The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 3 December, 2015 at 9.30am
Clinical Education Centre

Meeting in Public Session

All matters are for discussion / decision except where noted

	Item	Enc. No.	By	Action	Time
1.	**Chairmans Welcome and Note of Apologies**		D Badger	To Note	9.30
2.	**Declarations of Interest**		D Badger	To Note	9.30
3.	**Announcements**		D Badger	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 5 December 2015	Enclosure 1	D Badger	To Approve	9.30
	4.2 Action Sheet 5 December 2015	Enclosure 2	D Badger	To Action	9.30
5.	**Patient Story**		L Abbiss	To Note & Discuss	9.40
6.	**Chief Executive's Overview Report**	Enclosure 3	P Clark	To Discuss	9.50
7.	**Patient Safety and Quality**				
	7.1 Infection Prevention and Control Exception Report	Enclosure 4	D Wardell	To Note & Discuss	10.00
	7.2 Nurse Staffing/Safer Nurse Care Tool Report	Enclosure 5	D Wardell	To Note & Discuss	10.10
	7.3 Clinical Quality, Safety and Patient Experience Committee Exception Report	Enclosure 6	D Wulff	To Note & Discuss	10.20
	7.4 Integrated Dashboard	Enclosure 7	A Baines	To Note & Discuss	10.30
	7.5 Black Country Alliance Report	Enclosure 8	P Clark	To Note	10.40
	7.6 Charitable Fund Report	Enclosure 9	D Bland	To Note	10.50
	7.7 Quality Accounts Update Report	Enclosure 10	D Wardell	To Note	11.00
	7.8 Workforce Committee Exception Report	Enclosure 11	A Becke	To Note	11.10
	7.9 Research and Development Report	Enclosure 12	J Neilson	To Note	11.20
8.	**Finance**				
	8.1 Corporate Performance Report	Enclosure 13	J Fellows	To Note & Discuss	11.30
	8.2 Cost Improvement Programme and Transformation Overview Report	Enclosure 14	A Baines	To Note	11.40
9.	**Any other Business**				11.50

10.	**Date of Next Board of Directors Meeting** 9.30am 7 January 2016 Clinical Education Centre		D Badger		11.50
11.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		D Badger		11.50

Enclosure 1

The Dudley Group NHS
NHS Foundation Trust

Minutes of the Public Board of Directors meeting held on Thursday 5th November, 2015 at 9:30am in the Clinical Education Centre.

Present:

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

In Attendance:

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

15/106 Note of Apologies and Welcome

None to note.

15/107 Declarations of Interest

There were no declarations of interest.

15/108 Announcements

No announcements made.

15/109 Minutes of the previous Board meeting held on 1st October, 2015 (Enclosure 1)

It was noted that the date on the minutes should be revised to 1st October, 2015.

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

15/110 Action Sheet, 1st October, 2015 (Enclosure 2)

The Board noted that the date on the action sheet should read 1st October, 2015.

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

The Director of Strategy and Performance confirmed that the item relating the Clinical Strategy will not be presented at the Board Workshop on 19th November, 2015, as the meeting had been cancelled.

15/111 Patient Story

Liz Abbiss, Head of Communications and Patient Experience presented the patient story. The story related to a patient who was being treated on the Forget Me Not Unit.

The Board noted the positive story. The Chairman confirmed that this raises the question around what happens next for patients suffering with Dementia within the Health Economy and confirmed that he will raise this at his next meeting with David Hegarty.

The Chief Operating Officer confirmed that there is a Health Economy Care of the Elderly Group.

Mrs Becke, Non Executive Director, confirmed that the Arts and Environment Group are looking at how artwork is displayed within the hospital environment. The Chief Executive suggested the use of pinboards to enable patients to display their own pictures and photos within the ward area.

The Chairman and Board noted the patient story.

The Chairman to raise Health Economy care of Dementia patients at his next meeting with David Hegarty.

15/112 Chief Executive's Overview Report (Enclosure 3)

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

- **Friends and Family:** Continuing to perform well. Friends and Family had been discussed in detail at the Patient Experience Group earlier that week and it was noted that the Trust continues to perform well against neighbouring Trusts. Outpatients had been discussed at the Directors meeting and there will be a push in this area as a part of the Transformation work.

- **Forget Me Not Unit Update:** The Chairman voiced concern that the work on the environment was not yet complete. The Chairman, Director of Governance/Board Secretary and Chief Nurse to pursue outside of the Board meeting.

- **Never Events:** Awaiting final RCA on the second event before a decision is made on outcome.

- **Safe Effective Quality Occupational Health Standards and Accreditation (SEQOHS):** The Chief Executive confirmed that the Trust should be particularly proud of the service.

Dr Wulff, Non Executive Director suggested that the Board could send a letter of appreciation to the Occupational Health Team.

The Chairman and Board noted the report and the SEQOHS accreditation and the Chairman confirmed that he would write to Maudie McHardie.

The Chairman, Director of Governance and Chief Nurse to follow up outstanding environment issues on the Forget Me Not Unit outside of the Board meeting.

The Chairman to write a congratulation letter to Maudie McHardie regarding the SEQOHS accreditation.

15/113 Patient Safety and Quality

15/113.1 Infection Prevention and Control Exception Report (Enclosure 4)

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

MRSA: 2 post 48 hour cases now reported. The Chief Nurse confirmed that the second case was very complex and the Trust is still going through the RCA process. A report will be presented back to the next Board meeting. There had been 1 community acquired pre-48 hour case.

C.Diff: 25 cases noted against the 29 case tolerance level for the year. The Trust is meeting with the CCG to dicuss avoidability. A 6% increase has been experienced in the Health Economy. Progressis continuing with the C.Diff action plan and no cross contamination had been identified.

Norovirus: Now in season but no cases experienced within the Trust.

The Chairman and Board noted the report.

The Chairman confirmed that he would like to meet or improve on last year's C.Diff performance.

Dr Wulff, Non Executive Director, asked about feedback from the period of increased incidence on B3. The Chief Nurse confirmed that there was no cross contamination. There had been delays in isolation and late stool sampling but these were not factors that cause C.Diff.

The Director of Finance and Information confirmed that he had discussed the issue with the CCG and fines only apply to the lapses in care element.

The Chairman and Board noted the report and actions being taken. The Board agreed that it was anxious to hold the number of C.Diff cases to the same or less than last year and noted the fines for lapses in care.

15/113.2 Nurse Staffing Report (Enclosure 5)

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

The Board noted that there had been a slight reduction in amber shifts. The Chief Nurse confirmed that 30 trained nurses had commenced in September.

Three areas were noted to feature in amber shifts. The Board noted that the Trust had seen a reduction in shortfalls in Maternity and the much improved position.

There had been only one serious shortfall shift and this was on a ward with 10 patients, were there were enough numbers of staff but not enough registered nurses. No significant concerns on the shift and safety was maintained.

A letter had been received from Monitor and the CQC regarding a 1:8 nurse to patient ratio being used as a guiding principle but that professional jugement should be used. The Trust had undertaken a safer staffing review in October and results would be presented to Board on a 6 monthly basis.

There were 64 vacancies currently in the main ward areas. The Trust is looking at the use of Assistant Practitioner roles.

A number of recruitment activities are being undertaken and the Trust is going back to Europe in November. A series of recruitment days are also being held.

The Chief Executive confirmed that the window for international recruitment is only open for 6 months so the Trust needs to consider its options for international recruitment carefully.

The Chief Nurse confirmed that the Trust will review its position at the end of November.

The Chairman asked if the Trust is required to undertake returns based on the recommended ratios. The Chief Nurse confirmed that the Trust completes data on the Unify system and this does not include ratios.

The Chief Executive confirmed that she considered 1:8 to be an appropriate ratio.

The Director of Finance and Information suggested that the Trust should make a quick decision around international nurse recruitment.

The Chairman asked about the work being undertaken on retention. The Chief Nurse confirmed that nurses can move posts around the Trust much easier and this helps retain staff.

The Chief Executive confirmed that it may be worth considering adopting the principles of becoming a magnet hospital.

The Chief HR Advisor confirmed that she is working with the Chief Nurse to look at rebranding.

The Chairman and Board noted the report, graph, amber shifts and list of mitigations. The Board confirmed that they were assured by the mitigations detailed in the paper and noted that a decision needs to be made on international recruitment by the end of month. The Chairman noted that the Trust is looking at career development, branding and principles of a magnet hospital.

A decision to be made on international recruitment by the end of October 2015.

15/113.3 Clinical Quality, Safety and Patient Experience Committee Exception Report (Enclosure 6)

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

- Positive Assurances: Received on the performance of Trust around quality indicators. Dr Wulff highlighted the discrepancy around Stroke performance measures between locally and nationally reported targets. The Board also noted the dip in performance in relation to Critical Care and Reducing Ventilation Associated Pneumonia, an update report will be presented back to the Committee.

- Decisions Made/Items Approved: The Committee had approved 10 policies, 5 guidelines and 24 procedures. Approval had been granted to close 38 RCA action plans. Divisions had been reminded to close action plans in a timely manner.

- Actions to come back to the Committee: The Committee will receive and update from the Patient Experience Group on the actions taken as a result of the maternity patient experience survey run by Picker.

- A number of actions were scheduled to be presented to the Committee and these were also noted by the Board, including a full report on the two never events to be reviewed by the Committee. The Trusts Infection Control and Health Economy actions plans will also be presented to the Committee.

The Board noted that the Patient Experience Group will monitor the development and tracking of the action plan in respect to the picker survey.

The Chairman and Board noted the report and assurances received, decisions made, items approved and actions back to Committee.

15/113.4 Integrated Performance Report (Enclosure 7)

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

The report covered the Trust's performance to September 2015, and included the following highlights:

- Overall performance to the end of September
- Emergency Activity Target: Increase in numbers, expenditure had dipped but not below target.
- RTT: Continue to deliver against target with the exception of Urology and two other small areas. An action plan for Urology is in place.
- Cancer: August performance better than forecast but the Trust missed the target for September and will also miss the target for the quarter. The situation is predicted to be recovered for quarter 3.
- Infection Control: covered earlier on the agenda.
- Never Events: Covered earlier on the agenda.
- Out Patient Activity: Issues in Surgery. It had been agreed with the Divisions to produce a plan to achieve the target.

The Board noted that the end of the report had been revised to include the year end forecast.

The Chief Operating Officer raised the cancer action plan and suggested that the report should include tumour sites. The Director of Strategy and Performance confirmed that this will be included for next month.

Mr Bland, Non Executive Director asked if the 2 decimal places could be removed for clarity and show round percentages. The Director of Strategy and Performance confirmed that the team are working on redesigning reports to unify the reporting process for the first quarter of next year.

The Chairman and Board noted the report, key issues , cancer reporting information on tumour level and noted that the rounding of numbers will be taken on board as part of redesign process.

Detail on tumour site to be included in the Integrated Performance Report from December 2015.

15/113.5 Black Country Alliance Report (Enclosure 8)

The Chief Executive presented the Black Country Alliance (BCA) Report given as Enclosure 8.

The report was provided for information to enable the Board to keep up to date with BCA progress.

The Chief Executive confirmed that the Trust continues to try and support Walsall on Rheumatology.

The Director of Strategy and Performance is leading and exciting piece of work on Interventional Radiology and a pilot is being established in the new year for a 7 day service.

The Board noted that for Oncology, Sandwell will not supported by UHB going forward and Toby Lewis is leading on this piece of work.

Urology/Histology and Stroke. The organisations had responded to Commissioners on Stroke. Histology continues to be a challenge.

The noted that there is now a public element to the BCA Board meetings and a Communications Plan is being produced.

The Chairman voiced concern around the decision to hold the BCA Board in public and confirmed that he will follow this up directly with Terry Whalley.

The Chief Operating Officer commented that in relation to Stroke there had been come concerns relating to the notes of meeting.

The Chairman and Board noted the report and actions identified.

The Chairman to raise to decision to hold a public BCA Board meeting with Terry Whalley.

15/113.6 Revalidation Report (Enclosure 9)

The Medical Director presented the Revalidation Report given as Enclosure 9.

The Board noted that the Trust is performing well at completing appraisals and revalidation on time.

There had been a discussion with NHS England around how vigorous the Trust has been. The Board noted that the number of doctors appearing in the table at appendix 1 had reduced significantly. There will be an inspection by NHS England in February 2016.

The Medical Director confirmed that the Trust needs to split the Responsible Officer/Medical Director role and this depends on the recruitment of additional surgeons which are currently out to advert. A business case will be presented to Directors.

The Chairman confirmed that the figures in the report are positive and are reassuring.

The Chairman and Board noted the report and confirmed that they were anxious to see the separation of roles.

15/113.7 Audit Committee Exception Report (Enclosure 10)

Mr Miner, Chair of the Audit Committee presented the Audit Committee Exception Report given as Enclosure 10.

Mr Miner provided highlights from the report including the following key issues:

- Local Counter Fraud Service: Notification had been received of another potential case. Mr Miner is corresponding with NHS Protect on this issue.

- Risk and Assurance Register: The Committee had looked in detail at new style Risk and Assurance register. Mr Miner confirmed that both the internal and external auditors were impressed with approach.

- Losses and Special Payments: These are now monitored by the Audit Committee. Mr Miner confirmed that debts relating to overseas visitors features largely in report.

- Audit Committee Terms of Reference: Minimal changes had been made to the Terms of Refernce and were presented at Appendix A for Board approval.

The Chairman and Board noted the report and approved the new style Risk and Assurance Reg approach, noted the losses and special payments arrangement and ratified the minor revision to the Terms of Reference attached to the report. The Board also noted the additional local counter fraud case and that this will be followed through by the Chair of the Audit Committee.

15/113.8 Corporate Risk Register/Assurance Framework (Enclosure 11)

The Director of Governance/Board Secretary presented the Corporate Risk Register/Assurance Framework given as Enclosure 11.

The Board noted that the Risk and Assurance Group had met on 10th September, 2015 and agreed the Corporate Risk Register and Divisional and Directorate Risk Registers.

The Director of Governance/Board Secretary confirmed that he wanted to ensure that a meaningful summary is presented to the Board. The report looks at 3 levels of assurance and gives an aggregate view.

The Board noted that the Audit Comm receives further detail behind the elements of assurance.

The Board noted that one risk had increased.

Mr Miner confirmed that he had spent some time looking at the reporting process and was now comfortable with its presentation.

Mrs Ord, Associate Non Executive Director, confirmed that this had been discussed at the Council of Governors Governance Committee and asked about the levels of assurance and if level two assurance relies on Executive challenge, how does the Board know that the level of challenge is substantial and effective.

The Director of Governance/Board Secretary confirmed that the Governance and Assurance minutes are reported to Executives and are also subject to the internal audit process, there is also direct correlation with the Board reporting process.

Mr Miner confirmed that this was the essence of the work he had undertaken with the Director of Governance/Board Secretary around the process and he now felt assured.

The Chairman and Board noted the report and thanked Mr Miner and the Director of Governance/Board Secretary for their work and agreed that they were content with the changed structure.

15/113.8 Complaints Report (Enclosure 12)

The Director of Governance/Board Secretary presented the Complaints Report given as Enclosure 12.

The report shows the incidence of complaints over the quarter. The Board noted the slight increase on the previous quarter although this was still lower than this quarter in the previous year.

The Board noted the following key highlights:

- 100% of complaints received during the quarter were acknowledged within 3 working days.

- 44% of complaints received and closed during the quarter were answered within 40 working days.

The Board noted the additional national information included in the shaded column on page 2 of the report. One area was noted to be higher than the national average and this related to admission, discharge and transfers and work was being undertaken in this area. The Director of Governance/Board Secretary stated that if this information is taken with the area above on records, communication, information and appointments which was below the national average, then this provided a more clear reflection of the position.

There were no significant issues to note and the Trust was below the national average overall.

The Board noted the benchmarking information provided at page 3 of the report

The Director of Governance/Board Secretary confirmed that a number of claims had been closed without making payment.

Mr Miner, Non Executive Director, commented that the number of upheld or part upheld complaints had increased in quarter 2. The Director of Governance/Board Secretary confirmed that figures move up and down and the Trust are feeding back to complainants and they are more satisfied with the responses they are receiving. The Director of Governance/Board Secretary confirmed that he would consider alternative wording.

The Chairman and Board noted the report.

Dr Paul Harrison joined the meeting.

15/113.9 Nurse/Midwife Revalidation Report (Enclosure 13)

The Chief Nurse presented the Nurse/Midwife Revalidation Report given as Enclosure 13.

The Board noted that pilots commenced earlier in the year and at the end of October the NMC Board met to agree the go live date which will be April 2016. CPD hours had moved from 40 to 35 and the forms provided will be mandatory.

There had been a change of date to apply for revalidation and staff need to be made aware of this.

The Chief Nurse confirmed that during the 1st quarter 96 nurses or midwives are due to be revalidated, with 213 in quarter 2.

Dr Wulff, Non Executive Director asked if there will be a process for deferment. The Chief Nurse confirmed that staff can only defer due to ill health or some ongoing issue with the NMC. If a nurse fails revalidation they become a care support worker and re-submit their evidence.

Mrs Becke, Non Executive Director, commented that it was good news that the paperwork has been standardised and asked how staff were feeling. The Chief Nurse confirmed that the Trust had only recently received the information but would expect it to be positively received.

The Chief Nurse confirmed that the Trust is prepared as it can be and it has identified confirmers for all nurses and midwives.

Mr Fellows, Non Executive Director asked how the Trust receives assurance that nurses have been revalidated. The Board noted that there is system for this in HR.

The Chairman and Board noted the report.

15/113.10 End of Life Care Report (Enclosure 14)

Dr Wulff, Non Executive Director, presented the End of Life Care Report given as Enclosure 14.

The Board noted that this was the 2nd meeting of the End of Life Care Group. The report reflects assurances received from various workstreams and was generally positive.

Highlights from the report included:

- Macmillan Specialist Care at Home: A decision is awaited regarding continuing funding and there is a view that the money may come at short notice and Mary Stevens Hospice are preparing to appoint a Project Manager.

- Electronic Palliative Care Coordination System: Limited progress was noted and there is no clarity around funding. The Group had requested that partners come back with a clear report on implications.

The Chief Executive confirmed that Dr Jo Bowen had attended the Patient Experience Group and presented on bereavement survey and it was pleasing to note the results.

The Terms of Reference had been signed off and a Deputy Chair appointed. The Group will report to its member Boards and the Partnership Board.

Work had commenced on a Joint Commissioning Strategy for end of life care and the Group had requested comments and feeback .

The Director of Strategy and Performance confirmed that the Trust currently provides project management support and there had been no agreement that the Trust stops undertaking the project management role.

The Board noted the report and assurances received and decisions made and actions back to the Group, in particular the electronic system. The issue relating to Macmillan Specialist Care at Home will be resolved outside of the meeting.

15/114 Finance

15/114.1 Corporate Performance Report (Enclosure 15)

Mr Fellows, Committee Chair, presented the Corporate Performance Report, given as Enclosure 15.

The report provided a summary of the October Finance and Performance Committee meeting.

The Board noted that key highlights as follows:

Assurances Received :

- Continued good performance. The year end forecast position of £3.133m is still achievable.
- Some concern around activity levels and agency costs.
- KPIs performing strongly in general with some diagnostic breaches. A business case is being produced exploring additional facilities possibly based in the Community.
- CIP is slightly below the full year target.
- Looking at the possibility of senior business management support for IT.

The Committee approved the 2nd quarters return to Monitor on behalf of the Board.

The Chairman and Board noted the report and the current position. The Chairman commented that it was an encouraging report and noted the concern around activity and agency costs and noted that the Trust had self-certified itself as non compliant with the financial declaration of a risk rating of 3. The Board noted that the Trust had declared itself compliant regarding capital spending to the year end compliant with meeting the existing targets in the Risk Assurance Framework and declared that there were no other matters requiring an exception report to Monitor.

15/114.2 Cost Improvement Programme and Transformation Overview Report (Enclosure 16)

The Director of Strategy and Performance presented the Cost Improvement Programme and Transformation Overview Report, given as Enclosure 16.

The Board noted the high level position as follows:

- Year to date: Slightly ahead of target by just under £0.5m. There is a year end forecast deficit variance of just under £600k and it is clear that some schemes are over and some under performing.

- Maternity: It is anticipated that the Trust will recover its position.

- Looking at mitigation to bring forward proposed bed closures in 2016/17, particularly in relation to surgical activity to allow achievement of CIP in February.

- Developing 2016/17 Plan. Detail will be presented to the Executive Team the following week and then back to the Board for approval once it has been through the QIA process.

The Chairman and Board noted the report, and the projected year end position and actions taken to meet the year end target.

15/114.3 Annual Plan Quarter 2 Update Report (Enclosure 17)

The Director of Strategy and Performance presented the Annual Plan Quarter 2 Update Report, given as Enclosure 17.

The Board noted the quarterly update on the Annual Plan.

There were a number of amber areas around service development changes including 7 day working and a number of issues around staffing. The Trust is working through these issues.

In relation to planning for a viable future the Trust is taking part in Health Economy work, but the area has an amber rating as work not settled.

The Chairman and Board noted the report and the issues around the volatile position on partnerships. There is a clear expectation that the November event that should be a re-launch of the partnership and that proper preparation is undertaken. The Chairman will discuss with David Hegarty at his meeting the following Tuesday.

The Chief Executive confirmed that this will also be raised at the next CLT meeting.

The Board received the report.

15/115 Any Other Business

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

15/116 Date of Next Meeting

The next Board meeting will be held on Thursday, 3rd December, 2015, at 9.30am in the Clinical Education Centre.

Signed ……

Date ……

Enclosure 2

The Dudley Group NHS
NHS Foundation Trust

Action Sheet
Minutes of the Board of Directors Public Session
Held on 5 November 2015

Item No	*Subject*	*Action*	*Responsible*	*Due Date*	*Comments*
15/111	Patient Story	The Chairman to raise Health Economy care of Dementia patients at his next meeting with David Hegarty.	C	19/11/15	Done
15/113.5	Black Country Alliance Report	The Chairman to raise the decision to hold a public BCA Board meeting with Terry Whalley.	C	19/11/15	Done
15/102.4	Integrated Performance Report	Chairman to raise infection control as a whole Health Economy issue at his next meeting with David Hegarty.	C	10/11/15	To be raised at next 1:1 on 22/12/15
15/091.10	Annual Plan Quarter 1 Updates	Review of the work around the Clinical Strategy to be presented at the Board Workshop in November.	AB	19/11/15	To take place at Board Workshop on 7/12/15
15/113.2	Nurse Staffing Report	A decision to be made on international recruitment by the end of November 2015.	DW	30/11/15	Verbal update at Board
15/112	Chief Executive's Report	The Chairman, Director of Governance and Chief Nurse to follow up outstanding environment issues on the Forget Me Not Unit outside of the Board meeting. The Chairman to write a congratulation letter to Maudie McHardie regarding the SEQOHS accreditation.	C/GP/DW C	3/12/15 3/12/15	Meeting arranged for 2/12/15 Done
15/113.4	Integrated Performance Report	Detail on tumour site to be included in the Integrated Performance Report from December 2015.	AB	3/12/15	Done
15/080.9	Research and Development Report	The Board to receive an update on the availability of case notes at its September meeting.	PH	7/1/16	Update to January Board

Enclosure 3

The Dudley Group NHS Foundation Trust

Paper for submission to the Public Board Meeting – 3rd December 2015

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

SUMMARY OF KEY ISSUES:

- Friends and Family
- Junior Doctors Industrial Action
- Awards

IMPLICATIONS OF PAPER:

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

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

Decision	Approval	Discussion	Other

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

The Dudley Group NHS
NHS Foundation Trust

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

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

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

The Dudley Group NHS
NHS Foundation Trust

Chief Executive's Report – Public Board – December 2015

Patient Friends and Family Test: Update December 2015 Board

Community FFT (October 2015)

Based on the latest published NHS figures (September '15) the Trust did not meet the quality priority target of monthly scores that are equal to or better than the national average for the percentage who would recommend the service to friends and family members. The October results suggest that we will be back on track based on previous national averages. Response rates remain low.

Date range	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15
Community Nursing Services – percentage recommended	100%	100%	95%	83%	94%	94%	97%
Number of responses	5	24	58	24	33	65	79
Rehab and Therapy services – percentage recommended	100%	100%	100%	100%	96%	92%	95%
Number of responses	9	11	20	47	45	48	44
Specialist Services – percentage recommended	95%	95%	95%	100%	75%	92%	100%
Number of responses	22	20	38	19	4	12	3
Combined score – percentage recommended	97%	98%	96%	96%	94%	93%	97%
Total number of responses	36	55	116	90	82	125	126
National average percentage recommended	96%	95%	95%	95%	94%	95%	n/a*

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

Inpatient FFT (01.11.15 – 15.11.15 provisional)

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

Date range	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015 Provisional
Ward FFT percentage recommended	96%	97%	98%	97%	99%	97%	97%	98%
Ward response rate	16%	16%	14%	15%	20%	20%	13%	17%
National average percentage recommended	95%	96%	96%	97%	99%	96%	n/a*	

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

Key for inpatient RAG rating

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

A&E FFT (01.11.15 – 15.11.15 provisional)

The percentage of patients who would recommend the Trust's A&E to friends and family during the period 1st – 15th November increased to 98% compared to 95% for October. The latest published NHS England figures (September '15) show The Dudley Group scored 90% which is higher than the national average of 88%.

Date range	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015 Provisional
A&E FFT recommended percentage	90%	90%	92%	90%	95%	90%	95%	98%
A&E response rate	8%	15%	12%	7%	6%	3%	8%	5%
National average percentage recommended	88%	88%	88%	88%	95%	88%	n/a*	

national data not published at time of writing this report

Key for A&E RAG rating

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

Maternity FFT (01.11.15 – 15.11.15 provisional)

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

Maternity Area	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015	Nov 2015 Provisional
Antenatal , percentage recommended	95%	96%	98%	99%	99%	97%	94%	96%
National average percentage recommended	95%	96%	96%	95%	96%	95%	n/a*	
Response rate	30%	39%	24%	37%	38%	36%	49%	26%
Birth, percentage recommended	100%	100%	100%	100%	99%	100%	98%	97%
National average percentage recommended	97%	97%	97%	97%	97%	97%	97%	97%
Response rate	26%	20%	14%	21%	25%	27%	30%	44%
Postnatal ward, percentage recommended	100%	100%	98%	99%	99%	100%	100%	97%
National average percentage recommended	94%	93%	93%	94%	94%	93%	n/a*	
Response rate	26%	20%	14%	21%	25%	28%	4%	44%
Postnatal community, percentage recommended	100%	100%	93%	96%	92%	100%	100%	100%
National average percentage recommended	98%	98%	98%	98%	98%	98%	n/a*	
Response rate	8%	10%	12%	8%	4%	6%	30%	3%

national data not published at time of writing this report

Key for maternity RAG rating

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

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

Outpatients FFT

The Trust has not met the quality priority target of monthly scores that are equal to or better than the national average for the percentage of patients who would recommend the service to friends and family members.

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

- 'You, said we have' boards are being deployed in all patient waiting areas across the Trusts' outpatient departments to update patients about the actions we have taken in response to their feedback
- Reviewed patient gown provision in the imaging department and phasing in a new gown that is easier to put on and provides greater body cover/privacy
- Replaced signage in the main outpatients area that patients told us was confusing

FFT Outpatients Services	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sept 2015	Oct 2015
Number of respondents	49	93	82	66	67	742	721
Outpatients recommended percentage	84%	82%	82%	88%	90%	89%	88%
National average percentage recommended	92%	92%	92%	92%	92%	92%	n/a*

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

Improving the FFT response rates

To support response rate growth, work continues with senior managers and several initiatives will be rolled out during the next two quarters;

- Friends and Family App launched September 2015 and is seeing a growing number of responses
- Trust FFT webpage refreshed September 2015
- Proposed introduction of FFT SMS response option for A&E in Q4 subject to approval of business case

Junior Doctors Industrial Action

The Trust formulated an operational group chaired by the Chief Operating Officer and supported by the Medical Director to ensure that safe services could be maintained during the planned junior doctor strike on the 1st, 8th and 16th December.

The divisions of Medicine and Surgery (supported by the Nursing division and Pharmacy), were asked to provide assurance plans that identified that services that could be maintained during the action, and what the clinical model would be. Ensuring our ability to manage the front door and safely care for those patients already within the hospital. For the action planned for the 1st December these assurance plans were presented and agreed at the operational meeting on the 25th November 2015.

During the strike action there will be a fully operational command centre allowing the Trust to respond to any concerns as they occur, this team consists of senior medical/nursing colleagues along with senior management support, this team will be operational and on site from 7.30am until 10.00pm on each of the strike days.

Whilst assurance can currently be given for the safe delivery of services on 1st December, further work is required for the 8th and 16th December, and this assurance will be sought from the Chief Operating Officer/Medical Director through the operational meetings.

Awards

We are delighted to say the Trust won an HSJ 2015 award in the category of Acute, Community and/or Primary Care Services Redesign for our work in improving patient flow and consistently exceeding the four-hour A&E standard.

Sarah Causer, Lead Nurse for Older People, won a Nursing Times award in the category of Nurse Leader of the Year.

Consultant Neurologist Dr Michael Douglas was announced as winner of the Outstanding Neurologist in MS treatment category at the 2015 QuDoS (Recognising Quality in the Delivery of Services) in MS Awards. Judges agreed that our MS service is a wonderful example of a first class specialised service developed and led by Michael, and were impressed with how proactive he was in establishing it.

We have been shortlisted for the BSR (British Society for Rheumatology) Best Practice Award for our Temporal Arteritis Pathway, which is a fabulous achievement. The panel visited the Trust and met with Dr Rainer Klocke and others last week which allowed them to showcase the service.

Our nomination has been shortlisted for the NHS Board/Governing Body of the Year Award in the Health Education England West Midlands Leadership Recognition Awards for 2015. The awards ceremony takes place on Thursday 3rd December.

Enclosure 4

The Dudley Group NHS
NHS Foundation Trust

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

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

For the month of November (as at 26.11.15)

- No post 48 hr MRSA bacteraemia cases since 27th September.
- No Norovirus
- At end of month 8 the Trust is 12 cases over trajectory for this point in the year of 18 cases of post 48 hr C. difficile. The Trust is now 1 over the yearly trajectory of 29 cases.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

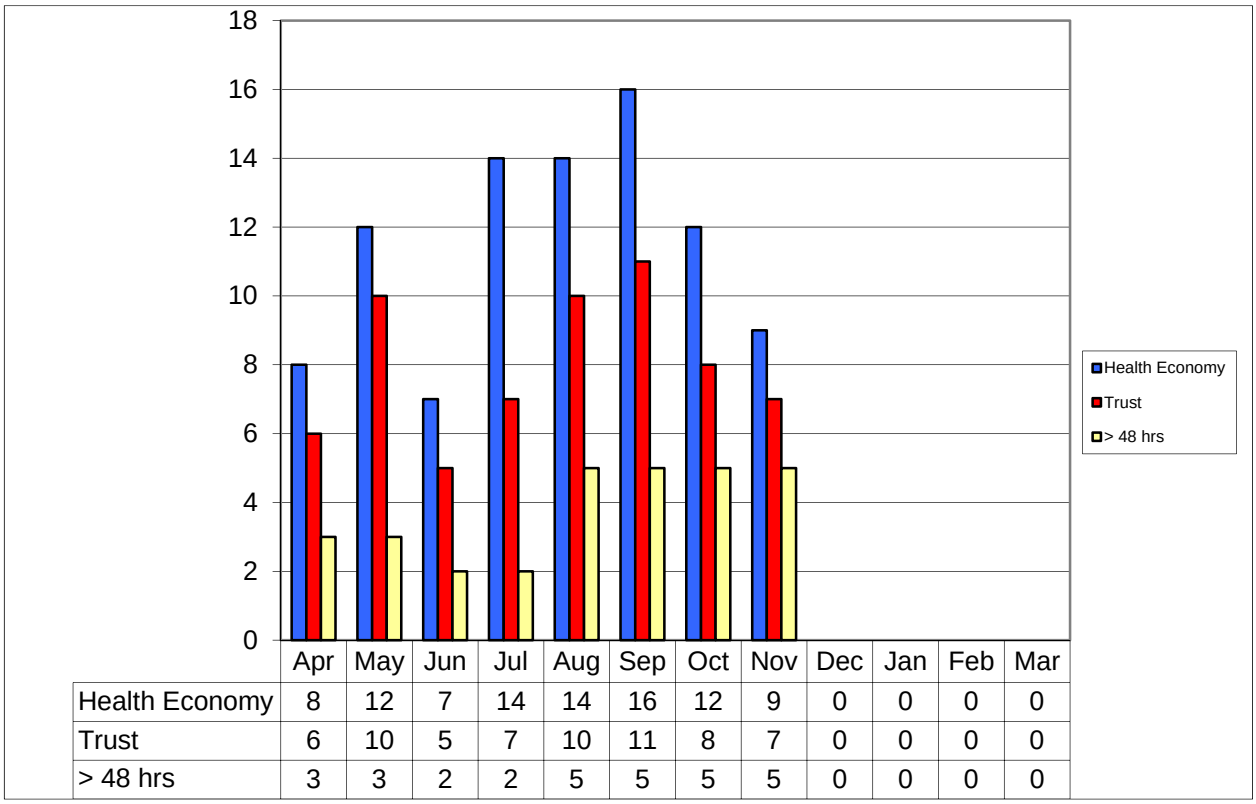
Decision	Approval	Discussion	Other
		√	

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

Summary:

Clostridium Difficile – The target for 2015/16 is 29 cases, equivalent to 12.39 CDI cases per 100,000 bed days. At the time of writing (26.11.15) we have 5 post 48 hour cases recorded November 2015.

C. DIFFICILE CASES 2015/16



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Health Economy	8	12	7	14	14	16	12	9	0	0	0	0
Trust	6	10	5	7	10	11	8	7	0	0	0	0
> 48 hrs	3	3	2	2	5	5	5	5	0	0	0	0

The process to undertake an assessment of individual C. difficile cases to ascertain if there has been a 'lapse in care' (resulting in a case being described as 'avoidable/unavoidable') as described in the revised national guidance[1], continues. Of the 30 post 48 hour cases identified since 1st April 2015, 15 cases have so far been reviewed by the apportionment panel, all of which have had apportionment agreed and 6 of these were deemed as avoidable. The main themes identified are: delay in sending sample, delay in isolation, poor documentation and incomplete stool charts.

At the time of writing the Trust is now at 30 post 48 hour C. difficile toxin cases. This is 1 over the yearly trajectory of 29 cases. As a result the progress of the attached C. difficile Action Plan and other relevant issues will be discussed at the Trust Infection Prevention and Control Meeting being held on 9th December 2015.

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

Norovirus - no further cases.

Reference

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

The Dudley Group NHS
NHS Foundation Trust

Action Plan
(Reduction in C Difficile& MRSA Bacteraemia)

Manager/Lead	Angela Murray, Matron Infection Prevention	**Executive Lead**	Dawn Wardell, Chief Nurse
Associated Staff	Heads of Nursing, Matrons, Lead Nurses, consultants	**Supporting Executives**	Paul Harrison, Medical Director
Date Action Plan agreed	**25/8/15**	**Action plan updated**	17/11/15

Action not started	**Action underway**	**Action completed**	**Actions Ongoing**

No	Recommendation	Actions Required	By whom	Progress to date	Agreed Completion Date	Status (rag)
1.	**Clear responsibilities and accountabilities for good infection control practice**	Meet with Lead Nurses to confirm Meet with Matrons to confirm role Meet with Infection Prevention Team as above Escalation of any CDiff case to CN and DCN Observation of cleaning standards and audits signed off	**D. Wardell** **Lead Nurse/ Matron**	Outline of expectations, responsibilities and roles undertaken with all groups individually Lead Nurse meeting now to commence with 15mins on Infection Prevention monthly Email sent to Chief Nurse and Deputies to advise of new case also outcomes of apportionment of cases **Still not occurring in all areas Heads of Nursing to follow up**	Complete and now ongoing Complete 1/12/15	
2.	**High profile of Infection prevention across the organisation**	Posters and other awareness materials made available Increase on training sessions at ward and departmental level Bare Below Elbows monitoring and empowerment of all staff to challenge. Escalation of any repeat	**Comms/IPT** **ALL**	Learning Event used to discuss a CDiff Case 2/10/15 Medical Director and Chiefs of Medicine and Surgery emails to all medical staff Improved challenge in place	Complete Complete Review on 1/12/15	

No	Recommendation	Actions Required	By whom	Progress to date	Agreed Completion Date	Status (rag)
		non-compliance. Bare Below Elbows posters to be commissioned from Comms		Awaited.	1/12/15	
3.	**All lead nurses and matrons have accurate and timely information on CDiff performance/outcomes of RCAs and audit data**	Infection Prevention ward dashboard created Feedback to Lead Nurses, Matrons and Medical Staff on outcomes of RCA and Lapse in Care decisions Huddle boards used to provide communication to staff on current performance and areas for improvement Areas non-compliant with HII audits being submitted will be escalated to matrons and HON if not resolved. Heat map of infection prevention issues developed for matrons meeting Areas having C Diff to be invited to weekly meeting until clear of cases for 3 months.	**A Murray, Matrons** **IPT/Matrons** **DW** **DW**	Lead Nurse Dashboard created and in use at meeting. Learning and sharing at lead nurse meetings. Feedback loop now in place with decision on outcome. If lapse in care and identified IPT member is allocated to work on actions with ward team. Spot check on use of huddleboards by matrons to be discussed at meeting Spot Check of Huddleboards to ensure information up to date Heat Map shared with Matrons 10/11/15 Arrange Weekly Meeting with CDiff Areas. Invites sent out for first meeting w/c 30/11	Complete Ongoing Complete Ongoing 3/12/15 Completed Review 4/1/16	
4.	**Information for patients to highlight any diarrhoea**	Signs to be put in ward toilets to advise to raise with staff if have diarrhoea. Norovirus posters also to be in 1/10/15place as per normal winter plan.	**Comms**	. Now in place in all in patient areas. Awaited new posters for public areas	Complete 1/11/15	

No	Recommendation	Actions Required	By whom	Progress to date	Agreed Completion Date	Status (rag)
5.	**Antibiotic Usage to be clinically appropriate and documented accordingly**	Work with Antibiotic Pharmacist on revising trust formulary for the IV to oral switch. Monitoring of usage and also individual cases feedback using RCA Staff to encourage doctors to note indication and duration on drug charts and notes. Staff to highlight patients at 24hrs IV use and 5 days antibiotics to medical teams	**P. Harrison** **IPT** **Matrons/lead Nurses**	Antibiotic stewardship group underway. Monitored at Infection Prevention Forum Evidence of challenge to be gained from Lead Nurse next meeting in October Trust Signed up to Antibiotic Guardian Campaign and Comms sent out	Completed and now ongoing Ongoing review 1/11/15 Completed	
6.	**Staff awareness of C Difficile is high and they are contributing to reductions**	Junior Doctors receive training on induction and understand issues All staff understand prevention and also the implications for patients and the trust of c diff cases. Potential for predictor tool for high risk patients.	**IPT/ Pharmacists** **DW**	Junior doctors induction has been updated for August intake IPT planning changes to next induction and all interactions with staff.	Complete Complete 1/11/15	
7.	**Isolation of new cases of diarrhoea within 2 hrs of presentation**	If new admission capacity team to be informed by A&E/EAU that side room is required. If already in patient then capacity advised of the 2 hour timescale and need to isolate. Flow chart for ward staff to enable early action	**IPT/ Matrons**	Matrons to liaise with Capacity and ED to explain 2hour standard Monitoring of isolation and encouraging escalation if not able to isolate To be on agenda for weekly back to basics meeting	Complete Complete and ongoing	
8.	**Link Nurses in all areas with an interest in reducing infection**	All ward areas have identified link worker. Training is provided to all link workers to a higher level knowledge	**IPT / Matrons**	IPT working on covering all areas with link staff following up with matrons at next meeting **Matrons and Heads of Nursing**	Complete Ongoing	

No	Recommendation	Actions Required	By whom	Progress to date	Agreed Completion Date	Status (rag)
		Regular meetings of link staff		**meeting with teams.** **Weekly Back to Basics Meeting with CDiff affected areas**	W/C 30/11/15	
9.	**A faecal specimen should be sent to the microbiology laboratory when the patient has had an episode of unexplained diarrhoea. If infective diarrhoea is suspected, a specimen should be sent immediately regardless of underlying disease or medications.**	Ward staff are aware of the SIGHT mnemonic and loose stool checklist Follow up where specimens not sent within time or inappropriately with ward staff for education. Monitoring of compliance by the infection prevention team.	**IPT/Matrons/ Lead Nurses**	Raised profile at lead nurses and matrons meetings. Will be an ongoing review but SIGHT is in place new posters available for training and awareness raising.	Ongoing	
10.	**Management of Lines, Peripheral and Central Lines minimises risk for patients of MRSA Bacteraemia**	Review of learning from cases within the Trust undertaken from RCA Messages to be disseminated around the organisation Sharing of learning at Matrons and Lead Nurse Meetings Pilot the review of peripheral lines use of one off visual check on patient status boards Removal of lines as soon as not required. Daily review at patient board round. Roll out of process used on B2 Consider how high risk patients are identified on admission and once deemed MRSA positive	**DW/HON/ Matrons Lead Nurses**	Initial pilot on B2 of magnets on patient status board on ward. Removal of a number of lines in a more timely way. Roll out across all areas of the Trust. Heads of Nursing and Matrons to do spot check to ensure that this is in place.	Ongoing But review on 9/12/15	

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd December 2015

TITLE:	**1. Results of Six Monthly 'Safer Nursing Tool' exercise** **2. Monthly Nurse/Midwife Staffing Position (October 2015)**		
AUTHOR:	Derek Eaves, Professional Lead for Quality Yvonne O'Connor, Deputy Chief Nurse	**PRESENTER:**	Dawn Wardell, Chief Nurse

CORPORATE OBJECTIVE: SGO1: Quality, Safety & Service Transformation Reputation, SGO2: Patient Experience, SGO5: Staff Commitment

SUMMARY OF KEY ISSUES:

PART 1: This is the fourth six monthly detailed review of nurse staffing levels using as a basis the Safer Nursing Care Tool (SNCT), comparing the results with the three previous exercises and the present establishments which are generally based on the Ward Review undertaken in 2014, unless wards have changed their speciality or bed numbers since then. Both methods are described in the paper and the results of each are provided and compared with a number of caveats. In addition, Nursing Sensitive Indicators are provided for each ward. Where appropriate, actions already being undertaken or further actions are suggested.

PART 2: This part of the paper contains the latest monthly information on nurse/midwife staffing. As previously stated, there is no set template for this information and so the intention behind the format of the attached has been to make potentially complex information as clear and easily understandable as possible. The paper indicates for the month of October 2015 when day and night shifts on all wards were staffed to planned levels (green). It also shows when the number of shifts were identified as amber (shortfall of registered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available), blue (shortfall of unregistered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available) or red (serious shortfall). The total number of these latter shifts is 55 which is a reduction from the last two months. The planned levels for each ward vary dependent on the types of patients and their medical specialities and national ratios apply to specialist areas such as intensive care, midwifery and paediatric areas. When shortfalls occurred the reasons for gaps and the actions being taken to address these are outlined and an assessment of any impact on key quality indicators has been undertaken.

IMPLICATIONS OF PAPER:

RISK	**Y** **Risk Register: Y**		**Risk Score and Description:** Nurse staffing levels are sub-optimal (20) Loss of experienced midwives (15)
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** 13: Staffing
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance with the Risk Assessment Framework
	Equality Assured	**Y**	**Details:** Better Health Outcomes for all Improved patients access and experience
	Other	**N**	**Details:**

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

To discuss and review the staffing situation and actions being taken and agree to the publication of the paper.

The Dudley Group NHS Foundation Trust

PART 1 Nurse Staffing Review

Introduction

This paper provides an overview of the nurse staffing situation at the Trust. It is the fourth six monthly paper following the recommendations of the national publications 'How to ensure the right people, with the right skills, are in the right place at the right time' and 'Hard Truths' authored by Jane Cummings, Chief Nursing Office for England and Mike Richards, Chief Hospital Inspector at the Care Quality Commission. It contains data from both the initial two exercises (February and September 2014) and the more recent exercises (March and October 2015) using the Safer Nursing Care Tool (SNCT) for all wards in the Trust for which the tool is applicable. It also contains present establishment data for comparison purposes which generally came from the internal extensive Ward Review process undertaken in January/February 2014 although a number of ward changes, and their associated establishments have changed since that time. From the first paper in early 2014, the Trust Board decided to adopt the figures from the Ward Review and agreed an extra £3million funding to increase the nurse establishment. The paper also contains a number of quality indicators for each ward (or Nurse Sensitive Indicators (NSIs) as the SNCT designates them).

In Part 2, the paper provides the now monthly information for the month of October 2015 on actual staffing levels at the Trust in relation to planned registered and unregistered staff.

A. Safer Nursing Care Tool (SNCT)

1. Introduction/Background

The AUKUH (Association of UK University Hospitals) staffing tool was formally launched at the CNO Summit on 1 November 2007. Further development work was then carried out by the NHS Institute and later, The Shelford Group. Following an extensive review of the tool, its definitions and multipliers, commissioned by the Shelford Group's Chief Nurses' Sub-Group, it was relaunched as The Safer Nursing Care Tool in mid 2013.

It can be seen there have been a number of organisations involved in this tool and a number of changes to it.

2. The Trust and the Safer Nursing Care Tool

The Trust has now four sets of data from this tool. The six monthly exercise requires staff on all wards to assess every patient's dependency (and categorising every patient into 1 of 5 care groups) over a twenty day period (Monday to Friday over four weeks). As the descriptions of each category are open to interpretation, it can be seen that it contains a professional judgement of which group every patient falls into. There therefore needs to be consistency of assessment.

3. Specialties the tool covers

It is worth noting that the originators of the tool indicate that this is an 'adult, generic' tool. It states that the tool is being further developed to better reflect the complexities of caring for older people in acute care wards. It stated in July 2013 that this latter version 'is almost ready for use', although this has not been published to date. It also states a tool is being developed for Accident and Emergency Departments.

4. Second Element of the Tool

As well as determining the level of acuity/dependency of all patients and calculating the nurse staffing required per ward based on the actual needs of those patients, the second element of the tool describes Nurse Sensitive Indicators (NSIs) such as care undertaken, patient feedback, complaints, pressure ulcers and falls. It is recommended that these should be monitored to ensure that the staffing levels determined in Element 1 are enabling the delivery of expected patient outcomes.

Links between patient dependency, workload, staffing and quality have been established in recent years. Evidence in the literature links low staffing levels and skill mix ratios to adverse patient outcomes. Monitoring Nurse Sensitive Indicators is therefore recommended to ensure that staffing levels, deliver the patient outcomes that we aim to achieve. However, even with optimum staffing establishments poor patient outcomes may result due to other reasons such as high turnover, sickness, leave or unfilled vacancies.

The initial six monthly report did not include this element with the Board regularly receiving separate reports on quality data such as complaints, nursing care indicators, incidents, safety thermometer results, healthcare associated infections and patient and staff experience data. However, this and the last two papers attempt to cover this element by including some of the relevant data that is produced for the Trust's monthly 'Ward Performance Reports'. Some of that data consists of the Trust's own Nursing Care Indicators (NCIs) but due to changes in some of the criteria of this system in September 2014 it is not possible to make historical comparisons on all criteria. In addition, due to further changes to the NCIs in September and October of this year the NSIs used in this latest report are for August not October 2015. Finally, for this and the last paper a number of other indicators, such as the Friends and Family Test results, have been introduced to hopefully give a wider view on quality on the ward.

5. Overview of SNCT Data

There are some fixed parameters with the SNCT e.g. the times allocated to each patient category. With regards to the parameters that are within the power of the Trust, it has been decided to use an average 23% time out/headroom for annual leave etc (only one value for all staff can be used and the tool suppliers suggest between 22-25%) while the accompanying Ward Review (see Section B below) data used 23.2% for permanent RN staff and 22.46% for permanent unqualified staff. In addition, within the SNCT it was decided to use the same RN to unqualified split throughout (60:40 split RN to unqualified staff) unlike the Ward Review, which has used differing figures for each ward. The SNCT default 68:32 has not been used.

It also needs to be pointed out that the SNCT calculation does not take into consideration the national directive of at least 1:8 RN/patient ratio for day shifts while this formed the basis of the RN calculations in the Ward Review, although recent communication from the centre indicates that this ratio should now be seen as guidance and is not a recommendation or directive.

The tool also provides 'benchmarks' of the average percentage of each category of patient per speciality from the wards that took part in research on which the tool is based.

B. Ward Review

Matrons, the then Director of Nursing and her Deputy discussed and debated the nurse requirements of each area, ensuring consistency with the then national requirement of at least 1:8 registered nurse to patient ratio for day shifts. This method therefore consisted of experienced nurses considering a range of issues associated with a ward, from its layout, the range of associated support staff such as ward clerks etc, the types of patient and their dependencies, skill mix within the team, the specialties of medical staff using the ward and such issues as the throughput and turnover of patients, any associated ward attenders etc. The system looked at the staffing and grade mix needs for each of the seven days of the week both for the day and night shifts for both RN and unqualified staff. The resultant figures went through a number of iterations, ensuring that there was consistency between similar wards etc. With expert help from the Finance Department this resulted in detailed data for each ward from which an establishment and associated cost was calculated. The whole process was validated by Mr S Davies, who was the Interim Turnaround Director at the time and checked by Price Waterhouse Cooper.

C. Data

Section 6 below contains the summaries of key data from both the four SNCT data collections and the Ward Review (or present establishment, if the ward and establishment has changed since the review) for each ward as well as the available Nurse Sensitive Indicators (NSIs), as described above.

In summary, with regards to the comparison between the ward review and SNCT figures, this needs to be interpreted with caution for the following reasons:

- For some of the wards there have been changes to the bed numbers and specialities
- It also needs to be remembered that the SNCT figures below do not take into account the workload associated with the numbers of admissions, discharges, transfers, escorts or deaths that occur on a ward and all of these activities take nursing time. Each ward will be different in this respect with some wards having a stable population of patients while others having possibly more than one person in a bed space during a twenty four hour period.
- In addition, the SNCT tool is based purely on the patient types and numbers in the 20 day study periods which do not include weekends.
- There are different percentages added in for relief/time-out/headroom
- Most importantly, the 1:8 RN/patient ratio for day shifts is not built into the SNCT.

6. SNCT and Comparative FTE Data

Ward A2

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Med
1	17	20	80	76	32
2	0	0	3	3	2
3	83	80	17	21	66
4	0	0	0	0	0
5	0	0	0	0	0
Beds	42	42	42	42	
Av Pat	41.8	41.3	41.5	36.6	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	40.2	39.3	28.3	25.6	34.35/38.64*
HCAs required	26.8	26.2	18.9	17.1	32.88/38.41*
Total FTE required	**67.0**	**65.6**	**47.2**	**42.6**	**67.23/77.05***

**Latter figures are for March 2015 onwards as the patient speciality of the ward changed after September 2014.*

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	97	100	86	96
Manual Handling	100	95	100	100
Falls Assessment			-	100
Tissue Viability Assessment	89	97	100	100
Nutritional Assessment	100	100	93	90
Medication Assessment	100	98	100	100
Nutrition (Total)			99	98
SL – Hand Hygiene			97	100
SL – Commode Audits			94	100
Friends and Family Test Score			96	99
Incidents				
Minor Incidents	10	6	8	10
Moderate Incidents	1	1	0	0
Major/Tragic Incidents	0	0	0	0
Complaints	0	0	1	1

Commentary: After the September 2014 study the ward was changed to a short stay area, hence the establishment change. The Acute Medical Society indicates that such areas require 1:6 qualified nurse to patient ratio hence the increase in establishment. The high turnover area means there can be more that 30 transfers of patients a day while the study only looks at the situation at one time-point in the day. The usefulness of the tool in such circumstances is therefore questionable (just like it is not suitable for the Emergency Department). NSIs are good and generally 'green'.

Conclusion: No action required.

Ward A3

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Rehab
1	19	29	25	25	38
2	0	0	0	1	7
3	80	71	75	74	52
4	0	0	0	0	4
5	0	0	0	0	0
Beds	28	28	28	28	
Av Pat	27.9	28	25.3	28	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	26.6	25.5	23.6	25.9	18.58/25.84*
HCAs required	17.7	17	15.7	17.3	21.92/19.20*
Total FTE required	**44.4**	**42.6**	**39.3**	**43.2**	**40.50/45.04***

**Latter figures are for March 2015 as the patient speciality of the ward changed after September 2014.*

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	98	96	100	93
Manual Handling	100	100	100	100
Falls Assessment			94	100
Nutritional Assessment	98	98	100	91
Medication Assessment	100	100	100	100
Nutrition (Total)			99	100
SL – Hand Hygiene			93	95
SL – Commode Audits			90	100
Friends and Family Test Score			90	100
Incidents				
Minor Incidents	12	5	6	3
Moderate Incidents	0	0	1	1
Major/Tragic Incidents	0	0	0	0
Complaints	0	2	1	0

Commentary: Occupancy remains high. After September 2014, the ward changed from Stroke Rehabilitation to care of the elderly, although the dependency of patients remains similar. The ward and establishment also includes FESU (Frail Elderly Short Stay Unit). As the ward has 28 beds decreasing the day RN staff would result in a ratio of 1:9.3. NSIs are good.

Conclusion: No action required.

Ward B1

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Surgery
1	81	79	80	82	62
2	18	3	1	2	15
3	0	18	18	16	22
4	0	0	0	0	1
5	0	0	0	0	0
Beds	26	26	26	26	
Av Pat	18	17	23.2	21.7	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	15.4	16.6	15.8	14.6	18.35
HCAs required	10.3	11.1	10.5	9.7	11.04
Total FTE required	**25.7**	**27.7**	**26.3**	**24.3**	**29.39**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	94	100	98	94
Manual Handling	68	86	81	100
Falls Assessment			100	100
Tissue Viability Assessment	88	98	100	100
Nutritional Assessment	26	96	100	47
Medication Assessment	100	86	89	98
Nutrition (Total)			97	97
SL – Hand Hygiene			100	100
SL – Commode Audits			100	100
Friends and Family Test Score			99	100
Incidents				
Minor Incidents	0	3	2	1
Moderate Incidents	0	0	0	0
Major/Tragic Incidents	0	0	0	0
Complaints	0	0	0	0

Commentary: Dependency remains similar to previous studies while occupancy has decreased slightly. NSIs have improved from January 2014. The nutritional assessment score has moved into green since August of this year. The SNCT study results and the present establishment are similar, although the present establishment has a slightly higher FTE which is probably accountable by the fact, as previously stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges. With 26 beds, reducing day RN staff would result in a ratio of 1:8.7

Conclusion: No action required except there needs to be continued close monitoring of the NSIs, in particular nutrition.

Ward B2 Trauma

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Trauma
1	65	68	58	60	34
2	16	13	2	5	5
3	19	19	40	35	57
4	0	0	0	0	2
5	0	0	0	0	3
Beds	24	24	24	24	
Av Pat	23.2	23	23.2	19.8	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	16.8	16.4	18.1	15.1	13.80
HCAs required	11.2	11	12.1	10.1	17.81
Total FTE required	**27.9**	**27.4**	**30.2**	**25.2**	**31.61**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	95	97	96	98
Manual Handling	98	100	83	100
Falls Assessment			98	89
Tissue Viability Assessment	97	98	96	100
Nutritional Assessment	100	100	100	100
Medication Assessment	98	100	94	100
Nutrition (Total)			99	96
SL – Hand Hygiene			100	100
SL – Commode Audits			98	100
Friends and Family Test Score			97	96
Incidents				
Minor Incidents	9	6	2	3
Moderate Incidents	3	3	0	0
Major/Tragic Incidents	0	0	0	0
Complaints	0	0	1	1

Commentary: Occupancy dipped in October while dependency remains constant. Incident numbers continue to be lower than previous. Both the SNCT study outcomes and the present establishment are similar, although the latter has a slightly higher FTE which is probably accountable by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges. NSI results are good.

Conclusion: No action required except there needs to be continued close monitoring of the NSIs.

Ward B2 Hip

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Ortho
1	62	68	43	63	42
2	19	3	7	1	22
3	19	29	50	36	34
4	0	0	0	0	1
5	0	0	0	0	0
Beds	30	30	30	30	
Av Pat	28.4	28.7	29.2	27.1	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	20.6	21.1	24.4	20.6	18.79
HCAs required	13.8	14	16.2	13.7	30.14
Total FTE required	**34.4**	**35.1**	**40.6**	**34.3**	**48.93**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	98	92	99	94
Manual Handling	97	98	100	100
Falls Assessment			100	100
Tissue Viability Assessment	90	95	100	100
Nutritional Assessment	89	89	100	97
Medication Assessment	100	100	100	96
Nutrition (Total)			99	95
SL – Hand Hygiene			100	100
SL – Commode Audits			98	100
Friends and Family Test Score			97	100
Incidents				
Minor Incidents	9	6	4	3
Moderate Incidents	3	2	0	0
Major/Tragic Incidents	0	2	0	0
Complaints	0	6	0	1

Commentary: Dependency has decreased. It was noted that in October there were fewer patients with dementia and fewer requirements for 1 to 1 nursing care in this month which is unusual and this has resulted in the tool suggested a lower FTE. Recent NSIs and those from March 2015 show an excellent improvement in quality indicators, with green RAG ratings across the indicators. As there are 30 beds on the ward, decreasing the day RN staff would result in a ratio of 1:10.

Conclusion: No action required.

Ward B3

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Surgery
1	54*	43	28	71	62
2	12*	11	29	6	15
3	34*	46	31	23	22
4	0	0	3	0	1
5	0	0	0	0	0
Beds	28+10SAU	38+4HDU	38+4HDU	38+4HDU	
Av Pat	35	29.2	38.9	34.5	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	27.6	24.2	32.9	24.6	24.84
HCAs required	18.4	16.2	21.9	16.4	16.44
Total FTE required	**46.0**	**40.4**	**54.8**	**41.0**	**41.28**

*Not including SAU

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	94	96	87	99
Manual Handling	94	84	44	88
Falls Assessment			98	98
Tissue Viability Assessment	100	87	97	100
Nutritional Assessment	98	**72**	**78**	**45**
Medication Assessment	100	99	100	93
Nutrition (Total)			67	87
SL – Hand Hygiene			96	93
SL – Commode Audits			100	100
Friends and Family Test Score			96	94
Minor Incidents	4	5	3	2
Moderate Incidents	1	0	0	1
Major/Tragic Incidents	0	0	0	0
Complaints	0	1	0	0

Commentary: In the light of a number of issues including the poor NSIs and apparent recent radical change in the dependency of patients, B3 underwent a review process in July 2015. The review found that the method of assessing the dependency of patients in March 15 was flawed. Following monitoring to ensure that there is a correct understanding of the tool, it can be seen that the latest results in October have resulted in the tool suggesting a similar FTE to the existing establishment. The NSIs have improved since March although some aspects still require improvement.

Conclusion: NSIs need to be continued to be closely monitored.

Ward B4

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Surgery
1	81	71	84	85	62
2	5	5	7	10	15
3	14	25	9	4	22
4	1	0	0	0	1
5	0	0	0	0	0
Beds	48	48	48	48	
Av Pat	45.1	43.1	47.3	46.8	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	30.4	30.9	31.0	30.1	30.36
HCAs required	20.3	20.6	20.7	20.0	24.66
Total FTE required	**50.7**	**51.6**	**51.7**	50.1	**55.02**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	97	92	97	99
Manual Handling	86	74	80	100
Falls Assessment			100	100
Tissue Viability Assessment	93	67	100	100
Nutritional Assessment	97	32	100	96
Medication Assessment	99	100	100	100
Nutrition (Total)			100	100
SL – Hand Hygiene			100	100
SL – Commode Audits			100	100
Friends and Family Test Score			100	100
Minor Incidents	5	7	6	4
Moderate Incidents	1	2	1	0
Major/Tragic Incidents	0	0	0	1
Complaints	1	1	0	1

Commentary: Dependency has decreased slightly. NSIs continue to improve. The SNCT study outcomes suggest smaller FTE than the establishment, which is probably accounted for by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges.

Conclusion: No action required.

Ward B5

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Surgery
1	87	97	95	95	62
2	9	2	3	3	15
3	5	1	3	2	22
4	0	0	0	0	1
5	0	0	0	0	0
Beds	22	30+4GAU	30+4GAU	30+4GAU	
Av Pat	21.9	33.3	33.1	33.3	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	14.0 (23.2)	20.2	20.4	20.5	18.93
HCAs required	9.3 (15.4)	13.4	13.6	13.7	16.44
Total FTE required	**23.3** (**38.6**)	**33.6**	**34.0**	**34.2**	**35.37**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	100	100	98	91
Manual Handling	100	100	67	100
Falls Assessment			100	100
Tissue Viability Assessment	100	100	100	90
Nutritional Assessment	88	50	90	97
Medication Assessment	97	100	100	100
Nutrition (Total)			94	100
SL – Hand Hygiene			100	100
SL – Commode Audits			100	100
Friends and Family Test Score			93	96
Minor Incidents	5	1	0	1
Moderate Incidents	2	2	0	0
Major/Tragic Incidents	0	0	0	0
Complaints	0	0	2	0

Commentary: There were 22 beds on B5 for the initial SNCT study but now there are 20 beds + SAU (10 beds) and Gynaecology Assessment Unit (GAU) (4 beds). The figures in brackets on the first study include the separate SNCT figures for SAU and GAU to assist with any comparison. As there are 30 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:10. Occupancy remains constant as does dependency. NSIs are variable. The SNCT studies suggest a smaller FTE than the ward review, which is probably accounted for by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges, which is a significant issue for this ward with the two assessment units.

Conclusion: No action required other than continue closely monitoring NSIs.

Ward B6

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % ENT
1	88	87	92	93	73
2	2	2	3	2	12
3	10	11	5	5	7
4	0	0	0	0	3
5	0	0	0	0	6
Beds	29	17	17	17	
Av Pat	28.2	16.4	16.5	16.1	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	18.3	10.7	10.3	10.0	13.06
HCAs required	12.2	7.1	6.9	6.7	8.22
Total FTE required	**30.4**	**17.8**	**17.2**	**16.7**	**21.28**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	94	100	100	91
Manual Handling	89	100	38	100
Falls Assessment			100	100
Tissue Viability Assessment	98	100	100	90
Nutritional Assessment	98	90	86	97
Medication Assessment	100	100	100	100
Nutrition (Total)			99	100
SL – Hand Hygiene			100	100
SL – Commode Audits			100	100
Friends and Family Test Score			98	100
Minor Incidents	9	1	2	0
Moderate Incidents	1	1	0	0
Major/Tragic Incidents	0	0	1	0
Complaints	1	1	2	0

Commentary: B6 had 29 beds during the first study but then lost 12 beds. Decreasing the day RN staff would only leave one nurse on duty. Dependency remains similar although this is expected to decrease with the recent commencement of acute ENT patients going to New Cross Hospital out of hours. NSIs remain variable but generally good. The latest SNCT study suggests a smaller FTE than the ward review, which is probably accounted for by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges.

Conclusion: No action required other than to continue closely monitoring NSIs.

Ward C1

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Med
1	39	24	46	56	40
2	14	29	1	3	10
3	47	47	53	41	48
4	0	0	0	0	1
5	0	0	0	0	2
Beds	48	48	48	48	
Av Pat	47.9	47.9	47.9	47.5	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	40.3	42.0	39.9	37.4	31.59
HCAs required	26.9	28.0	26.6	25.0	32.88
Total FTE required	**67.2**	**70.0**	**66.5**	**62.4**	**64.47**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	92	94	80	93
Manual Handling	100	99	30	76
Falls Assessment			61	100
Tissue Viability Assessment	100	100	98	100
Nutritional Assessment	81	90	24	93
Medication Assessment	100	100	100	100
Nutrition (Total)			94	93
SL – Hand Hygiene			100	97
SL – Commode Audits			100	100
Friends and Family Test Score			100	96
Minor Incidents	8	5	4	6
Moderate Incidents	0	0	0	0
Major/Tragic Incidents	0	0	0	1
Complaints	0	0	0	0

Commentary: As there are 48 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:9.6. Occupancy remains high with dependency decreasing in the latest studies. NSIs have improved since the deterioration in March. All four SNCT studies and the ward review have had similar results.

Conclusion: No action required.

Ward C3

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Med Eld
1	12	23/30	34	24	32
2	7	0/0	1	2	2
3	81	77/70	65	74	66
4	0	0/0	0	0	0
5	0	0/0	0	0	0
Beds	52	24/28	52	52	
Av Pat	48.1	24/27.8	49.2	51.5	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)*
RNs required	46.7	22.5/25.2	43.7	47.9	34.86
HCAs required	31.1	15/16.8	29.1	31.9	38.41
Total FTE required	**77.8**	**37.5/42.0**	**72.8**	**79.8**	**73.27**

**In September 2014 this ward was divided into two but them merged again afterwards.*

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	80	96	93	99
Manual Handling	86	100	100	100
Falls Assessment			100	100
Tissue Viability Assessment	92	100	100	100
Nutritional Assessment	97	94	97	100
Medication Assessment	100	100	100	100
Nutrition (Total)			98	100
SL – Hand Hygiene			100	100
SL – Commode Audits			100	100
Friends and Family Test Score			94	100
Minor Incidents	16	9	8	11
Moderate Incidents	0	5	4	1
Major/Tragic Incidents	0	0	0	0
Complaints	0	1	1	0

Commentary: At the initial SNCT study this ward had 52 beds. The ward was then split into two (C3A[24 beds]/C3B[28beds]) but was unified again under one lead nurse. The dependency of the patients varies due to the focus on care of elderly on this ward. The latest SNCT study suggests there should be a higher establishment on this ward but both the well-being workers and the acute confusion team give considerable assistance to this ward, which balances out this difference. NSIs are good.

Conclusion: No action required.

Ward C5

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Med
1	53	53	54	62	40
2	12	3	4	5	10
3	27	36	39	26	48
4	8	8	4	7	1
5	0	0	0	0	2
Beds	48	48	48	48	
Av Pat	47.7	47.4	48	47.9	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	37.9	38.5	38.4	36.6	31.59
HCAs required	25.3	25.7	25.6	24.4	32.88
Total FTE required	**63.1**	**64.2**	**64.0**	**61.0**	**64.47**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	96	100	98	98
Manual Handling	86	77	100	100
Falls Assessment			100	100
Tissue Viability Assessment	78	90	98	100
Nutritional Assessment	74	96	97	100
Medication Assessment	100	99	82	100
Nutrition (Total)			86	98
SL – Hand Hygiene			100	96
SL – Commode Audits			97	93
Friends and Family Test Score			100	100
Minor Incidents	10	3	10	3
Moderate Incidents	2	2	1	1
Major/Tragic Incidents	0	0	0	0
Complaints	0	1	1	1

Commentary: Occupancy remains high and dependency has decreased in the latest study. NSIs have improved considerably over time. All four SNCT studies and the ward review have had similar results.

Conclusion: No action required.

Ward C6

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Surgery
1	89	88	88	84	62
2	4	2	0	2	15
3	7	10	12	13	22
4	0	0	0	0	1
5	0	0	0	0	0
Beds	20	20	20	20	
Av Pat	19.1	17.2	17.3	16.9	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	12.2	11.1	11.2	11.2	15.82
HCAs required	8.1	7.4	7.5	7.5	10.96
Total FTE required	**20.3**	**18.5**	**18.7**	**18.7**	**26.78**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	92	100	98	99
Manual Handling	100	100	27	100
Falls Assessment			100	100
Tissue Viability Assessment	100	100	100	100
Nutritional Assessment	100	98	85	100
Medication Assessment	89	100	100	100
Nutrition (Total)			98	100
SL – Hand Hygiene			100	100
SL – Commode Audits			100	100
Friends and Family Test Score			98	100
Minor Incidents	6	4	4	1
Moderate Incidents	0	0	0	1
Major/Tragic Incidents	0	0	0	0
Complaints	0	0	0	0

Commentary: Dependency remains similar with a slight drop in occupancy. With 20 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:10. NSIs have improved over time. The establishment is a slightly higher FTE that the SNCT results which is probably accounted for by the fact, as stated, that the SNCT does not take into consideration the workload that comes from high numbers/turnover of admissions and discharges plus some outpatient clinic work that occurs on the ward.

Conclusion: No action required.

Ward C7

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Med
1	68	64	57	61	40
2	2	1	4	2	10
3	30	35	39	37	48
4	0	0	0	0	1
5	0	0	0	0	2
Beds	36	36	36	36	
Av Pat	35.7	35	35.7	36	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	26.2	26.5	27.8	27.5	26.86
HCAs required	17.5	17.7	18.6	18.4	21.92
Total FTE required	**43.7**	**44.1**	**46.4**	**45.9**	**48.78**

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	94	97	82	78
Manual Handling	87	89	90	100
Falls Assessment			100	70
Tissue Viability Assessment	98	100	96	96
Nutritional Assessment	56	94	100	94
Medication Assessment	99	98	100	100
Nutrition (Total)			94	95
SL – Hand Hygiene			96	100
SL – Commode Audits			88	100
Friends and Family Test Score			100	92
Minor Incidents	10	7	5	5
Moderate Incidents	3	2	1	1
Major/Tragic Incidents	0	1	1	0
Complaints	0	0	1	0

Commentary: Occupancy remains high and dependency has decreased slightly since the last study in March 2015. NSIs remain variable and have deteriorated recently and so the ward remains on escalation with an action plan in place. As there are 36 beds on the ward, decreasing the day RN staff would reduce the ratio to 1:9. FTEs from the SNCT and the ward review are similar.

Conclusion: No action required other than continue closely monitoring the NSIs.

Ward C8

	Feb 14	Sep 14	Mar 15	Oct 15	
Patient Level	% of patients	% of patients	% of patients	% of patients	Benchmark % Med
1	69	83	34	23	40
2	2	2	4	26	10
3	29	15	62	51	48
4	0	0	0	0	1
5	0	0	0	0	2
Beds	36+4 flex	36+4flex	36	44	
Av Pat	40.1	39.4	36	39	
Required Staff	SNCT	SNCT	SNCT	SNCT	Establishment (WTE)
RNs required	36.7	33.4	31.8	34.6	39.87/20.32*/38.11+
HCAs required	24.5	22.2	21.2	23.1	27.4/32.92*/38.41+
Total FTE required	**61.1**	**55.6**	**52.9**	**57.7**	**67.27/53.24*/76.52+**

**Figures for March 2015 as the patient numbers and speciality of the ward changed after September 2014.*
+Figures for October 2015 when stroke rehabilitation and the acute stroke unit were combined

Nursing Sensitive Indicators (NSIs)

	Jan 14	Aug 14	Mar 15	Aug 15
Nursing Care Indicators				
Patient Observations	98	96	96	94
Manual Handling	100	92	100	100
Falls Assessment			100	100
Tissue Viability Assessment	100	82	100	100
Nutritional Assessment	100	97	100	83
Medication Assessment	100	99	100	100
Nutrition (Total)			98	98
SL – Hand Hygiene			100	100
SL – Commode Audits			100	95
Friends and Family Test Score			100	97
Minor Incidents	8	4	5	13
Moderate Incidents	0	1	0	0
Major/Tragic Incidents	0	0	0	1
Complaints	0	0	0	2

Commentary: The ward has recently changed increasing the beds due to the relocation of the hyperacute stroke unit hence the increase in the ward establishment. Occupancy across the ward is not as high as other areas but two emergency beds have to be kept empty due to the stroke pathway guidance. Dependency is fluctuating and there are more level 2 patients this month with the merger of the two units. NSIs are good.

Conclusion: A staffing review will take place six months after the two units were combined.

7. Conclusion

It can be seen that even with the difficulties in comparing different methods of formulating how many staff are required on a ward that not too dissimilar results occur on most wards between the SNCT studies and the present ward establishments. From the analysis that can be undertaken on both the results of the establishment calculations and on the Nursing Sensitive Indicators, it would seem that the situation as it stands is reasonable across all areas, although some areas for action have been noted in terms of the care quality rather than staffing. While the present establishments seem to conform with the requirements of an 'objective' measure, it is still necessary to monitor what occurs on a day to day basis with such variables as staff sickness and vacancies affecting the staff available. The latest results of this monitoring for October 2015 follows in Part 2 below.

With regards to the quality indicators, as already stated, due to changes in some of the criteria of the NCIs in September 2014 it has not been possible to make full historical comparisons on all criteria after this date. In addition, further changes to these indicators were made in the previous report. Plans are underway in the Nursing Division, with help from the Finance Department, to have a comprehensive 'dashboard' of quality indicators for each ward which will help in providing a more straightforward and systematic picture of the quality of care on a ward which will be useful both operationally but also when reviewing the staffing and its interrelationship with quality in each area.

PART 2

THE DUDLEY GROUP NHS FOUNDATION TRUST

Monthly Nurse/Midwife Staffing Position

October 2015

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

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

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

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

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

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

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

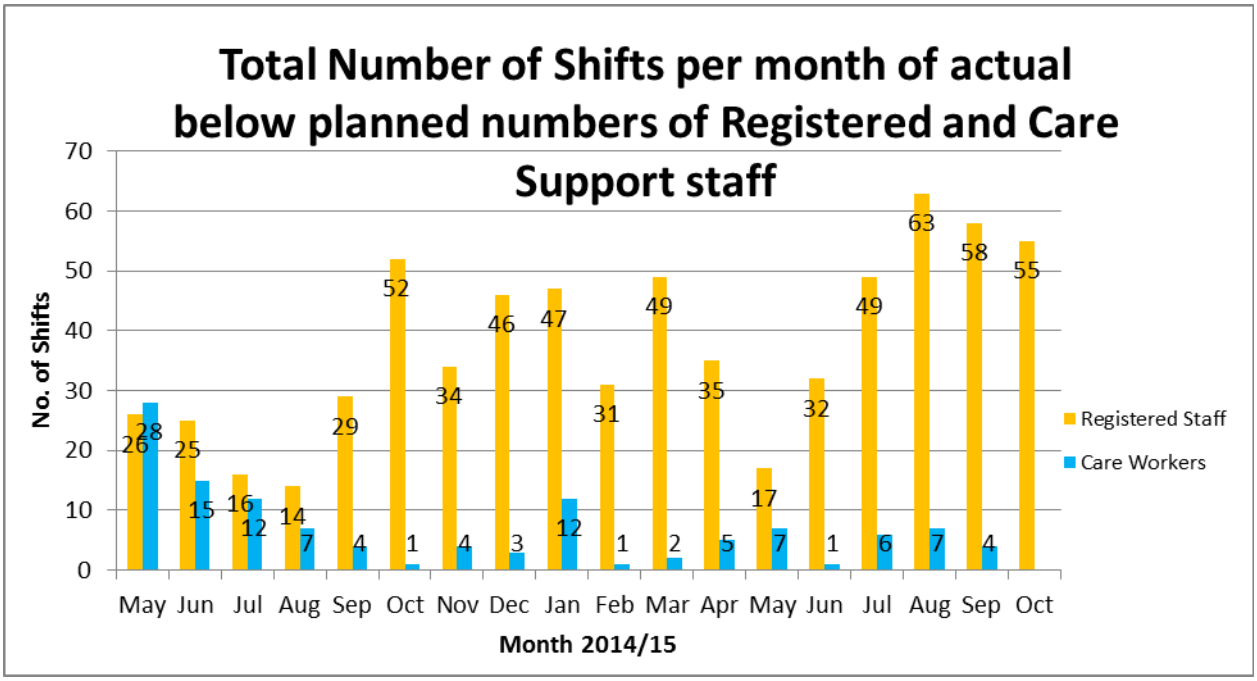
It can be seen from the accompanying chart that the number of shifts identified as amber (shortfall of registered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available), blue (shortfall of unregistered staff or when planned levels were reached but the dependency or number of patients was such that the extra staff needed were not available) or red (serious shortfall) is 55. This figure can be compared with previous months (see Table 1) and a downward trend from the high figure in August can be seen. In particular, the improved situation in maternity is noted. As in previous recent months, the shifts occur mainly on three wards. Staff on ward A3 (7 shifts down from 11 and 13 shifts in

Sept/Aug) have had to assist with the opening of the eight beds on A1 which has occurred due to capacity issues. The second area is C1 (10 shifts compared to 14 and 10 shifts in Sept/Aug) which still has vacancies although some new staff commenced in October. Finally, on ward B4 (12 shifts compared to 9 and 7 shifts in Sept/Aug) maternity leave and sickness have added to long term vacancies, some of which have been filled in October. There have been no serious shortfall (red) shifts this month. No safety issues occurred on any of the shifts with shortfalls.

Returning to the complete Trust picture, the staffing available met the patients' nursing needs in all cases. When shortfalls in the 1:8 RN to patient ratio for day shifts on general wards or when shifts have been identified as below optimum; the reasons for the gaps and the actions being taken to address these in the future are outlined below. As noted last month, the Trust received a joint letter from the TDA, Monitor, NHS England and the CQC indicating that the 1:8 RN to patient ratio should only be seen as guidance. The Trust has decided to still try to maintain this standard.

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

Table 1



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

MITIGATING ACTIONS TAKEN IN RESPONSE TO STAFFING ASSESSMENTS OCTOBER 2015

WARD	No.	RN/RM CSW	REASONS FOR SHORTFALLS	MITIGATING ACTIONS
A3	7	RN	Vacancy x7	Bank and agency did not fill. Due to patient numbers (capacity), Ward A1 was opened during this month as and when required. Staff from A3 also staff that ward when it has to open. Risk assessment of patient caseload is always undertaken and the nurse in charge takes a caseload of patients on many shifts. No patient safety issues are occurring. On one occasion lead nurse from C3 assisted.
B1	1	RN	Staff sickness	The 18 patients on the 26 bed ward meant that the ratio was 1:9. A supernumerary graduate nurse was also on the shift. The Lead Nurse assessed there was a safe level of staffing for the patients on that shift. No safety concerns occurred.
B2H	2	RN	Vacancyx1	On the night shift, the patient dependency was such that a nurse was moved to another ward as the night co-ordinator assessed the ward as safe and no safety issues occurred. On the day shift, the employed bank nurse cancelled her shift very late but the dependency of the patients was such that the Lead nurse assessed the wad as safe and no safety issues occurred.
B3	1	RN	Staff sickness	The nurse due to be moved from B4 to assist was unable to due to an emergency but the ward was assessed as safe by the nurse in charge and patient safety was maintained.
B4	16	RN	Maternity Leave x11, Sickness x5	Bank/agency unable to fill all of these shifts but with the dependency of the patients present on the ward safety was maintained with an RN ratio of 1:9.6 on 11 day time occasions. On one of the other shifts assistance came from the on-call lead nurse and on another the bed management nurse assisted. At all times safety maintained.
B6	2	RN	Vacancy	The bank was unable to fill the shifts but this was a weekend and there were only 12 patients on the ward and with two CSWs working on the day an done at night safety was maintained.
C1	10	RN	Vacancy x8, Sickness x2	On all occasions the lead nurse or nurse in charge assessed the situation and delegated staff appropriately to maintain patient safety.
C3	1	RN	Vacancy	Bank and agency were unable to fill. With the workload of the patients on the ward, safety was maintained.
C5	4	RN	Vacancy x2 Sickness x2	Bank unable to fill. On all occasions extra were CSWs employed. Safety was maintained.
C6	3	RN	Maternity Leavex1 Sickness x2	Bank was unable to fill. On two occasions the 20 bed ward had 10 patients and on the other 12 patients. On one occasion, a supernumerary RN was working. On another, a CSW was moved elsewhere. On all occasions the remaining staff were able to provide the required care to patients. There were no safety issues on all three shifts.
C8	3	RN	Vacancyx3	On all occasions a nurse was moved from HASU to main ward so that the workload was effectively distributed. The CNS and lead nurse provided support. There were no safety issues.

CCU/ PCCU	1	RN	Sickness Vacancy	Bank and agency unable to fill. Lead nurse worked clinically and matron assisted to ensure safety.
Maternity	4	RM	Vacancy Maternity leave	Escalation policy enacted on all occasions. Bank unable to fill. No patient safety issues occurred. On Each shift there was a delayed induction of labour.

Enclosure 6

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 3 December 2015

TITLE:	**24 November 2015 Clinical Quality, Safety and Patient Experience Committee Meeting Summary**		
AUTHOR:	Glen Palethorpe Director of Governance / Board Secretary	**PRESENTER**	Doug Wulff – Committee Chair

CORPORATE OBJECTIVES

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

SUMMARY OF KEY ISSUES:

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

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

To note the assurances received via the Committee, the decisions taken in accordance with the Committee's terms of reference and the support given by the Committee to the Executives to assess the risk regarding the Neonatal review across the West Midlands.

The Dudley Group NHS
NHS Foundation Trust

Committee Highlights Summary to Board

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

Declarations of Interest Made

None

Assurances received

- Operational Management assurance was provided with regard to the actions being taken in respect of choose and book. Where there is an identified higher % of appointment slot issues then an action plan is required and monitored via the operations management processes. The target for end of Q3 is 80% and in the report the Trust's position was 74.9% (but 77.89% if exclude ophthalmology a known area of concern for slot availability). Operational Management assurance was provided to ensure that no quality issues arise through the implementation of a manual triage process to ensure patients are allocated slots on the basis of clinical need;
- Operational Management assurance was provided in respect of the Stroke Co-Location, an item the Committee had asked for an update on in a previous meeting. This assurance covered that this move had improved the patients experience, improved the MDT working in that area, improved access to medical staff and continuity of lead clinician for the patient;
- Executive Management assurance was provided in respect of the actions to address an increased in healthcare associated infections. Further assurance was requested for the next meeting in respect of continued actions (see below for actions to a future committee meeting);
- Operational Management assurance was provided on the performance in respect of key quality indicators. The Committee, see above, received assurance on actions in respect of those indicators of concern; HCAI and stroke swallowing screen;
- Executive Management assurance was provided in respect of the outcome of the investigation into the second potential never event. This has been thoroughly investigated, the findings shared with the commissioner, and agreement reached that this incident does not meet the criteria for a never event;
- Executive Management assurance was provided over compliance with the Trust's contractual requirements for dealing with SIs;
- Executive Management assurance was received via the Quality and Safety Group in respect of the Trust's improved Nursing Care Indicator processes and that the outcomes of pharmacy audits are being reported to this group. The Committee asked that any issues which relate to Controlled Drugs be reported back to this

Committee (see action section below)

- Executive Management assurance was received via the Internal Safeguarding Board in respect of the agenda items, the Committee supported the continued challenge over the provision of Tier 4 CAMHS beds;
- Executive Management assurance was received via the Patient Experience Group on the undertaking of the internal quality and safety reviews, the outcome of the PLACE reviews and the improvement reflected in the outcome of the latest Voices bereavement Survey;
- Executive Management Assurance was provided on the Trust performance against the Quality Account action plan in respect of the recommendations made by the previous external auditors; and
- Executive Management assurance was received that a robust plan had been developed to deal with the planned action by Junior Doctors during December. This also included confirmation that the required assurance statement had been made to NHS England.

Decisions Made / Items Approved

- The Committee considered the proposed quality priorities and metrics for the forthcoming year and agreed that the priories would remain as Patient Experience, Pressure Ulcers, Infection Control and Nutrition / Hydration. In light of the assurance that the process is embedded, the Committee proposed the removal of mortality provided the Medical Director agreed. The Committed proposed to add two or three new priorities from either; Pain Management, Medicine Management or Falls. A proposal is to come back to the next meeting and then be presented to the Governors meeting in December.
- The Committee agreed that the quality metrics be investigated and the feasibility of a MET call measure rather than just cardiac arrest, of the readmission rate into medicine rather than surgery and of the percentage of elective admissions being replaced by the number of ED admissions with a fractured neck of femur treated within 2hrs be considered and reported back to the next meeting (see below for actions to come back);
- Approval of 2 Strategies, 1 Policy and 8 guidelines / procedures that had all been considered by Policy Group in November 2015;
- Approval to close 27 RCA action plans following assurance from the Corporate Governance Team that, where appropriate, actions plans completed had been evidenced; and
- The Committee asked that the Divisions through their performance management framework be reminded of the need to provide assurance that actions are closed timely given the increase in open actions that have passed their agreed implementation dates.

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

- The Committee is to receive a further update in the Trust infection prevention and control action plan at the next meeting;

- The Committee is to receive a final report on the Trust quality priorities and metrics at the next meeting;
- The Committee asked that the outcome of Pharmacy Audits that relate to controlled drugs be reported to this Committee;
- The Committee asked that the outcome of the work in respect of blood bank sample audits especially any further issues regarding non identification of patients;
- The Committee asked that once the RCAs had been concluded in respect of the two recent radiology SIs that these be reported in the SI report so that the Committee can have more detail on the Root Causes and actions being taken; and
- The Committee asked that a report be presented on the potential impact of the neonatal review being undertaken across the West Midlands and that the potential risk is reflected in the Corporate Risk Register.

Items referred to the Board for decision or action

The Board is asked to note that the Committee supports the Executive's view that the risk to the Trust of the current neonatal review across the West Midlands be assessed and included in the Corporate Risk Register.

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd December 2015

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

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

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

The Trust narrowly missed the 85% for the cancer 62 day target for GP referral (achieved 83.4%). As previously reported this is predominantly as a result of the activity at Royal Wolverhampton Trust where the backlog activity is being undertaken and we share the breach for the overall pathway performance. Continued performance management has been with weekly meetings for the Division with Directors

A further 5 Healthcare Acquired Infections of Clostridium Difficile occurred in October, making 25 in total for the year. It is unlikely that the annual target of 29 will be achieved. The Trust had 38 cases in 2014/15. The Chief Nurse has developed an action plan; no systematic failures in the Trust's systems have been uncovered. Further assurance was requested for the next meeting of the CQSPE in respect of continued actions

In last month's report an incident was identified as potentially being a never event. This has been thoroughly investigated, the findings shared with the commissioner, and agreement reached that this incident does not meet the criteria for a never event.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD

Board of Directors is asked to note the contents of the Integrated

Trust Board of Directors 3rd December 2015

Integrated Performance Report - October 2015

1. Introduction

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

2. Integrated Performance Report

The report for the period April 2015 to October 2015 is enclosed for consideration at Appendix 1.

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

- Delivery of the emergency access target (4hrs) where the Trust is consistently performing amongst the top organisations in the country
- Achievement of all three Referral to Treatment (RTT) 18 week targets
- Friends & Family Recommended scores across the Trust are all above target

Those areas requiring further attention include

- Delivery of Clostridium Difficile (C-Diff) target - see below
- The Friends & Family measure of how many responses are collected (the footfall) remains below that required in some areas. The performance in ED has marginally improved since last month. Scoping of the introduction of a two way texting system to improve response rates continues.
- Outpatient activity – follow-up outpatients and outpatient procedures continue to under-perform. The Divisions continue to determine the reasons for this and produce a plan for improving the level of activity over the remainder of the year.
- Community activity continues to be below target due to vacant community nursing posts & lower than expected referrals to some community teams. Recruitment into these posts continues although is not expected that this will recover the under-performance by the year end.

3. Cancer

The Trust narrowly missed the target for the 62 day urgent GP referral to treatment, achieving 83.4% against a target of 85%

This is predominantly as a result of the activity at Royal Wolverhampton Trust where the backlog activity is being undertaken and we share the breach for the overall pathway performance

The provisional figure for October is 85.1%.

The performance by tumour site is shown at Appendix 2.

4. Clostridium Difficile (CDiff)

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

There have been a further 5 cases in October, making 25 in the year to date. The current frequency means it is highly unlikely that the annual target of 29 will be achieved.

The Chief Nurse has produced an action plan and work to date has not identified a systematic failure in the system. The issue has been discussed at Clinical Quality, Safety and Patient Experience Committee and Performance and Finance Committee, Further assurance was requested for the next meeting in respect of continued actions

5. Never Events

In last month's report an incident was identified as potentially being a never event. This has been thoroughly investigated, the findings shared with the commissioner, and agreement reached that this incident does not meet the criteria for a never event.

Recommendation

Trust Board of Directors is asked to:

a. Note the contents of the report

Anne Baines
Director of Strategy and Performance

The Dudley Group NHS
NHS Foundation Trust

Appendix 1

Integrated Performance Dashboard 2015/16

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

Quality And Risk

Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target	YEF
Friends & Family – Community – Footfall	-	0%	0%	1%	1%	1%	1%	1%	-	-	-	-	-	1%	%	
Friends & Family – Community – Recommended %	-	97%	98%	96%	96%	94%	93%	97%	-	-	-	-	-	95%	%	
Friends & Family – ED – Footfall	20%	8%	15%	12%	7%	6%	3%	7%	-	-	-	-	-	8%	15%	
Friends & Family – ED – Recommended %	89%	90%	90%	92%	90%	95%	91%	96%	-	-	-	-	-	92%	95%	
Friends & Family – Maternity – Footfall	23%	23%	22%	21%	20%	22%	23%	25%	-	-	-	-	-	22%	15%	
Friends & Family – Maternity – Recommended %	99%	99%	99%	99%	97%	99%	99%	98%	-	-	-	-	-	98%	84%	
Friends & Family – Outpatients – Recommended %	-	84%	82%	82%	88%	90%	89%	88%	-	-	-	-	-	88%	%	
Friends & Family – Ward – Footfall	32%	16%	16%	14%	15%	20%	20%	23%	-	-	-	-	-	17%	25%	
Friends & Family – Ward – Recommended %	98%	96%	97%	98%	97%	99%	97%	97%	-	-	-	-	-	97%	95%	
HCAI – Post 48 hour Clostridium Difficile	38	3	3	2	2	5	5	5	-	-	-	-	-	25	15	
HCAI – Post 48 hour MRSA	0	0	0	0	0	0	2	0	-	-	-	-	-	2	0	
Incidents - Patient Falls, Injuries or Accidents	1,399	127	116	116	103	97	119	111	-	-	-	-	-	789		
Incidents - Pressure Ulcer	2,091	187	163	182	150	120	132	125	-	-	-	-	-	1,059		
Never Events	1	0	0	0	0	0	1	0	-	-	-	-	-	1	0	
Serious Incidents - Action Plan overdue	-	46	31	37	24	32	42	40	-	-	-	-	-	252		
Serious Incidents – Not Pressure Ulcer	108	6	9	9	10	7	11	11	-	-	-	-	-	63		
Serious Incidents - Pressure Ulcer	197	21	20	21	17	17	10	18	-	-	-	-	-	124		
Stroke - Suspected TIA Scanned < 24hrs of Presentation	85.47%	95%	100%	91.3%	88.89%	92.31%	85%	77.78%	-	-	-	-	-	91.54%	60%	
Stroke Admissions : Swallowing Screen	78.46%	81.25%	83.33%	72.09%	80%	74.07%	75%	77.78%	-	-	-	-	-	77.45%	80%	
Stroke Admissions to Thrombolysis Time	80%	69.23%	61.54%	42.86%	75%	61.54%	75%	37.5%	-	-	-	-	-	37.5%	%	
Stroke Patients Spending 90% of Time On Stroke Unit (VSA14)	88.84%	94.23%	92%	92.86%	94.34%	88.24%	92.68%	88.89%	-	-	-	-	-	91.84%	80%	

Finance

Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target	YEF
Budgetary Performance	(£2,722)k	£224k	£436k	£135k	£16k	£611k	£232k	£5k	-	-	-	-	-	£1,660k	£0k	
Capital v Forecast	87.8%	100%	98.6%	99.7%	93.7%	74.5%	66.2%	96.6%	-	-	-	-	-	96.6%	95%	
Cash v Forecast	109%	97.9%	104.9%	108.1%	87%	93.5%	94.8%	97.2%	-	-	-	-	-	97.2%	95%	
CIP - Actual Performance	(£2,129)k	£1,773k	£1,218k	£1,298k	£1,516k	£1,743k	£1,002k	£1,370k	-	-	-	-	-	£9,921k	£9,525k	
Debt Service Cover	0.85	0.72	0.93	1.05	1.13	1.01	1.08	1.09	-	-	-	-	-	1.09	2.5	
EBITDA	£15,817k	£1,138k	£1,814k	£2,079k	£2,145k	£829k	£2,283k	£1,909k	-	-	-	-	-	£12,197k	£11,079k	
I&E (After Financing)	(£8,033)k	(£783)k	(£123)k	£183k	£201k	(£1,124)k	£346k	(£31)k	-	-	-	-	-	(£1,331)k	(£2,493)k	
Liquidity	7.22	6.1	5.76	5.41	6.28	5.16	6.03	5.78	-	-	-	-	-	5.78	0	
SLA Performance	£6,271k	£978k	£468k	£458k	(£761)k	(£406)k	(£380)k	(£455)k	-	-	-	-	-	(£97)k	£0k	
SLR Performance	(£8,032)k	(£782)k	(£123)k	£184k	£201k	(£1,124)k	£344k	(£31)k	-	-	-	-	-	(£1,331)k	£0k	

The Dudley Group NHS
NHS Foundation Trust

Appendix 1 (contd)

Integrated Performance Dashboard 2015/16

Performance

Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target	YEF
A&E - A&E Attendances Seen Within 4 Hours (%)	94.7%	98.6%	98.8%	99.1%	99.3%	98.5%	97.6%	98.9%	-	-	-	-	-	98.7%	95%	
Activity - A&E Attendances	99,928	7,895	7,940	8,137	8,052	7,700	7,986	8,092	-	-	-	-	-	55,802	46,312	
Activity - Community Attendances	415,662	34,397	33,050	35,066	36,362	32,417	35,065	35,013	-	-	-	-	-	241,370	255,702	
Activity - Elective Day Case Spells	44,639	3,620	3,418	3,978	3,925	3,393	3,680	3,941	-	-	-	-	-	25,955	25,886	
Activity - Elective Inpatients Spells	6,953	482	525	580	580	508	537	574	-	-	-	-	-	3,786	4,236	
Activity - Emergency Inpatient Spells	50,876	4,426	4,282	4,183	4,205	4,079	4,104	4,314	-	-	-	-	-	29,593	28,368	
Activity - Outpatient First Attendances	125,382	10,390	10,058	11,359	11,531	9,339	11,715	12,019	-	-	-	-	-	76,411	71,494	
Activity - Outpatient Follow Up Attendances	320,876	25,984	24,327	27,879	27,363	23,237	26,684	26,899	-	-	-	-	-	182,373	191,394	
Activity - Outpatient Procedure Attendances	57,196	4,308	3,956	4,833	4,528	4,043	4,553	3,661	-	-	-	-	-	29,882	34,187	
Cancer - 14 day - Urgent Cancer GP Referral to date first seen	96.7%	97.7%	96.4%	95.5%	95.4%	93.8%	94.1%	94.3%	-	-	-	-	-	95.3%	93%	
Cancer - 14 day - Urgent GP Breast Symptom Referral to date first seen	96%	100%	98.7%	100%	97%	96.8%	95.9%	98.5%	-	-	-	-	-	98.2%	93%	
Cancer - 31 day - from diagnosis to treatment for all cancers	99.7%	100%	100%	100%	100%	100%	99.3%	97.7%	-	-	-	-	-	99.6%	96%	
Cancer - 31 Day For Second Or Subsequent Treatment - Anti Cancer Drug Treatments	100%	100%	100%	100%	100%	100%	100%	100%	-	-	-	-	-	100%	98%	
Cancer - 31 Day For Second Or Subsequent Treatment - Surgery	99.6%	100%	100%	100%	100%	100%	100%	100%	-	-	-	-	-	100%	94%	
Cancer - 62 day - From Referral for Treatment following national screening referral	97.3%	82.4%	91.3%	95.2%	100%	93.3%	96.3%	100%	-	-	-	-	-	94%	90%	
Cancer - 62 day - From Urgent GP Referral to Treatment for All Cancers	87%	83.6%	81.9%	88.5%	83.8%	85.1%	83.5%	85.1%	-	-	-	-	-	84.8%	85%	
RTT - Admitted Pathways within 18 weeks %	91.6%	95.2%	95.3%	96.1%	95.6%	96.1%	94.3%	92.5%	-	-	-	-	-	95%	90%	
RTT - Incomplete Waits within 18 weeks %	95.4%	95%	95.2%	95.2%	95.6%	94.9%	95.1%	94.6%	-	-	-	-	-	95.1%	92%	
RTT - Non-Admitted Pathways within 18 weeks %	98.7%	97.7%	97%	98%	98.3%	98.1%	98.3%	97.5%	-	-	-	-	-	97.9%	95%	

Staff/HR

Description	LYO	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target	YEF
Appraisals	87.2%	88%	80.6%	81.5%	80.8%	80.3%	80.1%	78.4%	-	-	-	-	-	78.4%	90%	
Mandatory Training (Substantive)	80.68%	81.53%	82.13%	82.8%	82.35%	83.51%	83.16%	84.11%	-	-	-	-	-	84.11%	90%	
Sickness Rate (Performance Dashboard)	3.81%	3.49%	3.69%	3.66%	3.51%	3.20%	3.28%	3.84%	-	-	-	-	-	3.53%	3.50%	
Staff In Post (Contracted WTE)	4,181.19	3,963.83	3,947.41	3,923.27	3,899.41	3,895.81	3,917.53	3,952.33	-	-	-	-	-	3,952.33		
Vacancy Rate	9.42%	8.55%	8.91%	9.54%	10.10%	10.39%	9.97%	9.95%	-	-	-	-	-	9.95%	%	

Glossary:- LYO – Last Year Out-turn ; YEF – Year End Forecast

The Dudley Group NHS
NHS Foundation Trust

Appendix 2

Cancer Tumour Site – October 2015 – ****PROVISIONAL****

Month	Target	Target	Brain	Breast	Colorectal	Gynaecology	Haematology	Head and Neck	Lung	Other	Sarcoma	Skin	Upper GI	Urology	Total
Oct-15	2WW	93%	100.0%	97.5%	87.2%	94.7%	100.0%	95.3%	95.7%			94.4%	96.2%	94.7%	94.2%
	2WW - Breast Symptomatic	93%		98.4%										100.0%	98.5%
	First Treatment	96%		100.0%	96.0%	100.0%	100.0%	100.0%	100.0%			81.0%	100.0%	100.0%	96.4%
	Subs Anti-Cancer Drug	98%		100.0%	100.0%		100.0%		100.0%					100.0%	100.0%
	Subs Radiotherapy	94%													
	Subs Surgery	94%		100.0%	100.0%							100.0%		100.0%	100.0%
	62 Day Traditional	85%		100.0%	66.7%	80.0%	100.0%	80.0%	72.7%			100.0%	40.0%	93.1%	88.7%
	62 Day - Breast Symptomatic	85%		100.0%											100.0%
	Screening	90%		100.0%	100.0%										100.0%
	Upgrades	85%			100.0%	100.0%	100.0%		100.0%			100.0%	100.0%	93.3%	98.8%

Note that the above is a snap shot of the provisional performance which continues to change as more patient data is loaded and validated. As a result of the snap shot approach the figures may vary slightly from the figures in the main dashboard.

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 3 December 2015

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

CORPORATE OBJECTIVES

ALL

SUMMARY OF KEY ISSUES:

Update report on the specific projects.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF BOARD

Decision	Approval	Discussion	Other
			Y

RECOMMENDATIONS FOR THE BOARD

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

The Black Country Alliance CAN – November 2015

Welcome to the November edition of the Black Country Alliance CAN, your monthly update on news from across the alliance. The Black Country Alliance (BCA) Board met for the third time on November 25th. Among other issues discussed the Board agreed for the Chair of the Clinical Reference Group to attend future meetings and to establish a stakeholder reference group to involve and inform other organisations or representatives in the work of the Alliance.

Here is a brief update on the current projects being undertaken within the Black Country Alliance together with a roundup of other news items.

Stroke Services

The three Chief Executives, Medical Directors and stroke leads within the Black Country Alliance met during November to discuss stroke services. Further engagement sessions are planned through to the end of January. The BCA has been invited to present a proposal to the regional stroke review team. As well as developing the extensive work that has been done to date to review acute stroke units and hyper-acute stroke units, the BCA team agreed to also look at rehabilitation and home services with a view to a shared pathway approach for patients within the BCA geographical area. We want to create a sustainable model of excellence locally and will review options to mutually support each partner Trust, including for out of hours care, telemedicine and repatriation.

Terry Whalley, Black Country Alliance Programme Director, can provide more information – terry.whalley@nhs.net

Interventional Radiology

The work stream looking at Interventional Radiology have proposed a pilot of non-vascular services 7 days a week in 2016 that will begin by alternating between the acute sites already offering an Interventional Radiology service. The BCA Board agreed that the pilot should start in March 2016 and will have a shared rota involving colleagues from across all three Black Country Alliance Trusts.

Anne Baines, Director of Strategy at DGFT and Executive Sponsor for the Interventional Radiology work, can provide further details of the proposed pilot – anne.baines@dgh.nhs.uk

Rheumatology

Walsall Healthcare NHS Trust have successfully secured a locum consultant rheumatologist and interviews are taking place in early December for substantive consultant rheumatologists who will be Black Country Alliance appointments. This allows for substantial patient services at each Trust while we progress a shared BCA rheumatology service.

Dr Roger Stedman, Medical Director at SWBH and Executive Sponsor for the Rheumatology work, can provide further details of the arrangements – roger.stedman@nhs.net

Oncology Services

SWBH are making good progress with provision of consultant oncologists to the Trust, following notice received from University Hospitals Birmingham that their existing provision ends in April 2016.

The Trust is establishing a transitional local service for 2016-17 with a view to working with partner Trusts to establish a Black Country Oncology Service from 2017-18. It is proposed that the developing service spans existing common and rare tumour groups served by the Trusts. The BCA Board will examine how much oncology care can be safely delivered within the Black Country in the future.

Dr Roger Stedman, Medical Director at SWBH, can provide further information on the development of these ideas – roger.stedman@nhs.net

Procurement

The BCA Board considered whether there could be opportunities to benefit from some joint procurement activities and the Chief Executives agreed to meet with procurement leads at the three Trusts to discuss how to take this forward.

Terry Whalley, Black Country Alliance Programme Director, can provide more information – terry.whalley@nhs.net

How to get involved – Your Ideas

There is now an opportunity to send in your ideas for the work that the Black Country Alliance can prioritise in 2016/17. The BCA Board want to receive your proposals between now and the end of January 2016. These ideas will then be considered by at the February BCA Board meeting at which a number will be selected to add to the scope of BCA work for 2016/17.

To submit your idea, please complete the simple one page Summary on a Page attached, and send to Blackcountry.alliance@nhs.net as soon as possible or at the latest by 31 January 2016.

Date for diaries

Clinical Conference - the Black Country Alliance will be hosting its first clinical conference on February 5th 2016. This will be attended by around 50 clinical and nursing leaders from each of the three Trusts.

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

For queries email Blackcountry.alliance@nhs.net

Paula Clark
Chief Executive
The Dudley Group

Toby Lewis
Chief Executive
Sandwell and West Birmingham

Richard Kirby
Chief Executive
Walsall Healthcare

Enclosure 10

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd December 2015

TITLE:	**1. Quality Account – Update second Quarter 2015/16** **2. Quality Priorities - 2016/17** **3. Quality Metrics - 2015/16** **4. Actions from Deloitte Findings/Recommendations from Quality Report External Review 2014/15**		
AUTHOR:	Derek Eaves Professional Lead for Quality	**PRESENTER:**	Dawn Wardell Chief Nurse

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

SUMMARY OF KEY ISSUES:

1. The attached paper indicates the Trust's position at the end of the second quarter (with more uptodate figures for Infection Control) for the Quality Priority target areas. With regards to the five specific quality priority areas:-

Patient Experience – For inpatients, the Trust scores are above the national average and so this target is presently being met. Unfortunately, that is not the case for both outpatients and community. Actions being taken to try and rectify the situation are listed.

Pressure Ulcers – Due to the time lag of the assessment and investigation process into whether pressure ulcers are avoidable or not, it is difficult to come to a firm conclusion on whether the targets are being met but at present this looks to be the case but it is premature to be definitive about this.

Infection Control – There have been two post 48 hour MRSA bacteraemias in September so the target of zero for the year which was being met up to then is now not achieved. By mid-November the Trust has already reached its yearly target of 29 C. Difficile cases. The report discusses the avoidability or otherwise of those reported. All efforts are now being made to ensure that we have less than the 38 cases recorded last year (2014/15).

Nutrition/Hydration - The overall Trust score is 97% for the quarter (the same for Q1) which means the target is presently being met. Looking ahead to when all individual wards have to be 93% or above, this was not achieved in both quarters and so remedial action is being taken with these wards to ensure the final quarter target will also be achieved.

Mortality – At this time the partial picture (due to the 12 week time lag) shows a Trust average of over 99% for Q2. A more conservative estimate of the final position indicates that we will still exceed last year's target and also achieve this full year's target of 90% or over.

2/3. The Trust has to annually agree for the following year the Quality Priority topics and the Quality Metrics for the present year. The paper indicates the discussion on these at the last CQSPE meeting.

4. The paper also gives an update of the Trust's position with all of the recommendations from the Deloitte External Assurance Review of the Quality Report 2014/15.

IMPLICATIONS OF PAPER:

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

ACTION REQUIRED OF COMMITTEE:			
Decision	**Approval**	**Discussion**	**Other**
		✓	

RECOMMENDATIONS FOR THE BOARD: To note:

1) The latest position with the quality priority targets

2) Both the Council of Governors and the CQSPE will discuss the quality priority topics for 2016/17 in December and the latter will make a recommendation to the Board to ratify at its January meeting.

3) The CQSPE will discuss the quality metrics for 2015/16 in December and make a recommendation to the Board to ratify at its January meeting.

4) The actions from the external review of the 2014/15 quality report have been completed.

THE DUDLEY GROUP NHS FOUNDATION TRUST

1. QUALITY ACCOUNT UPDATE - SECOND QUARTER 2015

QUALITY PRIORITY 1: PATIENT EXPERIENCE. TARGETS: a) Achieve monthly scores in the inpatients Friends and Family Test (FFT) that are equal to or better than the national average. b) Achieve monthly scores in the outpatients FFT Test that are equal to or better than the national average. c) Achieve monthly scores in the community Friends and Family Test that are equal to or better than the national average.

April-September 2015 data and commentary

Quality Priority	April 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Trust inpatient FFT %	96	97	98	97	99	97						
National %	95	96	96	97	96	96						
Trust outpatient FFT %	84	82	82	88	90	89						
National %	92	92	92	92	92	92						
Trust community FFT	97	98	98	96	94	93						
National %	96	95	95	95	96	95						

It can be seen from the results that the Trust is achieving its inpatient target with the Trust results being above the national average. Unfortunately, that is not the case for a) the outpatients FFT since its commencement in April 2015 although the trend of the Trust results is upwards and b) the community FFT which has dipped below the national figure from August 2015. As a result of the latter, efforts are being made to:

a) improve the response rate (due to the possibility that patients with a negative reaction are more likely to respond compared to those who are satisfied with their experience). The Patient Experience Team is working closely with managers across the Trust to reinforce the importance of maintaining response rates on or above target. To support response rate growth, several initiatives that have been rolled out or scheduled to implement in the quarter include:

- Friends and Family App launched early September 2015
- Refreshed the Trust FFT test webpage September 2015
- Introduction of FFT SMS response option for A&E in Q4 and then phased roll out across the Trust by early 2016/17.

b) The Trust is analysing the comments received which are fed back to the lead staff in each of the outpatient areas so that improvements can be made to the patient experience. As part of this process we have introduced a 'You said, we have' initiative which includes having posters displayed in the appropriate areas.

Board Sponsor: Paula Clark, Chief Executive **Operational Lead:** Liz Abbiss, Head of Communications and Patient Experience

QUALITY PRIORITY 2: PRESSURE ULCERS: Hospital: a) Ensure that there are no avoidable stage 4 hospital acquired pressure ulcers throughout the year. b) Ensure that the number of avoidable stage 3 hospital acquired pressure ulcers in 2015/16 reduces from the number in 2014/15. **Community** a) Ensure that there are no avoidable stage 4 pressure ulcers acquired on the district nurse caseload throughout the year. b) Ensure that the number of avoidable stage 3 pressure ulcers acquired on the district nurse caseload in 2015/16 reduces from the number in 2014/15.

April-September 2015 Data

Hospital and Community
The quarterly figures are shown below for incidents of pressure ulcers:

	HOSPITAL			COMMUNITY		
Period	**2014/15**	**Apr-Jun 15**	**Jul-Sep 15+**	**2014/15**	**Apr-Jun 15**	**Jul-Sep 15+**
No. of stage 3	41	12	4	11	2	0
No. of Stage 4	1	0	0	0	0	0
Total	42	12	4	11	2	0

+Please note than these figures are very likely to change dependent on the outcomes of RCA investigations as to whether reported pressure ulcers are avoidable or unavoidable the results of which may only be available up to three months after the incident is reported.

April-September 2015 Commentary

The figures for Apr-Jun 2015 are now definite. For the second quarter there are a further 19 pressure ulcers that have been reported but not yet discussed at the pressure ulcer meeting and are therefore awaiting a decision as to whether they are avoidable or not. Only 4 of these are potentially for the hospital. Based on previous figures and outcomes it is unlikely they will all be avoidable which means hospital figures remain on track to meet trust objectives.
Community numbers remain low but there are 15 incidents awaiting discussion. Again, based on previous reports many of the community pressure ulcers are unavoidable but it is difficult at this point to predict numbers and more will be known for the next report once decisions are known. Again, the present situation suggests that the community figures remain on track to meet trust objectives.

Board Sponsor: Dawn Wardell, Chief Nurse
Operational Lead: Lisa Turley, Tissue Viability Lead Nurse

QUALITY PRIORITY 3: INFECTION CONTROL TARGETS: Maintain or reduce our MRSA and Clostridium difficile (C. diff) rates in line with national and local priorities. All cases will undergo a root cause analysis, the results of which will be discussed jointly by the Trust and Dudley Clinical Commissioning Group to agree on any avoidability/lapses in care. MRSA Bacteraemia (blood stream infections) target is to have no post 48hr cases; C. difficile is no more than 29 post 48hr cases in 2015/16.

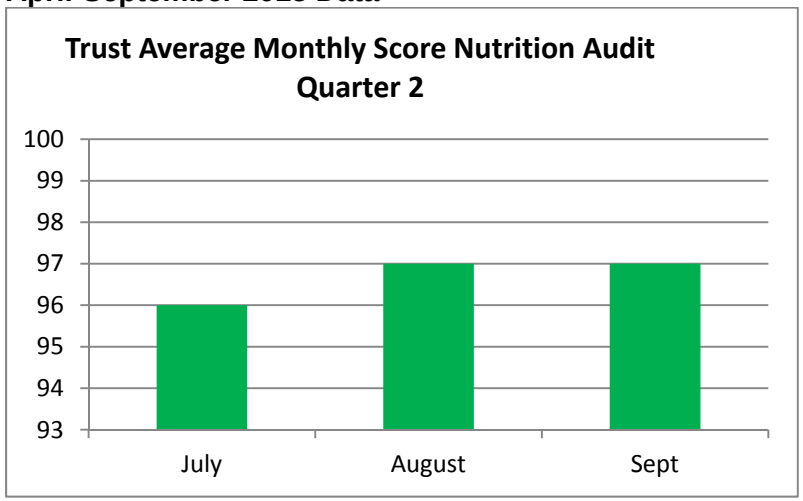
April 2015-todate Data and Commentary

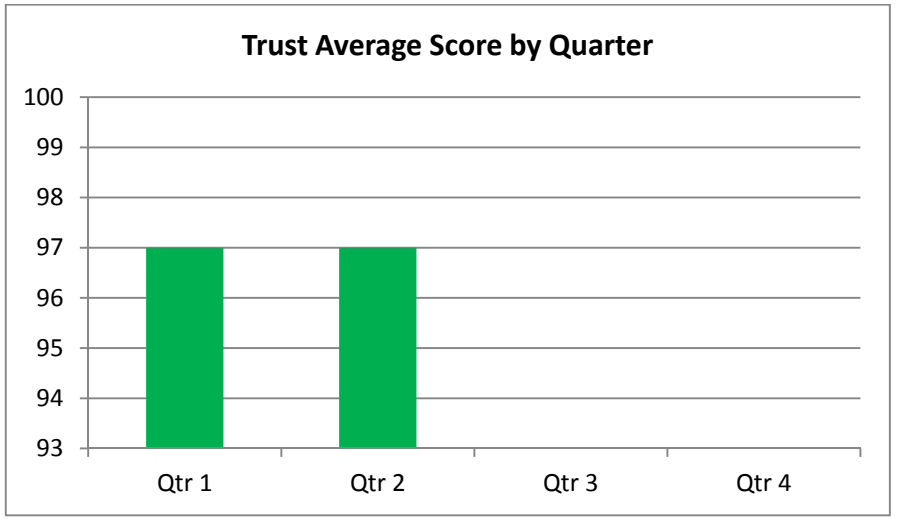
There were 3 MRSA bacteraemia identified during the month of September. Two of these cases were identified as post 48 hours and a post infection review is being led by the Trust. The other bacteraemia is identified as being a pre-48 hour case and a post infection review is being led by Dudley CCG. The threshold for Clostridium difficile for the financial year is 29 cases. As of mid-November, twenty nine post 48 hour cases have been identified and eleven of these cases had completed the process to determine avoidability. Following discussion with the CCG six cases had been determined as unavoidable as no lapses in care were identified. With the Trust having already reached its target for the year, all efforts are now being made to ensure that we have less than the 38 cases recorded last year (2014/15).

Board sponsor: Dawn Wardell, Chief Nurse **Operational lead:** Dr. E Rees, Director of Infection Prevention and Control

QUALITY PRIORITIES 4: NUTRITION/HYDRATION: Ensure that the overall score of the monthly nutrition and hydration audit (made up of 24 items): a) is 90 per cent or above in each of the first three quarters for the Trust as a whole b) has a 'Green' rating (93 per cent or above) in the final quarter for every ward in the hospital.

April-September 2015 Data





Key: Green – 93% and above Amber – 92% to 75% Red – Below 74%

April-September 2015 Commentary

The overall Trust score is again 97% for the second quarter which means the target is presently being met. Looking ahead to when all individual wards have to be 93% or above, there are some areas that aren't consistent with this target and so additional targeted training is being taken with these wards to ensure the final quarter target will also be achieved.

Board Sponsor: Dawn Wardell, Chief Nurse
Operational Leads: Kaye Sheppard, Head of Nursing-Medicine, Jenny Davies, Matron for GI and Renal Services, Rachel Tomkins, Matron for Elderly

QUALITY PRIORITY 5: MORTALITY. Ensure that 90 per cent of in-hospital deaths available for review undergo specialist multidisciplinary review within 12 weeks by March 2016.

July-September 2015 Commentary

Our Mortality Tracking Process includes clinical coding, validation, multidisciplinary specialist audit and where necessary senior medical and nursing review led by our Deputy Medical Director. This process takes up to 12 weeks in total to ensure that each and every death occurring in hospital is understood and that we are responsive to the information we gather from the process. We must also take into account those audits delayed as a result of issues beyond our control such as cases referred to the coroner. The 12 week target gives specialties up to 31st December 2015 for deaths occurring up to the end of September to be validated and audited. Therefore at this time we can only provide the results that are available so far for Q2 which show a Trust average which exceeds the target of 90% (see table below), which shows a significant improvement since the introduction of the target in April 2014.

It should be noted that that although Oncology has reviewed 54.4% of deaths using the Mortality Tracking System, this is an improvement from the previous position where no deaths were recorded or reviewed using the system. The Trust is assured that deaths in oncology have always reviewed in a cross organisational Multidisciplinary team meeting but participation in the Trusts' mortality review process by clinicians from partner organisations has been limited.

Latest Available Data: July-September 2015

Meeting or Exceeding 90% Target **Above 50%-Below 85%** **Below 50%** **N/A – No deaths applied**

	% audited within 12 weeks	Specialty	% audited within 12 weeks
Cardiology	100	Renal	86.7
Gastroenterology	100	Haematology	91.6
General Medicine	82.8	Oncology	54.5
Medical Assessment	100	Care of the Elderly	100
Respiratory	98.3	ENT	N/A
Stroke Medicine/Stroke Rehab	71.4	General Surgery	88.2
Diabetes	100	Urology	100
Endocrinology	100	Vascular Surgery	87.5
Rheumatology	N/A	T&O Rehabilitation	100
Gynaecology/Plastic Surgery	N/A	Trauma and Orthopaedics	100

Board sponsor: Paul Harrison, Medical Director **Operational lead:** Teekai Beach, Directorate Manager to Medical Director

2. SUGGESTIONS REGARDING QUALITY ACCOUNT PRIORITIES FOR 2016/17

On the 24th November the Clinical Quality, Safety and Patient Experience Committee (CQSPE) discussed the possible priority topics for next year. They looked at the present topics and different suggested topics that were made at a survey undertaken at the recent Annual Members meeting. The continuing use of Patient Experience, Pressure Ulcers, Infection Control and Nutrition/Hydration was generally agreed. It also was agreed that there are three further topics which are suitable for inclusion. These are pain control, falls and medicines management. There was also a debate about whether mortality as a topic should be retained as our systems of monitoring and investigating deaths are now of a high standard. It was decided not to make a decision at this time but to explore these possibilities further both with appropriate staff and the Governors. The CQSPE will make a decision at its December meeting.

3. QUALITY METRICS FOR QUALITY ACCOUNT 2015/16

As well as the requirement to have at least three quality priorities in the Quality Account, Monitor mandates that in Part Three of the report, Trusts should include three quality metrics for each of the three domains of quality. The Trust Board should agree these each year. Again, the CQSPE discussed the possible metrics to include in the 2015/16 report and decided to explore these further and make a decision at December's meeting.

4. ACTIONS TAKEN FOLLOWING RECOMMENDATIONS FROM DELOITTE'S REVIEW OF THE 2014/15 QUALITY REPORT

Each year, following the external audit of the quality report, the auditors may suggest some recommendations for the Trust. The Board was presented with Deloitte's report 'Findings and Recommendations from the 2014/14 NHS Quality Report External Assurance Review' earlier in the year. Below is an update of the recommendations and the actions taken:

THE DUDLY GROUP NHS FOUNDATION TRUST
ACTION PLAN FROM DELOITTE QUALITY REPORT EXTERNAL ASSURANCE REVIEW 2014/15

Indicator	Recommendation	Original Management Response	Who & Priority	Progress at November 2015
18 week referral-to-treatment	**1) Performance Reporting** The Trust should consider combining the Incomplete RTT tracking list with the number of RTT patients identified on the Open Pathway Report prior to submitting its monthly return.	The recommendation of merging the Open Pathway Report with the Incomplete RTT month end report prior to submission is one that we would support, however, not until there is assurance that the Open Pathway Report has been fully validated. The Trust has been working on validating the Open Pathway report since November 2014 but more work is required before the report is robust enough to be used as part of the monthly RTT submission. Until this is done, the Trust would not be showing an accurate RTT incomplete position.	K Shine (A Troth) HIGH	COMPLETED. The Open Pathway report is now fully validated. A single report combining the Open Pathway and Incomplete reports and this has been in place since September 2015.
18 week referral-to-treatment	**2) Staff Training** The Trust should consider targeted training for and communication with departments or staff who are repeatedly found to incorrectly record activity outcomes or fail to appropriately stop the clock, in line with national RTT guidance.	Yes, this is already done as a result of validating the over 18 week records, but will be extended to include any erroneous actions.	K Finlow (N. Hobbs/ J.Raden) HIGH	COMPLETED. Previous response is continuing, plus process has been adopted that any staff member that is incorrectly recording outcomes or failing to stop the RTT clock appropriately is being re-trained by our Access Team Manager.

18 week referral-to-treatment	**3) Sample Audits** In line with best practice, the Trust should consider undertaking sample audits across RTT lists. Audits should focus on data quality across the RTT pathways, as well as data completeness to monitor whether patients are being transferred between RTT lists appropriately.	Yes, records are reviewed as a result of validating the over 18 week records, but will be extended to include a random selection of RTT pathways each month to ensure accuracy.	K Finlow (N.Hobbs/ J. Raden) MEDIUM	COMPLETED. Over 18 week records are continued to be validated. This is Trust wide. In addition, when secretary training takes place the Access Team Manager is undertaking spot checks on the relevant consultants waiting list to ensure management of the waiting list is done correctly.
18 week referral-to-treatment	**4) Weekly and Monthly Reports** The Trust should consider using the weekly reports for their current review and validation purposes, but not to create the RTT lists for monthly submission. The Trust should consider using a full month extract to create the RTT lists in time for the submission deadline. This full month extract should be able to incorporate in-month validation and delayed entry of clinic outcomes.	The Information Department already produces a month end RTT report based on the weekly extracts together with a further month end report which looks for pathways that have had their outcome codes entered late, however, it does not currently look for pathways where a valid RTT status code was initially included in the weekly report but then subsequently changed with another valid RTT status code later in the month. Therefore, a new query needs to be created to look for these attendances where the RTT status code has been validated at a later date.	K. Shine (A Troth) MEDIUM	COMPLETED. Additional work undertaken between the Information Department and the Operational teams on other forward looking reports have negated this requirement.
62 day cancer waits	**5) Staff Training** The Trust should consider providing training to the Rapid Access Administrators to ensure that rescheduled appointments are not incorrectly recorded as DNAs and inappropriate adjustments are not applied.	The Trust will organise training. All Rapid Access Administrators to receive update training on the management of DNAs.	J. Gritton MEDIUM	COMPLETED. Reinforcement of DNA guidance and accurate recording of this information has taken place within the Rapid Access/MDT Team to ensure correct waiting time adjustments are made.

Nutrition reassessments	**6) Staff Training** The Trust should consider providing refresher training for Lead Nurses that undertake the NCI audit to ensure local guidance around weekly re-assessments is consistently interpreted.	With the changes in some of the criteria of the NCIs, in October 2014 all Lead Nurses attended a training event. All Lead Nurses will be reminded of the rules and processes involved with the system to reduce the risk of error.	K. Broadhouse (D Eaves) MEDIUM	COMPLETED. This was undertaken. Also, the NCI system has been further reviewed and further training and updated training materials produced. In addition, the smaller group of Matrons rather than Lead Nurses now undertake the audit to ensure greater consistency and accuracy of the data.

5. SUMMARY/CONCLUSION

The Board is asked to note:

1) The latest position with the quality priority targets
2) Both the Council of Governors and the CQSPE will discuss the quality priority topics for 2016/17 in December and the latter will make a recommendation to the Board to ratify at its January meeting.
3) The CQSPE will discuss the quality metrics for 2015/16 in December and make a recommendation to the Board to ratify at its January meeting.
4) The actions from the external review of the 2014/15 quality report have been completed.

Compiled by D. Eaves. November 2015

Enclosure 11

Committee highlights report to Board

Meeting	Meeting Date	Chair	Quorate	
Workforce & Staff Engagement Committee	24th Nov 2015	Ann Becke	yes	no
			yes	

Declarations of Interest Made

None

Assurances Received

1. The Trust People Plan RAG report was received, providing assurance that the plan is being implemented. Amber areas of slippage are mainly due to a vacancy in Organisational Development

2. An update on the staff friends and family test was received. Q2 of 2015/16 had 681 respondents. The number of staff who recommend the Trust as a place to a) receive care increased from 77% to 84% and b) work increased from 47% to 66%

3. Workforce KPI's were received for October 2015. Appraisal compliance has fallen and the performance ratings appear biased towards meet or exceed expectations. The appraisal and performance rating policy will be reviewed.

4. A leadership development update was received which set out details of the new programmes and attendees to date.

5. A report on medical appraisals and revalidation was received which detailed the Trusts compliance with the regulations. There will be an independent verification visit of the Trust by NHS England in February 2016.

6. A report detailing the work undertaken to implement the Nurse Agency Rules was received. The fall from 80%+ off-framework usage to 5% was noted. The work to implement the more recent price caps across all staff groups is likely to be challenging.

7. The minutes and actions from the LETG meeting on 1 October 2015 were received. A verbal update was given at the meeting, particularly focusing on the challenges facing medical recruitment and Physician Associates.

8. A verbal update was given on the steps being taken to maintain business continuity during the planning industrial action involving junior doctors.

Decisions Made / Items Approved

1. In order to reduce duplication and bureaucracy, the Staff Health & Wellbeing Group will no longer report to this committee, although it will continue to meet as a project / working group. Its assurance items will be dealt with by the Health & Safety Group.

2. The Committee received seven Trust policies for ratification.

Actions to come back to Committee / Group (Items Committee / Group keeping an eye on)

None specifically

Items referred to the Board / Parent Committee for decision or action

None

Enclosure 12

The Dudley Group NHS Foundation Trust

Paper for submission to Board of Directors on 03/12/2015

TITLE:	**RESEARCH & DEVELOPMENT**		
AUTHOR:	**M Marriott, R Storey, R&D Facilitators/ J R Neilson, Head of R&D**	**PRESENTER**	**Jeffrey Neilson, Head of Research & Development**

CORPORATE OBJECTIVE: SO1 through to SO6 (research seeks to improve all aspects of patient care)

SUMMARY OF KEY ISSUES: Update on research funding, recruitment, training, activity, staffing

IMPLICATIONS OF PAPER:

RISKS	**Risk Register No**	**Risk Score**	**Details:**
COMPLIANCE	**CQC**	**Y**	**Details:** Evidence to support compliance with Essential standards of Quality & Safety Outcome 16 – Assessing and monitoring the quality of service provision.
	NHSLA	**Y**	**Details:** Staff working on approved studies will be covered by normal NHS indemnity arrangements.
	Monitor	**Y**	**Details:** R&D activity included in the Annual Report.
	Other MHRA	**Y**	**Details:** SAEs for all drug/device studies are reported on study by study basis to MHRA by study sponsor

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		√	

RECOMMENDATIONS FOR THE COMMITTEE:

The Board of Directors is asked to receive the report, and note and approve its contents.

REPORT OF THE HEAD OF RESEARCH & DEVELOPMENT TO THE BOARD OF DIRECTORS ON 3rd DECEMBER 2015

Summary

Finance

The Research & Development (R&D) Department continues be funded primarily from National Institute for Health Research, Clinical Research Network (CRN) funding along with income from commercial research trials.

The department has received an indication of its core funding allocation from the CRN for the financial year 2016/2017 which shows a funding increase of £26 437 to a total of £563,154. In addition, the department bids for strategic funding from the CRN; which represented over £100 000 in additional funding for 2015/2016.

The department target for commercial income is to match the amount received from the CRN in 2015/2016 and 2016/2017.

Recruitment

Our recruitment activity based on the total number of written informed consents received between October 2014 and September 2015 reached 50% of the pre-set target. However, based on study complexity, the Dudley Group achieved 8276 ABF units (98% to target), comparing very favourably with the Royal Wolverhampton NHS Trust (8030), while Sandwell & West Birmingham Hospitals NHS Trust accrued 11292 units, having received approximately £200K more than Dudley in core funding. See page 2 of Appendix 1, dated October 2015.

Dudley's recruitment figures are now being boosted by the contribution of the biomedical scientists based in the Clinical Research Unit's laboratory, led by Jackie Smith. We have opened two simple blood sample studies, run by trained phlebotomists with research training, and overseen by clinicians from Chemical Pathology.

Activity

National Institute for Health Research portfolio studies only:

Number of recruiting studies as of 12/06/2015: 113 comprising 90 academic (a) and 23 commercial (c).

Closed studies still collecting data: 66 (a) 27 (c).

Recruiting non NIHR studies: 15 (a); 3 (c)

Publications for 2015 calendar year: 135 to date – this figure includes conference posters and articles.

Hidden benefits of research

The department has now established links with Dudley CCG. The team continue to identify studies that provide benefits to the Dudley health economy. For example, a new cancer study will represent considerable savings in chemotherapy costs, but requires funding for additional diagnostic costs to identify which patients will benefit from additional treatment.

Education and Training

Sue Merotra, Lead Research Nurse, is training to deliver the NIHR course, Master Class for Principal Investigators. Margaret Marriott provided two courses in September 2015 and has scheduled three half-day Good Clinical Practice (GCP) refresher workshops at Russells Hall Hospital during early 2016. This is mandatory training for all research active staff. The courses are also advertised on the NIHR Learn website. A full day Introduction to GCP course is planned for 22/06/2016. The local clinical research network's training programme is also available to Dudley research staff.

R&D office-based staff are training for and implementing two important operational changes: (a) the implementation of a network-wide project database (EDGE) which will aid recruitment; (b) changes to the application and set-up process for research studies, led by the Health Research Authority (HRA). The EDGE database is available from 23/11/2015; the next round of HRA changes will affect Dudley researchers from 30/11/2015.

Research Governance Implementation

A total of 31 studies were assessed by the protocol review sub-committee between 09/06/2015 and 22/11/2015.

Reported Serious Adverse Events (SAE) for the period 13/06/2015 – 23/11/2015:

Haematology: 21
Chemical Pathology: 7
Stroke 1

14 of these SAEs are thought to be drug related (1 in Stroke; 13 in Haematology).

(SAE is any event (related or not) to the treatment given in the trial; for example an emergency hospital admission whilst in a trial will be an SAE, regardless of the reason for admission. During cancer treatment, for example, hospital admissions are not unusual whether the patient is in a trial or not. The higher SAE figures for haematology reflect the number of haematological malignancy studies in this specialty.)

Staffing

The cancer studies team remains understaffed. The support provided by CRN WM is not sufficient to provide enough continuity to take on new oncology studies. This matter has been raised with the CRN Service Delivery Manager for Dudley Group.

- A new 1.00 WTE dispensary trials pharmacist came into post on 17/08/2015.

- A new 1.00 WTE Research Support Officer commenced on 20/07/2015.

- The Radiology Department research lead role is now shared between Drs Adrian Hall and Aabha Sinha.

- CRN research funding is being used to support fixed term data manager posts to assist the cancer and generic nurse teams.

Issues

- We are not opening new oncology studies due to lack of research nurse time. 1.00 WTE Band 6 research nurse has returned to duty after sickness. However, a 1.00 WTE Band 7 nurse has been replaced with 0.4 WTE Band 6 Wolverhampton nurse and 0.4 WTE of Dudley research nurse time, taken from the rheumatology team. This does not provide sufficient continuity or the capability and capacity to negotiate study set up while continuing to care for and recruit research participants.

- The second issue relates to the completion of Siemens-generated paperwork required for Siemens MES to undertake safety checks of equipment loaned to the Trust for specific research studies. A number of equipment suppliers have refused to sign the required Siemens FHC608 form. An information sheet has been developed by R&D to explain the relationship between the PFI partners; this has partially helped. One equipment supplier still refuses to sign, a situation that will effectively prevent recruitment to a new commercial study.

- Case note availability update: research staff can now email two named contacts in the Medical Records Department to request urgent case notes for research purposes. Delays persist as Medical Records try to clear their backlog.

Recommendations

The Board of Directors is asked to receive the report, and note and approve its contents.

APPENDIX 1

NIHR Report, October 2015

National Institute for Health Research

Clinical Research Network
West Midlands

The Dudley Group NHS Foundation Trust

Trust Report

October 2015

Recruitment data is

- *as provided by national CRN Coordinating Centre on* **09/11/2015**
- *based on recruitment figures uploaded by individual study teams by 10pm the previous night*
- *reported up to the end of previous month only to reflect more accurate data due to upload delays.*

Enquiries: servicedesk.crnwestmidlands@nihr.ac.uk

HLO 1: Increase the number of participants recruited at your Trust into NIHR CRN Portfolio studies

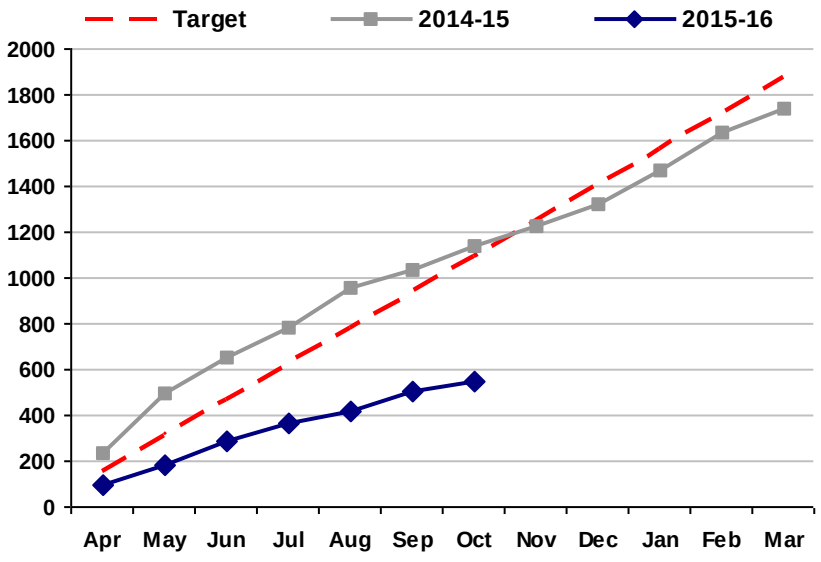
Full year target	1881
Pro rata	1097
Recruits to date	544

Performance 50%

>= 100% | >= 90% | < 90%

Type of Study	Studies		Recruits	
Commercial	9	*13%*	60	*11%*
Non-Commercial	59	*87%*	484	*89%*
	68		**544**	

	This year Target	This year Recruitment	Last year
Apr	157	99	233
May	314	184	497
Jun	470	285	651
Jul	627	368	782
Aug	784	419	953
Sep	941	508	1031
Oct	1097	544	1136
Nov	1254		1230
Dec	1411		1325
Jan	1568		1469
Feb	1724		1635
Mar	1881		1740



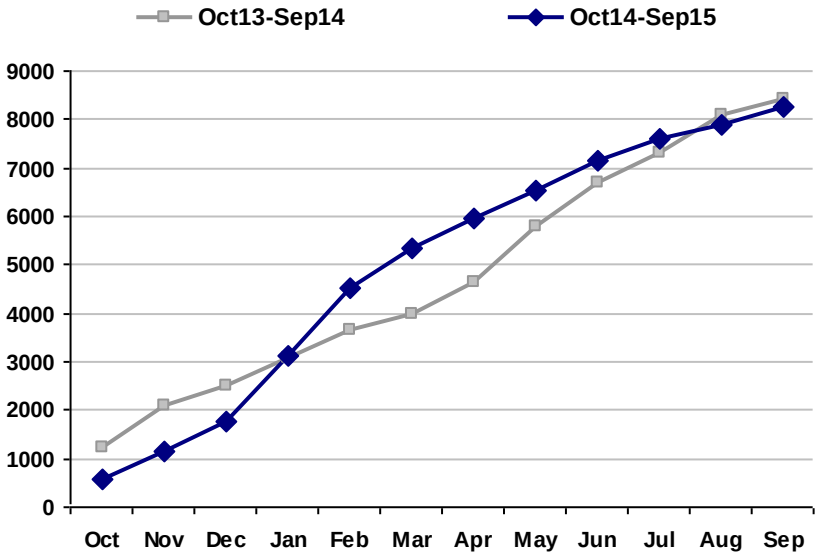
Recruitment converted to Activity Based Funding units for your Trust

Previous year	8430
This year	8276

% of Previous year 98%

>= 100% | >= 90% | < 90%

	Oct13-Sep14	Oct14-Sep15
Oct	1249	584
Nov	2083	1133
Dec	2489	1777
Jan	3076	3130
Feb	3677	4511
Mar	3971	5332
Apr	4644	5953
May	5796	6541
Jun	6712	7163
Jul	7332	7612
Aug	8114	7909
Sep	8430	8276



Comparison of all Organisations in CRN:West Midlands.

Recruitment in FY 2015-16, up to end of last month

Key: Recruitment >= Pro rata target | Recruitment >= 90% of Pro rata target | Recruitment < 90% of Pro rata target

Organisation		Target	Pro rata *	Recruits to date	% of pro rata
SSSFT	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	620	362	754	208%
P Care	Primary Care	14033	8186	14765	180%
DWMHPT	Dudley and Walsall Mental Health Partnership NHS Trust	220	128	214	167%
BCPFT	Black Country Partnership NHS Foundation Trust	120	70	115	164%
SSTPT	Staffordshire and Stoke On Trent Partnership NHS Trust	650	379	564	149%
WVT	Wye Valley NHS Trust	246	144	157	109%
UHBNHSFT	University Hospitals Birmingham NHS Foundation Trust	5587	3259	3300	101%
BSMHFT	Birmingham and Solihull Mental Health NHS Foundation Trust	930	543	536	99%
BCH	Birmingham Children's Hospital NHS Foundation Trust	1413	824	807	98%
RWT	The Royal Wolverhampton NHS Trust	2000	1167	1131	97%
SATH	Shrewsbury and Telford Hospital NHS Trust	1800	1050	1017	97%
HEFT	Heart of England NHS Foundation Trust	7205	4203	4051	96%
WHCT	Worcestershire Health and Care NHS Trust	60	35	33	94%
UHNM	University Hospitals of North Midlands NHS Trust	2901	1692	1466	87%
SWFT	South Warwickshire NHS Foundation Trust	670	391	329	84%
CWPT	Coventry and Warwickshire Partnership NHS Trust	970	566	469	83%
SWBH	Sandwell and West Birmingham Hospitals NHS Trust	2718	1586	1262	80%
UHCW	University Hospitals Coventry and Warwickshire NHS Trust	5146	3002	2374	79%
GEH	George Eliot Hospital NHS Trust	652	380	300	79%
BCHC	Birmingham Community Healthcare NHS Trust	425	248	189	76%
WHT	Walsall Healthcare NHS Trust	310	181	119	66%
BHFT	Burton Hospitals NHS Foundation Trust	821	479	312	65%
BWNFT	Birmingham Women's NHS Foundation Trust	6000	3500	2191	63%
WAHT	Worcestershire Acute Hospitals NHS Trust	1340	782	422	54%
RJAH	The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Tr	1250	729	364	50%
DGNHSFT	The Dudley Group NHS Foundation Trust	1881	1097	544	50%
NSCHT	North Staffordshire Combined Healthcare NHS Trust	92	54	25	47%
ROHNHSFT	The Royal Orthopaedic Hospital NHS Foundation Trust	1260	735	270	37%
WMAS	West Midlands Ambulance Service NHS Foundation Trust	455	265	83	31%
SCH	Shropshire Community Health NHS Trust			11	
Non NHS	Non NHS			131	
** Pro rata target is based on the number of complete months which have elapsed.*		**61775**	**36035**	**38305**	

HLO 2: Increase the proportion of studies in the NIHR CRN Portfolio delivering to recruitment target and time.

Studies that have CLOSED in 2015-16 only, where your Trust is classed as Lead

	Pass	Fail	Result
HLO5a Commercial	0	0	N/A
HLO5b Non-commercial	0	0	N/A

HLO 3: Increase the number of commercial contract studies delivered through the NIHR CRN

Number of Commercial Studies OPENED, compared with previous year.
Based on Date of NHS Permission in each financial year.

	2014-15 Total	Pro rata target	2015-16 year to date	% of Pro rata target opened this Year
Your Trust	9	5.25	7	133%
Other Trusts (combined)	309	180.3	124	69%

HLO 4: Reduce the time taken for NIHR studies to achieve NHS permission through CSP

This measure is not RAG-rated at Trust level and is provided for information only, to show how your Trust contributes to this CRN measure.

Proportion of studies achieving the 15-day CSP Process Improvement target

	Pass	Fail	Result
where your Trust is the Lead Trust for a study (if any)	1	0	100%
where your Trust is a Participating Site in a study	22	0	100%

HLO 5: Reduce the time taken to recruit first participant into NIHR CRN Portfolio studies

Measure: Number of studies achieving first recruit within 30 days of permisson.

Studies are counted only where the first participant HAS been recruited, in the current financial year.

	Pass	Fail	Result
HLO5a Commercial	0	0	N/A
HLO5b Non-commercial	1	6	14%

Enclosure 13

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors
On 3rd December 2015

TITLE	**Corporate Performance Report - October (Month 7)**		
AUTHOR	**Paul Taylor** **Director of Finance and Information**	**PRESENTER**	**Jonathan Fellows** **F & P Committee Chairman**
CORPORATE OBJECTIVE: S06 Plan for a viable future			
SUMMARY OF KEY ISSUES: **Summary reports from the Finance and Performance Committee meeting held on 26th November 2015**			

RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Risk to achievement of the overall financial target for the year**
COMPLIANCE	**CQC**	**Y**	**Details:** **CQC report 2014 now received, and Trust assessed as "Requires Improvement" in a small number of areas.**
	NHSLA	**N**	
	Monitor	**Y**	**The Trust remains on monthly monitoring by Monitor.** **Monitor has confirmed that the Trust is in breach of its authorisation conditions regarding future financial sustainability. Undertakings have been signed by Trust to resolve this position**
	Other	**Y**	**Details:** **Significant potential exposure to performance fines by commissioners**

ACTION REQUIRED OF BOARD:			
Decision	**Approval**	**Discussion**	**Other**
			X
RECOMMENDATIONS FOR THE BOARD: **The Board is asked to note the contents of the report.**			

The Dudley Group NHS
NHS Foundation Trust

Meeting	Meeting Date	Chair	Quorate	
			yes	no
Finance & Performance Committee	26th November 2015	Jonathan Fellows	yes	

Declarations of Interest Made

None

Assurances Received

- **The October performance of a £0.031m deficit fell short of plan but the year-end forecast position of £3.133m remains achievable**
- **Key issues that may affect that position are:**
  - The continued lower levels of activity being undertaken, particularly outpatients and community attendances which are significantly below plan;
  - The level and cost of agency staff, particularly given increasing numbers of registered nurse and medical staff vacancies;
  - The extent of contract penalties and other income not received from CCGs and Trusts in-year although several key issues had been resolved;
- **New Qualified Nurse agency controls now in place with Trust required to maintain spend within target thresholds (October performance was 4.8% against 4% target).**
- **Further agency controls regarding use of off-framework agencies and price caps introduced on all agency staff groups from 23/11/15.**
- **The cash-flow and statement of balances position of the Trust were slightly below plan in October.**
- **Capital expenditure to October was fractionally under plan but is forecast to spend in full. Concern was raised regarding the number of potential sizeable developments that are working through the system.**
- **Key performance targets are being met with exception of RTT waits (Urology and Gastroenterology), Diagnostic Waits (Non Obstetric Ultrasounds) and Infection Control (confirmed that C-Diff fines will be based on lapses in care).**
- **The financial recovery plan (FRP) is forecast to achieve £16.4m of a planned target of £16.7m (improvement of £0.3m from last month). Plans are also in place to produce project summaries for all 2016-17 FRP plans by the end of November 2015 in preparation for Monitor visit in December.**
- **Further assurance/update reports were received for IT, Nursing, Allocate, Cancer Performance, Facilities & Estates and Procurement. Key points to note were as follows:**

- Summary report relating to IT EPR consultancy project out for comment with focus on cultural change, developing dashboard for 65 KPIs that represent Trust, moving ahead with project to move community NCRS data to Oasis;
- Confident of achieving Q3 cancer targets but new requirement to review patients waiting over 104 days (12 patients all waiting at RWH);
- Trust capability concerns raised regarding electrical infrastructure

Decisions Made / Items Approved

- **Future Allocate updates to be included as a slide within Nursing update report.**

Actions to come back to Committee

- **Plan mapping expected starters/leavers within Nursing and the associated impact on key agency targets**
- **Separate report summarising the Trust performance against the new agency controls**
- **Rectification plan for Diagnostic waits**

Items referred to the Board for decision or action

- **None**

Enclosure 14

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on 3rd December 2015

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

CORPORATE OBJECTIVE:

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

SUMMARY OF KEY ISSUES:

The Trust has a CIP target of £16.7m for 2015/16. The Trust has achieved £9.92m CIP against a year to date plan of £9.54m. However, we are forecasting to achieve £16.36m against a full plan of £16.70m. This is a forecast deficit position of £340k an improvement on the previous month.

Transformation Executive Committee (TEC) met on 16th November to:

- Review overall CIP delivery status and progress.
- Scrutinise Exception Reports for projects off plan and agreed mitigations for the shortfall that will be reported next month.

The detailed position has also been presented to Finance and Performance Committee on 26th November 2015.

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

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

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

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

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

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

ACTION REQUIRED OF COMMITTEE

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Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE COMMITTEE

Note progress during October, delivery of CIP to date and the current forecast outturn proposal

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

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

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

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

The Dudley Group NHS
NHS Foundation Trust

Trust Board of Directors

Service Transformation and PMO Update

3rd December 2015

Executive Summary

The Trust has an overall Cost Improvement Programme (CIP) target of £16,701k in 2015/16. To support this, the Trust has developed 34 projects to deliver savings in 2015/16. The Trust has identified provisional plans for 2016/17, made up of 39 projects which are forecasted to achieve £12,400k CIP savings.

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

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

Transformation Executive Committee (TEC) met on 16th November to review the current CIP status. A summary of CIP performance as at Month 7 is provided below (with supporting detail overleaf):

CIP Project Plans	Full Year Plan	YTD Plan	YTD Actual	YTD Variance	Y/E FOT	Y/E FOT Variance
TOTAL	£16,701k	£9,537k	£9,921k	£384k	£16,361k	-£340k

Based on the Month 7 position, the Trust has achieved 59% of the full year plan and is **£384k** ahead of year to date plan. However, to date the Trust is forecasting under performance of **£340k** against the **£16,701k** CIP plan. TEC reviewed all projects for performance against planned delivery and agreed mitigations for the shortfall that will be reported next month.

Of the 34 projects due to deliver savings in 2015/16, all 34 Project Initiation Documents (PIDs) have been approved by the Transformation Executive Committee (TEC) and Quality Impact Assessment (QIA) panel. The **BPT Hip Fragility** and **Orthodontics Income** PIDs were approved by TEC this month.

The Trust has identified 39 projects for delivery in 2016/17. Of these, 5 have been approved by TEC and the QIA panel. A number of the provisional plans were submitted for TEC review this month.

Executive Summary

Figures reported in £000's

	Planned	Actual	Forecast	Variance
FYE	£16,701	£9,921	£16,361	-£340
YTD	£9,537	£9,921	£9,921	£384

Exec Lead : Paul Taylor			Click for Details
Planned Recurrent	£3,357	Planned Non Recurrent	£645
Forecast Recurrent	£4,487	Forecast Non Recurrent	£645

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

Value for money Infrastructure

	Planned	Actual	Forecast	Variance against Plan
FYE	£4,002	£3,075	£5,131	£1,130
YTD	£2,334	£3,075	£3,075	£740

Keeping People Closer to Home

	Planned	Actual	Forecast	Variance against Plan
FYE	£0	£11	£28	£28
YTD	£0	£11	£11	£11

Exec Lead : Paul Bytheway			Click for Details
Planned Recurrent	£2,873	Planned Non Recurrent	£300
Forecast Recurrent	£3,421	Forecast Non Recurrent	£300

Exec Lead : Julie Bacon			Click for Details
Planned Recurrent	£9,331	Planned Non Recurrent	£125
Forecast Recurrent	£7,393	Forecast Non Recurrent	£63

Delivering Efficiency and Productivity

	Planned	Actual	Forecast	Variance against Plan
FYE	£3,173	£2,434	£3,746	£573
YTD	£1,786	£2,434	£2,434	£648

Workforce

	Planned	Actual	Forecast	Variance against Plan
FYE	£9,526	£4,401	£7,455	-£2,071
YTD	£5,416	£4,401	£4,401	-£1,015

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