302	273	294	228	560	868	691	448	288	4,608
Ambulance Handover - 30 min – breaches (WMAS view)	1,885	340	261	292	370	376	362	317	696	1,003	842	545	399	5,803
Ambulance Handover - 60 min – breaches (DGH view)	213	33	27	28	64	48	25	11	122	155	109	59	35	716
Ambulance Handover - 60 min – breaches (WMAS view)	284	42	32	34	78	61	29	15	138	187	138	73	49	876
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	95.50%	94.70%	97%	97.60%	98%	84.90%	94%	94.70%	95.20%	95.60%	96.20%	95.20%	93.20%	94.70%
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	97.40%	97.20%	97.10%	100%	100%	97.10%	97.20%	99.30%	96.30%	94.20%	96.60%	99.10%	92.40%	97.30%
Cancer - 31 day - from diagnosis to treatment for all cancers	99.10%	98.40%	100%	97.30%	96.50%	98.70%	100%	100%	98.80%	99.20%	98.60%	99.10%	98.40%	98.70%
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	99.60%	100%	100%	100%	96.10%	95.80%	100%	100%	100%	100%	100%	100%	100%	99.30%
Cancer - 31 Day For Subsequent Treatment From Decision To Treat	99.80%	100%	100%	100%	98.50%	98.70%	100%	100%	100%	100%	100%	100%	100%	99.60%
Cancer - 62 day - From Referral for Treatment following a Consultant Upgrade	95.60%	93.70%	94.60%	91.70%	94.50%	90.30%	92%	100%	91%	93.80%	91.40%	93.90%	89.60%	93.10%
Cancer - 62 day - From Referral for Treatment following national screening referral	97.90%	92.30%	100%	100%	95%	90.40%	100%	100%	100%	100%	100%	100%	100%	98.40%
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	85.10%	86.60%	76.70%	78%	82.80%	83.10%	91.10%	93.10%	87.70%	85.20%	89.10%	83.90%	84.40%	85.20%
Cancer: Patients on a 62 day pathway treated on or over 104 days (1: patients treated at DGFT)	17	1	1	1	5	1	0	0	2	2	2	3	-	18
Cancer: Patients on a 62 day pathway treated on or over 104 days (2: patients treated at a Tertiary Centre)	30	1	7	3	0	3	1	1	3	2	2	2	-	25
Cancer: Patients on a 62 day pathway treated on or over 104 days (3: combined)	47	2	8	4	5	4	1	1	5	4	4	5	-	43
Maternity: Breastfeeding Data Coverage Rates	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Number of Births Within the Trust	4,496	391	351	372	403	390	375	404	378	342	372	312	345	4,435
RTT - Admitted Pathways within 18 weeks %	92.40%	86.30%	88.70%	88.60%	90.80%	89.90%	88.60%	88.50%	86.20%	88.70%	87%	86.30%	85.30%	87.90%
RTT - Incomplete Waits within 18 weeks %	95.40%	94.20%	94.60%	95%	94.30%	94.10%	94%	93.70%	93.80%	93.30%	93.50%	94%	92.80%	94%
RTT - Non-Admitted Pathways within 18 weeks %	96.50%	93.20%	94.50%	93.10%	92.80%	92.80%	92.80%	93%	90.70%	91.30%	94.10%	93.40%	95.10%	93.10%

SUMMARY | PERFORMANCE | CQSPE | FINANCE | WORKFORCE

The Dudley Group NHS Foundation Trust

Waiting Time - Diagnostic 6 Week Maximum Wait (VSA05)	97.40%	95.98%	94.27%	96.86%	97.79%	97.70%	98.34%	98.56%	99.15%	99.36%	99.29%	99.45%	99.44%	97.85%

The Dudley Group NHS Foundation Trust

Finance Dashboard

Finance														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Agency spend	-	£849k	£979k	£717k	£951k	£896k	£965k	£948k	£660k	£912k	£1,292k	£1,245k	£1,198k	£11,613k
Bank spend	-	£1,158k	£1,183k	£1,313k	£1,377k	£1,284k	£1,336k	£1,321k	£1,452k	£1,289k	£1,429k	£1,454k	£1,809k	£16,404k
Budgetary Performance	£1,467k	(£72)k	(£369)k	£412k	(£135)k	(£2,185)k	£2,380k	(£2,278)k	(£4,241)k	(£3,804)k	(£3,996)k	(£2,398)k	(£3,937)k	(£20,622)k
Capital v Forecast	63.70%	72.60%	52.70%	49.60%	57.90%	57.10%	64.30%	72.20%	79.10%	88.90%	98.60%	102.90%	106.60%	106.60%
Cash Balance	£17,367k	£20,481k	£18,145k	£18,113k	£20,697k	£18,584k	£16,074k	£18,192k	£16,033k	£14,305k	£9,733k	£8,617k	£8,617k	£8,617k
Cash v Forecast	65.60%	80%	74.90%	84.10%	95.90%	99%	98.70%	118.60%	98.90%	92.40%	56.10%	43.50%	54.60%	54.60%
Creditor Days	13.1	13.2	12.1	13.1	12.9	13.4	16.2	15.5	14.8	17	15.8	16	16.4	16.4
Debt Service Cover	1.77	0.57	1.06	1.45	1.56	1.34	1.66	1.51	1.44	1.02	0.91	0.79	0.79	0.79
Debtor Days	19.4	16	17.7	17.6	16.4	16.8	20.3	19.3	18.9	14	15.5	14.4	7.4	7.4
EBITDA	£32,776k	£137k	£1,645k	£2,653k	£2,171k	£4k	£4,192k	£716k	(£1,551)k	(£2,768)k	(£888)k	(£1,401)k	(£568)k	£4,342k
I&E (After Financing)	£10,004k	(£980)k	£514k	£1,541k	£1,043k	(£1,123)k	£3,193k	(£296)k	(£2,660)k	(£3,879)k	(£2,015)k	(£2,478)k	(£2,379)k	(£9,518)k
Liquidity	16.43	14.7	14.56	14.99	15.2	13.16	15.25	13.57	11.94	4.17	0.72	-3.26	-7.63	-7.63
SLA Performance	£1,937k	£97k	£246k	(£476)k	(£370)k	(£933)k	£489k	(£644)k	(£352)k	(£1,500)k	£195k	(£85)k	(£569)k	(£3,902)k

Staff/HR Dashboard

Staff/HR														
Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Appraisals	82.90%	81.90%	83.60%	82.90%	83.90%	83.90%	84%	87.20%	88.10%	86.90%	84.40%	79.90%	70.50%	70.50%
Flu Vaccination Rate	-	-	-	-	-	-	-	52.90%	66.70%	70.10%	72.10%	75.86%	-	
Mandatory Training	83.90%	84.60%	84.80%	84.50%	85%	85.40%	86%	85.90%	86.90%	86.60%	87.10%	87%	85.90%	85.90%
RN average fill rate (DAY shifts)	89.69%	91.39%	92.12%	91.39%	90.57%	87.67%	88.54%	88.35%	88.18%	87.63%	89.24%	93.69%	87.87%	89.64%
RN average fill rate (NIGHT shifts)	94.25%	94.46%	95.10%	95.81%	92.18%	91.62%	91.18%	89.53%	91.15%	90.20%	93.24%	101.54%	90.39%	92.85%
Sickness Rate	4.02%	3.42%	3.80%	3.93%	4.14%	4.25%	4.18%	4.45%	5.01%	5.08%	5.66%	4.54%	4.26%	4.40%
Staff In Post (Contracted WTE)	4,278.19	4,184.78	4,178.82	4,204.73	4,176.26	4,179.26	4,196.01	4,216.59	4,219.28	4,215.48	4,221.17	4,228.07	4,270.43	4,270.43
Turnover Rate (Rolling 12 Months)	8.74%	8.63%	9.13%	9.25%	9.29%	9.21%	9.20%	9.26%	9.19%	9.28%	9.62%	9.68%	9.74%	9.74%
Vacancy Rate	7.89%	8.74%	8.67%	8.77%	9.20%	9.45%	9.14%	8.63%	7.50%	7.53%	7.66%	7.62%	6.63%	6.63%

The Dudley Group NHS Foundation Trust

Executive Summary by Exception

Key Messages

1 Performance Matters — Committee: F&P

A&E 4 hour wait

The combined Trust and UCC performance was below target in month at 81.44%. Whilst, the Trust only (Type 1) performance was 70.04%.

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

	Attendances	Breaches	Performance
A&E Dept. Type 1	8425	2524	70.04%
UCC Type 3	5776	96	98.34%

Cancer Waits

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

Cancer – 62 Day from Urgent GP Referral to Treatment performed below target for the month at 84.4% (Provisional). Previous month confirmed performance was 83.6%

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

No. of Patients treated on or over 104 days (DGFT) 3

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

No. of Patients treated on or over 104 days (Combined) 5

2WW

The target was achieved once again in month. During this period a total of 1185 patients attended a 2ww appointment with 80 patients attending their appointments outside of the 2 week standard, achieving a performance 93.33% against the 93% target.

Referral To Treatment (RTT)

The performance of the key target RTT Incomplete Waiting Time indicator remained above target, with performance of 92.84% in month against a target of 92%, a decrease in performance from 94% in the previous month. Urology did not meet the target in month at 86.46%, down from 89.02% in previous month. Ophthalmology is at 82.89%, up from 82.53% in the previous month. Plastic Surgery at 87.74% down from 89.09%. General Surgery at 90.22% down from 92.06% and Neurology 91.71% down from 94.32%. There were no 52-week Non-admitted Waiting Time breaches in month.

Diagnostic waits

The diagnostic wait target was achieved in month with a performance of 99.44%. The number of patients waiting over 6 weeks was 34.

Of the 34, MRI accounted for 29 (5 other).

Executive Summary by Exception cont.

Key Messages

2 Financial Performance Matters — Committee: F&P

Pre STF, the cumulative March consolidated position resulted in a £10.495m deficit, which is £13.025m worse than plan. The position represents a deterioration from the Trust forecast £8.6m deficit but is in-keeping with NHSI expectations. All figures are now subject to audit and exclude an impairment of £1.428m. Despite this position the Trust has been allocated a further £2.241m STF from the bonus element resulting in a total value of £4.728m STF earned during the year. The key headlines for the year are summarised by a shortfall of contract income, a significant pay overspend (agency/bank), a small non pay underspend (influenced by a series of one-off benefits) and the adverse impact of a revaluation exercise.

The position on the Trust's liquidity ratio was -8.0 days against a planned position of 11.7 days at Month 12. Liquidity continues to deteriorate against plan as a result of the movement from plan on I&E, the receipt of no STF in the 2nd half of the year and the impact on cash.

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

CQSPE

HCAI

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

	March	YTD
Total No. of cases due to lapses in care	N/A	17
Total No. of cases NOT due to lapses in care	N/A	11
No. of cases currently under review (ytd)	2	N/A
Total No. of cases ytd.	N/A	30

There were 0 post 48 hour MRSA cases reported in month.The last post 48 hours MRSA cases was 916 days ago

Friends and Family Scores

We continue to focus on engaging with our patients and their families. The Chief Nurse will oversee the volunteers from 1 May 2018 and we will focus activity of engagement and improving our Friend and Family scores.

Falls

We continue to reduce the number of patients who fall in our care and also the level of harm incurred.

Pressure Ulcers

We continue to focus on improvement and learning in relation to Pressure Ulcers in both the community and the hospital. Additional details and assurance is provided to the CQPSEC. The last patient to develop an avoidable Grade 4 pressure ulcer occurred in the Community, in January 2018. However we have reported a grade 3 which evolved to a grade 4 unavoidable pressures ulcer in March 2018.

Never Events

There were 0 never events in month.

Mixed Sex Sleeping Accommodation Breaches (MSA)

There are 11 MSA breaches in month; 6 medical, 4 SHDU and 1 ITU. 2 out of the 4 SHDU patients and the 1 ITU patients were medical patients that were unable to transfer to medical wards in a timely manner.

VTE Assessment On Admission: Indicator

The indicator did not achieve the target in month with provisional performance at 94.11% against a target of 95%. This is an increase on the previous month's performance of 92.90%.

The Dudley Group NHS Foundation Trust

Executive Summary by Exception cont.

Key Messages

4 Workforce — Committee: F&P

Staff Appraisals:

This includes all non-medical appraisals in the Trust. The trends indicate significant improvements in performance in 2017/18 compared with that of 2016/17. This peaked in November 2017 where the Trust achieved an overall compliance rate of 88.10%. However, performance has dipped slightly over the main winter months. This was expected and until February the rates of compliance continued to be very positive. It was expected that performance would dip further from February as a result of the formal announcement of the new appraisal window that would require all future appraisals to take place between April-June each year. We have been monitoring bookings with compliance in some areas reaching 90%. We will review bookings against actual appraisals at the end of April to ensure we are meeting our expected trajectory. Where teams are not meeting their expected outcomes individual support and accountability meetings will take place. However, the expectation is that by 30th June 2018 at least 90% of staff in the Trust will have had their appraisal for 2018/19.

Mandatory Training:

As with appraisal compliance the Trust has seen a significant improvement in performance in 2017/18 compared with that of 2016/17. We are currently having a consistent compliance rate of around 86%. There have been some changes to mandatory training requirements with particular emphasis on Safeguarding and Infection Control. We have recently introduced an additional support mechanism for staff who will now receive email notification leading up to non-compliance for particular areas. It is therefore important to use the new system alongside the benefits to staff and patients to manage performance at Divisional and departmental level in order to achieve overall compliance of 90%.

Sickness Rate:

The Trust has set itself an ambitious target of 3.5% associated to sickness. The sickness rate increased across the winter period. This is consistent with seasonal variations but was higher than the rate for the same time last year. Since February we are seeing a reduction in absence and we are expecting further reductions in April 2018. We have introduced new measures in the absence policy and support to managers. There is a new leadership development programme in place alongside greater emphasis and initiatives regarding staff engagement. We would expect that the measures supported at Workforce Committee will continue to see an improvement in rates.

Turnover & Vacancy Rate:

The turnover rate continues to cause concern as it is over 1% higher than at the same time last year. However, this has been offset with successful recruitment campaigns that has supported higher levels of the substantive workforce and reduced our vacancy rate. The Workforce Committee are committed to understanding the reasons for turnover and applying a number of measures associated to engagement for new staff as well as development opportunities for staff, to encourage greater levels of retention. In terms of recruitment we continue to have regular and targeted recruitment events that continue to be very effective.

The Dudley Group NHS Foundation Trust

Patients will experience safe care - "At a glance"

Executive Lead: Siobhan Jordan

Patients will experience safe care - Quality & Experience

	Target (Amber)	Target (Green)	Mar-18	Trend	Month Status
Friends & Family Test - Footfall					
Friends & Family Test - ED	14.5%	21.3%	19.5%	↓	
Friends & Family Test - Inpatients	26.0%	35.1%	34.9%	↑	
Friends & Family Test - Maternity	21.7%	34.4%	36.3%	↑	
Friends & Family Test - Outpatients	4.7%	14.5%	4.6%	↑	
Friends & Family Test - Community	3.5%	9.1%	3.5%	↓	
Friends & Family Test - Recommended					
Friends & Family Test - ED	89.9%	93.4%	74.5%	↓	
Friends & Family Test - Inpatients	96.3%	97.4%	93.7%	↓	
Friends & Family Test - Maternity	96.0%	98.1%	97.9%	↓	
Friends & Family Test - Outpatients	94.6%	97.2%	91.7%	↑	
Friends & Family Test - Community	96.4%	97.7%	97.4%	↑	
Complaints					
Total no. of complaints		N/A	185	↑	
Complaints closed within target			100.0%	↔	
Complaints re-opened			0	↔	
PALs Numbers			286	↑	
Ombudsman					
Dementia (1 month in arrears)					
Find/Assess		90%	87.1%	↓	
Investigate		90%	100.0%	↔	
Refer		90%	95.1%	↓	
Falls					
No. of Falls			64	↓	
Falls per 1000 bed days		6.63	3.4	↓	
No. of Multiple Falls		N/A	3	↓	
Falls resulting in moderate harm or above			1		
Falls resulting in moderate harm or above per 1000 bed days		0.19	1	↑	
Pressure Ulcers (Grades 3 & 4)					
Hospital Avoidable		0	2	↑	
Hospital Non-avoidable		0	0	↔	
Community Avoidable		0	1	↔	
Community Non-avoidable		0	5	↓	
Mixed Sex Accommodation Breaches					
Single Sex Breaches		0	11	↑	

Patients will experience safe care - Patient Safety

	Target (Amber)	Target (Green)	Mar-18	Trend	Month Status
Mortality (Quality Strategy Goal 3)					
HSMR Rolling 12 months (**Latest data Jan 18**)	110	105	109		
SHMI Rolling 12 months (**Latest data Dec17**)	1.10	1.05	1.03		
HSMR Year to date (**Latest data Jan 18**)			112		
Infections					
Cumulative C-Diff due to lapses in care		15	16		
MRSA Bacteraemia		0	0	↔	
MSSA Bacteraemia		0	3	↑	
E. Coli - Total hospital		0	2	↔	
Stroke Admissions - PROVISIONAL					
Stroke Admissions: Swallowing Screen		75%	100.0%	↑	
Stroke Patients Spending 90% of Time on Stroke Unit		85%	89.8%	↓	
Suspected High Risk TIAs Assessed and Treated <24hrs		85%	87.5%	↓	
VTE - PROVISIONAL					
VTE On Admission		95%	94.1%	↑	
Incidents					
Total Incidents			1397	↓	
Recorded Medication Incidents			304	↑	
Never Events			0	↓	
Serious Incidents			11	↓	
of which, pressure ulcers			5	↓	
Incident Grading by Degree of Harm					
Death			1	↔	
Severe			3	↓	
Moderate			5	↓	
Low			248	↑	
No Harm			1209	↑	
Percentage of incidents causing harm		28%	17.5%	↓	
NQA Think Glucose					
NQA Think Glucose - AMU/SAU	85%	95%	90%	↓	
NQA Think Glucose - General Wards	85%	95%	93%	↑	

Performance - "At a glance"

Executive Lead: Karen Kelly

The Dudley Group NHS Foundation Trust

Performance - Key Performance Indicators

	Target	Mar-18	Actual YTD	Trend	Month Status
Cancer Reporting - TRUST (provisional)					
All Cancer 2 week waits	93%	93.2%	94.8%	↓	
2 week wait - Breast Symptomatic	93%	92.4%	97.3%	↓	
31 day diagnostic to 1st treatment	96%	98.5%	98.7%	↓	
31 day subsequent treatment - Surgery	94%	100.0%	99.3%	↔	
31 day subsequent treatment - Drugs	94%	100.0%	100.0%	↔	
62 day urgent GP referral to treatment	85%	83.6%	79.3%	↓	
62 day screening programme	90%	100.0%	98.5%	↔	
62 day consultant upgrades	85%	88.9%	92.9%	↓	
Referral to Treatment					
RTT Incomplete Pathways - % still waiting	92%	92.8%	94.4%	↓	
RTT Admitted - % treatment within 18 weeks	90%	85.4%	88.0%	↓	
RTT Non Admitted - % treatment within 18 weeks	95%	95.2%	93.1%	↑	
Wait from referral to 1st OPD	26	22	335	↓	
Wait from Add to Waiting List to Removal	39	40	500	↓	
ASI List		2252		↑	
% Missing Outcomes RTT		0.1%	0.1%	↑	
% Missing Outcomes Non-RTT		7.4%	5.0%	↑	
DM01					
No. of diagnostic tests waiting over 6 weeks	0	34	1640	↑	
% of diagnostic tests waiting less than 6 weeks	99%	99.4%	97.9%	↓	
ED - TRUST					
Patients treated < 4 hours Type 1 (Trust ED)	95%	70.0%	78.4%	↑	
Patients treated < 4 hours Type 1 & 3 (ED + UCC)	95%	81.6%	86.6%	↑	
Emergency Department Attendances	N/A	8425	103444	↑	
12 Hours Trolley Waits	0	0	0	↓	
Ambulance to ED Handover Time - TRUST					
30-59 minute breaches		288	4608	↓	
60+ minute breaches		35	716	↓	
Cancelled Operations - TRUST					
% Cancelled Operations	1.0%	2.0%	1.4%	↑	
Cancelled operations - breaches of 28 day rule	0	2	17	↑	
Urgent operations - cancelled twice	0	0	0	↔	

Performance - Key Performance Indicators cont.

	Target	Mar-18	Actual YTD	Trend	Month Status
GP Discharge Letters					
GP Discharge Letters	90%	76.7%	78.4%	↓	
Theatre Utilisation - TRUST					
Theatre Utilisation - Day Case (RHH & Corbett)		76.4%	76.3%	↓	
Theatre Utilisation - Main		89.5%	86.5%	↑	
Theatre Utilisation - Trauma		90.0%	91.2%	↑	
GP Referrals					
GP Written Referrals - made		7133	85025	↓	
GP Written Referrals - seen		5812	72170	↓	
Other Referrals - Made		3066	32651	↓	
Throughput					
Patients Discharged with a LoS >= 7 Days		7%	7%	↔	
Patients Discharged with a LoS >= 14 Days		4%	3%	↑	
7 Day Readmissions		4%	3%	↓	
30 Day Readmissions - PbR		7%	7%	↓	
Bed Occupancy - %		93%	90%	↑	
Bed Occupancy - % Medicine & IC		94%	95%	↓	
Bed Occupancy - % Surgery, W&C		91%	88%	↑	
Bed Occupancy - Paediatric %		92%	61%	↑	
Bed Occupancy - Orthopaedic Elective %		82%	77%	↑	
Bed Occupancy - Trauma and Hip # %		94%	94%	↓	
Number of Patient Moves between 8pm and 8am		109	1175	↑	
Discharged by Midday		14%	15%	↓	
Outpatients					
New outpatient appointment DNA rate	8%	12.3%	11.2%	↑	
Follow-up outpatient appointment DNA rate	8%	10.3%	8.1%	↑	
Total outpatient appointment DNA rate	8%	11.1%	10.0%	↑	
Clinic Utilisation		81.5%	82.1%	↓	
Average Length of stay (Quality Strategy Goal 3)					
Average Length of Stay - Elective	0.0	3.0	3.2	↓	
Average Length of Stay - Non-Elective	3.4	6.1	5.4	↑	

Financial Performance - "At a glance"

Executive Lead: Tom Jackson

Performance - Financial Overview

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
ACTIVITY LEVELS (PROVISIONAL)								
Elective inpatients	555	520	-6.3%	-35	6,630	5,868	-11.5%	-762
Day Cases	3,996	3,919	-1.9%	-77	47,760	48,827	2.2%	1,067
Non-elective inpatients	5,238	3,498	-33.2%	-1,740	61,667	54,050	-12.4%	-7,617
Outpatients	38,089	37,239	-2.2%	-850	449,254	441,866	-1.6%	-7,388
A&E	8,610	8,425	-2.1%	-185	101,622	103,444	1.8%	1,822
Total activity	**56,488**	**53,601**	**-5.1%**	**-2,887**	**666,933**	**654,055**	**-1.9%**	**-12,878**
CIP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Income	137	139	0.9%	1	1,375	1,186	-13.7%	-189
Pay	1,219	1,594	30.8%	375	7,714	3,606	-53.3%	-4,108
Non-Pay	331	313	-5.4%	-18	3,570	4,082	14.4%	512
Total CIP	**1,688**	**2,047**	**21.2%**	**358**	**12,659**	**8,874**	**-29.9%**	**-3,784**
INCOME	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
NHS Clinical	28,187	26,959	-4.4%	-1,228	328,887	321,792	-2.2%	-7,095
Other Clinical	128	175	36.6%	47	1,538	1,356	-11.8%	-182
STF Funding	1,000	0	-100.0%	-1,000	8,574	2,487	-71.0%	-6,087
Other	1,842	3,120	69.4%	1,278	22,129	24,649	11.4%	2,520
Total income	**31,157**	**30,254**	**-2.9%**	**-904**	**361,128**	**350,285**	**-3.0%**	**-10,843**
OPERATING COSTS	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Pay	-17,181	-18,950	10.3%	-1,769	-206,496	-214,698	4.0%	-8,202
Drugs	-2,759	-2,747	-0.4%	12	-32,762	-33,260	1.5%	-498
Non-Pay	-8,898	-8,815	-0.9%	83	-88,064	-87,307	-0.9%	757
Total Costs	**-28,837**	**-30,512**	**5.8%**	**-1,674**	**-327,322**	**-335,266**	**2.4%**	**-7,944**

Performance - Financial Overview - TRUST LEVEL ONLY

	Month Plan	Month Actual	Variance %	Variance	Plan YTD	Actual YTD	Variance %	Variance
	£'000	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
EBITDA	**3,433**	**1,694**	**-50.7%**	**-1,739**	**33,718**	**15211**	**-54.9%**	**-18,507**
Depreciation	-766	-824.66	7.7%	-59	-9,309	-9251	-0.6%	58
Restructuring & Other	0	0	n/a	0	0	0	n/a	0
Financing Costs	-1,117	-3,240	190.1%	-2,123	-13,393	-15324	14.4%	-1,931
SURPLUS/(DEFICIT)	**1,550**	**-2,371**	**-252.9%**	**-3,920**	**11,016**	**-9363**	**-185.0%**	**-20,379**
SOFP	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Capital Spend	2,180	2,850	30.7%	670	16,084	17152	6.6%	1,068
Inventory					2,836	2991	5.5%	155
Receivables & Prepayments					12,139	10669	-12.1%	-1,470
Payables					-17,330	-21260	22.7%	-3,930
Accruals							n/a	0
Deferred Income					-2,971	-1639	-44.8%	1,332
Cash & Loan Funding	**£'000**	**£'000**		**£'000**	**£'000**	**£'000**		**£'000**
Cash					25,440	13,899	-45.4%	-11,541
Loan Funding							n/a	0
KPIs								
EBITDA %	11.02%	5.44%	-5.6%		9.34%	4.34%	-5.0%	
Deficit %	4.97%	-7.61%	-13%		3.05%	-2.67%	-5.7%	
Receivable Days					0.0	0.0	n/a	
Payable (excluding accruals) Days					0.0	0.0	n/a	
Payable (including accruals) Days					0.0	0.0	n/a	
Use of Resource metric					1	4		

The Dudley Group NHS Foundation Trust

Workforce - "At a glance"

Executive Lead: Andrew McMenemy

People	Target	Actual		Month
	17/18	Mar-18	YTD	Trend	Status
Workforce					
Sickness Absence Rate	3.75%	4.26%	4.34%	↑	
Staff Turnover	10.0%	9.7%	9.3%	↓	
Mandatory Training	90.0%	85.9%	85.8%	↔	
Appraisal Rates - Total	90.0%	70.5%	83.1%	↓	

Enclosure 9

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board on 3rd May 2018

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

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

In 2017/18, the Trust had an overall Cost Improvement Programme (CIP) target of £12.5m. To support this, the Trust identified 58 schemes to contribute to the £12.5m identified. 3% of the CIP was identified as non-recurrent savings.

Overview

Based on the month 12 position (March 2018, Appendix One), the Trust achieved c. £8.9m against the end of year plan of £12.6m giving a variance of -£3.7m. This variance is accounted for predominantly by three schemes:

- Nursing bank and agency reduction
- Surgery contact income growth
- Theatre productivity

A 2017/18 CIP lessons learned report is attached as Appendix Two to support planning and delivery of the CIP in 2018/19 (£25m). The report has been produced with input from the members of the Annual Planning Group which has overseen the planning and development of the 2018/19 CIP programme. It presents both the positive and negative lessons learned as well as the impact of these issues and the actions that have been (or can be) taken to support achievement in 2018/19. The report is structured into the lessons learned from i) CIP identification and planning; ii) CIP delivery; and iii) CIP monitoring and reporting.

IMPLICATIONS OF PAPER:

RISK	**Y**	**Risk Description:** COR061: Failure to remain financially sustainable in 2017-18 and beyond COR080: Failure to deliver 2017/18 Cost Improvement Programme
	Risk Register: **Y**	**Risk Score:**

			COR061: 16 COR080: 12
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSI	**Y**	**Details:** CIP forms part of annual planning and reporting requirements.
	Other	**N**	**Details:**

ACTION REQUIRED OF TRUST BOARD

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE TRUST BOARD:

- Note the year end delivery of CIP

The Dudley Group NHS
NHS Foundation Trust

Trust Board

CIP Summary Report: Month Twelve (March 2018)

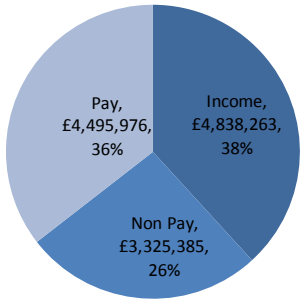
Date of Trust Board: 3rd May 2018

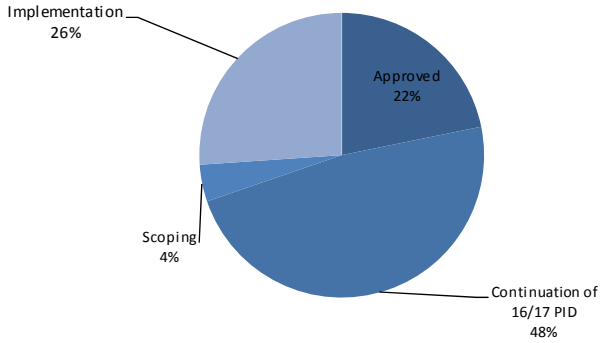
Executive Summary – 2017/18

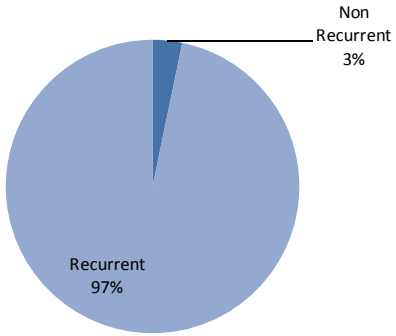
The Trust has an overall Cost Improvement Programme (CIP) target of £12.5m in 2017/18. To support this, there are 57 schemes on the work programme which contribute to the £12.5m identified, and 3% of of the CIP has currently been identified as non recurrent savings.

A summary of CIP performance as at Month 12 is provided below (with supporting detail overleaf):

CIP Project Plans	Full Year (FY)			YTD Performance Against Identified Plans			Y/E Forecast of Identified Plans	
	FY Target	FY Identified	Variance Against FY Target	YTD Pan	YTD Actual	YTD Variance	FYE Forecast	FYE Variance
Total	£ 12,500,000	£ 12,629,609	£ 129,609	£ 12,629,609	£ 8,874,167	-£ 3,755,442	£ 8,874,167	-£ 3,755,442





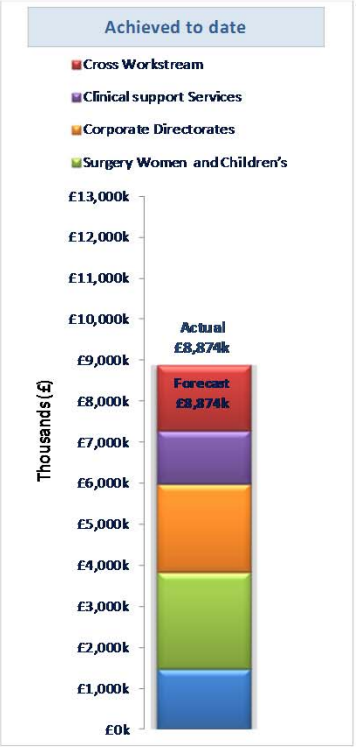


The Sparkline trends in this report give an indication of monthly fluctuations. However, the row height will determine the range, eg, larger row heights will appear to show larger ranges, but this is not the case.

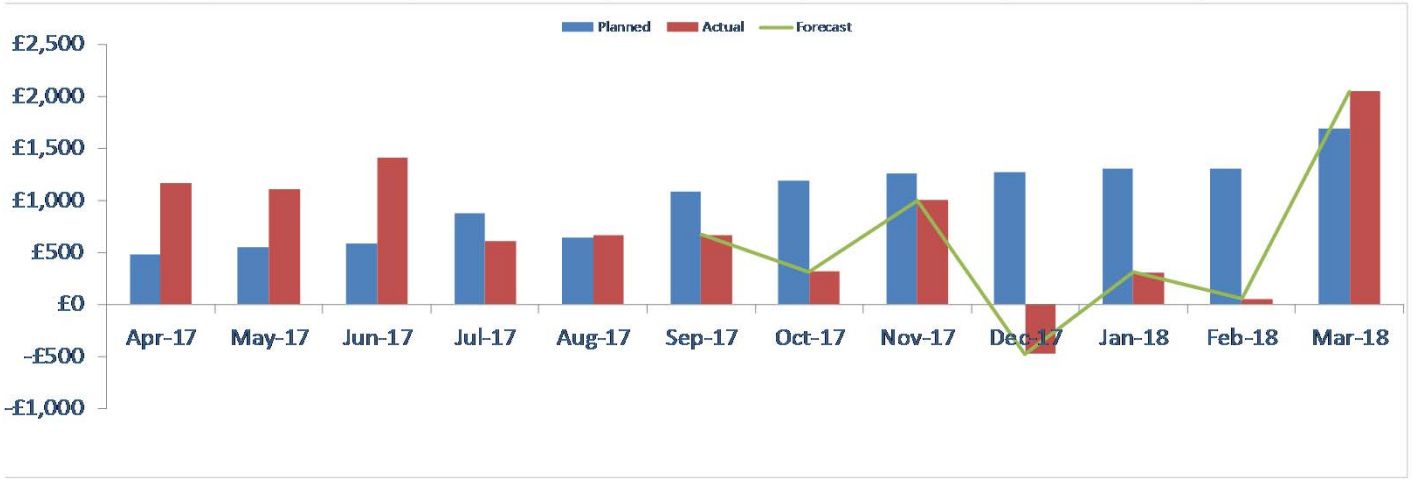
Executive Summary – 2017/18

	YTD	FYE			Submitted Plan
Planned	£12,629,609			Identified	£12,629,609
Actual	£8,874,167			Target	£12,500,000
Forecast		£8,874,167			
Variance	-£3,755,442	-£3,755,442			£129,609

Programme (Click for details)	YTD Plan	YTD Actual	YTD Variance	FYE Plan	FYE Forecast	FYE Variance
Surgery Women and Children's	£3,232,624	£2,362,444	-£870,180	£3,232,624	£2,362,444	-£870,180
Medicine and Integrated Care	£1,457,627	£1,484,342	£26,715	£1,457,627	£1,484,342	£26,715
Clinical support Services	£998,746	£1,293,874	£295,128	£998,746	£1,293,874	£295,128
Corporate Directorates	£2,019,407	£2,139,990	£120,583	£2,019,407	£2,139,989	£120,582
Cross Workstream	£4,921,205	£1,593,518	-£3,327,687	£4,921,205	£1,593,518	-£3,327,687
View all Projects	£12,629,609	£8,874,167	-£3,755,442	£12,629,609	£8,874,167	-£3,755,442



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



Appendix Two Lessons Learned from 2017/18 CIP

1. CIP Identification and planning

Positive		
Successes	**Impact**	**What has changed/can change for 2018/19?**
1.1 Managers and senior clinicians from all directorates/specialties were engaged in identification of CIP schemes through a series of workshops.	Managers and senior clinicians contributed to identification of CIP schemes and were aware of the scale of the CIP challenge which has supported divisional ownership of schemes.	This approach was taken between October and December 2017 to generate ideas for 2018/19 CIP schemes. In 2018/19, greater representation from senior nurses was encouraged. The organisation is moving towards seeing CIP setting as a continuous process rather than a 'once a year' event.
1.2 Benchmarking information was used to inform CIP setting, including Lord Carter Model Hospital.	CIP schemes aimed at improving productivity were identified (e.g. theatre productivity (SWC009, plan of 600k), best practice tariffs (BPT): • HIPs BPT (SWC001) plan of £39k, • BPT stroke (MIC002) plan of £84k, • BPT emergency care (MIC005) plan of £65k, • BPT COPD (MIC008) plan of £213k.	Model Hospital information was used to support identification of CIP for 2018/19 and resulted in opportunities being identified and schemes proposed for paediatrics, Cardiology, General Surgery, General Medicine and Gastroenterology.
1.3 All schemes had an approved Quality Impact Assessment (QIA) which was reviewed by a QIA Approval Group (Medical Director, Chief Nurse, Deputy Director of Finance, project lead, supported by a project manager).	All schemes were reviewed in the early stages of planning for impact on patient safety and quality in line with the QIA Standard Operating Procedure and any necessary adjustments were made.	Template and process for QIA approval have been reviewed. The Trust's template was considered to be in line with national best practice. QIAs are complete/being completed and a process for approval is in place.

Negative		
Issues	**Impact**	**What has changed/can change for 2018/19?**
1.4 The Trust had agreed a very stretching corporate financial plan, including a challenging CIP plan to deliver the 2017/18 control total. The detailed CIP plan was not fully owned by all key stakeholders. Additionally not all baseline budgets were fully owned by decision makers.	It is almost impossible to drive the delivery of both the overall financial plan and its incorporated CIP plan if the plans are not fully recognised and owned in the first instance. It is difficult to hold officers to account for delivery if there is not full recognition and acceptance of the baseline plan and associated CIPs.	The plan for 2018/19 needs full sign off by Divisions and officers in the first instance, both the base budget and the CIP target.
1.5 Benchmarking data for the Trust suggest there are variations in productivity and by how much. However, the Trust has not always followed through with determining why these differences occur and what can be done to address them. Divisions challenge the validity of Model Hospital and other nationally produced benchmarking data.	The Trust has not pursued all potential 2017/18 CIP schemes associated with variation identified in benchmarking information. It has not been used in some situations (e.g. Pathology) because the Trust identified errors in the external benchmarking data. In addition, some managers have challenged the data (e.g. because the data is often 12 months older than the data we hold ourselves in the Trust). Where information has been used, the Trust has sometimes set targets which are too ambitious. For example, for SWC001 Best Practice Tariff (BPT) HIPs data showed we were above the national average but we set our own internal stretch target that was too high in relation to the demographics of our patient population. Therefore, activity was not realised and the schemes under-delivered by £10k.	Model Hospital, RightCare and other benchmarking data have been supplied to Divisions to support development of CIP schemes. 'Deep dives' are taking place where data suggests that variation occurs and this is currently being used to support identification of further schemes or to increase the value of schemes already identified (e.g. paediatrics, General Surgery, General Medicine, Endoscopy, Cardiology). A NHSI session is planned for early May 2018 to support manager's understanding and application of Model Hospital data.
1.6 Completed project planning documentation is not always detailed enough	This has resulted in lack of detailed project plans, identification and monitoring of risks, and identification of interdependencies. Where the documentation is not detailed enough, it can be difficult for staff not involved in the scheme to understand the project and provide challenge/support.	Project planning documentation has been reviewed and some adjustments made. Project management support has been offered to managers to support completion. Project initiation documents are not being approved unless they are completed fully.

2. Delivery

Positive		
Successes	**Impact**	**What has changed/can change for 2018/19?**
2.1 Several schemes have over-delivered against plan	Schemes that over-delivered have mitigated the shortfall in CIP from underachieving schemes. For example: • SWC020 T&O coding of outpatients over-delivered by £146k; • MIC003 Rehab Coding over-delivered by £85k; • CS002 SW Staffordshire Breast Screening over-delivered by £91k; • CSS008 Medicines' Procurement over-delivered by £170k; • COR002 Estates & Facilities PFI over-delivered by £230k.	All schemes, including those that are meeting or exceeding their financial plans, will be challenged to 'stretch' their delivery further. This will mitigate the impact of any schemes that are underperforming.

Negative		
Issues	**Impact**	**What has changed/can change for 2018/19?**
2.2 Double-counting of CIP within divisional budgets	CIP was planned but this had already been incorporated into budgets which led to under-delivery. For example, Surgery has an assumed growth in elective care worked into the divisional budget which was also incorporated into the CIP for contract income growth (SWC006). This scheme under-delivered by £636k.	All schemes have been analysed for double counting and are intended to link directly to a budget heading. Schemes have not been approved where this has been identified.
2.3 There was too much reliance on CIP schemes that were predicated on growth of demand / activity.	These schemes have not delivered as anticipated where this growth has not been realised. For example, BPT Stroke (SWC006) has not delivered as the number of strokes reduced resulting in a shortfall of £84k; Community Imaging Hub (CSS001) has not delivered partly because forecast demand was not realised resulting in a shortfall of £60k	CIP schemes based on growth in activity/demand have been challenged and an evidence-base produced before they have been agreed. Schemes that involve increasing productivity have been assessed to ensure they are from a viable commissioning source. They have also been based on reduction in the requirement for premium rate activity, rather than increased income.
2.4 CIP schemes that were predicated on income were not discussed with relevant CCGs beforehand	These schemes have under-delivered. For example, BPT Emergency Care (MIC005) did not deliver as the CCG set a local tariff for this activity leading to a shortfall of £65k; the Wyre Forest scheme (SWC004) was not discussed with Wyre Forest CCG prior to commencement. Whilst activity from the Wyre Forest has increased, the CCG are requesting an explanation of why extra activity over contracted numbers has occurred.	CIP schemes that are predicated on growth in income have not been approved without evidence of the agreement of the relevant commissioner. All income schemes for 2018/19 have been risk-assessed and challenged at Executive Directors meeting in December 2017 and January 2018. A decision was made to not accept income growth plans unless CCG approval was achieved.

2.5 Too great a reliance on a small number of high value schemes	The under-delivery of these schemes meant that £5.6m of CIP was at risk : • SWC006 Contract income growth (plan £2m, delivery of £1.3m); • ALL012 Medical Bank and Agency (plan £1m, delivery of 940k, the shortfall in the Medical Bank and Agency scheme was mitigated by £1.2m of national winter pressures funding received by the Trust); • ALL003 Nursing Bank and Agency (plan £2.6m savings, additional cost of £120k meaning under-delivery of £2.7m).	High value schemes will be needed to ensure that the Trust meets its 2018/19 CIP target of £25m. However, these have been/will need to be fully risk assessed and monitored rigorously throughout the year as they need to be realisable. The Financial Improvement Group will provide more rigorous challenge.
2.6 Schemes that were reliant on recruitment and retention of staff did not deliver fully	These schemes did not deliver fully due to recruitment delays or inability to recruit due to lack of appropriately skilled staff in the recruitment pool. Time taken to train new staff also needed to be taken into account. This applies to three of the Bank and Agency schemes (nursing, medical and AHP). The delay in the recruitment of an orthodontics consultant (SWC003) led to the scheme under-delivering by £5k; and delays in the recruitment of Radiographers contributed to non-delivery of the CIP (£60k) associated with the Community Imaging Hub (CSS001).	Schemes predicated on recruitment of staff have been risk assessed. This includes schemes where there is a shortage of particular staff groups either regionally or nationally. Finances have been profiled and adjusted to provide adequate time for recruitment and the full year savings plan adjusted accordingly. Schemes with recruitment plans now need to specify their timeline including interview dates and training as part of their project plan.

2.7 Schemes have taken longer to embed than anticipated	This has been as a result of a lack of detailed project planning or lack of management understanding of the complexity of processes involved to implement changes required. This has often led to lack of capacity of managers and clinicians to undertake this detailed work. These issues have arisen with the outpatients' optimisation project (ALL001) which has under-delivered by £270k.	Project plans are being reviewed prior to approval of project initiation documents and being challenged where they are not robust enough. Interdependencies between projects have been mapped. Project Steering Groups will be put in place for high risk projects and challenge will be provided by the Financial Improvement Group.
2.8 The complexity of some schemes were not fully understood at the planning stage	This has led to delays in projects. For example, information that was more complex than originally anticipated took longer to analyse in the Outpatients' optimisation scheme (ALL001). This has led to delays and a shortfall in financial delivery (£270k). The complexity of the patient journey led to a delay in patients accessing pulmonary rehab (MIC015) in the timescale originally anticipated leading to a shortfall in CIP of £10k.	2018/19 projects which are complex and require complex data analysis have remained/will remain in 'pipeline' until the analysis is complete.
2.9 Schemes which cut across directorates and divisions may not have been fully 'worked up' because interdependencies were not identified.	This has led to delays which have resulted in under-delivery. For example, the Stroke BPT (MIC002) required cross-working between the Stroke Team and the Emergency Department which has been hampered by pressures in A&E. The scheme under-delivered by £84k. It has been suggested that cross-cutting Bank and Agency schemes may have lacked divisional ownership as it was not clear what proportion of the savings each division were responsible for delivering.	Interdependencies for 2018/19 have been mapped. Responsibility has been assigned for savings relating to the cross-cutting schemes in the 2018/19 plan.
2.10 Clinical ownership and participation in delivery of some CIP schemes has taken longer than anticipated.	It has taken longer to embed new processes and ways of working resulting in delays to project delivery. For example, it took longer to gain clinical commitment to new processes in the theatre productivity scheme (SWC009) which led to delays that contributed a shortfall in CIP achieved of £430k.	Divisional project leads have been encouraged to gain clinical commitment to and involvement in CIP projects from the outset. We have introduced a terms of engagement for all parties to accept their role in the project.

2.11 Lack of service resilience	The impacts of unforeseen staff sickness, maternity leave and resignations have impacted on the capacity of smaller services to deliver day to day activity as well as progress their CIP schemes. For example, nurse and consultant sickness has impacted on the delivery of SWC schemes, particularly SWC021 Pain CNS. In addition, the continuity of planning and implementation of schemes in Surgery, Women and Children's Division have been difficult because of the management turnover. It has also been difficult to identify management capacity to simultaneously mange CQC quality issues, operational issues, CIP implementation and other initiatives that have arisen throughout the year.	This will be identified as a risk in project plans.

3. Monitoring and reporting

Positive		
Successes	**Impact**	**What has changed/can change for 2018/19?**
3.1 Transformation Executive Committee (TEC) meetings have taken place monthly and a report on the delivery of CIP provided each month.	CIP information has been available for monitoring of project and financial delivery which has been reported to the Finance and Performance Committee and Board.	TEC has been replaced with the Financial Improvement Group. Reports will continue to be produced, but are being redesigned to enable more effective oversight.

Negative		
Issues	**Impact**	**What has changed/can change for 2018/19?**
3.2 The frequency of TEC (monthly) has enabled high level oversight of delivery, but has perhaps not been frequent enough to monitor and provide challenge to the delivery of underachieving schemes.	Project plans have been tracked monthly through project status and exception reports. This has meant that some slippage in project plans, risks and obstacles to progress have not been reported in a timely way because of the length of time between TEC meetings. Some of these could have been addressed with more frequent meetings and more frequent challenge to progress could have taken place.	The appropriate frequency of FIG (currently monthly) is being considered. An additional meeting is already planned in early May 2018 to provide greater oversight of progress of scheme maturity levels. Whilst it is recognised that financial reporting will take place monthly, it could be possible to track the progress of project plans for high risk and high value schemes more frequently.
3.3 The content and quality of project highlight reports and exception reports is not always as robust as it could be and reports are not always received. Some divisional project leads consider monthly reporting to be a bureaucracy.	This has meant that the project managers have had to 'chase' documentation for inclusion in TEC/Finance & Performance Committee papers rather than use the time to support project delivery. The quality of some reports mean that it is not always clear how the project is performing against its project plan and what is being done to bring the project back on track. This, as well as missing reports, means it is difficult to monitor progress and provide support and challenge to projects.	To reduce the reporting burden on divisions, we are considering new criteria for the production of monthly project reports (e.g. reports are only produced if a project is of or above a certain financial value, or where the finances are not delivering). RAG ratings are currently applied to monthly status reports but their application is being reviewed.

Enclosure 11

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board on 3rd May 2018

TITLE:	**Trust Annual Plan: Quarter 4 Monitoring Report**		
AUTHOR:	**Lisa Peaty, Deputy Director: Strategy and Business Development**	**PRESENTER**	**Natalie Younes Director and Strategy and Business Development**

CLINICAL STRATEGIC AIMS

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

CORPORATE OBJECTIVE: All objectives

SUMMARY OF KEY ISSUES:

The performance report for the Trust's 2017/18 Operating Plan is in Appendix One and the Quarter Four position is attached as Appendix Two. Areas of non-delivery have been discussed at the committees of the Board during 2017/18. They remain key priorities for action which will be focused on in 2018/19/

Strategic Objective	RAG rating			
	Red	Amber	Green	No Status
Deliver a great patient experience	1	4	8	2
Deliver safe and caring services	6	5	8	1
Drive service improvement, innovation and transformation	2	16	9	1
Be the place people choose to work	1	7	8	0
Make the best use of what we have	1	1	4	0
Plan for a viable future	0	1	5	6
Total	11	34	42	10

Eleven measures of achievement are rated as red. Mitigating actions are in place for these measures of achievement, all of which are also on the Board Assurance Framework, Corporate or Divisional Risk Registers.

- *Deliver a great patient experience*
  - 95% emergency access standard met (BAF567/Corporate Risk 376)
- *Safe and caring services*
  - Incident reporting rate (BAF573/CE379)
  - Serious incidents managed in line with national standards (BAF573/CE379)
  - 50% reduction in use of agency staff (BAF597/Corporate Risk 116)
  - Monthly trajectory towards £3.73m cap on agency spend (BAF597/Corporate Risk 116)
  - Pressure ulcers (hospital & community) (BAF572/Corporate Risk 087)

- Pain and medication management (BAF572)

- *Drive service improvement, innovation and transformation*
  - Increase clinical pharmacy time by 80% (CSS293)
  - Improve model in place for Oncology Service (BAF588)

- *Be the place people choose to work*
  - Increase the staff survey response rate to 48% (BAF589)

- *Make the best use of what we have*
  - £12.5m CIP and a £2.45m surplus control total achieved (COR061, COR080).

The measures of achievement that are rated as red have been carried forward to the Trust's 2018/19 Annual Operating Plan to be progressed with strengthened mitigation in place. The agreed priorities will be overseen via the committees of the Board and reporting groups.

The Quarter One report for 2018/19 will include a strategic narrative of where the Trust measures against each of its strategic objectives.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description:** The plan supports mitigation of risks on the Trust's risk register
	Risk Register: N		**Risk Score:** N/A
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** The plan supports all CQC objectives and is a key element within the Well Led objective
	NHSI	**Y**	**Details:** The plan supports the trust to deliver NHS I annual planning requirements
	Other	**N**	**Details:**

ACTION REQUIRED OF TRUST BOARD:

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE TRUST BOARD:

- The outcome of Quarter Four for each of the goals is noted.

†† - **denotes initiatives contained in the Clinical Strategy**

The Dudley Group NHS
NHS Foundation Trust

Operational Plan 2017/18: Quarter Four Monitoring Report

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
Strategic aim one: deliver a great patient experience					
✓ **Improve engagement and involve patients, carers and the public in their care and the work of the Trust** ✓ Implement approaches that engage and involve patients, carers and the public in their care / service developments and provide opportunities for feedback ✓ Improve the FFT response rate trust-wide ✓ Further develop mechanisms to implement	✓ *Percentage positive monthly FFT/patient survey scores equal to or better than the national average for all areas (Inpatients, Outpatients, Maternity, Emergency Department and Community).*	March 2018	Chief Nurse		**Progress update and risks to delivery**: Achieved by Maternity in January (97.2%) and February (97.9%) and community in February (97.2%). It has not been achieved in the other areas with February figures as follows: ED 75.5%, Inpatients 95.1% and Outpatients 89.3%. **Mitigating actions**: Continue with dedicated work delivering service specific and Trust wide actions plans. A Community Patient Experience Group has been established with nominated FFT champions.
	✓ *An agreed 6 month trajectory of improvement until the monthly FFT response rate is equal to national average.*				**Progress update and risks to delivery**: A FFT response rate equal to or better than the national average was achieved in January and February for ED (21.2%, 22.6%), Maternity (38.4%, 35.9%), and Inpatients (30.1%, 34.6%). It was achieved by community in February (4%) and outpatients in January (5.9%). It was not achieved in February for Outpatients (4.4%) and Community in January (3.3%). **Mitigating actions**: These include the: • expansion of FFT SMS survey method across the Trust in Q3; • introduction of Feedback Friday and FFT champions nominated in community; • introduction of dedicated Patient Experience Volunteers.
	✓ *Annual National Patient Survey results equal to or better than the national average.*				**Progress update and risks to delivery**: There was some improvement (8 questions in the Adult Inpatient Survey) compared to our previous year's performance. There has been a significant decline in scores relating to noise, pain and hydration. The CQC national report and benchmarking schedules will be published either late in Q1 or early in Q2 2018/19. The results for 2017 survey will not reflect fully the improvement actions delivered since July 2017 **Mitigating actions**: All areas have action plans in place to improve the results for next year. Local surveys will be introduced to demonstrate improvements.

†† - denotes initiatives contained in the Clinical Strategy

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG				Risks to Delivery & Mitigating Actions
✓ learning from feedback. ✓ Increase the use of Listening into Action (LIA) with Patient Groups	✓ *Undertake LIA with patients groups for example dementia, learning disability and end of life*							**Progress update and risks to delivery**: LIA events have occurred during the quarter and continue to be planned with information on user/support groups being collated. Engagement is monitored by the Patient Experience Improvement Group. Patient stories are shared at Board, with one patient attending in person. **Mitigating actions**: Other regular listening activities are scheduled. Recent events include stroke user group and maternity 'whose shoes' event. Patient and staff stories have been brought to each Board meeting and shared at Full Council for Quarter 4.
✓ **Maintain high performance in national operational performance standards:** • **Urgent care** • **Patient flow** • **Delayed transfers of care** • **Imaging** • **Cancer** • **Referral to treatment time** ✓ Rebuild and reconfigure the UCC to provide more effective front door streaming ✓ Deliver best practice models for discharge	✓ *95% emergency access standard met.*	March 2018	Chief Operating Officer	92.3 %	88.0 %	84.2 %	86.6 % Year end	**Progress update and risks to delivery**: Expectations from NHS England are that the target of 90% will be met. **Mitigating actions:** include increasing consultant cover within ED and implementing the CQC recommendations (other actions below also contribute to this target).
	✓ *Best practice models for discharge delivered*							**Progress update and risks to delivery**: A DTOC Action Plan for the health economy is in place which includes an agreement at A&E Delivery Board of planned spend for Better Care Fund monies. **Mitigating actions** include increased capacity within Dudley social care and increased investment in discharge coordinators to cover ward delays.
	✓ *Additional Mental Health Crisis team support available*							**Progress update and risks to delivery**: Mental Health Crisis Team support is already available through A&E and plans are in place to develop this further through the A&E Delivery Plan. **Mitigating actions**: Work is ongoing with the Mental Health Team to expand service provision and to share breach data with the Mental Health Trust on a weekly basis.
	✓ *Reduce Delayed Transfers of Care from March 2017 baseline*							**Progress update and risks to delivery**: A DTOC Action Plan for the health economy is in place which includes an agreement at A&E Delivery Board of planned spend for Better Care Fund monies. There is an increased number of community beds via the local authority, including the introduction of 5 beds for patients with dementia through the Dudley Walsall Mental Health Trust. The number of DTOCs for Dudley has been within the expected trajectory during Quarter 4. **Mitigating actions** include an internal daily review to check ward-based assessments; a review of the format of the daily site meeting to inform decisions to progress on discharge; the 'top 20' meeting re-initiated; and BCF funding to support community, rather than hospital based, assessments. Discharge to Assess is being discussed at the A&E Delivery Board.

†† - denotes initiatives contained in the Clinical Strategy

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG				Risks to Delivery & Mitigating Actions
✓ Work in partnership with Dudley and Walsall Mental Health (MCP) to improve 24 hour access to mental health services in A&E ✓ Deliver the Dudley Health Economy Delayed Transfers of Care Improvement Plan (High Impact Change Model) ✓ Develop and implement a demand and capacity plan to deliver definitive cancer diagnosis within 28 days ✓ Assess the potential impact of Rapid Diagnostic Centres on the Trust's activity in conjunction	✓ *Maximum 62day wait for first treatment from: i) urgent GP referral for suspected cancer ii) NHS cancer screening service referral*	March 2018	Chief Operating Officer					**Progress update and risks to delivery**: The Cancer Action Plan continues to be worked through and progress monitored via the now fortnightly Cancer Performance meetings. The 62 day treatment target has been achieved since September 2017 with the exception of February 2018 when lower numbers of treatments were completed. An Interim Deputy Director of Operations within the Clinical Support Services Division was appointed in February 2017 with a specific project management brief to deliver sustainable cancer performance, partly funded via a successful NHSI bid. **Mitigating actions** include an internal cancer action plan based on good practice tools; external review of processes undertaken by NHSI's Intensive Support Team with ongoing support, and recruitment of the Deputy Director of Operations with a focus on cancer performance.
	✓ *National Cancer Dashboard in place*							**Progress update and risks to delivery**: The Trust already contributes to the national cancer dashboard and will ensure that it continues to comply with the implementation of the national dashboard as it is developed further nationally. **Mitigating actions**
	✓ *Six week wait for diagnostic procedures (96%)*			95.7 %	97.9 %	99.3 %	98.7 %	**Progress update and risks to delivery**: There has been continued successful delivery of the DM01 standard since November 2017. Risks include the breakdown of CT and MRI scanners and also other diagnostic procedures outside of the Imaging Department failing the standard (i.e. Echocardiogram (Cardiology), Colonoscopy and Gastroscopy). **Mitigating actions** include ongoing monitoring of diagnostics outside of the Imaging Department (see above); continued and increased usage of the Guest CT and MRI facility (subject to continued recruitment drives) and weekly monitoring of potential breaches and mitigation plans via the reports issued by the Informatics Team.
	✓ *RTT – 92% of incomplete pathways*			94.2 %	93.1 %	93.6 %	93.4 %	**Progress update and risks to delivery**: On-going monitoring is taking place by the via RTT team. **Mitigating actions**:

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
with neighbouring trusts. ✓ Implement community imaging hub at The Guest Outpatients Centre to increase capacity ✓ Meet the 18 weeks referral to treatment standard across all specialties					
✓ **Redesign a number of integrated pathways and services as a partner in the MCP** †† ✓ Further develop the redesign of community nursing services to deliver MCP aims ✓ Implement community based consultant services in	✓ *To be determined on the outcome of procurement* ✓ *Clinics in place* ✓ *Regular discussion in place with practices and localities*	March 2018	Medical Director/ Chief Operating Officer		**Progress update and risks to delivery** **Mitigating actions**: **Progress update and risks to delivery**: **Mitigating actions**: **Progress update and risks to delivery**: **Mitigating actions**:

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
elderly care, respiratory, diabetes and paediatrics ✓ Work closely with primary care to optimise the outcomes of the MCP					
Strategic aim two: deliver safe and caring services					
➢ **Deliver the Trust's Quality Strategy Priorities** ✓ Implement the priorities within the Trust's Quality Strategy • Pressure ulcers • Infection control • Nutrition and hydration • Medication management ✓ Improve delivery in incident management	✓ *Targets outlined in the Trust's Quality Strategy achieved: zero Pressure ulcers: hospital and community* • *Ensure that there are no avoidable stage 4 hospital and community acquired pressure ulcers throughout the year.* • *Ensure that the number of avoidable stage 3 hospital and community acquired pressure ulcers in 2017/18 reduces from the number in 2016/17.*	March 2018	Chief Nurse		**Progress update and risks to delivery**: Recruitment to the Tissue Viability Team is now complete. The interim Tissue Viability Manager continues to review processes and an additional senior nurse for the community has been seconded to assist with the tissue viability process. The focus of tissue viability training has been adapted to recognise and reduce the risk of pressure ulcer development. **Mitigating actions**: Bespoke training sessions continue. The Trust joined NHSI "National Stop the Pressure" Pressure Ulcer Collaborative in October 2017 and this work is now coming to a conclusion. This will lead to improved pre-damage reporting, a decrease in the number and severity of pressure ulcers, and encourage a multi-professional focus on pressure ulcers.
	✓ *Targets outlined in the Trust's Quality Strategy achieved.* *i) Infection control* • *Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause*				**Progress update and risks to delivery**: Targets have been achieved. A risk surrounds the new national definition of 'lapse in care' which now includes staff being not compliant with mandatory training. **Mitigating actions**: Training methods are being diversified and availability of training increased with annual updates. Continual monitoring of infection control processes are in place. Oversight has been strengthened as have reports to Board. External support is in place to assist performance.

†† **- denotes initiatives contained in the Clinical Strategy**

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
✓ Review the use of National Early Warning Scores to identify deteriorating patients and minimising impact ✓ Deliver the action plan on the reduction in patient falls within the Trust	*analysis, the results of which will be discussed jointly by the Trust and Dudley CCG to agree on any avoidability/lapses in care.*	March 2018	Chief Nurse		
	✓ *Targets outlined in the Trust's Quality Strategy achieved. Nutrition and hydration (CLM) - Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items):* • *is 95% or above in each of the first three quarters for the Trust as a whole* • *has a 'Green' rating (95% or above) in the final quarter for every ward in the hospital*				**Progress update and risks to delivery**: One of the targets was met this year (MUST in the community). THE MUST score in the hospital for the full year was 93%. With regards to the nutrition audit, the target was met in the first two quarters but not the third. In the fourth quarter, 14 of the 20 wards/departments achieved the target. A known risk is the use of temporary staff and capacity issues. **Mitigating actions** include increased staffing on the wards, increased focus in this area, close monitoring and action. The Deputy Chief Nurse has been asked to ascertain what further actions can be undertaken to improve performance. These targets have been retained for 2018/19.
	✓ *Targets outlined in the Trust's Quality Strategy achieved. Pain and Medication management (CLM)* • *Ensure that in 95% or more cases, all prescribed medications will either be: a) signed and dated as administered or b) have an omission code recorded.*				**Progress update and risks to delivery**: the two targets were both missed this year, both at 93% for the full year (for medication there was improvement in the last quarter when the target for that period was met). **Mitigating actions** include increased staffing, increased focus in this area, close monitoring and action planning as well as strengthening the use of nurse bank and agency check list and an audit of compliance with the check list. These targets are being retained for 2018/19.
	✓ *Reduce the number of omitted medication errors by 50%*				**Progress update and risks to delivery**: There has been a reduction in the number of omitted medication incidents from 2016/17 when the average

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
					number per quarter was 31. In 2017/18: Q1= 28, Q2 = 26, Q3 = 21, Q4= 18. The reduction has been 25% which means that the 50% target has not been met. **Mitigating actions** include increased staffing onwards, increased focus in this area, close monitoring and action. Monthly audits were introduced in Quarter 2. Link nurses were introduced in August 2017.
	✓ *Incident reporting rate increase by 10% each Quarter*	March 2018	Chief Nurse		**Progress update and risks to delivery**: The following were the incident figures for the last quarter of 16/17 and each of the four quarters this year starting with Q4 of last year1: 4070, 3902, 4502, 4709 and 4309. The percentage changes from quarter to quarter were: -4%, 15.4%, 4.6% and -8.5%. **Mitigating actions** include publicity on ensuring that incidents are reported and are closed in a timely fashion. The central governance team has been increased to be able to directly support divisions to provide timely feedback on reported incidents which will aid foster a better reporting culture. These extra staff will be in post by the middle of quarter one of 2018/19.
	✓ *Best practice (aligned with partner specialist provider) National Early Warning Systems (NEWS) in place including Paediatric Early Warning Systems (PEWS), Modified Obstetric Early Warning System (MOEWS)(CLM)*				**Progress update and risks to delivery**: Full implementation of NEWS was completed August 2017. An audit was completed in quarter 3 and monthly audits are now incorporated in monthly quality indicators (NCIs). This audit shows there needs to be improvement in the use of the system. **Mitigating actions**: Training for staff on the use of NEWS continues for all new staff and forms part of the annual resuscitation update for staff. A re-evaluation of the current PEWS is occurring so that our scoring system matches our tertiary referral centre BCH.
	✓ *Reduce the number of avoidable falls that result in harm in our inpatient services by a third (PS/JP)*				**Progress update and risks to delivery**: The target is for 7 or less in 2017/18. This year there have been definitely two avoidable falls with the potential avoidability of one fall with harm still being investigated. Therefore, this target has been met. **Mitigating actions**: The falls action plan continues to be implemented.
	✓ *All serious incidents to be managed in line with national Standards: All Serious incidents, including Never Events, sent to commissioners*	March 2018	Director of Governance		**Progress update and risks to delivery**: In Quarter 4, not all Root Cause Analyses were delivered in the 60 day deadline. **Mitigating actions**: An escalation process from the Governance Team to the Chief Nurse has been established. Serious Incidents are now discussed as part of regular divisional performance review meetings.

†† - denotes initiatives contained in the Clinical Strategy

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
	within 60 days				
➢ **Deliver agreed CQUIN requirements** ✓ Develop and deliver all CQUIN schemes	✓ *CQUIN schemes are delivered to expected levels*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: 7 of the 11 CQUINs are expected to fully achieve. Risks are associated with the following schemes: reducing infections; e-referrals, mental health, safe and proactive discharge; and medicines optimisation (SACT). **Mitigating actions**: Regular monitoring and monthly confirm and challenge meetings are in place. Plans are being developed to address issues which have prevented achievement in 2017/18 to support achievement in 2018/19.
➢ **Maintain good mortality performance** ✓ Continue to develop arrangements for learning from the death of patients in our care, including publication of data	✓ *SHMI/HSMR within expected range*	March 2018	Medical Director		**Progress update and risks to delivery**: This indicator remains within normal limits. **Mitigating actions**:
	✓ *100% of hospital deaths have a multidisciplinary review*				**Progress update and risks to delivery**: 100% of notes have been reviewed. **Mitigating actions**:
Deliver Safe staffing levels ✓ Ensure all clinical areas are staffed to Best Practice Standards, including all ward and community teams ✓ Review of	✓ *50% Reduction in use of agency staff*	March 2018	Chief Nurse/ Medical Director/ Director of HR		**Progress update and risks to delivery**: Due to the increased capacity and the opening of contingency areas, this target has not been achieved. Control measures have been tightened to ensure agency staff usage is kept to a minimum especially the use of non-framework staff. Non recruitment of substantive staff remains the main risk. The recruitment and retention lead is currently developing a formal recruitment strategy in conjunction with HR. **Mitigating actions**: include the continuation of recruitment events especially within qualified nursing areas as well as the successful management of medical agency cap following the introduction of the eight Trust consortium from November 2017. Monitoring of agency use continues whilst balancing safe patient care with sustained financial stability.
	✓ *Monthly trajectory toward the full year target of £3.73m cap*				**Progress update and risks to delivery:** The anticipated spend for the whole year is £6.15m. The main risks are ongoing vacancies alongside

†† - **denotes initiatives contained in the Clinical Strategy**

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
Allocate Rostering System ✓ Review all of Trust's Clinical Nurse Specialists (CNS) ✓ Implementation of Job Planning for all Consultant posts	*on maternity and nursing agency spend is met*	March 2018	Chief Nurse/ Medical Director/ Director of HR		turnover of staff at a rate above our target of 8.5%. **Mitigating actions**: A staffing review is in progress and a recruitment plan is in place. In addition to successful and ongoing substantive recruitment, the Trust is also committed to getting greater and immediate efficiencies by enhancing the bank rate for the winter period and whilst additional clinical capacity is open. This will increase the bank fill rate and also support the reduction of agency bookings for this short term period.
	✓ *Substantive staffing in place to cover agreed establishment requirements in both the community and hospital areas. Ensure that there is a reduction in vacancy rates.*				**Progress update and risks to delivery**: The staffing review continues with the main inpatient areas completed. The other hospital areas such as OPD and Renal Unit are progressing through the approval process. The community review is nearly completed. The main risk is non recruitment of substantive staff. **Mitigating actions**: Monthly recruitment events are occurring with additional recruitment activity for specific areas.
	✓ *Job Plans in place for consultants and specialist doctors*				**Progress update and risks to delivery**: An entry for all clinical groups has been made on the Allocate system, but only eight specialties have the level of detail necessary for planning for seven day services. A piece of work supported by Allocate around job planning is in progress and training for Clinical Directors has been put in place. Clinical Directors have been trained to use the Allocate system. **Mitigating actions**: The job planning round for 2018/19 will commence in July using the agreed template, after which job plans will be fit for purpose and in place for all consultants.
➢ **Deliver improvements in maternity care** ✓ Develop and implement the Maternity Transformation Programme (Better Births) ✓ Deliver improved	✓ *Reduce neonatal deaths*	March 2018	Chief Nurse		**Progress update and risks to delivery**: The draft five year plan for Maternity Transformation was written by the Black Country LMS and submitted to the National Maternity board in October 2017. Neonatal deaths recorded in the Datix system were eight for 2016/17 and six for 2017/18. The LMS clinical implementation work stream commenced in February 2018 and the focus will be on choice personalisation and safety. **Mitigating actions**: There are three work streams currently in progress. The Infant Mortality work stream has built on existing good practice across the Black Country. Re-evaluation of previous work streams in December 2017 means that strategic oversight and operational work streams will be improved moving forward.
	✓ *Reduce babies with brain injuries that occur at or soon after birth*				**Progress update and risks to delivery:** The draft 5 year plan for Maternity Transformation was written by the Black Country LMS and submitted to the National Maternity board in October 2017. We are waiting for the national

†† - denotes initiatives contained in the Clinical Strategy

Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
maternity dashboard		March 2018	Chief Nurse		neonatal mortality review tool to be launched by NHS England / MBRRACE. The nature of these cases is such that immediate figures are not readily available. The National Perinatal mortality review tool has been used since March 2018 **Mitigating Actions:** There are three work streams currently in progress. The Infant Mortality work stream has built on existing good practice across the Black Country. Re-evaluation of previous work streams in December 2017 means that strategic oversight and operational work streams will be improved moving forward. The LMS clinical implementation work stream commenced in February 2018 and the focus will be on choice personalisation and safety.
	✓ *Zero avoidable maternal deaths*				**Progress update and risks to delivery**: The draft 5 year plan for Maternity Transformation was written by the Black Country LMS and submitted to the National Maternity board in October 2017. New work streams are in progress to implement actions included in the LMS plan **Mitigating actions**: There are three work streams currently in progress. The Infant Mortality work stream has built on existing good practice across the Black Country. Infant mortality reduction is now incorporated as an outcome for the clinical implementation work stream.
	✓ *Progress towards key maternity dashboard*				**Progress update and risks to delivery**: An updated locally agreed dashboard in use. The dashboard is reviewed on a monthly basis at CQSPE. **Mitigating actions**: There are plans for a nationally agreed dashboard to be implemented and the Trust is awaiting further information from the national team.
Strategic aim three: drive service improvement, innovation and transformation					
➢ **Deliver effective medical research activities** ✓ West Midlands CRN Higher Level Objectives (HLO 1-3)	✓ *West Midlands CRN Higher Level Objectives (HLO 1-3) achieved*	March 2018	Medical Director		**Progress update and risks to delivery**: This action is being reviewed for 18/19 Annual Plan. **Mitigating actions**:

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
achieved.					
✓ **Increase access to 7 day services** †† ✓ Implement plans to deliver key standards ✓ Actively contribute to appropriate clinical networks to deliver seven day services for emergency vascular surgery, stroke, major trauma, heart attacks and paediatric intensive care	✓ *Improve the position from the audit completed in April 2016 for:* • *first consultant review in 14 hours*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: Directorates have implemented a number of initiatives to secure review by a consultant in 14 hours although compliance cannot be confirmed until a further audit is undertaken. **Mitigating actions**: Directorates have submitted plans to improve 14 hour access and these are being reviewed by the Medical Director and Chief Operating Officer. A new rota to provide extended Consultant Obstetrician evening and weekend cover, and dedicated Gynaecology Consultant of the Week were implemented in January to increase Consultant review within <14 hours of admission. A proposed model for Trauma cover was presented by the Clinical Director and Clinical Service Lead to the Surgery, Women and Children Performance Review in March 2018.
	✓ *Improve the position from the audit completed in April 2016 for:* • *Consultant directed intervention*				**Progress update and risks to delivery**: Many services are available already on site or through SLAs. **Mitigating actions:** A plan is in place to extend MRI provision through the community imaging hub and a plan for interventional endoscopy is being developed.
	✓ *On-going review of high-dependency patients by consultants twice daily*				**Progress update and risks to delivery**: This has been delivered in most high dependency areas, but more work is required in some and plans are in place to support. **Mitigating actions**: Meetings are in place to support plans in these areas for Vascular/Surgical/Medical HDU.
	✓ *Improve the position from the audit completed in April 2016 for:* • *Timely access to diagnostics*				**Progress update and risks to delivery**: The opening of the Guest CT and MRI suite has contributed towards improved timely access. Increasing the opening hours and throughput of this facility will bring about further improvements. **Mitigating actions** include a review of capacity within Imaging and ongoing recruitment campaigns, particularly in respect to Radiographers.
	✓ *Trauma network peer review recommendations implemented*				**Progress update and risks to delivery**: All recommendations are being reviewed for implementation by the directorate. Some actions have been completed (e.g. governance structure). **Mitigating actions**: Work is taking place between Directorate Manager and clinical teams to implement the recommendations, including working towards

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
					an ED Level 2 trained Trauma nurse being on shift 24/7 and appointing a Trauma Coordinator. Business cases for Trauma and Rehab coordinators are expected at Directors in April 2018.
✓ **Transform and re-organise services to drive efficiency and improve key services** ✓ Deliver phase two of Outpatients Transformation ✓ Implement theatres transformation plans ✓ Develop and implement plans for the hybrid theatre ✓ Address performance challenges in ophthalmology ✓ Implement the GIRFT recommendations for relevant specialities ✓ Develop and deliver	✓ *Referral and clinical management processes reviewed and new processes implemented*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: Progress has been made on letter review and a plan is in place to progress advice and guidance – this is on track. We will be implementing paper switch off from the end of May 2018. Work is in progress to reduce cancellations and improve ASI and slot utilisation. Two way text messaging has been implemented. A Live Slot utilisation report and active monitoring is in place to maximise slot utilisation. ASIs are being monitored via the patient access team. **Mitigating actions**:
	✓ *Records management processes reviewed and new processes implemented*				**Progress update and risks to delivery**: Processes have been reviewed internally and changed to support operational delivery. **Mitigating actions**: Further work is required on notes' delivery for theatres and OPD. A proposal for Health Records modernisation was tabled and agreed at Directors on 27/3/18.
	✓ *Recruitment and retention strategy for theatre staff in place*				**Progress update and risks to delivery**: There has been a high level of Band 5 leavers for external opportunities at band 6 and above during April and May 2018. External review has identified areas for focused improvement. **Mitigating actions:** Analysis has concluded that the Recruitment and Retention strategy has had a positive effect, but has not yet addressed the vacancy issue. Further actions include increasing the geographical area for university graduates (which has resulted in recruitment from Stoke area) and a rolling advert on NHS Jobs for Band 5 Anaesthetics & Recovery Practitioners.
	✓ *Theatre scheduling undertaken using EPR*				**Progress update and risks to delivery**: The EPR project is on-going. Vacancies has been filled. Delivery has improved from August 2017. **Mitigating actions**: An action plan is about to be delivered.
	✓ *Phase two of theatre reconfiguration complete*				**Progress update and risks to delivery**: Further work is being undertaken with an external company. **Mitigating actions**: FEI theatre productivity workstream is being implemented.
	✓ *Hybrid Theatre business case written and approved* ✓ *Hybrid theatre implementation*				**Progress update and risks to delivery**: The business case has been written and approved. Plans were originally in place to build within 2018/19, but have been deferred to 2019/20 due to capital funding constraints. **Mitigating actions**: Architectural planning is being progressed.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
improved pathways for MSK, Respiratory and Neurology in line with the RightCare initiative to reduce unwarranted variation ††	✓ *Reduced waiting time for ophthalmology*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: The use of ODS and additional DGFT capacity have reduced overdue follow ups to <800. A Nurse Injector is in post. An Ophthalmology away day planned for 23rd January 2018 and an action plan has been developed and implemented. **Mitigating actions**: Mitigating actions include the completion of building work and improved ODS capacity. A further Ophthalmology away day is planned for 4th July 2018.
✓ Improvements in service performance delivered for Renal	✓ *Hip prosthesis rationalised*				**Progress update and risks to delivery**: Savings have been realised **Mitigating actions**:
✓ Implement the Hospital Pharmacy Transformation Plan (HPTP)	✓ *ENT day case rates improved*				**Progress update and risks to delivery**: Day case rates have been optimised within ENT and all clinically appropriate patients are admitted as day cases. **Mitigating actions**:
✓ Implement improvements to hospital discharge process	✓ *Consultant physician input to vascular surgery in place*				**Progress update and risks to delivery**: A business case was approved in October 2017. The first attempt to recruit a consultant was unsuccessful. **Mitigating actions**: The post will be readvertised at a time to attract final year SpRs securing CCT.
✓ Develop MSK Services††	✓ *Implement actions from Ophthalmology GIRFT Review*				**Progress update and risks to delivery**: An Ophthalmology action plan has been developed and presented at CQSPE. A private company has been engaged to clear the backlog of new and follow up patients. **Mitigating actions**:
✓ Expansion of community ENT clinics (incl Audiology) ††	✓ *Improved pathways developed, agreed and implemented Ophthalmology*				**Progress update and risks to delivery**: In Ophthalmology, a number of pathway improvements are already in place and the service is working to improve capacity further as below: • nurse injector to start interdependent theatre sessions; • minor Eye Conditions to go out in the community; • Virtual Glaucoma Pathway with Oct Cirrus; • Cornea Nurse specialist in training. **Mitigating actions**: Consultants are doing extra clinics to mitigate risks and engaging with the private company.
✓ Develop a model to	✓ *Improvement in efficiency (metrics to be approved once plan approved)*				**Progress update and risks to delivery**: The plan is in place to improve theatre efficiency and is linked with CIP.
	✓ *Increase clinical pharmacy time by 80%*				**Progress update and risks to delivery:** Performance against this metric worsened during Quarter 4 due to high levels of vacancies and flexing of beds without skilled backfill. Clinical

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
support Acute Oncology Service†† ✓ Review of provision of plastics/skin cancer services†† ✓ Develop a more integrated clinical model for therapy services†† ✓ Expansion of orthodontics service††		March 2018	Chief Operating Officer		Pharmacy patient facing activity reduced from average of 70% to 46%. This has started to improve late in Quarter 4 and is anticipated to increase to 60% in Quarter 1 2018/19 as pharmacists come into post and complete their induction. **Mitigating actions**: Each vacant post is reviewed prior to post holder departure, recruitment is fast–tracked and post holders will join the Trust in April 2018. In the meantime, the use of bank staff is maximised to fill shift gaps. There was minimal use of 1.5 agency pharmacist in Quarter 4 only to prevent further deterioration of service provision.
	✓ *Increase pharmacy prescribers to 70%*				**Progress update and risks to delivery**: Two pharmacists have completed prescribing course and are undergoing Trust review for inclusion onto the NMP register. This will increase pharmacist prescriber numbers to 30%. A pharmacist prescriber business case was agreed by Executive Directors in June 2017 and is pending funding. This case for change and two further pharmacist prescribers will support future achievement of this measure. **Mitigating actions:** The business case funding will significantly enhance this action. In addition, recruitment to vacant general pharmacy posts supports pharmacist prescribers to undertake their extended role.
	✓ *Implement e-chemo prescribing system (October 2017)*				**Progress update and risks to delivery**: Significant configuration and pharmacist validation has been completed in line with the project plan. Tumour group roll out has been hindered by lack of clinician validation and training. A date has been set from which paper-based chemotherapy prescriptions will not be permitted, of which the Haematology/Oncology Management Team are aware. Clinician validation time availability remains a challenge and is under negotiation via a service level agreement. **Mitigating actions**: Project Team and Board meetings continue to provide direction and leadership to the new post holders. A revised plan has been agreed with NHS England Specialised Commissioning.
	✓ *Reduce number of patients with length of stay of 2 weeks or longer*				**Progress update and risks to delivery**: Work on the systematic management of 14 day length of stay continues **Mitigating** actions include the implementation of red to green, introduction of an elderly care physician to support pre-operative optimisation and post-operative review.
	✓ *Improved pathways developed, agreed and implemented: MSK*††				**Progress update and risks to delivery**: Options for a MSK triage service are being developed as part of the Right Care initiative and the MCP. **Mitigating actions**:

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
	✓ *Improved model in place for †† Oncology Service*	March 2018	Chief Operating Officer		**Progress update and risks to delivery:** Changes to the cancer pathway at a neighbouring Trust may lead to a decrease in resource available to DGFT. A revised SLA has not been finalised.
					Mitigating actions: discussion is taking place with New Cross in relation to a revised SLA for the provision of acute oncology services at DGFT. There is no imminent resource impact as a direct result of the changes at Sandwell but we are aiming to improve the overall provision of acute oncology at DGFT as art of a new SLA.
	✓ *Revision of plastics/skin cancer services undertaken and †† implemented*				**P Progress update and risks to delivery**: the business case was approved in August 2017. Implementation is underway, with 2 new consultants having commenced.
					Mitigating actions:
	✓ *Improved pathways developed, agreed and implemented: †† Therapies Services*				**Progress update and risks to delivery:** An integrated Single point of access as part of the MCP model will include rapid access to therapy services. A business case has been developed for a rapid access service and presented to the CCG for their support. The CCG have revised their requirements which means that the service model is being reconsidered.
					Mitigating actions: Regular dialogue with the CCG is taking place and CCG changed requirements are being considered by steering group which was set up to manage the development of the business case.
	✓ *Increased capacity of †† orthodontics service*				**Progress update and risks to delivery**: Two consultants have been appointed and commenced in October 2017, but one consultant has resigned. The Orthodontics service will be operational. Limited orthodontics capacity across the Black Country may mean that there is an increase in referrals to DGFT. Substantive consultant appointment were made in March 2018.
					Mitigating actions:
Strategic aim four: be the place people choose to work					
➢ **Enhance colleague engagement** ✓ Develop a programme to enhance colleague engagement	✓ *Staff Survey embedded*	March 2018	Director of HR/ Chief Nurse		**Progress update and risks to delivery**: The staff survey results were published in March 2018 with a report being presented to Trust Board in March 2018 and an action plan being developed.
	✓ *Improvement in the national Staff Survey engagement score to 3.8%*				**Progress update and risks to delivery**: The engagement score for the 2017 survey was 3.79 and although it did not meet our target of 3.8, it was above the national average. Plans are in place to support better engagement for the 2018 staff survey in order to secure an improved response rate.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG				Risks to Delivery & Mitigating Actions
✓ Embed the Staff Survey as a tool to help managers share best practice and make improvements to staff engagement	✓ *Increase the response rate to 48%*	March 2018	Director of HR/ Chief Nurse					**Progress update and risks to delivery**: The response rate for the 2017 survey was 36% and significantly below the proposed target. **Mitigating actions**: Plans are in place to support better engagement for 2018 staff survey and realise the target for an improved response rate.
	✓ *Extend staff Friend and Family Test update*							**Progress update and risks to delivery**: The FFT for staff has been extended and revised and continues to provide the additional questions to support feedback from staff throughout the whole year.
	✓ *Staff story presented at Board*							**Progress update and risks to delivery**: The Trust Board has been receiving a Staff Story for over 6 months and will continue to be presented each quarter.
➢ **Maximise workforce capacity and capability, undertaking workforce redesign where appropriate** ✓ Create an employee development programme underpinned by an employee training needs analysis ✓ Create an Organisational Development Programme	✓ *Mandatory training target of 90% met be end of year*	March 2018	Director of HR	85%	85%	Oct 86% Nov 87% Dec 87%	87%	**Progress update and risks to delivery**: A system for recording and tracking compliance for each manager has been updated and improved. **Mitigating actions:** HR is supporting managers to understand and implement the policy on level one and two mandatory training.
	✓ *New roles in place i.e. Nursing Associate, clinical apprentice and nursing volunteers*							**Progress update and risks to delivery**: The second cohort of Trainee Nursing Associates in conjunction with the University of Wolverhampton commenced in January 2018. Clinical apprenticeships are underway. **Mitigating actions:** The revised CSW apprenticeship programme continues in line with demand for substantive CSW posts.
	✓ *Information Governance training target of 95% met by end of the year*			98%	83%	85%	85%	**Progress update and risks to delivery:** Staff are able to complete this training via either attendance at a 1hr face-to-face session (held twice per month Trust-wide, in addition to local sessions in ward areas), or completion of the e-Learning Healthcare Data Awareness module. **Mitigating actions:** Managers are being provided with regular updates on training undertaken/outstanding by their teams so that non-compliance can be checked and progressed. Discussions are taking place about the development of a Trust-hosted e-learning module to simplify access to the on line training.
	✓ *Employee development programme in place*							**Progress update and risks to delivery:** The Executive Programme commenced in October 2017. Divisional programmes commenced in March 2018. Band 6-8 programmes were in development during March 2018 and will commence in April 2018.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG				Risks to Delivery & Mitigating Actions
✓ Enhance mechanisms to identify potential to support succession planning opportunities ✓ Improve performance against recruitment key performance indicators (KPIs) ✓ Boost staff retention through structured support ✓ Introduce new nursing roles		March 2018	Director of HR					**Mitigation actions:** Membership of Aqua will support some of the development programmes.
	✓ *Leadership Forum commenced*							**Progress update and risks to delivery**: The Leadership Forum Took place in November 2017. This has been established quarterly with two events having taken place already with the next scheduled for May 2018. **Mitigation actions:**
	✓ *Appraisal target of 90% met by end of year*			85%	84%	Oct 87% Nov 88% Dec 87%	79%	**Progress update and risks to delivery**: The appraisal rate fell during February and March due to the changeover to the new appraisal window commencing on 1st April 2018. **Mitigation actions:** There are bookings confirmed for over 70% of appraisals scheduled to take place between April and June 2018, with more bookings to be added.
	✓ *Recruitment and retention KPIs delivered*							**Progress update and risks to delivery**: The recruitment KPIs have provided good focus on performance that has improved from the point when they were first published. There continue to be concerns around the target associated with shortlisting and interview. **Mitigation actions**: The trust is exploring a system to support and make recruitment processes more efficient across the trust. The system would generate and send automatic alerts to recruiting managers for out date recruitment actions. In the meantime, particularly for consultant posts, the Trust is improving our processes for shortlisting and liaising with applicants, as well as ensuring interview dates are set at the time a post is advertised.
➢ **Maximise employee-well being** ✓ Improve workforce performance in sickness, mandatory training, appraisal ✓ Implement a smoke free site	✓ *Sickness absence target 3.5% met by end of year.*			3.9 %	4.2%	Oct 4.2% Nov 5% Dec 5%	4.5%	**Progress update and risks to delivery**: The absence rate has fallen from over 5% to 4.5% in February. **Mitigating actions:** Managers are being supported to manage sickness absence and to apply the sickness absence policy. The absence policy has also been revised to support better outcomes and improve attendance. There are also new training programmes for managers on how to manage absence more effectively.
	✓ *Achieve 5% improvement in two of the 3 health & well-being staff survey questions*							**Progress update and risks to delivery**: The survey results identified improvements in two of the three health and wellbeing questions, but below the 5% benchmark. **Mitigating actions:** A programme of work is being developed to support stress awareness and management of stress for staff and to improve action on health and wellbeing for 2018/19. The focus in 2018/19 will be on ensuring staff are aware of action on health and wellbeing and stress management.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
	✓ *staff well-being events are held at least four times a year focusing on physical and mental health*				**Progress update and risks to delivery**:
	✓ *Site smoke free in 2018/19*				**Progress update and risks to delivery**: This has now been confirmed by the Trust Board with expected date of delivery December 2018.
Strategic aim five: make the best use of what we have					
➢ **Implement the Digital Trust Programme** ✓ Implement the core foundation systems for the Digital Trust ✓ Deliver a Proof of Concept Shared Record between GP's and DGFT	✓ *Each phase of the Digital Trust plan delivered in line with project plan*	March 2018	Chief Information Officer		**Progress update and risks to delivery**: Timescale for EPR go live was moved to 23th April to fit in with Divisions plans. **Mitigating actions:**
	✓ *Proof of Concept Shared Record developed*	Nov 2017			**Progress update and risks to delivery**: The shared record is now positioned as an MCP IT population Health solution so any proof of concept will be carried out with the GP partnership directly, rather than through the CCG. **Mitigating actions:**
➢ **Match capacity to demand** ✓ Implement an operational demand/capacity management tool	✓ *Operational demand/capacity management tool implemented*	March 2018	Chief Operating Officer		**Progress update and risks to delivery**: Demand and capacity modelling has been completed, but not embedded within services. **Mitigating actions**: Further work is being undertaken until demand is managed and appropriate capacity is in place. The Deputy Director of Surgery, Women & Children is undergoing NHSI Demand and Capacity training.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
➢ **Deliver the agreed financial plan** ✓ Set budgets that will achieve a £2.45 m surplus and monitor progress. ✓ Deliver CIP of £12.5m and a financial control target of £2.45m surplus ✓ Identify and target specific areas of efficiency as identified through the Model Hospital Portal	✓ *Budgets set that achieve a £2.5m surplus* ✓ *£12.5m CIP and a £2.45m surplus control total achieved*	March 2018	Director of Finance/ Director of Strategy & Business Planning		**Progress update and risks to delivery**: **Mitigating actions**: **Progress update and risks to delivery**: The full year target is £12.5m of which £8.9m has been achieved at the end of Quarter 4. The shortfall is predominantly related to schemes linked to nursing bank and agency spend and surgery contract income growth. **Mitigating actions**
➢ **Develop a Clinical Strategy which ensures a sustainable clinical organisation** ✓ Engage clinical workforce in the development	✓ *Refreshed Clinical Strategy in place*	June 2017	Medical Director / Chief Nurse		**Progress update and risks to delivery**. The Clinical Strategy has been approved and published. The strategy will be reviewed in 2018/19 in the light of the development of community services, the need to support a frail and elderly population and the aspiration to develop our existing specialist services.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG				Risks to Delivery & Mitigating Actions
of the strategy ✓ Reflect the impact of external initiatives within the strategy (i.e. STP, BCA, MCP).								
Strategic aim six: deliver a viable future								
➢ **Play an active part in the STP arrangements in the Black Country and West Birmingham** ✓ Implement the Sustainability and Transformation Plan	✓ *STP implemented*	March 2018	Chief Executive					**Progress update and risks to delivery**: The STP is being implemented in conjunction with partners. The Trust is driving the Urgent Care workstream and leading the Acute Collaborative on behalf of the STP partners. The Trust attends monthly meetings. Since January 2018, the Trust has engaged in the LMS Strategic Committee to develop the maternity workstream.
➢ **Play a part in the implement-ation of the Black Country Provider partnership initiatives.** ✓ Deliver the aspirations of the BCPP procurement	✓ *Savings identified achieved*	March 2018	Chief Executive					**Progress update and risks to delivery**: This action is dependent on implementation and delivery of BCPP schemes below.
	✓ *BCPP procurement work stream implemented*							**Progress update and risks to delivery**: The BCPP Procurement work stream is now fully implemented and is complete. **Mitigating actions**
	✓ *Implement the Black Country Pathology Review*							**Progress update and risks to delivery**: The business case for the creation of the BCPS with a Hub based at Wolverhampton and Essential Service Laboratory (ESL) at Russells Hall Hospital was approved by DGFT Board on 8th February 2018. Workshops have been undertaken with the Pathology Service to validate and agree staffing levels at the Hub and ESLs and detailed mapping of IT infrastructure implications has taken

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
work stream including the Nationally Contracted Products Programme. ✓ Work in partnership to develop a model for delivery of Black Country Pathology Services ✓ Develop opportunities for pharmacy benefits across Black Country Trusts ✓ Maximise back office opportunities		March 2018	Chief Executive		place. Logistical implications have also been identified and defined. Workstreams have been set up to progress IT infrastructure procurement; estates build (capital funding has been secured) and clinical standardisation. Clinical and operational risks have been mapped and an operating model that addresses these risks and minimises any potential disruption has been developed. A detailed transition and implementation plan is under development. The Trust's HR departments are launching a TUPE consultation with staff impacted. **Mitigating actions**: DGFT is represented on each work stream. The Clinical Director is the lead for DGFT. A Non-Executive Director attends the BCPP Pathology Board.
	✓ *Deliver identified pharmacy benefits*				**Progress update and risks to delivery:** Three projects are under way: • Pharmacy Aseptic Unit review and rationalisation – each Trust Chief Pharmacist has submitted a return to NHS Improvement on their Pharmacy aseptic service as part of the National Aseptic Service review undertaken by Deloitte. We are awaiting budget allocations to assess viability of a 6 month project manager contract. Project scoping work continues in the background to develop site file development. • Medicines Safety – all Trusts have completed missed dose audit, benchmarked their results and learning has been undertaken where necessary. Medication Safety Officers are developing the next missed dose audit with regional leads. • Medicines administration Pharmacy Technician Project – a pilot project has been completed at Walsall Hospital and learning is being shared across BCPP. Scoping is on hold at DGFT until pharmacy workforce issues are resolved. **Mitigating actions**: Meetings are in process to monitor delivery of each project.
	✓ *Back office opportunities identified and delivered*				**Progress update and risks to delivery**: The Trust is committed to progress a shared back office function at an STP level. The Trust is working with Sandwell & West Birmingham Hospitals NHS Trust, Royal Wolverhampton NHS Trust and Walsall Healthcare NHS Trust to review how the finance, procurement payroll and Human Resources function could be delivered in a collaborative model. An outline business case has been prepared which provided a number of options of how the services could be provided on a collaborative basis going forward. A revised business case is being prepared following comments from all trusts involved. A timescale has not been set for this.

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Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
					Mitigating actions:
✓ **Work proactively with BCHCare FT to become the provider of MCP services** †† ✓ Develop and submit a joint bid in conjunction with BCHCare Foundation Trust ✓ Support and engage staff in the change process ✓ Develop and implement revised care pathways	✓ *Bid developed and submitted*	March 2018	Chief Executive		**Progress update and risks to delivery**: A decision has been made on organisational form with DGFT as the lead partner. Ahead of a formal decision by governors and board, it is proposed that DGFT split to form two new Foundation Trusts, one of which will be the MCP. Initially, a division would be created within DGFT for a period of transition with the establishment of a transition board to work on developing the structures, form and governance of the MCP. Risks include i) agreement of risk gain share across the health economy; ii) the impact of new models of care in the trust, iii) the utilisation of capacity generated by the new models of care for the trust's benefit; iv) financial risk of splitting the DGFT and establishing the MCP. There is also no funding to support the costs of separation. **Mitigating actions** include i) ensuring timescales and capacity to respond to milestones in a timely way with a project manager in place to coordinate and ensure pace; ii) understanding the detail of the impact on the business of DGFT; iii) development of a detailed project initiation document and plan; iv) developing a risk gain share agreement across health economy with support from NHS I and NHS E. A series of workshops have arranged for this.
	✓ *Revised care pathways scoped*				**Progress update and risks to delivery**: Scoping work is ongoing but will be developed more fully at the time to support the submission of the bid. **Mitigating actions:**
	✓ *Bid successful*				**Progress update and risks to delivery**: Regular discussions weekly with GP collaborative have taken place throughout the PQQ and will continue through bidding process,
	✓ *Communications plan in place for staff*				**Progress update and risks to delivery**: **Mitigating actions**:
➢ **Develop the Trust's market share in the Wyre Forest**	✓ *Establish clinics at Bewdley Medical Centre*	March 2018	Director of Strategy & Business Planning		**Progress update and risks to delivery**: Wyre Forest CCG do not wish to expand the number of clinics and will review this as part of contract negotiations for 2018/19. **Mitigating actions**: DGFT will participate fully in contract negotiations.

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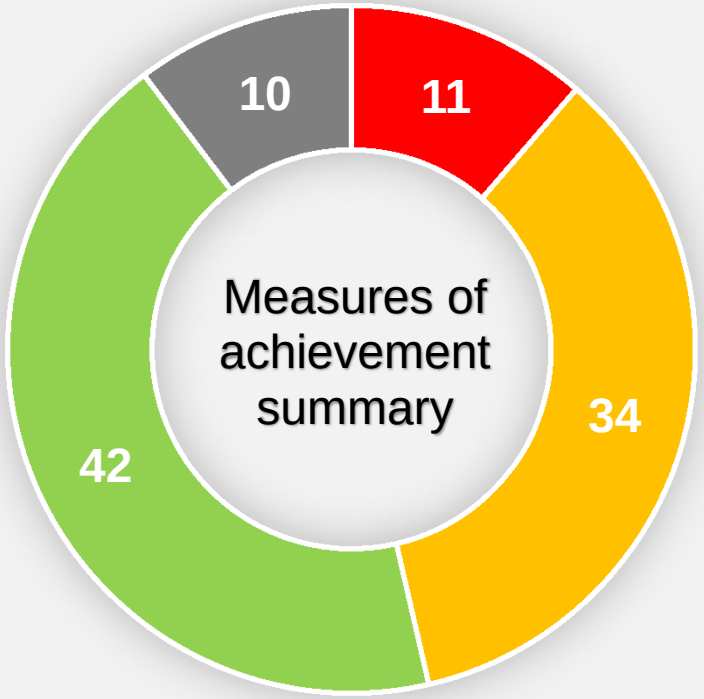
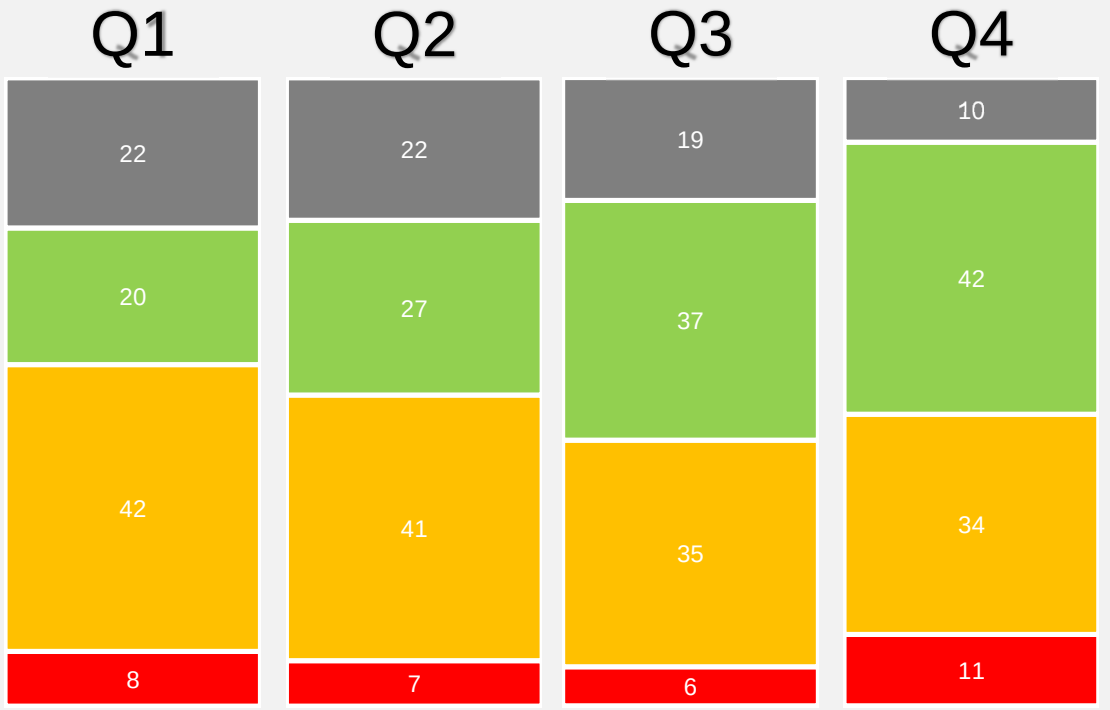
Goal & Actions	Measures of Achievement	Time-scale	Lead	Q1, Q2, Q3 & Q4 RAG	Risks to Delivery & Mitigating Actions
✓ Identify and exploit opportunities for increasing the Trust's market share in the Wyre Forest.	✓ *Expand clinics located at Hume Street*				**Progress update and risks to delivery**: Wyre Forest CCG do not wish to expand the number of clinics and will review this as part of contract negotiations for 2018/19. **Mitigating actions**: DGFT will participate fully in contract negotiations.

OPERATIONAL PLAN PERFORMANCE

The Dudley Group NHS Foundation Trust

Q4 2017/18





1 Deliver a great patient experience

2 Deliver safe and caring services

3 Drive service improvement, innovation & transformation

4 Be the place people choose to work

5 Make the best use of what we have

6 Deliver a viable future

Enclosure 12

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board of Directors on 3 May 2018

TITLE:	Patient Experience Report – Quarter 4, 2017/18		
AUTHOR:	Jill Faulkner Head of Patient Experience	**PRESENTER:**	Siobhan Jordan Chief Nurse
CORPORATE OBJECTIVE: SO1: Deliver a great patient experience			

SUMMARY OF KEY ISSUES:

The Trusts number one priority is to deliver an outstanding patient experience. This report details:

- Patient Experience
- National Survey Programme
- Friends & Family Test (FFT)
- NHS Choices
- Patient Complaints
- Compliments
- Patient Advice & Liaison Service (PALS)

This report covers the period January to March 2018 referred to as Quarter 4 (Q4). The aim of this report is to detail the multiple forms of patient feedback received and to evidence actions being taken to continually focus and improve the care we deliver and the experience received by both the patient and their family.

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

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

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To note the content of the Q4 Patient Experience report.

Patient Experience Report

1. Introduction

The Trust's number one priority is to deliver an outstanding patient experience. This report details:

- Patient Experience
- National Survey Programme
- Friends & Family Test (FFT)
- NHS Choices
- Patient Complaints
- Compliments
- Patient Advice & Liaison Service (PALS)

The aim of this report is to detail the multiple forms of patient feedback received and to evidence actions being taken to continually focus and improve the patient and their families' experience.

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

The **Patient Experience Improvement Group (PEIG)** is held on a fortnightly basis. This meeting is well attended with representation from across the Trust.

Action plans from the all national surveys are presented and monitored at the PEIG. The Trusts National Adult Inpatient survey has been a standing item at every meeting to ensure accountability and that actions have been delivered. Following receipt of results of the 2017 Adult Inpatient survey, (presently under embargo until publication late May/early June) the 2018 action plan is being devised and this will remain a standing item on the group agenda.

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

- Adult Inpatients Survey (National)
- Cancer Patient Experience Survey (National)
- Children & Young People Survey (National)
- Community Services
- Dementia
- Emergency Department Survey (National)
- End of Life/Voices
- Guest Outpatient Centre Review
- Maternity Survey (National)
- Mini PLACE assessment activity
- PLACE (National)

Community Patient Experience Group chaired by the Head of Patient Experience meets regularly to oversee improvement actions directly related to the delivery of community services and FFT response rate improvement. This group reports in to the PEIG.

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

Within Q4 we successfully:

- Campaigned for the replacement of outdated and unreliable car parking pay machines and car park equipment with programme of works commencing April 2018
- Commissioned a review of snack provision for inpatients and awaiting outcome of budgetary discussions
- Expanded the use of the 'follow up calls model' to T&O patients within 48 hours of discharge from hospital to assess: pain management and any concerns with a wound
- Water fountains installed in the Surgery Assessment Unit
- Reviewed tea and coffee provision on wards for those recently bereaved
- Review of Guest Outpatient Centre and improved the physical environment for patients and staff including the creation of staff break way area and the installation of curtains and blinds
- Dementia friendly signage installed on the majority of toilet doors on wards and in public areas
- Coloured toilet seats were installed in line with the Dementia Strategy actions, the Trust has been working on this for many years
- Relocated 11 toilet roll holders to improve accessibility for those patients in danger of falling
- Continued to host Feedback Friday events across the Trust sites
- Support the wider Trust to deliver patient experience actions

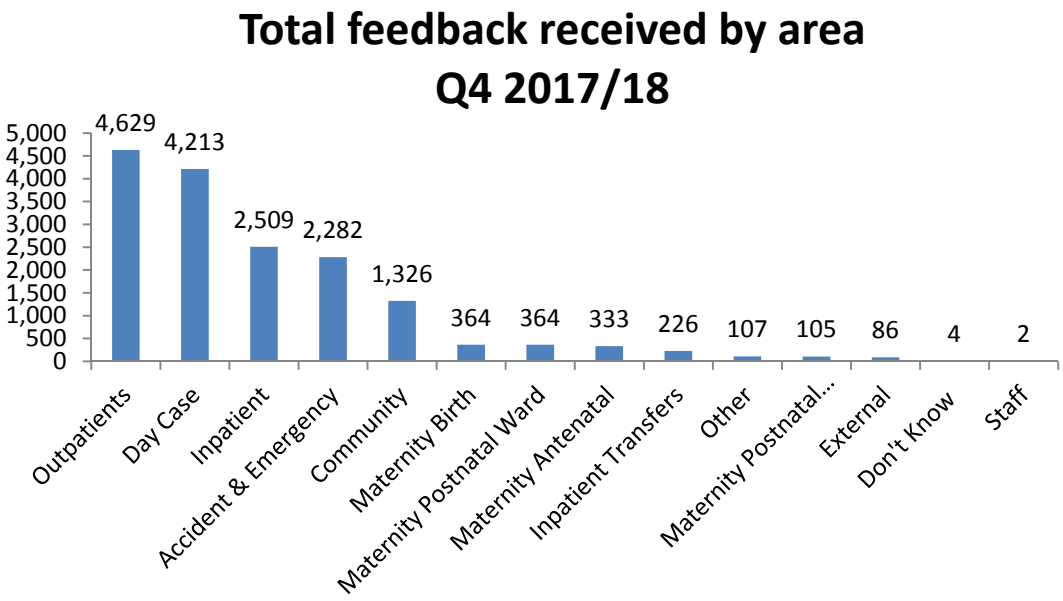
Dragons Pen provided the opportunity to include installation of a digital fish tank within the Georgina Unit waiting room and LED skylights across the Trust to improve the environment for our patients. Fundraising activities are underway and an update will be reported in Q1, 2018/19.

An action from the various surveys and patient feedback has been to re-establish **Patient User Groups** within the Trust. During the quarter the following user events have been held:

- 'Whose Shoes' maternity listening event
- Stroke Listening into Action event
- Elderly Care Service Users event

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

Patient feedback
The Trust received16,550 pieces of feedback during Q4 in comparison to 19,642 received in the previous quarter. This included responses to the Friends and Family Test (FFT) utilising a variety of mediums such as paper, SMS, App and the web. Additionally we collate feedback through real time Surveys, NHS Choices, complaints, compliments and PALS.



2. National Survey Programme

2017 Maternity Survey

At the end of January the results of the 2017 Maternity survey were published (http://www.cqc.org.uk/publications/surveys/surveys). The 2017 Maternity Survey is part of a national survey programme run by CQC to collect feedback on the experiences of women using NHS maternity services across the country.

- The Trust's response rate was 34.1% based on 100 women completing the survey (national response rate was 37.4%).
- Our overall rating was "about the same" compared to other trusts.
- Of the 51 questions in the survey the Trust scored better than the previous year on 27 questions, worse on 15 questions and about the same for 9 questions.
- Analysis of the results has been completed and 14 actions have been identified for improvement; 11 are complete. To ensure sustained improvement, monitoring will continue to be overseen by the PEIG.

The Survey will be administered annually from 2018 (previously bi-annually) and is expected to sample women who had given birth during the month of February.

2017 Adult Inpatient Survey results – UNDER EMBARGO

During February 2018 the Trust received the first set of results from its survey contractor (Quality Health) for the 2017 Adult Inpatient survey. The results are for local use only and under embargo until national publication by the CQC in the summer of 2018 (date to be advised).

The survey results have been shared widely across the Trust and an action plan developed to address any areas for improvement.

See appendix 1 for details of forthcoming national surveys.

3. Friends and Family Test (FFT)

FFT gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely (on a scale ranging from extremely likely to extremely unlikely) they are to recommend the service to their friends and family if they needed similar care or treatment. The FFT is intended as a service improvement tool, measuring performance continually and enabling increased responsiveness to near and real time feedback. It is also a mechanism to encourage and motivate staff and reinforce good practice. It is used to benchmark services both internally and externally.
Improving FFT response rates across all areas remains a focus with improvements seen following the expansion of the SMS FFT survey solution to all areas. The Patient Experience team continues to work with all areas to support initiatives to improve the response rate.

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

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

Community Services Response rates

	2017								2018		
Ward	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Community Nursing Services	1.1%	0.8%	5.1%	10.7%	6.1%	3.7%	11.3%	10.8%	9.6%	7.4%	9.2%	6.9%
Rehabilitation & Therapy Services	1.5%	1.3%	1.4%	0.6%	2.7%	1.7%	3.4%	4.2%	2.8%	2.7%	3%	2.6%
Specialist Services	0.1%	0%	0.1%	0.3%	0.6%	0.3%	0.4%	1.2%	0.7%	0%	0.3%	0.6%
Overall	**1.1%**	**0.9%**	**2.1%**	**3.3%**	**3.2%**	**1.9%**	**4.9%**	**5.2%**	**4.3%**	**3.3%**	**4%**	**3.4%**

ED services Response Rates

	2017									2018		
Ward	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Acute Medical Unit									75%	69.9%	100%	100%
Emergency Ambulatory Care												
Emergency Assessment Unit	53.3%	36.1%	68.9%	55.4%	60.1%	63.5%	72.9%	86.2%				
Emergency Department	11.6%	11%	12.3%	11.3%	12%	15.9%	24.7%	20.6%	13.5%	16.9%	16.4%	14.9%
Overall	**15.4%**	**13.7%**	**17.1%**	**15.3%**	**16%**	**19.6%**	**28.5%**	**24.7%**	**17%**	**21.2%**	**22.6%**	**19.5%**

Maternity services Response Rates

	2017									2018		
Ward	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Antenatal	25.1%	62.6%	45.1%	76%	100%	96.1%	64.1%	56.6%	16.4%	47.8%	68.6%	42.7%
Birth	32.8%	50.5%	50.1%	47.5%	53.2%	27.8%	35.7%	53.9%	28.4%	39.2%	28.5%	41.2%
Postnatal Community	28.8%	33%	18.1%	17.1%	36.3%	21.6%	7%	7.1%	14.5%	27.8%	19.8%	9.7%
Postnatal Ward	32.8%	50.7%	50.1%	47.3%	52.4%	27%	35.1%	53.2%	28.5%	38.3%	29%	41.5%
Overall	**30.9%**	**48.9%**	**40.4%**	**48.6%**	**56.3%**	**39.6%**	**34.8%**	**45.1%**	**23.6%**	**38.4%**	**35.9%**	**36.3%**

Outpatient services Response Rates

	2017									2018		
Ward	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Outpatients	1.5%	1.9%	2.3%	2.6%	4.8%	2.9%	10.9%	5.9%	3.5%	5.9%	4.4%	4.6%
Overall	**1.5%**	**1.9%**	**2.3%**	**2.6%**	**4.8%**	**2.9%**	**10.9%**	**5.9%**	**3.5%**	**5.9%**	**4.4%**	**4.6%**

Inpatients services Response Rates

Ward	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
A1												
A2	4.9%	11%	0.2%	15.3%	7.7%	1.5%	17.8%	4.2%	1.9%	2.2%	1.7%	2.4%
A3	38%	0%										
A4												
B1	38.2%	41.4%	47.4%	34.6%	51.1%	55.6%	73.5%	61.3%	50.3%	45.6%	58.4%	63.8%
B2 Hip	18.5%	26.9%	29.4%	36.3%	23.8%	22.8%	32%	19.1%	32.8%	38.4%	55.3%	40.7%
B2 Trauma	54%	58.3%	91.1%	100%	100%	74.4%	100%	100%	100%	100%	88.8%	78.5%
B3	12.1%	24.1%	15.2%	21.9%	21.3%	18.5%	29.4%	36.3%	27.8%	30.5%	29.1%	27%
B4	6.1%	30.8%	46.6%	37.5%	21.5%	35.4%	50.2%	39.7%	37.2%	50.7%	34.7%	35.1%
B5	18.1%	61.3%	55.1%	70.6%	19.4%	29.3%	52.7%	56.9%	54.1%	48.2%	48.2%	39.8%
B6	0%	5%					48.4%	3.2%	33.3%	5.3%	0%	0%
C1	27.9%	33.6%	20%	31.2%	8.9%	22.8%	61.5%	38.7%	19.8%	21.9%	34.8%	34%
C2	17.7%	12.4%	14.6%	20.9%	30.5%	11.9%	16.3%	19.1%	26.1%	14.6%	8.4%	17.4%
C3	19%	13.4%	45%	40.2%	62.8%	58%	53.3%	40.7%	13.8%	46%	50%	38.5%
C4	19.1%	18.1%	49.1%	59.1%	40%	38.4%	38.8%	48%	60%	49%	56.8%	62.5%
C5	12.8%	47.9%	37.6%	48.7%	23.6%	50.3%	50.5%	54.7%	45.1%	40.8%	22.9%	19.7%
C6	10.8%	15%	18.4%	30.6%	32.8%	21.6%	32.9%	33.9%	25.5%	38.8%	31%	69.2%
C7	18.4%	38.3%	59.2%	31.7%	38.7%	27.3%	36.2%	27.3%	29.8%	34.4%	27.3%	24.2%
C8	9.7%	26.2%	13.9%	16.4%	40.9%	28.2%	21%	29.8%	13.4%	6.1%	7.5%	28.7%
CCU & PCCU	16%	24.5%	21.5%	27.2%	23.4%	6.2%	30.8%	26.9%	18.9%	17%	25.5%	20.4%
Day Case	38%	32.5%	34.9%	33.2%	34.6%	29.6%	32%	32.3%	30.2%	30.2%	38.1%	36.6%
Evergreen	69%	59.8%	49.4%	61.4%	41%	15.6%	4.3%					
ITU	0%		50%		100%	100%	100%	100%	0%	33.3%	100%	66.6%
MHDU	100%	62.5%	61.5%	50%	40%	16.6%	46.1%	42.8%	72.7%	100%	30%	33.3%
Neonatal	8.3%	15.9%	32.5%	61.1%	31.4%	31.5%	6.1%	100%	65%	54.9%	42.8%	41.1%
SHDU	60%	0%	100%			100%	100%	100%	0%	33.3%		100%
Overall	**28.7%**	**30.8%**	**32.8%**	**34.2%**	**32.3%**	**27.8%**	**33.9%**	**33.9%**	**30.9%**	**30.1%**	**34.6%**	**34.9%**

Note: where gaps appear there is no data available as ward area currently designated to other activity or there has been no responses received.

RAG rating legend – response rate

Area	Below national average	Equal to or above national average	Equal to the top 20% of trusts nationally
Emergency Department Services	<=14.4%	>=14.5% - 21.2%	21.3% +
Inpatients	<=25.9%	>=26% - 34.4%	35.1% +
Community	<=3.4%	>=3.5% - 9.0%	9.1% +
Maternity - Ante Natal	<=21.6%	>=21.7% - 34.3%	34.4% +
Maternity - Births	<=21.6%	>=21.7% - 34.3%	34.4% +
Maternity - Community	<=21.6%	>=21.7% - 34.3%	34.4% +
Maternity - Wards	<=21.6%	>=21.7% - 34.3%	34.4% +
Maternity – Combined	<=21.6%	>=21.7% - 34.3%	34.4% +
Outpatients	<=4.6%	>=4.7% - 14.4%	14.5% +

The FFT percentage recommended scores for Q4 are as follows:

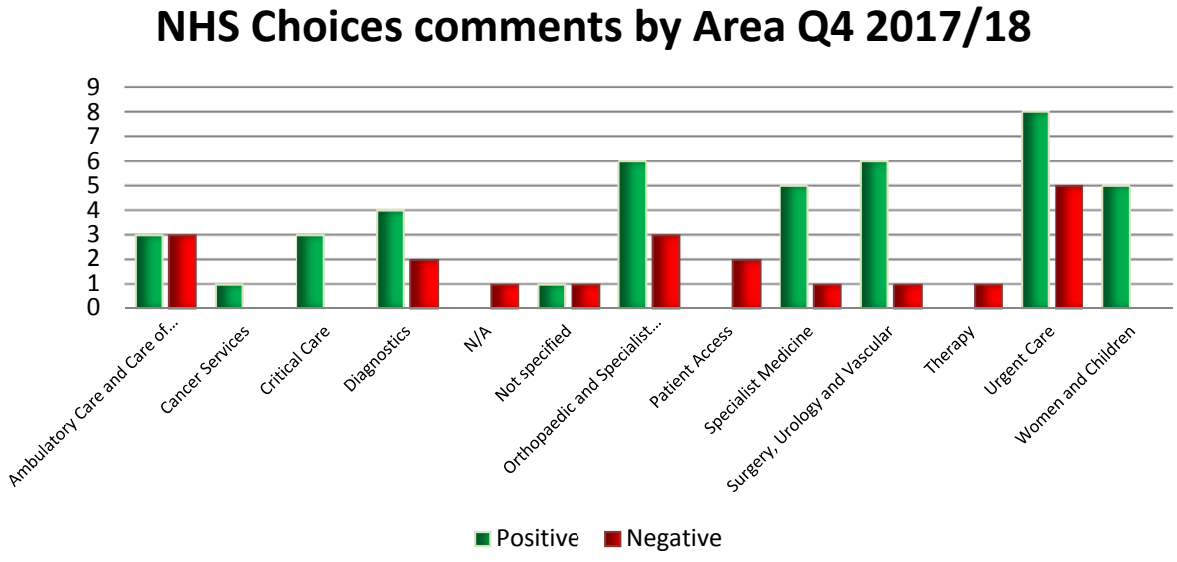
% recommended FFT Scores	Jan 18	Feb 18	Mar 18	% recommended FFT Scores	Jan 18	Feb 18	Mar 18
Inpatient	**94.1**	**94.1**	**93.7**	**Maternity Antenatal**	**90.9**	**90.9**	**97.7**
National	96	96	n/a	National	97	97	n/a
A and E	**74.4**	**74.4**	**74.5**	**Maternity Birth**	**97.8**	**97.8**	**97.0**
National	86	85	n/a	National	97	97	n/a
Community	**96.3**	**96.3**	**97.4**	**Maternity Postnatal Ward**	**100**	**100**	**98.5**
National	95	96	n/a	National	95	95	n/a
Outpatients	**91.7**	**91.7**	**91.6**	**Maternity Postnatal Community**	**100**	**100**	**100**
National	94	94	n/a	National	98	98	n/a

n/a = national data to be published mid May 2018

4. NHS Choices

In Q4, 62 people uploaded feedback electronically to NHS Choices or Care Opinion, (62 in Q3). Of those 62 comments, 68% (58% in Q3) were positive and 32% (42% in Q3) were negative. Table 1 below details the comment received by area (where identified) for Q4.

Table 1



5. Complaints

The Trust received 122 complaints during Q4 compared to 101 in Q3 and 115 in Q2. This is an increase of 21% compared to the previous quarter and a 6% increase from Q2.

Two key metrics within the complaints service is that:

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

The table below shows complaints activity and total number of complaints open as at 31 March 2018:

Complaints outstanding as of 31 March 2018	Complaints received in March 2018	Complaints Closed in March 2018	Complaints brought forward	Complaints overdue as of 31 March 2018
185	42	18	167	121

The table below details the length of time that complaints have been open (not as yet closed) as of 31 March 2018.

0 – 28 working days	29 – 40 working days	41 – 60 working days	61 - 100	101 - 178
50	14	40	33	48

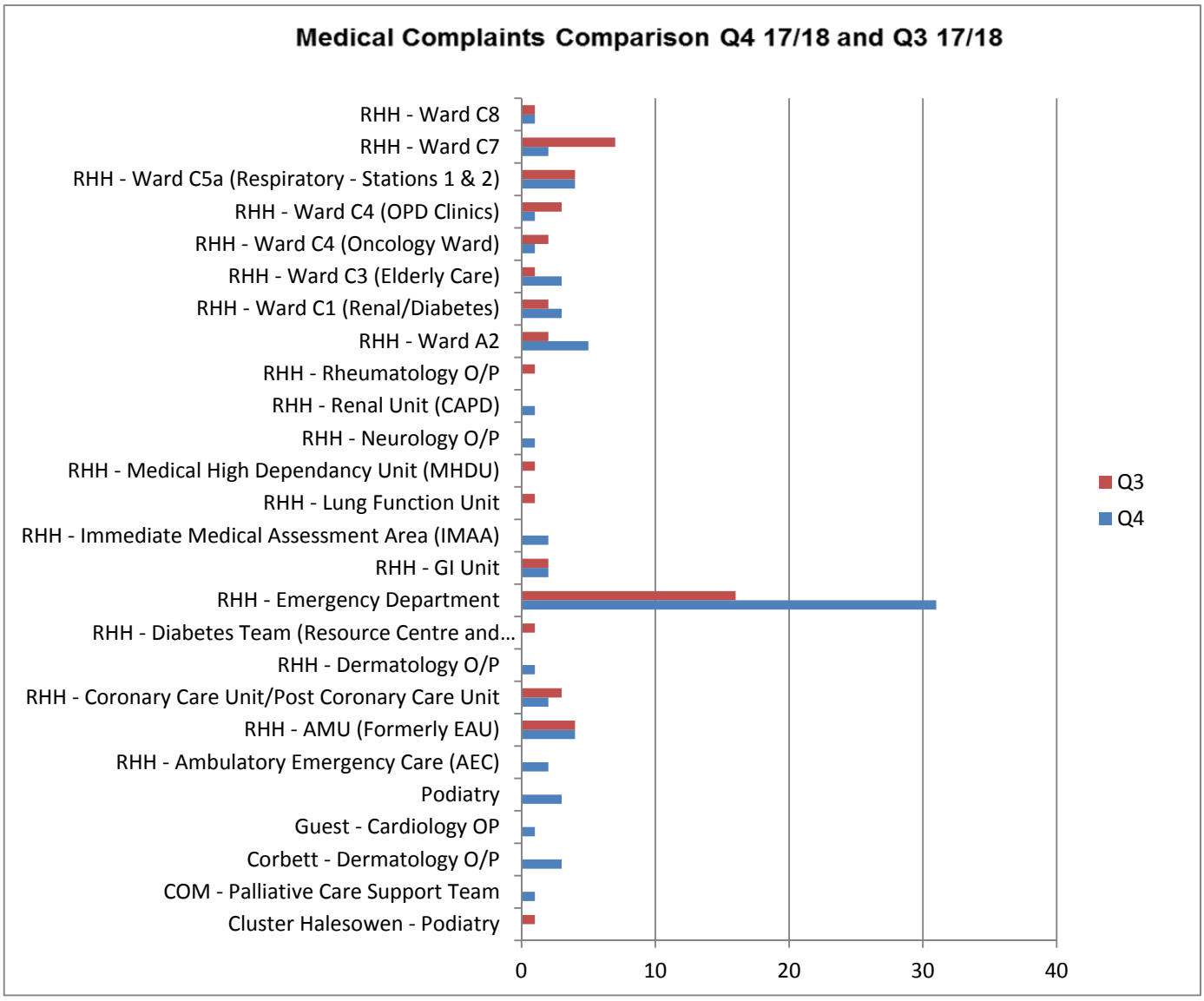
The Trust had 304,018 clinical patient contacts in Q4 which equates to 0.0401% of patients/families making a complaint.

The divisional performance during Q4 is as follows:

- Surgery Division received 42 complaints
- Medicine & Integrated Care Division received 74 complaints
- Clinical Support Division received 3 complaints
- Other 3 complaints (parking, environment, Action Heart)

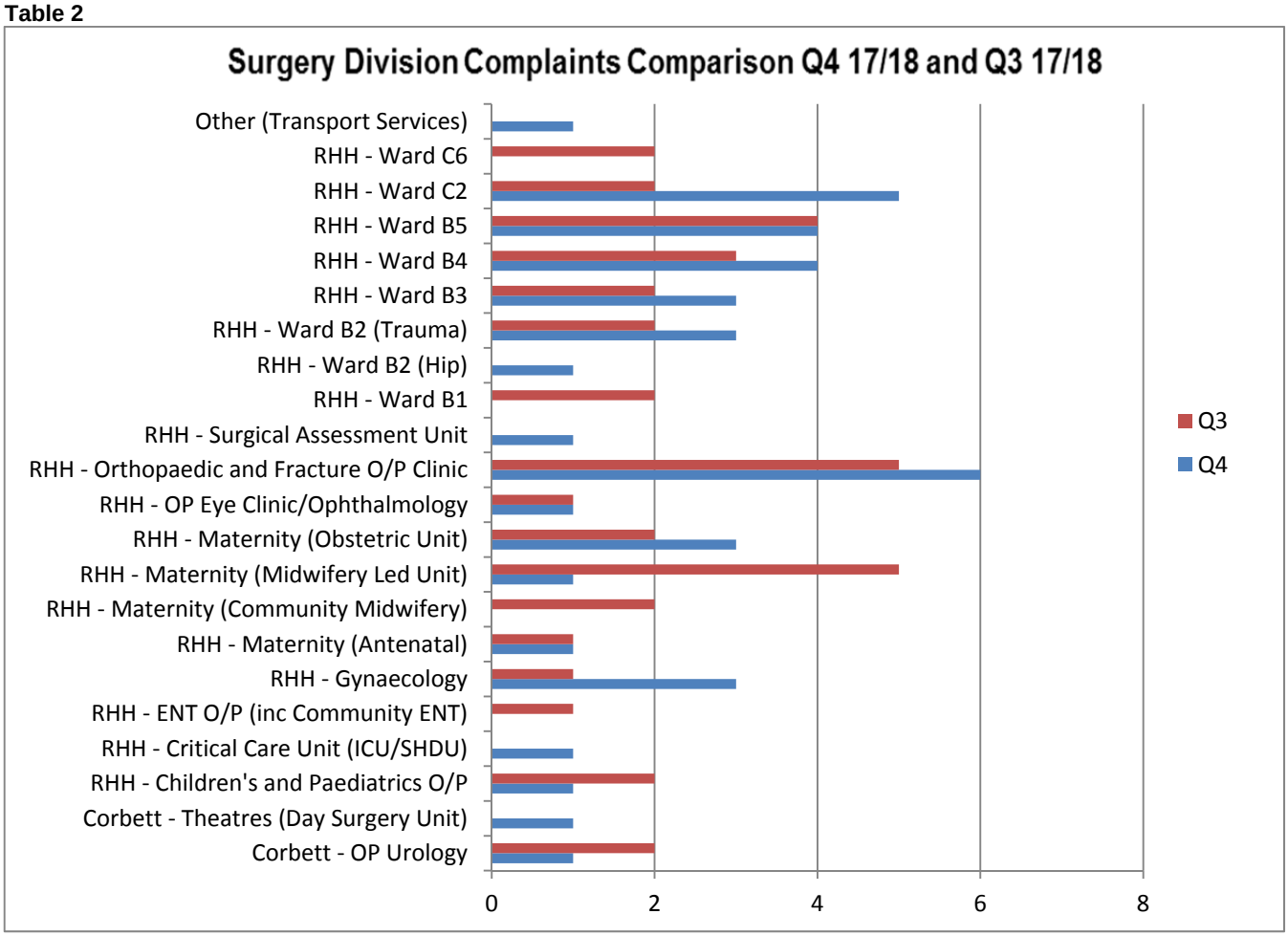
The following graphs illustrate complaints received within the division and which specific area of the Trust. They also demonstrate a comparison between Q4 and Q3.

Table 1



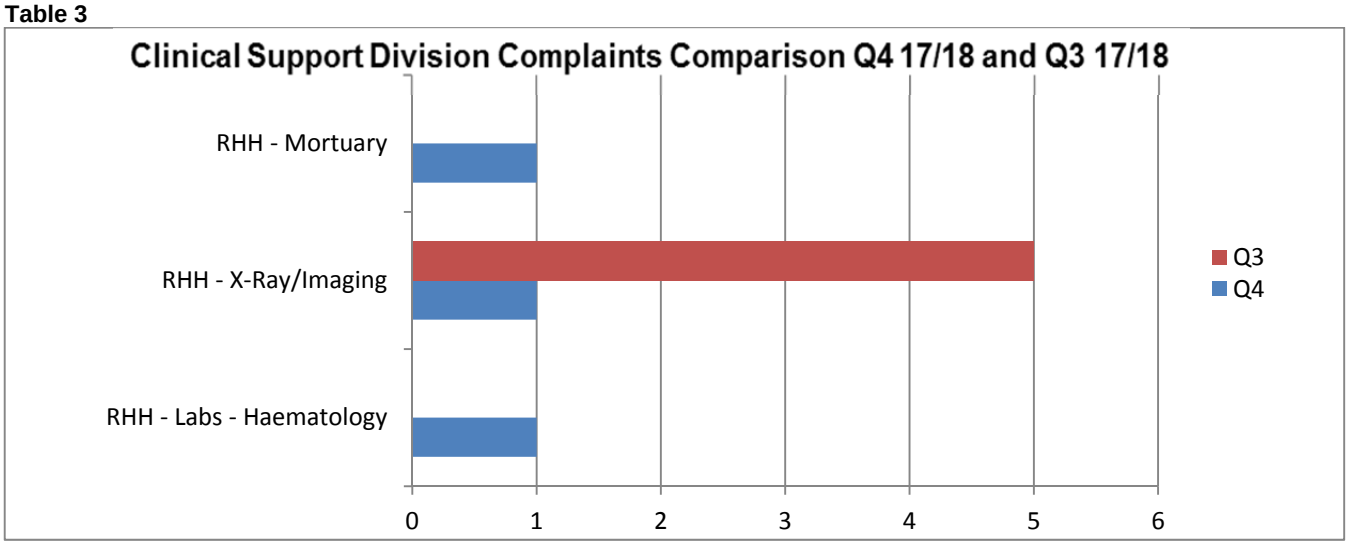
The Emergency Department has seen a significant rise in complaints. Wards A2 and C3 have also seen an increase in complaints received. The Head of Patient Experience and the Patient Experience Coordinator discuss complaints received on a weekly basis with Divisions.

Table 2



There has been an increase in complaints received regarding gynaecology and ward C2. Wards B2, B3, B4 and the orthopaedic and fracture clinic have also seen an increase. The Head of Patient Experience and the Patient Experience Coordinator discuss complaints received on a weekly basis with Divisions.

Table 3



There has been an increase in complaints received regarding the mortuary service and haemotology. The Head of Patient Experience and the Patient Experience Coordinator discuss complaints received on a weekly basis with Divisions.

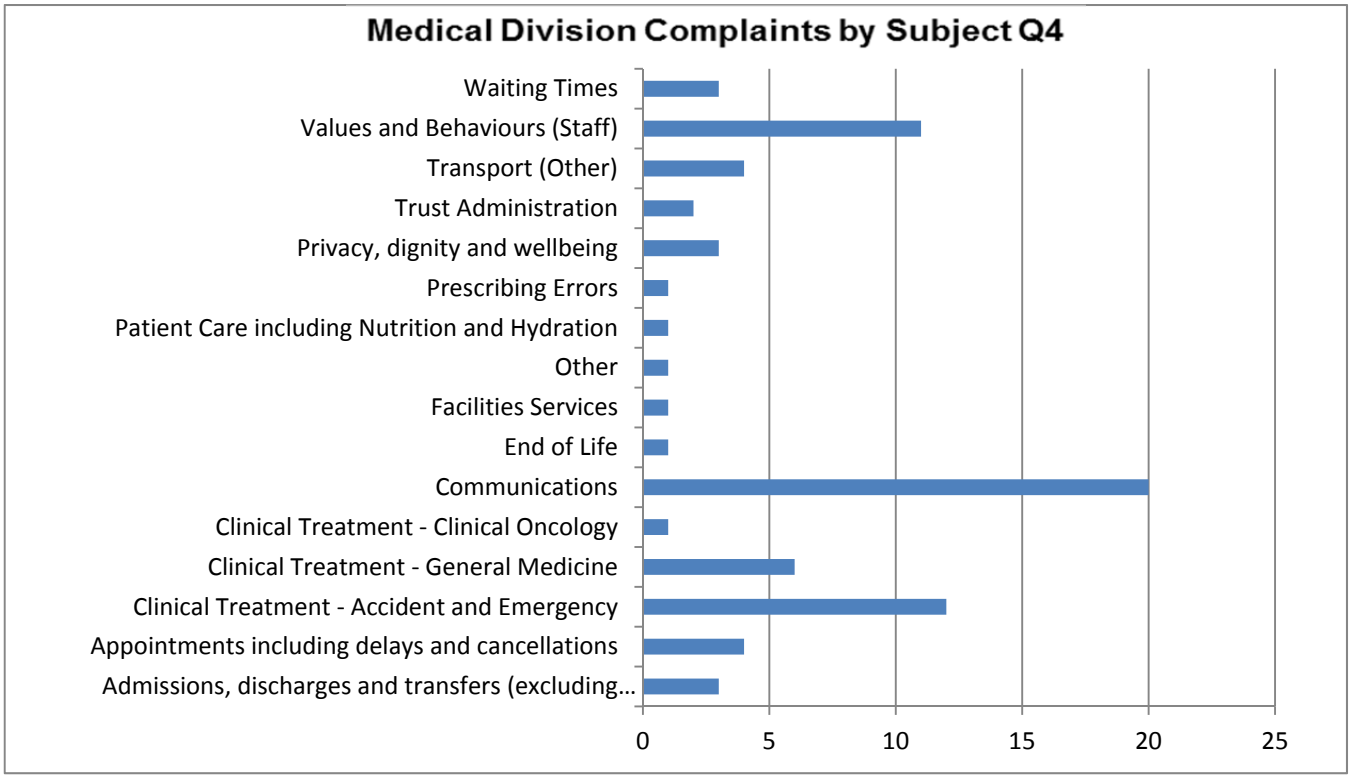
There has been one complaint received regarding community services relating to podiatry at Halesowen. To ensure concerns are raised within the community setting the community booklet is being updated with robust details of how to make a complaint or raise concerns. The Chief Nurse is concerned by the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

Medicine & Integrated Care Division

During Q4, a total of 74 complaints were received by the Medical & Integrated Care Division which indicates an increase of 40% from Q3, 2017/18 (53) and 90% increase (39) for the same period last year (Q4, 2016/17). The Emergency Department has seen the most complaints during Q4 followed by ward A2.

Please note that Table 1 and Table 5 will differ in terms of the number of complaints received as opposed to number of complaints received by team responsible as all subjects within a complaint are captured and logged separately. For example, one letter of complaint may cover a range of subjects linked to multiple divisions, areas and teams responsible. Table 4 details complaints received by subject.

Table 4

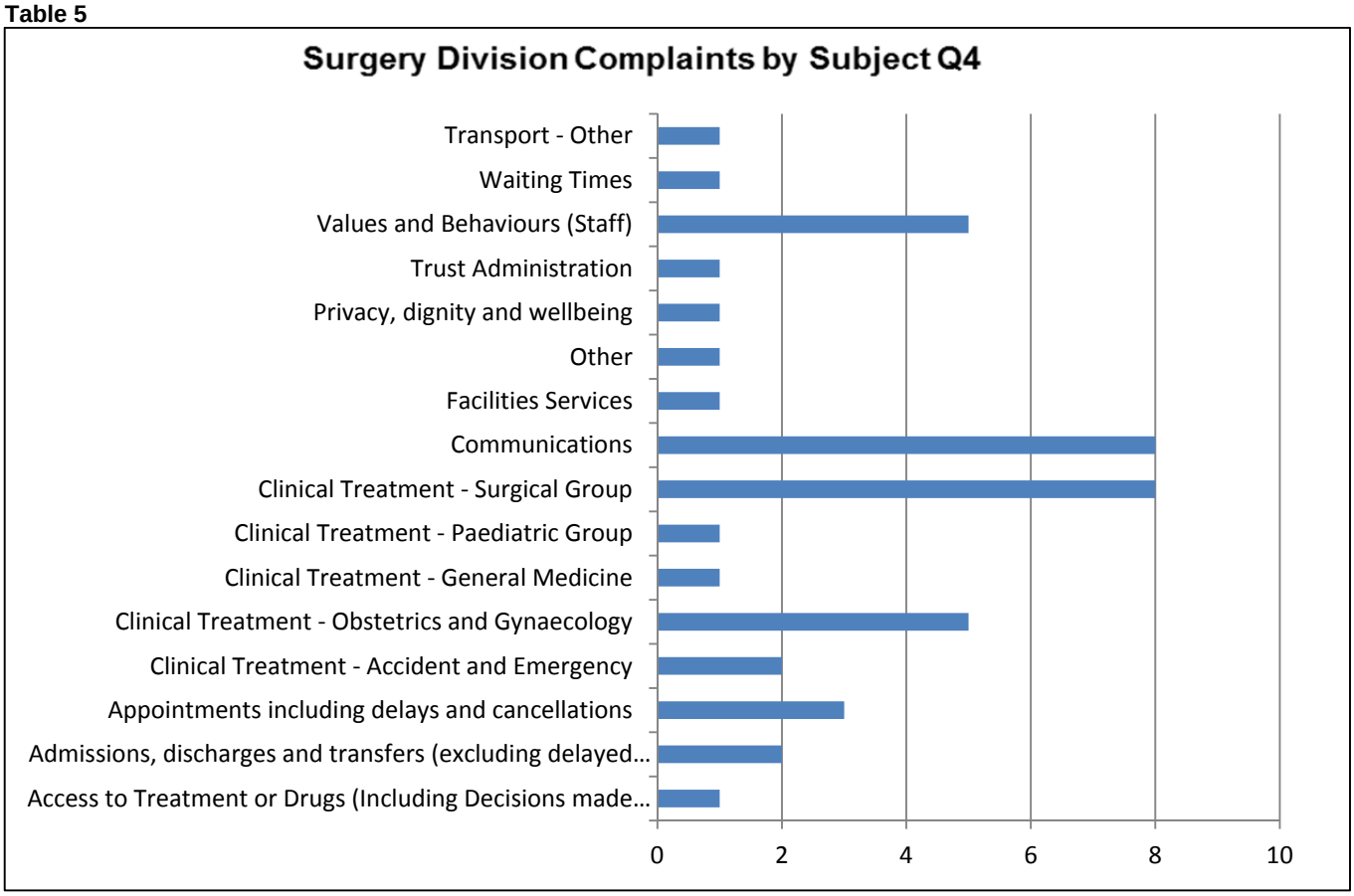


Surgery Division

During Q4, a total of 42 complaints were received by the Surgical Division which indicates an increase of 8% from Q3, 2017/18 (39) and 23% increase (34) for the same period the previous year (Q4, 2016/17). Further analysis has identified that maternity (Obstetric Unit), orthopaedics and fracture clinic outpatients, ward B4, general surgery (female) and gynaecology department have seen a significant increase in complaints.

Please note that Table 2 and Table 5 will differ in terms of the number of complaints received as all subjects within a complaint are captured and logged separately. Table 5 details complaints received by subject.

Table 5

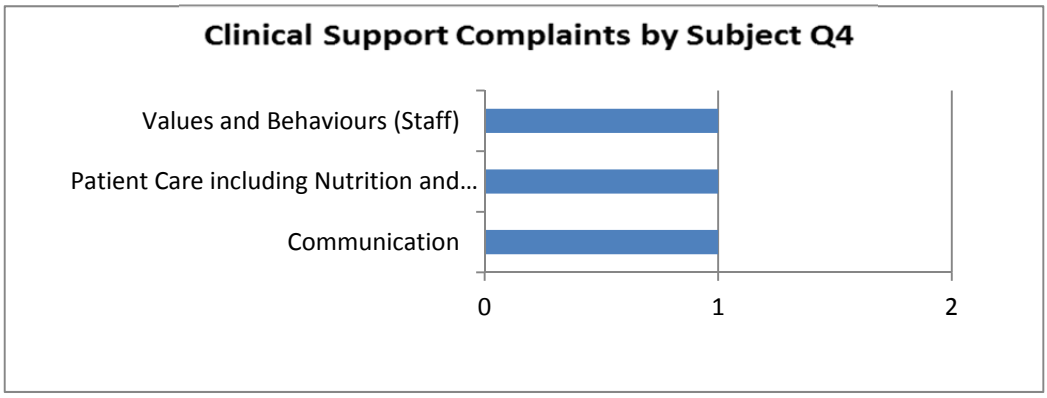


Clinical Support Division

During Q4, a total of 3 complaints were received by the Clinical Support Division which indicates a 63% increase from Q3 (8).

There has been a significant decrease in complaints related to the Imaging Department and it is suggested that this is as a result of the customer care training that has taken place as a result of complaint received. Table 6 details complaints received by subject.

Table 6



Complaint Themes

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

Quarter 4, 2017/18
Communications
Values and behaviour (Staff)
Clinical Treatment – Surgical Group
Clinical Treatment – Accident and Emergency
Clinical Treatment – Obstetrics and Gynaecology

Reopened Complaints

During Q4 the Trust received correspondence from 11 complainants who were dissatisfied with their original complaint response from the Trust.

This included clinical and chronological discrepancies within the initial response letter. The complaints were initially closed in Q1 and Q2. Out of the 11 reopened complaints, 5 have now been responded to.

These related to:

- Medicine & Integrated Care Division 2
- Surgery Division 8
- Clinical Support 1

Complaint responses

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

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

Within the reported quarter the Trust replied to 81 complaints in total. Of the 81 responses 16 (20%) were closed within 40 working days.

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

Five local resolution meetings (LRM) took place in Q4 which impacted on the 40 working day timescale being extended to accommodate such a meeting.

Members of Parliament

The Trust received 2 new complaints from Members of Parliament (MPs) during Q4. Both of these complaints are currently under investigation and awaiting response from the division. The complaints relate to Medicine and Integrated Care (1) and Corporate Services (1).

Local Government Ombudsman

The Trust received no applications from the Local Government Ombudsman (LGO) during Q4.

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

Parliamentary Health Service Ombudsman

The Trust received no applications from the Parliamentary Health Service Ombudsman (PHSO) during Q4 and none have been resolved during this quarter.

Complaints Satisfaction Surveys

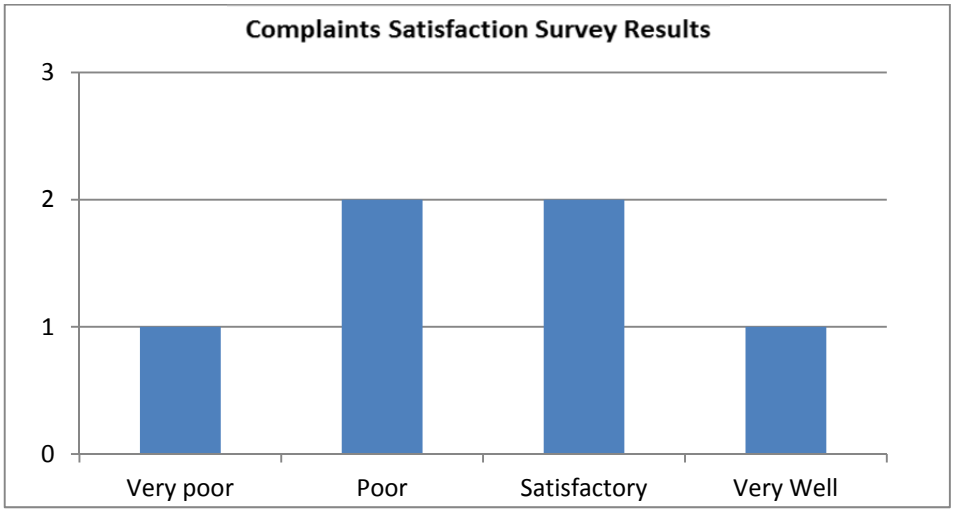
It is mandated that all trusts participate in the complaints satisfaction survey and is part of the NHS Complaints Legislation (2009). All complainants have the opportunity to complete a complaint satisfaction survey.

Of the 122 complaints received in Q4, 65 complaint satisfaction surveys were sent out and of those sent the Trust has received 6 completed surveys back. It has been agreed locally that surveys are sent out 6 weeks after closure to allow time for the complainant to consider the response.

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

Table 7 illustrates the feedback received from the complaints satisfaction survey received in Q4.

Table 7



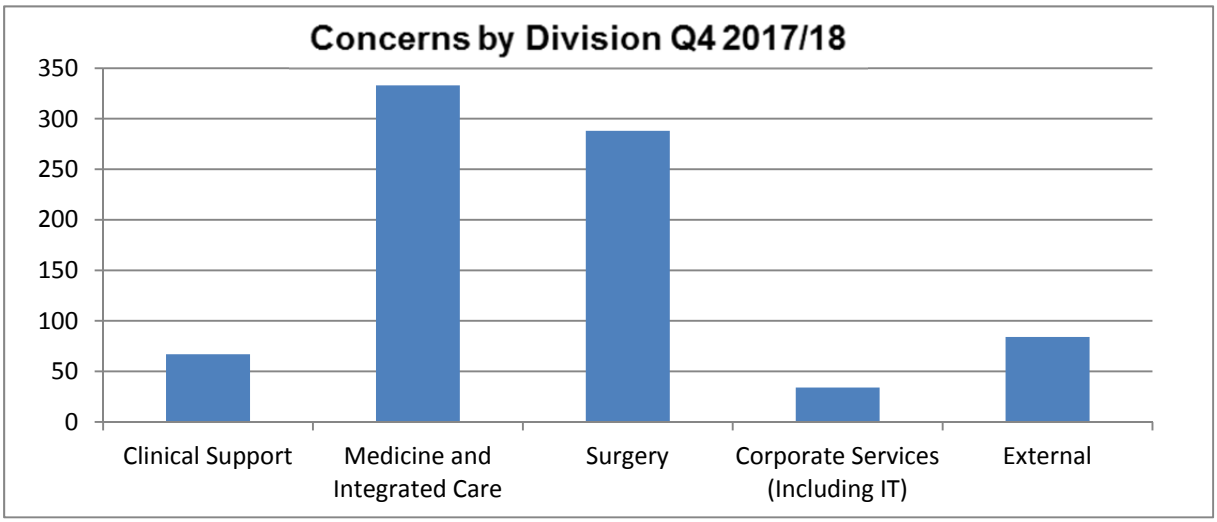
6. Compliments

The Trust continues to receive a high number of compliments equating to around 0.4% of patient activity. All compliments received by the Chief Executive and the Chief Nurse are acknowledged personally and shared with the staff involved. A total of 1,830 compliments were received in Q4 which represents a 7% decrease from Q3 (1,966), 2017/18.

7. Patient Advice Liaison Service

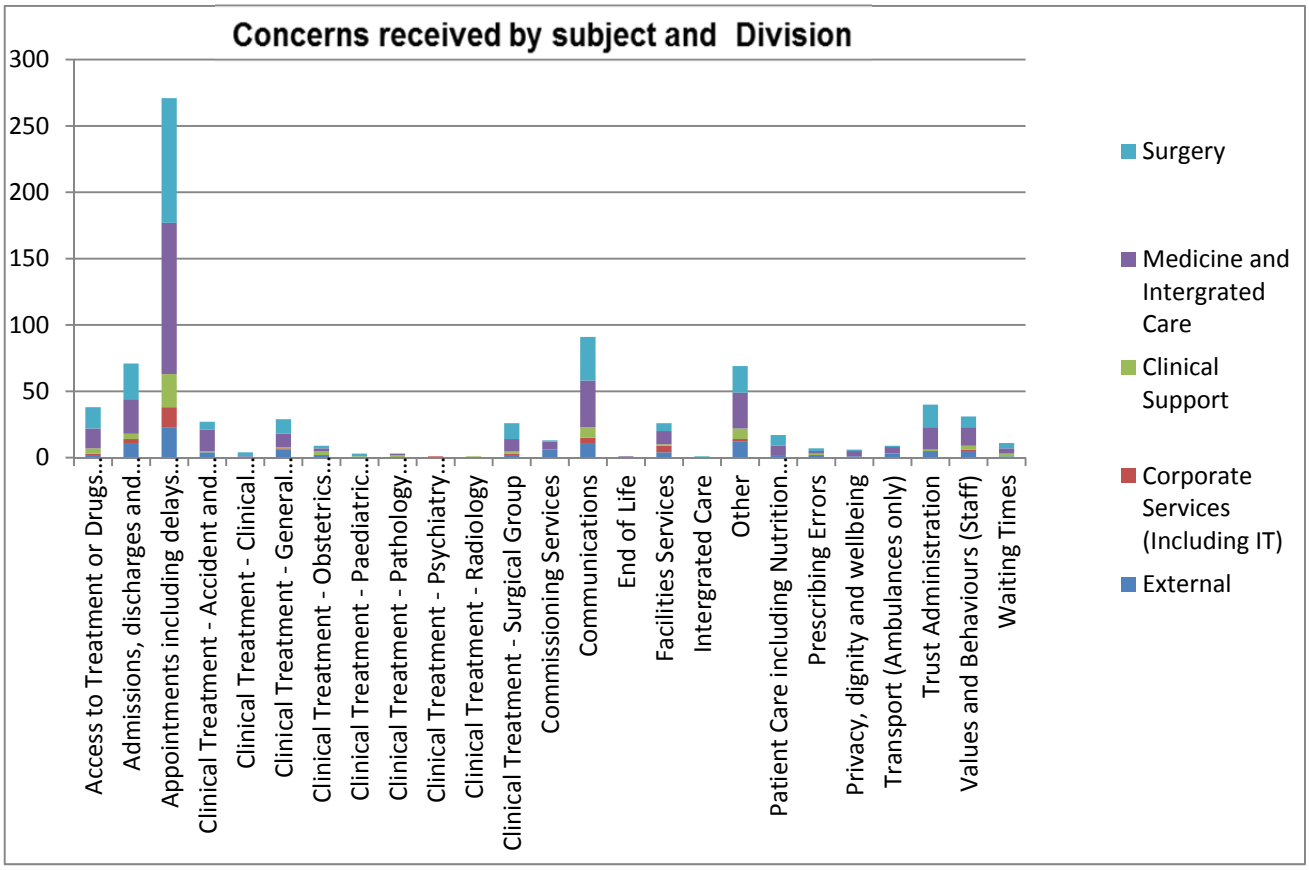
Patient Advice Liaison Service (PALS) received 806 new concerns in Q4, which is a 10% increase compared to Q3 (731). Table 1 details the breakdown by division during Q4:

Table 1



Please note that the tables below show a greater number of categories than PALS concerns received as some have multiple categories assigned to an individual concern. The most commonly raised concerns relate to delayed appointments and communication.

Table 2



The PALS team receives an average of 67 new concerns each week. These are escalated as appropriate (internally/externally) with the aim to seek resolution within 24 hours. Details of the time taken to resolve will be included in the next report.

A member of the PALS team is now located on the main reception at Russells Hall Hospital to increase accessibility and visibility of the service.

Conclusion

This report is intended to provide an overview of activity related to Patient Experience including national CQC surveys, Friends & Family Test, NHS Choices, Patient Complaints, compliments and the Patient Advice & Liaison Service (PALS).

The Chief Nurse supported by the Head of Patient Experience is committed to the development of staff and continuous improvement as well as improving the way we report this detail.

Appendix 1 NHS Patient survey programme: outline programme and publication dates

Dated: issued by survey co-ordination centre, October 2017

Fieldwork dates will be confirmed following support received from the Confidentiality Advisory Group under section 251 of the NHS Act 2006. Publication month is included here 12 months in advance, and the exact publication date is confirmed at least one month in advance of that date. Any change to the publication date would be recorded under 'notes' with the reason for the change.

Lead sector	Survey	Fieldwork timing	Expected month of publication	Notes
2016/17 surveys				
Acute Trusts	2016 Adult Inpatients	September 2016 to January 2017	31 May 2017	Survey published
Acute Trusts	2016 Emergency Department	October 2016 to March 2017	17 October 2017	Survey publication delayed from August 2017 owing to data adjustments.
Acute Trusts	2016 Children and Young patients	January – May 2017	28 November 2017	Survey publication originally planned October 2017. Publication month changed to allow for agreement on weighting methodology.
Acute Trusts	2017 Maternity	April – August 2017	January 2018	Publication moved from December 2017 to allow for additional data processing.
2017/18 surveys				
Acute Trusts	2017 Adult Inpatients	September 2017 to January 2018	May/ June 2018 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.

2018/19 surveys				
Acute Trusts	2018 Maternity	April – August 2018	January 2019 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
Acute Trusts	2018 Adult Inpatients	September 2018 to January 2019	May/ June 2019 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
Acute Trusts	2018 Children and Young People	January – May 2019	September 2019 (TBC)	NHS providers will need to fund implementation on the same basis as in previous years.
TBC	2018 Emergency Department	TBC	TBC	NHS providers will need to fund implementation on the same basis as in previous years.

Enclosure 13

The Dudley Group
NHS Foundation Trust

Paper for submission to the Trust Board
May 2018

TITLE:	**Digital Trust Programme Committee Update**		
AUTHOR:	**Mark Stanton (CIO)**	**PRESENTER**	**Mark Stanton (CIO)**
CLINICAL STRATEGIC AIMS			
	Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.		

CORPORATE OBJECTIVE:

SO3: Drive service improvements, innovation and transformation
SO6: Deliver a viable future

SUMMARY OF KEY ISSUES:

1. Due to a number of critical issues the DTPC has approved the slippage of the go-live date by 3 weeks from 26th April to 17th May 2018.
2. Reviews will take place to understand the impact to June and October rollout's
3. The system meets mandatory compliance against SCCI 0129 standard (Suppliers) and the SCCI 0160
4. A number of GP sites have successfully been integrated into Trust systems to establish a proof of concept for record sharing using Allscripts dBMotion population health product. This will form the technology platform for a Population Health system to support the MCP (subject to additional funding)

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
	X	X	

The Dudley Group
NHS Foundation Trust

RECOMMENDATIONS FOR THE BOARD

The Board is asked to support a proposed Go-live of eObS on the 17th May 2018 and note the assurance around compliance

The Dudley Group NHS Foundation Trust

Committee Highlights Summary to Board
May 2018

Committee	Meeting Date	Chair	Quorate	
			yes	no
Digital Trust Programme Committee	18st April 2018	Ann Becke	X	

Declarations of Interest Made

None

Assurances received

Project status – Digital Trust

Readiness assessments have been conducted by both Trust project staff and the supplier, these both show that a number of critical dependencies have not been met.

These were rated as "Go live Blockers (GLB)" to go live at 2am on 26th April therefore a revised plan was submitted to the Committee and approved

- Go-live rollout 1 - 17th May 2018 for Vital Signs recorded electronically at the bedside on tablet devices immediately calculating NEWS scores and providing decision support across the Trust.
- A review of impact to go-live dates in June and October will be carried out along with any cost impact and presented at the May DTPC

The Current issues that need resolution to meet the proposed go-live date are:

- Software issues with the mobile device used to manage eObs, this is being addressed by the vendor with a high confidence of a resolution.
- Training attendance levels are improved as a result of the Chief Nurse involvement, but projections are still well short of the required 85% threshold by 17th May 2018. This requires ownership at departmental level in the same way that mandatory training targets are achieved but to date the project team has not been able to instil the importance of training attendance with team leaders. A series of steps around escalation, monitoring and Comm's were agreed to help meet the target.
- Issues exist with PAS/EPR integration, the vendor has provided an acceptable workaround which has been risk assessed and is currently undergoing testing with commitment to a full fix in the next major upgrade to the PAS software

These issues will be reviewed at a series of Go/No go meetings leading up to the 17th May 2018.

The DTPC received assurances against out mandatory Compliance from the newly

appointed Clinical Safety officer (CSO):-

- The Health and Social Care Act 2012 states that all digital deployments must be compliant with the SCCI 0129 standard (Suppliers) and the SCCI 0160 standard (Trusts)
- SCCI 01060 compliance Requires the Trust to have in place robust clinical risk management process (CRMP) for ALL IT projects
- SCCI 01060 compliance Requires the Trust to have in place a project (or individual development) life-cycle clinical risk management *file*
- A baseline assessment of the Trusts SCCI0160 compliance has been undertaken using the NHS-Digital Audit tool
- Presented is the Trust's baseline position, specifically in relation to Sunrise – the Summary tab highlights compliance with the management system (suitable for all systems) and current compliance for the Sunrise Project.

The DTPC received updates that integration between EMIS practice Manager at 3 GP surgeries and Trust systems for record sharing was now live with more practices coming on stream in the coming weeks. Integration is through the Allscripts DbMotion product which forms part of the MCP bid.

Applications for the DCCIO position have now closed after re-advertising with only 2 applications both from surgery. Interviews will go ahead but consideration will be given around how representation across the Trust could work with lack of medical applicants.

Decisions Made / Items Approved

- Approval of a rollout 1 go-live of 17th May 2018 subject to current issues being resolved.

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

- Review of impact on Rollout2/rollout3 by introducing a 3 weeks slippage in rollout 1
- Review of DCCIO role

Items referred to the Board for decision or action

Approval of a rollout 1 go-live of 17th May 2018 subject to current issues being resolved.

Comments relating to the DTPC from the CCIO
N/A
Comments relating to the DTPC from the CNIO
N/A

Enclosure 14

The Dudley Group
NHS Foundation Trust

Paper for submission to the Board on 3 May 2018

TITLE:	**Annual Certifications**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Glen Palethorpe Director of Governance / Board Secretary
CLINICAL STRATEGIC AIMS			
Develop integrated care provided locally to enable people to stay at home or be treated as close to home as possible.	*Strengthen hospital-based care to ensure high quality hospital services provided in the most effective and efficient way.*	*Provide specialist services to patients from the Black Country and further afield.*	
CORPORATE OBJECTIVE SO 6 – Plan for a viable future			

Introduction

The Board is required to make a number of declarations at the year end, in respect of its annual plan the following self-certification is required.

For this year the NHS Improvement have adjusted the template declarations slightly to those required last year. General Condition 6 has been added to declaration 1 and the declaration that was not applicable for us about the Academic Heath Science Centers has been removed from declaration 2.

Certifications

Declaration 1 relating to General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts) and Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

Declaration 2 relating to Condition FT4 – Corporate Governance and Training for Governors

Conclusion

The Trust has maintained its systems for compliance with its License conditions and many of these processes and their effectiveness are described within the Trust's Annual Report and Annual Governance Statement. The work undertaken by the Board and the respective Committees of the Board have not identified any failure to comply with these conditions and therefore the Trust based on the summary provided within this paper are recommended to certify, as it did last year, that it is compliant with these conditions.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Description: underpins a number of risks relating to well led, statutory compliance with FT license requirements**
	Risk Register: N		**Risk Score: N/A**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: well led**
	NHS improvement	**Y**	**Details: License requirement**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATION FOR THE BOARD

That the Board approves the Trust self certification as complaint for each element within the required annual declarations.

The Board note that this declaration with be placed on the Trust's website in accordance with NHS I's requirements.

Introduction

The Board is required to make a number of declarations at the year end, in respect of its annual plan the following self-certification is required.

For this year the NHS Improvement have adjusted the template declarations slightly to those required last year. General Condition 6 has been added to declaration 1 and the declaration that was not applicable for us about the Academic Heath Science Centers has been removed from declaration 2.

Certifications

Declaration 1 relating to General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts) and Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

Declaration 2 relating to Condition FT4 – Corporate Governance and Training for Governors

Trust Position

Declaration 1

General Condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

The Board is required to confirm it is compliant with the following certification, or explain why it can't certify itself as complaint.

Following a review for the purpose of paragraph 2(b) of license condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the license, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

It is recommended the Board a positive "confirmed" declaration is made. This is supported by the view of NHS Improvement within their regular meetings and that the Trust is segmented in segment 2 where only segments 3 & 4 indicate a risk or actual breech of the License.

Continuity of service condition 7 – Availability of Resources

The Board is required to make one of the following three declarations

1a After making enquires the Directors of the Licensee have reasonable expectations that the Licensee will have the Required Resources available to it after

taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

1b After making enquires the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking account in particular (but without limitation) and distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box in section 3 below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested services

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

It is recommended that declaration 1a is made. Whilst the Trust has not achieved its control total for 2017/18 the Trust's Executive has been able to make a positive assessment of the Trust's going concern which reported positively that the Executives could make this declaration as part of recommending the accounts for audit (this was reported vial the Audit Committee). The Board has accepted its 2017/18 control total and has approved a plan to achieve this.

Declaration 2

Condition FT4 - Corporate Governance Statement

The Board is required to indicate it is complaint with the following statements or if not state why it is non complaint.

1) The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

It is recommended the Board signify its compliance as the Board is assured from the work of the Audit Committee, its Internal and External Auditors and their opinions received during the year. Whilst the Trust awaits the final CQC rating for well led, the Trust has developed and action plan based on the initial feedback for this area. The Board's view as to its governance processes is reflected within the Trust's Annual Governance Statement.

2) The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time.

It is recommended the Board signify its compliance as the Trust Board Secretary has made the Board, Audit Committee and Executives aware of monitor guidance and any impact / improvements to be made within Trust systems as a result.

3) The Board is satisfied that the Trust implements:

(a) Effective board and committee structures;
(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and
(c) Clear reporting lines and accountabilities throughout its organisation.

It is recommended the Board signify its compliance as these processes were referred to and their effectiveness was considered by the Accountable Officer when drafting the Trust's Annual Governance Statement with this description then considered by the Audit Committee as it endorsed the AGS for submission to the Auditors. Respective Committee reporting to the Board is operating effectively as evidenced by the regular reports to the Board from each Committee Chair. The Board recognises that work is needed to allow the Clinical Quality, Safety and Patient Experience Committee to enhance its effectiveness by strengthening the committee's reporting groups one such group being the Risk and Assurance group which has moved to a monthly meeting cycle.

4) The Board is satisfied that the Trust effectively implements systems and/or processes:

(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;
(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;
(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);
(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;
(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;
(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and
(h) To ensure compliance with all applicable legal requirements.

It is recommended the Board signify its compliance as the Board both directly and through its Committee structure has been assured that the Trust's designed systems of internal control have been operating effectively and as intended over the year. Where issues have arisen during the year, for example in respect of operational performance, timely actions have been implement to improve these areas, albeit that the area of delivery of the Emergency Access standard has not

been achieved for this year. Assurance is routinely and regularly obtained as to the quality of the data supporting the Trust's performance reporting and decisions being taken. The Board recognised that it would not achieve its cost improvement plan and the consequent impact on the Trust's ability to achieve its control total. The Board provided NHS Improvement a revised control total as part of its quarter four reporting and has taken steps to enhance its financial grip and control which have been reported through Finance and Performance Committee. Key risks and associated assurance has been reported to the Audit Committee and Board during the year and the process has been subject to Internal Audit review which concluded positively over the Trust corporate risk and assurance processes.

5) The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:

(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;
(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;
(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;
(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;
(e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and
(f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

It is recommended the Board signify its compliance as there is clear leadership and accountability for the delivery of high quality and safe services within the Trust. This is detailed with the Trust's Quality Account and the statements contained therein. The Board both directly and through its Committee structures ensures that a focus is maintained on the delivery of quality services. The Trust's quality priorities continue to be set in consultation with the Governors and other stakeholders with regular reporting of the delivery against these priorities provided to the Board and the Council of Governors and our Commissioners. The effectiveness of these processes was again considered by the Accountable Officer in drafting the Annual Governance Statement which in turn was subject to consideration by the Audit Committee prior to its submission to the Auditors and inclusion within the Annual Report.

6) The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.

It is recommended the Board signify its compliance as the Trust has established a process that ensures that all Board Members are "fit and proper" persons. This process has been applied to Board appointments made in the year with the outcome of this reported to the Board's Remuneration and Nominations Committee as part of the relevant appointment process. An annual review of all Board Members continuation as fit and proper persons was also reported to the Board at the end of the year. The Board through its Workforce and Staff Engagement Committee has been assured over the actions being taken to mitigate the workforce risks in relation to recruitment and retention. Regular reporting is provided to the Board on the Trust's compliance with the nursing safer staffing levels and the revalidation of its nursing and medical workforce. All transformation schemes are subject to a detailed quality impact assessment and this rigor includes those schemes which include any workforce reduction and through this process the Board is assured that the Trust retains an appropriately qualified workforce to deliver its services. The Trust has established programmes of Executive and Senior Management development coupled with leadership forums all of these activities are designed to support and strengthen the personnel on the Board, those reporting to the Board and those within the rest of the Trust.

Declaration 3

Training of Governors

The Board is required to indicate it is complaint with the following statement or if not state why it is non complaint.

The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

It is recommended the Board signify its compliance as the Trust has established a programme of training for the Governors, which includes training as part of their induction supplemented by workshops where new information on developments are discussed. The Trust's training package was reviewed in 2016/17 against NHS Providers govern well modular training package to ensure the breadth of the Trust's programme remained comprehensive. This review found no issues with the breadth of training provided. Also at each Council of Governors meeting a presentation is made by an area of the Trust on its work thus allowing Governors to knowledge to be enhanced. These sessions have included information on day Case Surgery, Winter Planning, the Digital Trust and End of Life.

Enclosure 15

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 3rd May 2018

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

CORPORATE OBJECTIVES

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

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: COR461, COR119, HR387, BAF589, BAF590, BAF580, BAF597.**
	Risk Register: Y		**Risk Score: 20, 8, 12, 12, 12, 20 & 16.**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details: links all domains**
	Monitor	**Y**	**Details: links to good governance**
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
Y	Y		Y

RECOMMENDATIONS FOR THE BOARD

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

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

Committee	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	24th April 2018	Julian Atkins	**yes**	**no**
			Yes	

Declarations of Interest Made

No declarations registered.

Assurances received

Matters Arising

1. The Committee received confirmation of new and substantive nursing staff being auto-enrolled onto the Trust bank, therefore providing a larger pool of staff to be considered for bank shifts and minimise the use of agency bookings.
2. Paul Stonelake, Responsible Officer reported on medical appraisals, highlighting some difficulties with compliance that would be taken forward alongside support from the Medical Director and Director of Workforce.

Workforce Governance

3. The standard report highlighting risks associated with the workforce was presented. The Director of Workforce highlighted the main workforce related risks associated to the Corporate Risk Register, Workforce Directorate Risk Register and the draft Board Assurance Framework. The Committee considered that risk BAF589 had a current risk rating that was too low and asked for this to be considered and changed to at least a risk score of 12. It was acknowledged that the BAF risks would be considered further at the forthcoming Board Development session.
4. The Committee received a policy update with confirmation on policies being developed but at this time no policies were reported as being out of date.

Workforce Education

5. The Committee received an update report on progress at the Trust alongside our apprenticeship scheme in order to support our Workforce Strategy and develop the opportunities provided by the new apprenticeship schemes. In particular the Committee considered potential opportunities provided by the nurse apprentice scheme. It was agreed that an option appraisal should be developed further alongside a workforce plan for nursing and presented at the next Committee meeting.

6. The Committee received an update on the implementation of the new Band 6-8 Development programme. The first cohort commenced early in April 2018 with 15 members. It was confirmed that cohort two had 16 prospective applicants and that cohort three had over 20 expressions of interest. The Committee were pleased with the progress and requested regular updates based on feedback from participants and also cost effectiveness of the programme. The Committee were also encouraged by future plans to develop the programme and consider accreditation.

Workforce Performance

7. The Workforce Key Performance Indicators were presented to the Committee with an emphasis on sickness absence, employee relations, mandatory training and turnover. The Committee requested further analysis of the reasons for turnover and actions to support retention at the next Committee meeting. Andrew Boswell, Lead for Mandatory Training provided his detailed report on Mandatory Training and asked the Committee to agree that all Bank Staff undertake Priority One training as a minimum requirement, prior to commencement with Priority 2 & 3 training completed within 30 days of commencement. The Committee agreed this recommendation.

Workforce Strategy

8. The Committee received the revised Workforce Strategy and supporting Workforce Business Plan that reflected the workforce priorities for 2018/19. The Committee agreed the revisions to the Workforce Strategy and Workforce Business Plan for 2018/19.

9. The Committee received an update on the actions supporting the feedback from the Staff Survey in 2017 alongside plans to support better levels of engagement with both the Staff Survey and Staff FFT in 2018.

Workforce Change

10. The Committee were provided a brief update of the progress alongside the BCP with confirmation of the initiation of the consultation process as the first part of TUPE commencing week commencing 30th April 2018.

Decisions Made / Items Approved

1. To review the workforce related risk BAF589 associated to Staff Engagement from 9 to risk rating of 12.

2. Approval of Bank staff to undertake Priority One mandatory training as a minimum requirement prior to commencement with Priority 2 & 3 training to be completed within 30 days of commencement.

3. Approval of the 2018/19 Workforce Strategy and supporting Workforce Business Plan.

Actions to come back to Committee (items the Committee is keeping an eye on)
1. The Committee require further feedback regarding: • Update on Leadership Programme; • Workforce Related Risks; • Apprenticeship Action Plan – with emphasis on Nurse Apprenticeship Programme.
Items referred to the Board for decision or action
The Committee on this occasion does require any decision from the Board.