The Dudley Group NHS
NHS Foundation Trust

Board of Directors Agenda
Thursday 5th December 2013 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 – P Assinder**		J Edwards	To Note	9.30
2.	**Declarations of Interest**		J Edwards	To Note	9.30
3.	**Announcements**		J Edwards	To Note	9.30
4.	**Minutes of the previous meeting**				
	4.1 Thursday 7th November 2013	Enclosure 1	J Edwards	To Approve	9.30
	4.2 Action Sheet 7th November 2013	Enclosure 2	J Edwards	To Action	9.30
5.	**Patient Story**	Video	D Mcmahon	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 Clinical Quality, Safety and Patient Experience Committee Exception Report including Mortality Report	Enclosure 4	D Bland	To Note & Discuss	10.00
	7.3 Infection Prevention and Control Exception Report	Enclosure 5	D Mcmahon	To Note & Discuss	10.10
	7.4 Keogh Review Progress Update	Enclosure 6	P Clark	To Note & Discuss	10.20
	7.5 Francis Report	Enclosure 7	P Clark	To Note & Discuss	10.30
	7.6 Risk and Assurance Committee Exception Report	Enclosure 8	A Becke	To Note & Discuss	10.40
	7.7 Quality Accounts Report	Enclosure 9	D Mcmahon	To Note	10.50
	7.8 Information Governance Report	Enclosure 10	R Callender	To Note	11.00
	7.9 Stroke Strategic Review Process	Enclosure 11	R Beeken	To Note	11.10
	7.10 Emergency Plans Assurance Report	Enclosure 12	R Beeken	To Note	11.20
	7.11 How to ensure the right people, with the right skills, are in the right place at the right time	Enclosure 13	D Mcmahon	To Note & Discuss	11.30
	7.12 Diabetes Mandatory Training	Enclosure 14	A Reeves	To Note	11.40
8.	**Finance**				
	8.1 Finance and Performance Report	Enclosure 15	D Badger	To Note & Discuss	11.50

9.	**Date of Next Board of Directors Meeting** 9.30am 9th January, 2014, Clinical Education Centre		J Edwards		12.00
10.	**Exclusion of the Press and Other Members of the Public** To resolve that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest. (Section 1 [2] Public Bodies [Admission to Meetings] Act 1960).		J Edwards		12.00

The Dudley Group NHS
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Minutes of the Public Board of Directors meeting held on Thursday 7th November 2013 at 9:30am in the Clinical Education Centre.

Present:
John Edwards, Chairman
David Bland, Non Executive Director
Ann Becke, Non Executive Director
Richard Miner, Non Executive Director
Richard Beeken, Director of Strategy, Performance and Transformation
Paula Clark, Chief Executive
Paul Assinder, Director of Finance and Information
Denise McMahon, Nursing Director
Paul Harrison, Medical Director

In Attendance:
Helen Forrester, PA
Elena Peris - Cross, Administrative Assistant
Liz Abbiss, Head of Communications and Patient Experience
Rebecca Edwards, Deputy General Manager
Mandy Aworinde, Clinical Nurse Specialist

13/065 Note of Apologies and Welcome

Apologies were received from Jonathan Fellows, Non Executive Director, David Badger, Non Executive Director and Richard Cattell, Director of Operations

13/066 Declarations of Interest

There were no declarations of interest received.

13/067 Announcements

The Board made note of their congratulations to the Council of Governors for winning the leadership award at the Health Education West Midlands Leadership awards, the Council of Governors have now been shortlisted for the national awards.

13/068 Minutes of the previous meeting on 3rd October, 2013 (Enclosure 1)

Paul Harrison, Medical Director asked for the minutes to be amended at page 5 where he spoke about the electronic antibiotic prescribing, he asked for the minutes to read; 'Paul Harrison, Medical Director pointed out that a significant potential factor in preventing us from further improving in this area is antibiotic prescribing. On discussing this with Clinical Directors and others it is clear that electronic prescribing would help improve this.'

David Bland, Non Executive Director asked for his comment on the Integrated pioneer bid on page 4 to read, ' David Bland noted his concern that The Dudley Group is not represented on the Health and Wellbeing Board.

13/069 Action Sheet 3rd October, 2013 (Enclosure 2)

13/069.1 Charitable Funds- Georgina Chairs meeting.

This action has been completed.

13/069.2 Chief Executives Report – Georgina Unit, Patient Experience.

This has been included within the Chief Executives report.

13/069.3 Francis Report

This is on the Agenda at item 7.4

13/069.4 Patient Story

The action on the sufficient supply of headphones on wards has been completed.

Ann Becke, Non Executive Director pointed out that she attended a patient safety walkround on B2 and they found that they still had not received a supply of headphones.

The Chief Executive informed the Board that it was the responsibility of the ward to inform Communications when they need extra supplies of headphones.

Liz Abbiss assured the Board she would contact B2 and help them receive the headphones.

13/069.5 Risk and Assurance – profile to the Finance and Performance Committee.

Paul Assinder, Director of Finance and Information informed the Board that this action had been completed; he added that Kevin Shine, Deputy Director of Information is putting a lot of his time into this.

13/069.6 Audit Committee- Sickness absence.

This action has been completed.

13/069.7 Quarterly Safeguarding Report

This is on the Private Board Agenda.

13/070 Patient Story - Maternity

Denise McMahon presented, verbally, a letter received from a patient, explaining that there is not a hard copy included in the papers due to the vast amount of personal information included within it. This letter had been chosen as it was a community based experience.

The Chief Executive asked if the mentioned staff had been given the positive feedback.

Denise Mcmahon assured the Board that they had, she made note of how it was positive to see that although a bite with cellulitis would not be classed as a major concern from a hospital perspective it was clear that this was distressing for the patient and consequently the hospital and community staff worked well as a team to ensure he had fast and efficient care.

Ann Becke, Non Executive Director added that this story showed how being flexible for the patient improved their overall patient experience.

13/071 Chief Executive's Report (Enclosure 4)

The Chief Executive presented her report including:

Cancer Survey: The Chief Executive informed the Board that we were working on the action plan; she made the Board aware that she had no doubts that the Colchester events could not be repeated here as our system is robust. When the CQC, Chief Inspector of Hospitals (Mike Richards) review team are here we will be asked to give them this assurance.

Friends and Family Test: The ED token system has started and has substantially increased the amount of feedback we receive from 1% to 27.5%. The card system is still available alongside this. The national roll out into Maternity has been delayed however; we have taken the decision to trial the system in our Maternity unit. The National data from the Friends and Family tests results are due out today,7th November.

95% 4 hour ED wait target: We have experienced a bad start to quarter 3 and are taking a number of measures to set us back on track including a 'Director of the Day' initiative that has started this week. Richard Cattell, Director of Operations will still have the executive responsibility for capacity however Directors with an operational background are taking part in a daily rota to assist and allow time for Richard Cattell to give other operational management issue across the Trust sufficient time.

Another method of improving the situation that we have taken into consideration is having an on-call Manager on site into the evening. The Chief Executive added that the target for this quarter remains achievable but it will be a huge challenge.

The Chairman agreed with the changes to capacity management to support the Director of Operations and noted that we are doing all we can to deal with the symptoms of delays in waiting times but asked how we are addressing the long term causes as this is a very a volatile area.

Paul Harrison, Medical Director pointed out that there has been a lot of press coverage lately on the rise in numbers of frail elderly being seen in ED: a recognition that this is one of the big factors causing increased delays in ED, as their care is often more complex.Wwe are working at almost full capacity; with not much headroom to cope with any further increases in activity over the winter period.

The Chief Executive expressed her concern that we are still having too many delayed discharges. The Board were informed that Matrons are now addressing capacity issues for the first few hours of each day. This is to allow better planning of discharges and capacity management. Operations were looking at room space in ED to deal with any surges of patients.

Richard Beeken, Director of Strategy, Performance and Transformation commented that it is not the number of attendees that is causing a problem; it is the case mix and acuity of patients that has changed significantly with enhanced care needs, that is delaying the transfer of patients.

Paul Harrison, Medical Director suggested a strong reminder to the organisation that the Trust is struggling to achieve the 95% target in the Emergency Department. .

The Chairman and the Board endorsed the Director of the Day initiative noting that the Trust is not alone on the struggle with the 4 hour ED wait target and other Trusts are also seeing the same pressure.

13/072 Quality

13/072.1 Clinical Quality, Safety and Patient Experience Committee (Enclosure 5)

David Bland, Committee Chair, presented the Exception Report given as Enclosure 5. He mentioned that the reports are out of sync with Board however we will get back on track next month. The Board noted the following key points:

- **Quality Dashboard:** The CQC are bringing in a new model from April 2014 with a new set of indicators. There is still no certainty of what the indicators will be.

- **Ward Based Pharmacists:** The Committee received a good presentation and it was approved at the Finance and Performance Committee. Richard Beeken informed the Board that this is being rolled out in December.

- **Serious Incident Monitoring Report:** There were 8 new incidents in August however none breached the 2 day reporting and none breached the completion of the RCA within the agreed time scales. The Committee have supported the closure of the 3 SI's recommended.

Paul Harrison pointed out that the Mortality reporting is out of sync due to there not being meeting in August; we must ensure we catch up with this.

13/ 072.2 Audit Committee (Enclosure 6)

Paul Assinder, Director of Finance and Information presented the Audit Committee Report in Jonathan Fellows' absence, including the following issues:

External Audit: The Committee met on the 15th October and considered the external audit plans for the upcoming audit process. Deloitte have made point that 'going concern' reviews will be a bigger feature of audits.

Quality Accounts: There are three local indicators still to be determined. Deloittes have noted the deadline for accounts and the reports have all been brought forward. The Board agreed to delegate authority to sub committees of the Board to sign off the Quality Accounts.

Charitable Funds Audits: The Plan has been approved by the Board

Clinical Audit: A further 50 recommendations have been included in the plan and excellent progress and management of the clinical audit process has been made.

Internal Audit: A further 5 internal audit reports have been finalised, three of which had a red rating around the following:

- European Working Time Directive: They could not find evidence for assurance around this however the Allocate system will provide this information.
- Pre employment checks for bank workers: There was some inconsistencies found, the checks are undertaken by departments and directorates and so centralising this work is being considered.
- Internal Audit on Appraisals: there were inconsistencies around the documentation used and filing in personal files.

The Committee had debated the need for NEDs involvement in the tenders over the value of £175,000. It was agreed this is good practise and so we will continue to do this however it was suggested we implement a rolling rota for NEDs involvement.

The Board approved the external audit plans and the early draft of the Annual Report to be considered at the Finance and Performance Committee, they took note of the 3 red opinions and actions taken by the Audit Committee. Approval was given to the involvement of NEDs in the tendering process.

David Bland, Non Executive Director asked for this to be subject to defining levels of requirement.

Ann Becke, Non Executive Director requested clarification as to what parts of the process they need to be involved in.

Clarification is needed on how much time commitment is needed from a Non Executive Director during a tender process.

13/072.3 Infection Prevention and Control Exception Report (Enclosure 7)

Denise McMahon, Director of Nursing, presented the Infection Prevention and Control Exception Report given as Enclosure 7**.** Board members noted the following issue:

C.Diff: The Board noted the concerning figures of C-diff, the Trust ended with 5 cases in October and we already have 2 in November, we are now on 29 against a target of 38. Urgent meetings have been held this week to look for connections. The cases have all been found on different wards and the only connection is that all the patients were on peg feeds, an RCA is in progress.

Denise McMahon informed the Board that it has been decided the Trust will be using a different cleaning fluid called Biosolve; the company have offered to give us a one month's free trial, it is important we continue to act pro-actively.

Denise reminded the Board that the financial and reputational effects of not hitting the C.diff target would be damaging.

The Board noted that interviews for a Matron in Infection Control are taking placing today.

Paul Harrison, Medical Director pointed out that we were not as good as some other trusts at antimicrobial prescribing.

Denise McMahon agreed that this was still an issue, she expressed her concern that we will be one microbiologist down for 12 weeks which may slow down the progress we are making with antimicrobial prescribing.

Paul Harrison pointed out that we do not have a system that automatically monitors prescribing; we currently rely on consultants doing this manually.

Paul Assinder, Director of Finance and Information asked if we have assurance we are doing everything we can.

Denise McMahon confirmed that we are working well against the action plan and the only weak area is the antibiotic prescribing.

The Chairman expressed his concern that if we continue along the current trajectory we will have 50 against a target of 38 leading to a definite fine from the CCG, we need to ensure constant attention is given to this.

Denise McMahon agreed and added that individual conversations need to be held with individuals who are not complying with infection control measures.

The Chairman took note of the good results on MRSA and Norovirus and also the concerns over the Trusts position with C-diff.

The Chief Executive pointed out the importance of improving our figures from last year so that we can demonstrate year on year reduction in C.Diff cases.

Denise McMahon assured the Board that she would bring the results of the RCAs to the next Board meeting.

The Board noted the position and the work needed on antibiotic prescribing and dealing with outliers in performance.

13/072.4 Keogh Review Progress Update (Enclosure 8)

The Chief Executive presented the Progress update given as enclosure 8.

The Board were reminded that the green highlighted parts of the table mean the action is on track and the Blue parts mean that action has been completed.

The Chief Executive assured the Board that she was working closely with Liz Abbiss, Head of Customer Relations and Communications to get the patient experience action which is highlighted as amber back on track, a meeting is being held with the CCG and Healthwatch and work is being completed with David Bland as Board lead for Patient Experience, an action plan is completed and will go to the Clinical Quality, Patient Safety and Experience Committee.

The Chief Executive informed the Board that we were still waiting for the AUKUH spreadsheet however we are continuing to recruit and look at staffing solutions. We are also posting nurse to bed ratios on our wards on a daily basis.

The Board noted that all other actions are on track.

The Chairman asked when the template for the AUKUH tool would be ready.

Denise McMahon assured the Board that she had chased Ruth May again this week; she will raise it at the Nursing Directors meeting next week.

The Chief Executive informed the Board that we are currently gaining information on Nurse staffing levels from the CQC reviews our staff are taking part in.

Denise McMahon explained the need to go oversees for recruitment and said that we have acquired contact details of services in Poland and Spain

Paul Assinder reminded the Board that we spend the same as other trusts on Nursing; but should manage the amount we spend on bank and agency staff better.

13/072.5 Dementia Report (Enclosure 9)

The Board were joined by Mandy Aworinde, Clinical Nurse Specialist, Older people, and Rebecca Edwards, Deputy General Manager.

The Chairman and the Board noted thanks to Kathryn Willets, a previous Non Executive Director who contributed a lot to the improvement of the trusts Dementia services.

Rebecca Edwards informed the Board that this report was a 6 monthly update to the Board and the Board noted that there were 4 key work streams of the services; identification and diagnosis, care and treatment, improvement of the environment and support for carers of people with Dementia. The Dementia CQUIN has been achieved consistently for 5 months with the Trust screening, assessing and referring 90% of emergency admissions over 75 appropriately, the additional support of a band 2 post has contributed to this.

A care bundle for Dementia is being piloted on C3 and has so far been used with 12 patients.

The Chief Executive asked that we ensure we are not giving staff too many care bundles to perform.

Rebecca Edwards was pleased to announce that Mandy Aworinde's team have signed up to the RAID model transformation programme and have made a small decrease to the length of stay of Dementia patients.

The Chairman asked how we are implementing this model.

Rebecca Edwards informed the Board that Mandy's team would like to set up a frail/elderly assessment unit following visits to other trusts with dedicated units and seeing the positive work; we have applied to public health for the space to set up a day room on A2.

Paul Assinder, Director of Finance and Information notified the Board that on a patient safety walkround on B3 he found that the Team there were looking at setting up a memory room.

Rebecca Edwards added that they had invited Jenny Bree, Matron, to their regular meetings. We are ensuring carers of patients with Dementia are receiving appropriate support and people are undertaking support surveys that have given us positive results; we are on target to meet the CQUINN in this area.

Ann Becke, Non Executive Director noted that a dementia unit would be a real achievement for the Trust and asked if the Estates Strategy for this is achievable.

Richard Beeken explained what he was awaiting the outcome of discussions Rebecca Edwards is having with the medical teams over the need for a discrete unit.

Paul Harrison pointed out that one problem is that patients with Dementia do not come into the Trust predominantly for that reason and have other co-morbidities therefore we need to ensure we get the setting for their care correct.

The Board noted the report and the positive improvements of the Trust's care for dementia patients.

13/072.6 Research and Development report (Enclosure 10)

Paul Harrison, Medical Director presented the report given as Enclosure 10 explaining that this was carried over from last month's agenda. The Board noted the following points:

- **Observational studies:** This was previously raised at Board and there is now an increase with a Research and Development facilitator having a beneficial effect.
- **Table in report:** The Dudley Group are doing well in the table against the other trusts considering the size of us compared to others.
- **GCP:** We achieved the Good Clinical Practise accreditation in May 2013.
- **Issue:** staffing issues in Research and Development has resulted in reduced support for setting up new studies and processing study amendments.

The Board noted the good performance and the contents of the report.

13/072.7 Board Assurance Framework (Enclosure 11)

The Chief Executive presented the report given as Enclosure 11 explaining that this report was the regular update to the Board and asked if there were any questions in relation to the contents of the report:

Ann Becke, Non Executive Director expressed her concern around the low figures of the Diabetic managegement mandatory training.

The Chief Executive explained that we started on 0 this year and Learning and Development are continuing to push in this area.

Ann Becke suggested introducing a target.

The Chief Executive pointed out that this was debated and she agreed with the idea of introducing a phased target, she assured the Board she would follow this up with Annette Reeves, Associate Director for Human Resources.

David Bland, Non Executive Director asked if we were confident the data on Datix is accurate.

The Chief Executive confirmed that we are.

Ann Becke, Non Executive Director added that the issue was with the system upgrade that created a problem with pulling the data off the system in time for the meeting.
The Chairman noted that there is still work to do to fill the gaps in assurance.

The Board noted the contents of the report.

Associate Director of Human Resources, Annette Reeves is to investigate a phased target approach to the Diabetic Management mandatory training

13/072.8 Role of Governor (Enclosure 12)

The Chairman presented the Report given as Enclosure 12 noting thanks to David Badger, Non Executive Director and Rob Johnson, Lead Governor for leading this work. He explained that the Trust, working with the Governor Development Group, had been developing this template: the two Francis reports and the Keogh review, where they make recommendations on the role of Governors, had given added impetus to the work . Subject to Board agreement this will go to the Council of Governors tonight, 7th November, for their consideration and endorsement.

Paul Assinder, Director of Finance and Information made the point that a lot of the work was already happening and we were codifying it in the paper. We had received a lot of feedback from external organisations on our good practise and his had been recognised by the recent award to our Council of Governors (CoG).

Ann Becke, Non Executive Director noted the point at Appendix A that states attendance of a Non Executive Director at a full council meeting.

The Chairman clarified that any Board Member may attend the Council of Governors meetings if they wish to but do not have to unless they have an item to present. Board members engagement is better placed in working with CoG committees.

Ann Becke, Non Executive Director asked for this to be clarified in the paper.

The Board approved the report.

13/ 072.9 Quality Metrics (Enclosure 13)

Denise McMahon presented the Quality Metrics paper pointing out that this was linked to the annual quality accounts report.

Denise informed the Board that Monitor's guidance is that timelines are included and benchmarking is undertaken. The teams view is to stay the same for 2013/14 but to review and possibly amend the indicators for 2014/15, subject to any recommendations from the CQC. This will be presented and discussed at the Council of Governors tonight.

The Board agreed on the recommendation to use the same metrics this year as last year and then await further guidance from the CQQ (Sir Mike Richards' team) before changing in 2014/15.

13/073 Finance

13/73.1 Finance and Performance Report (Enclosure 14)

Paul Assinder, Director of Finance and Information presented the report from the meeting held on the 31st October given as Enclosure 14, including the following issues:

- **CIP programme:** Good progress has been made so far but there are still some concerns; the Committee have identified £7.1m to date of savings on the Trusts £12.4m CIP. A forecast of £2.6m is the forecast under delivery of CIP, meetings have been held with the General and Emergency Medicine directorates to identify savings to hit their targets this year however there is a risk with achievement.

- **Allocate staffing system:** The Committee received a report from Yvonne O'Connor who informed them that the roll out of this system is on schedule to be fully rolled out by the end of the financial year.

- **Appraisals:** The Trust has an 80% total appraisal rate across the Trust and work has been completed in the surgical directorate that has found without maternity leave and new staff figures the true rating is 92%.

- **Outline Business Case for Electronic Health Record:** The Committee recommended the Board's approval; this is being discussed on the Private Board Agenda.

- **Financial Performance:** The month of September was disappointing with a £1m deficit for the month. The overall year to date deficit is £219k. The annual deficit for this year is forecast at £0.5m.

Paul Assinder, Director of Finance and Information explain that the Executive team are doing more work to mitigate this and hopefully with this action we can report a balanced position next month. The reasons for the deterioration are due to changes in the way the tariff payment for maternity care is allocated between providers, leading to a loss of income of c.£1m and spend on agency nursing. The Trust has spent more on agency staging in the 1st 6 months of this financial year than the whole of the previous year.

- **Performance:** The Trust has hit the Q2 ED target; the target for Q3 will be discussed on the private Board agenda.

- **C.Diff:** The Committee have noted the concerns around the C.Diff figures and have referred the matter to the Clinical Quality, Safety and Patient Experience committee to look at causes and mitigation actions.

- **Update of SHMI:** The Trust remains within the expected ranges.

The Board noted the recommendations on the OBC health records and referral of the increase in C.Diff numbers to the Clinical Quality, Safety and Patient Experience Committee.

Ann Becke, Non Executive Director asked how the decrease in income relates to the maternity cap.

Paul Assinder explained that it is down to a change in tariff arrangements , we are more vulnerable due to the nature of our service.

Paul Harrison, Medical Director pointed out that this exemplifies the problem of being unable to determine if a service is profitable and makes it difficult to plan strategies going forward

Richard Beeken, Director of Performance, Strategy and Transformation explained that we must plan how we provide the same service with 10% less money.

The Board noted that the OBC for the new Electronic Health Record system will be considered in the private section, because it is commercially confidential and the Deterioration of the financial position.

13/074 Any Other Business

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

13/075 Date of Next Meeting

The next Board meeting will be held on Thursday, 5th December, 2013, 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 7 November 2013

Item No	***Subject***	***Action***	***Responsible***	***Due Date***	***Comments***
13/072.2	Audit Committee	Clarification is needed on the time commitment required by Non Executive Directors during a tender process.	PA	5/12/13	Minimum of one hour
13/072.7	Board Assurance Framework	Associate Director for Human Resources to investigate phased target for Diabetes Management Mandatory Training.	AR	5/12/13	On Agenda

Enclosure 3

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors held in Public – 5th December 2013

TITLE:	**Chief Executive's Report**		
AUTHOR:	**Paula Clark**	**PRESENTER**	**Paula Clark**

CORPORATE OBJECTIVE:
SG1, SG2, SG3 SG4, SG5

SUMMARY OF KEY ISSUES:

- 95% Hospital/Emergency Department 4 Hour Wait Target
- Friends and Family Test Performance
- Staff Survey 2013
- Speak Out Safely and Whistleblowing
- CQC Wave 2 Hospital Inspection

IMPLICATIONS OF PAPER:

RISK	**N**		**Risk Description:**
	Risk Register: N		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Equality Assured	**N**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		x	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To note contents of the paper and discuss issues of importance to the Board

The Dudley Group NHS
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Chief Executive Update – December 2013

95% Hospital/Emergency Department 4 Hour Wait Target:
Following a very challenging October we have improved performance during November although we have still had a number of very difficult days. We have put in place a number of schemes using the CCG winter pressures incentive funds designed to help us cope better with the emergency pressures facing us during the winter months.

For the Winter Incentive scheme we have:

- Committed 50% of the potential incentive scheme value, balancing the risk of not receiving the funding with the costs of implementing the winter services
- Responded to the CCG about this scheme as we appear to be the only provider with such a challenge as other CCGs have passed winter funding direct to their acute providers.

All funded schemes are in place (consultants triaging ambulance patients, GP in ED, spot purchasing, trackers in ED, discharge facilitator in surgery, A2/Station 1 operating as frail elderly unit, Care Home Select to improve discharges, Troponins to reduce length of stay, junior doctors cover in ED, Weekend Consultant cover to improve discharges and weekend Therapy cover

We are also increasing management and executive time on the ensuring patient flows are managed to the optimum. Working with colleagues in Social Care we are also trying to ensure community services are also working to capacity so that we can both prevent admission but also facilitate more timely discharges into community settings and reduce the delayed transfers of care which are still too high at over 70.

The Ambulatory Emergency Care trial is proving very effective since its launch with 300+ patients through it. It is very successful at creating flow of patients from ED early on and then into the evening. Good, timely access to diagnostics has made a real difference.

Friends and Family Test Performance:

Inpatients and A&E Friends and Family Test:

	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13
Date range	01.04.13 30.04.13	01.05.13 31.05.13	01.06.13 30.06.13	01.07.13 31.07.13	01.08.13 31.08.13	01.09.13 30.09.13	01.10.13 31.10.13	01.11.13 26.11.13
Number of eligible inpatients	1930	1962	1929	1987	1968	1967	2007	1604
Number of respondents	408	573	505	500	549	423	632	519
Ward FFT score	66	75	74	71	73	74	76	76
Ward footfall (min'm 15% required)	21%	29%	26%	25%	28%	22%	31%	32%
Number of eligible A&E patients	4206	4380	4194	4652	4488	4238	4237	3323
Number of respondents	17	62	353	265	153	477	981	809
A&E FFT Score	53	71	59	55	43	59	61	62
A&E footfall (min'm 15% required)	0%	1%	8%	6%	3%	11%	23%	24%
TRUST FFT Score	65	74	68	65	66	66	67	68
TRUST footfall	7%	10%	14%	12%	11%	15%	26%	27%

Inpatient FFT Score		A&E FFT Score		FFT Scores key	
	80+		70+		Top 20% of Trusts (based on Q1 scores)
	72-79		60-69		Between Trust baseline and top 20%
	<72		<60		Trust Q1 baseline

% of footfall (response rate)	Period		
	Apr-Jun 13	<15%	15% +
	Jul 13-Mar 14	<20%	20% +

An increase in score and response rate can be seen for both the inpatient and A&E friends and family test. The new token system in A&E continues to produce an increased response rate which has resulted in a more settled and, therefore, reliable score to work from.

Maternity Friends and Family Test:

			Preliminary
15% response rate required		Oct-13	Nov 13 to 26/11
Maternity - Antenatal	Score	58	55
	Response rate	29% (of 294)	16% (of 255)
Maternity - Birth	Score	76	89
	Response rate	15% (of 386)	27% (of 298)
Maternity - Postnatal ward	Score	78	84
	Response rate	15% (of 383)	27% (of 298)
Maternity - Postnatal community	Score	75	88
	Response rate	13% (of 315)	21% (of 226)
Combined	Score	65	78
	Response rate	21%	23%

The Friends and Family Test was rolled out into Maternity services on 1st October in line with the national programme. For maternity the question is asked throughout a woman's progression through her pregnancy, birth and postnatal care. A postcard survey is given at the following times:

(1) 36 week antenatal appointment
(2& 3) At discharge following birth (covering birth and postnatal ward)
(4) At discharge from community postnatal service

October data shows that the process has started well achieving an overall response rate of above the required 15 per cent. Postnatal community responses were on the low side in October but preliminary data for November shows an improvement.

A lower score for antenatal is observed and patients report this to be due to waiting times when visiting antenatal clinics at Russells Hall Hospital. When looking at a breakdown of scores for October, Russells Hall Hospital antenatal clinics scored 51 and community clinics scored 69. The maternity team explain that women attending the antenatal clinic at Russells Hall Hospital at 36-weeks will be receiving consultant-led care and will therefore require further tests during their clinic appointment. They will review whether any further action can be taken to improve these waiting times.

National data for Maternity is due to be published in February 2014 when we will see how we compare with other trusts.

Benchmarking: National/regional position (October)
Not available at the time of preparing the report (27.11.13).

Learning from Complaints Open Meeting:
As part of our progress on the Keogh Action Plan we are holding an open meeting for past complainants on Monday 2nd December. A number of recent complainants have been invited and the purpose of the event is to hear the reason why they complained, what it felt

like to be in the complaints process and what we could do better in the future. We will also be asking about whether the complainants felt we had addressed their concerns as the complaint was closed. Learning will then be fed back into how we better manage the service in the future.

Staff Survey 2013:
I am pleased to report that we have reached a 50% return rate this year. This is a vast improvement on last year when our return rate was in the low 30% range. The Comms Team have worked tirelessly to drive a good return rate and they are to be congratulated for this achievement.

Speak Out Safely and Whistleblowing:
The Francis Report put emphasis on ensuring that trusts have systems and processes in place to ensure staff can speak out about concerns that have about patient care and safety. We have a good track record of staff using our current systems. Staff have come to me directly or to the Nursing Director and also used her “drop in” service. In order to make sure this open culture is embedded and well known we have joined the RCN “Speak Out Safely” Campaign and are ensuring that staff can find whistleblowing links and information easily on The Hub.

CQC Wave 2 Hospital Inspection:
We have now been given the dates for the CQC Hospital Inspection and these have been set for 25th to 27th March.

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th December 2013

TITLE:	Summary of key issues from the Clinical Quality, Safety & Patient Experience Committee held on 10th October 2013		
AUTHOR:	Julie Cotterill Governance Manager	**PRESENTER:**	David Bland (NED) CQSPE Committee Chair

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

SUMMARY OF KEY ISSUES:

Quality Dashboard Report for Month 5 (August 2013/14) - the following key issues were hghlighted:

- **C.Difficile** – There were 2 confirmed C.Diff cases in August which brought the Trust back within its year to date trajectory. The provisional figure for September was 6 cases bringing the Trust back in the Monitor and local health economy trajectory.
- **TAL Appointment booking within 4 days** – A performance notice was raised by the CCG with regard to the continued failure of this KPI. The Trust had challenged the CCG process and specifically the time period for the first contact to be made with the patient and the booking of the appointment.
- **Maternity: Increase in Breastfeeding initiation rates by 2% per year** – The breast feeding initiation rate indicator was back within target for August, following two months where the target was missed.
- **Maternity Smoking in Pregnancy** – The target for August was 15%. The Trust achieved 19.1%.

The Committee considered the detailed analysis showing the ward breakdown and specifically the wards with three red rated indicators. The scores for protected mealtime assistance were particularly low for July. The scores for Think Glucose were also down. Saving Lives had dropped to 60% in August from 100% in July. The Trust was no longer an outlier for any procedures listed in NHS Choices.

Reporting Groups

New Intervention Group - the Committee received five applications from a consultant ophthalmologist. All procedures were approved with the proviso that a review would be undertaken and reported back in 12 months time. The Committee discussed the need to undertake business and clinical evaluations when procedures replaced an existing process and felt that admission and length of stay should also be considered.

Intelligent Kindness – The Intelligent Kindness Think Tank was established to develop the intelligent kindness agenda. Reverend Stobert introduced Schwartz rounds in March 2013. These are now part of the Grand Round lunchtime programme. A "Listening for Kindness" pilot project will be undertaken in outpatients to develop listening skills with the aim of empowering staff to listen to each other and then use the skills and values to listen to patients. This will be launched in January 2014.

Clinical Audit Findings - much of the report content was considered at the recent Audit Committee. There were 165 audits on the plan. To avoid duplication, it was agreed that future reports would be removed from the forward planner and transferred to Audit Committee.

NICE Guidelines - since the last report the 'not yet assessed overdue' NICE Guidance had increased by 35% from 15 to 23. Clinical Directors were informed. The increase in the 'not yet assessed overdue' NICE Guidance was disappointing as initial intervention from the Trust Management Executive had drawn a positive response. The position status had also been added to the Directorate Performance Review meetings. The guidance in the amber status "practice is partially compliant with guidance" had also increased. Fully implemented and compliant guidance had increased from 68 to 74 in the last quarter showing a positive improvement.

The Committee **received** the information on the current NICE Guidance position and **noted** the level of compliance and the actions being taken to further improve the process of escalation and obtaining timely feedback.

Monthly Mortality Update - The following points were highlighted:

- **Reference 0813/1** - Congestive Heart Failure (non-hypertensive one of the highest conditions in excess deaths for the last two SHMI reports. A clinical audit was undertaken in cardiology to identify reasons for the current trend.
- **Reference 0813/2** - High number of excess deaths in cancer conditions. A CD and MSH training session focussed on the use of primary diagnosis in cancer patients. Work was in progress regarding primary diagnoses.
- **Reference 0913/2** - Validate evidence that there has been a national increase in crude mortality. The action plan stated that work had not commenced but the timeframe was October 2013.
- **Reference 0913/3** - Review of Trust position against AQuA mortality checklist to be presented at CQSPE and reference 0913/4 - Directorate Mortality Reports were circulated in the Trust Mortality Report format, highlighting the trust and directorate position with associated actions. Actions from Performance Reviews will be reflected in the Trust Quarterly Report. These had been implemented.

The Committee **received** the report and **noted** the current position and work in progress. It also **accepted** the amended report format and **approved** the action plan and noted progress on agreed actions.

Patient Safety Group (10th September 2013). The following issues were highlighted

- **Wheelchairs:** Matrons had raised concerns about the lack of wheelchairs. 30 wheelchairs were ordered in July, another 30 were on order which should be in service by the end of September.
- **Community Equipment:** Concern had been raised about the Community EBME Contract.
- **Telemetry/Wi-Fi:** Current equipment used for remote monitoring of cardiology patients on designated cardiology area/ward and outlying wards was now 5 or 6 years old and at the end of its useful life. Replacement costs were substantial. The Director of Operations was progressing this.
- **Reporting patient falls as RIDDOR's -** Guidance was received from the Health and Safety Manager on recent changes to RIDDOR reporting requirements.
- **Drug calculations -** following a recent drug calculation error all ward staff in the affected area were subsequently competency assessed. 12/16 failed the test. A working party was established and a drug calculation paper agreed for use for all new staff nurses coming into the Trust.

Safeguarding Group (26th September 2013). The following issues were highlighted:

- **Section 11 Audit** - The self assessment audit covering the assessment of safeguarding processes for 2013 was complete and an action plan had been developed. No areas of concern were noted.
- **Learning Disabilities CQUIN** –the Learning Disability Nurse was in post. A training plan was in place to ensure that 95% of staff in ED, EAU and Pre Operative Assessment (225 staff) were trained by the end of December 2013.
- **Child Death Rapid Response Rota** – This rota was predominantly covered by the Designated Nurse for Safeguarding, Clinical Commissioning Group and the Trust's Named Nurse for Safeguarding Children with some weekend cover provided by the Trust's Safeguarding Consultants when they were the Paediatrician on call at weekends. There were continuing concerns about rota cover.

Friends and Family Report - the Committee received the Friends and Family Survey Results for September 2013. The A&E figures for August dropped to 43 but increased to 59 in September. A token system had been in place for two weeks and the response rate had increased to 22% during the final 7 days of September. Only 3% of comment cards had been returned in August.

Serious Incident Monitoring Report (September 2013) - 13 new incidents were reported. All incidents were under investigation and had been reported appropriately. There were 42 open general SI's in total (21 undergoing investigation, 17 awaiting assurance that all actions identified from the RCA investigation had been completed and 4 recommended for closure). There were no breaches in the 2 days from identification of the incident and reporting and there were no breaches to complete the investigation in the agreed time scales. The Committee **noted** the current position and supported the closure of the 4 SI's recommended.

RCOG Report on Patterns of Maternity Care in English NHS Hospitals - The Committee received the Royal College of Obstetricians and Gynaecologists report on Patterns of Maternity Care in English NHS Hospitals. This was the first in a planned series of annual reports examining variations in maternity services using a defined set of indicators. The Trust was below the national mean percentages for the majority of standards apart from induction of labour rates and elective caesarean section rates which were above the national mean but below the mean of the top 10% of units for all but the elective caesarean section rate in primigravid patients (5.2% v 5.0%). The Trust rate of major perineal injury in multiparous patients undergoing assisted delivery was above the national mean but below the mean of the top 10% of units (3.3%, 2.5% and 4.6% respectively).

Renal Mortality Outlier Alert from Renal Registry - the Trust was identified as an outlier for haemodialysis. On review 2008 was identified as a year of excessive mortality. On a 4 year rolling period this one year had increased the index to create the alert. Issues were identified with data collection:-

- Over-reliance on system clerical administrator to make decisions about validity of data.
- Lack of clinical leadership/oversight of returns to the Renal Registry.

The Committee agreed to await the outcome of the pending independent peer review of this service, which includes the data collection for the Renal Registry as one of the terms of reference.

Approval of Guidance for Recruitment of High Calibre and Committed Employees – Recruitment levels have continued to rise over the last 12 months. The introduction of e-Disclosure and Barring checks supported a reduction in the length of time to obtain pre-employment checks. This process has been well received, proved efficient and is being rolled out across the organisation in areas where on-going checks are required. References are requested electronically which has increased the turnaround time and ensures greater confidentiality of information. Electronic files are now used to store all candidate information and pre-employment checks which has increased the security of this data as well as allowing the ability to transfer documents to line managers electronically.

Exit Interview - A new electronic Exit Interview form was introduced to the Trust in December 2012. Some questions had been updated on this. Low return rates were a problem and 63% of the 60 completed forms were from Junior Doctors who were on rotation. The Committee discussed the poor response rate and action taken to address this. An e-form was being developed to capture information.

***Please Note**: The full Committee minutes are available for Board members on the Directors drive.*

IMPLICATIONS OF PAPER:			
RISK	Y		**Risk Description:** Committee reports ref to the risk register
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:** Outcome 1 - Respecting & Involving people, 4 – Care & welfare of people, 7 – Safeguarding, 16 – Assessing & monitoring quality of service
	NHSLA	Y	**Details:** Risk management arrangements e.g. safeguarding
	Monitor	Y	**Details:** Ability to meet national targets and priorities
	Equality Assured	Y	**Details:** Better health outcomes for all Improved patient access and experience
	Other	Y	**Details:** Quality Report/Accounts

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		✓	

RECOMMENDATIONS FOR THE BOARD:

To note the key issues arising from the Clinical Quality, Safety & Patient Experience Committee held on 10th October 2013 and refer to the full minutes for further details.

The Clinical Quality, Safety & Patient Experience Committee was established to provide assurance to the Board on Clinical Quality and Safety standards, (including Clinical Effectiveness, Patient Safety and Patient Experience). It sets clear quality performance expectations and ensures the development and delivery of high quality care and continuous improvements through innovation and the use of levers such as CQUINS. It identifies and advises on quality improvement priorities and the organisational learning from these and monitors compliance with Health Standards ensuring the Trust fulfils its obligations with regard to the Health Act (2009) and Monitor in the production of an Annual Quality Account and Report.

Enclosure 5

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th December 2013 - PUBLIC

TITLE:	Infection Control Report				
AUTHOR:	Denise McMahon Director of Nursing		**PRESENTER:**	Denise McMahon Director of Nursing	
CORPORATE OBJECTIVE: SG01: Quality, Safety & Service Transformation Reputation – To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.					
SUMMARY OF KEY ISSUES: The Board of Directors are asked to note Trust Performance against C. Difficile and MRSA targets and the other notable infections.					
IMPLICATIONS OF PAPER:					
RISK	**Y**		**Risk Description:** Infection Prevention and Control		
	Risk Register: Y		**Risk Score:**	IC010 – Score: 16	
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:**	Outcome 8 – Cleanliness and Infection Control	
	NHSLA	**N**	**Details:**		
	Monitor	**Y**	**Details:**	Compliance Framework	
	Equality Assured	**Y/N**	**Details:**		
	Other	**Y/N**	**Details:**		

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	✓	✓	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:

To receive report and note the content.

GLOSSARY OF INFECTIONS

MSSA

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

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

MRSA

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

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

E Coli

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

What types of disease does *E. coli* cause?
The commonest infection caused by *E. coli* is infection of the urinary tract, the organism normally spreading from the gut to the urinary tract. *E. coli* is also the commonest cause of cystitis (infection of the bladder), and in a minority of patients the infection may spread up the urinary tract to the kidneys, causing pyelonephritis.

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

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

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

C difficile

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

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

How do you catch it?
Another person may acquire C.difficile disease by ingesting the bacteria through contact with the contaminated environment or patient. In most healthy people the C.difficile will not be able to multiply in the gut and they will not develop disease. In some more vulnerable people, particularly those whose normal gut bacteria have been disrupted by antibiotic treatment, the C.difficile may be able to multiply in the gut and go on to cause disease.

SUMMARY OF WARDS AND SPECIALTIES

Area	Speciality
A1	Rheumatology & Pain
A2	Stroke/General Rehabilitation
A4	Acute Stroke
B1	Orthopaedics
B2	Hip & Trauma Orthopaedics
B3	General Surgery
B4	Mixed Colorectal & General Surgery
B5	Female Surgery
B6	Ear, Nose and Throat, Maxillo-Facial & Urology
C1	Renal
C3	Elderly Care
C4	Georgina Unit/Oncology
C5	Respiratory
C6	Respiratory/ Gastro Intestinal Medicine (GI Medicine) Overflow
C7	Gastro Intestinal Medicine (GI Medicine)
C8	Acute Medical Unit/Short Stay Unit
CCU/PCCU	Coronary Care Unit/Post Coronary Care Unit
Critical Care Unit	Critical Care
EAU	Emergency Assessment Unit
ED	Emergency Department
GI Unit	Gastro Intestinal Unit
MHDU	Medical High Dependency Unit
OPD	Out Patients Department
SHDU	Surgical High Dependency Unit

Report to: Board of Directors

Subject: Infection Prevention & Control Report

Summary:

Clostridium Difficile - The target for 2013/2014 is 38 cases; at the time of writing the report 33 cases have been recorded.

C. Difficile Cases Post 48 hours – Ward breakdown:

Ward	Totals for 12/13	April '13	May '13	June '13	July '13	August '13	September '13	October '13	As of 25th November 13	Totals so far 13/14
A1	2	0	0	0	0	0	0	0	0	0
A2	12	0	1	0	1	1	1	1	0	5
A3	0	0	0	0	0	0	1	1	0	2
A4	0	0	0	0	0	0	1	0	0	1
B1	0	0	0	0	0	0	0	0	0	0
B2	1	0	1	0	0	0	0	0	2	3
B3	4	0	0	0	0	0	1	0	0	1
B4	3	0	0	0	0	0	1	0	0	1
B5	0	0	0	0	0	0	0	0	0	0
B6	2	0	0	0	0	0	0	0	0	0
C1	7	1	1	0	0	0	0	0	1	3
C3	6	0	1	1	1	0	1	1	0	5
C4	4	0	0	0	0	0	0	0	0	0
C5	1	0	0	2	0	0	0	1	2	5
C6	3	0	0	0	0	0	0	0	0	0
C7	7	0	0	0	0	0	0	0	1	1
C8	2	0	0	0	0	1	0	1	0	2
MHDU	0	0	0	1	1	0	0	0	0	2
CCU/PCCU	0	0	0	1	0	0	0	0	1	2
Critical Care	0	0	0	0	0	0	0	0	0	0
EAU	1	0	0	0	0	0	0	0	0	0
SHDU	1	0	0	0	0	0	0	0	0	0
Total	**56**	**1**	**4**	**5**	**3**	**2**	**6**	**5**	**7**	**33**

See Appendix 1 – Board Report (2013/2014)

C. difficile – We have reported 33 post 48 hour toxin positive cases against a trajectory of 25 cases so far this year (annual target no more than 38 cases). The Trust has held a series of urgent meetings involving the Clinical Commissioning Group (CCG), Commissioning Support Unit (CSU) and Public Health England (PHE) to review and establish an action plan to bring the number of new cases back within trajectory.

MRSA – Annual Target 2 (Post 48 hrs) - There have been no cases in the last month and no cases so far this financial year.

Norovirus – There have been no confirmed cases of Norovirus in the Trust.

(N13) Clostridium difficile infections

Monthly number of C.diff cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	Cumulative % Over/Under Target	Trust Total	Health Economy
Apr-13	1	3	-66.7%	1	3	-66.7%	5	7
May-13	4	3	33.3%	5	6	-16.7%	10	11
Jun-13	5	3	66.7%	10	9	11.1%	6	6
Jul-13	3	3	0.0%	13	12	8.3%	9	11
Aug-13	2	3	-33.3%	15	15	0.0%	8	11
Sep-13	6	3	100.0%	21	18	16.7%	12	17
Oct-13	5	4	25.0%	26	22	18.2%	9	17
Nov-13	7	3	133.3%	33	25	32.0%	15	15
Dec-13		4			29			
Jan-14		3			32			
Feb-14		3			35			
Mar-14		3			38			
FY 2013-14	33	38	-13.2%				74	95

The CCG target for Cdiff is 38 cases for the financial year. The vital signs reporting framework has indicated that samples taken during the first 48 hours of admission to hospital should not be considered as hospital acquired.

The Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours.

The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

(N1) MRSA infections

Monthly number of MRSA cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total
Apr-13	-	0	0.0%	-	0	0.0%	-
May-13	-	0	0.0%	-	0	0.0%	-
Jun-13	-	0	0.0%	-	0	0.0%	-
Jul-13	-	0	0.0%	-	0	0.0%	-
Aug-13	-	0	0.0%	-	0	0.0%	-
Sep-13	-	0	0.0%	-	0	0.0%	-
Oct-13	-	0	0.0%	-	0	0.0%	-
Nov-13	-	0	0.0%	-	0	0.0%	-
Dec-13		0			0		
Jan-14		0			0		
Feb-14		0			0		
Mar-14		0			0		
FY 2013-14	-	0	-				-

As a Foundation Trust the regulator, Monitor, measures compliance against the contract with our commissioners Dudley CCG. NHS England (previously the NHS Commissioning Board) has established a national zero tolerance approach regarding MRSA bacteraemia for 2013/14 onwards.

MSSA infections

Monthly number of MSSA cases

Month / Year	Total	Cumulative
Apr-13	6	6
May-13	6	12
Jun-13	-	12
Jul-13	6	18
Aug-13	7	25
Sep-13	4	29
Oct-13	9	38
Nov-13	-	38
Dec-13		
Jan-14		
Feb-14		
Mar-14		
FY 2013-14	38	

E.coli infections

Monthly number of E.coli cases

Month / Year	Total	Cumulative
Apr-13	25	25
May-13	13	38
Jun-13	14	52
Jul-13	22	74
Aug-13	32	106
Sep-13	17	123
Oct-13	22	145
Nov-13	-	145
Dec-13		
Jan-14		
Feb-14		
Mar-14		
FY 2013-14	145	

Enclosure 6

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th December 2013

TITLE:	**Keogh Improvement Plan and Progress Update – November 2013**		
AUTHOR:	**Julie Cotterill Governance Manager**	**PRESENTER**	**Paula Clark Chief Executive**

CORPORATE OBJECTIVE: SGO1: Quality, safety & service transformation, reputation, SGO2: Patient Experience, SGO5: Staff commitment

SUMMARY OF KEY ISSUES:

The Board met with Monitor representatives on 15th August to discuss the Keogh Review and Action Plan and to agree how the Trust would track progress against this. It was agreed that the Monitor template would be used to confirm the Trust position monthly.

The attached report focuses on the urgent actions discussed at the Risk Summit. The "Improvement Plan & our Progress" describes the issues identified by Keogh, the actions we are taking and how we will keep the public updated on progress. Progress is monitored in accordance with a colour coded key on the front cover where "blue" denotes "delivered".

"How we are checking that the Improvement Plan is working" summarises how the Trust is checking that the actions we are taking are being delivered and how the Board is assured that actions have been implemented and quality of service has improved.

Whilst the Trust has continued to progress the identified actions, some residual work remains to ensure actions are implemented in full and fully embedded.

IMPLICATIONS OF PAPER:

RISK	**R**		**Risk Description:**
	Risk Register:	**Y**	**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 1 - Respecting & Involving people Outcome 4 – Care & welfare of people Outcome 7 - Safeguarding Outcome 12 – Requirements relating to workers Outcome 16 – Assessing & monitoring quality of service provision
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance requirements
	Equality Assured	**Y**	**Details:** Better health outcomes for all Improved patient access and experience
	Other	**Y**	Details: Confirmation of action to DoH

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD

The Board is requested to receive the report, note the progress against urgent actions and identify any further actions required.

The Dudley Group NHS Foundation Trust

Keogh Action Plan and Progress as at 25th November 2013

KEY
Delivered
On Track to deliver
Some issues
Narrative - Disclose delays/risks/plan to recover
Not on track to deliver

The Dudley Group NHS Foundation Trust - Our Improvement Plan & our Progress

What are we doing?

- The Keogh review made 39recommendations, of which 9 were urgent. A Risk Summit , chaired by Paul Watson(Regional Director – Midlands and East, NHS England) was held on 6th June 2013 and focussed on supporting the Trust in addressing the urgent actions identified to improve the quality of care and treatment. The Trust recognised all of the recommendations and has ensured that related actions are being addressed by the Trust to improve the quality of services provided to patients.
- Specifically, the Keogh review said that the Trust needed to:
    - Review current nursing and staffing levels using a nationally recognised tool and action any changes required for improving both the quality and safety of care.
    - Review the staffing levels on two large (72 bedded) wards and take action to split these into separate wards
    - Further embed a culture of learning from incidents, complaints and mortality reviews, including reviewing data more systematically to target improvements.
    - Review the complaints process and the way we respond to patients needs.
    - Fully embed patient safety and quality processes at ward level.
    - Review and simplify the Quality Governance processes and arrangements and communicate these to staff
    - Review the performance information required to obtain complete assurance on quality improvement

The Trust has responded positively to the review process with some urgent issues already addressed and many other actions in progress. The Trust accepted the findings and welcomed the support of risk summit members to increase the pace and focus of improvement. Further support was offered to develop clinical leadership with input from NHS England and the NHS Leadership Academy to embed accountability and ownership for quality improvement in the organisation.

- This “Plan and Progress” document shows our plan for making these improvements and demonstrates how we are progressing. It builds on the “key findings and action plan following risk summit” document which we agreed immediately after the review was published http://www.nhs.uk/NHSEngland/bruce-keogh-review/Pages/published-reports.aspx.

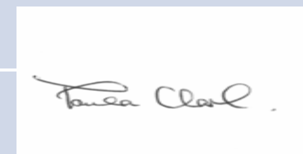
Who is responsible?

- Our actions to address the Keogh recommendations have been agreed by the Trust Board.
- Our Chief Executive , Paula Clark, is ultimately responsible for implementing actions in this document together with the Executive Directors who provide the executive leadership for quality, patient safety and patient experience .
- Ultimately, our success in implementing the recommendations of the Keogh plan will be assessed by the Chief Inspector of Hospitals who will re-inspect our Trust during 2014.
- If you have any questions about how we’re doing, please contact Paula Clark (01384 321012 or at communications@dgh.nhs.uk

How we will communicate our progress to you

- We will update this progress report monthly and will continue to hold a monthly Board meeting in public where we will update our local community on the progress we are making.
- We will share our progress with our Governors and stakeholders by providing regular updates and briefings
- We will update our staff by providing regular briefings, through our Trust magazine and via our intranet .

Signed by the Chief Executive of The Trust (on behalf of the Board)



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Paula Clark

The Dudley Group NHS Foundation Trust - Our Improvement Plan – October 2013

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Comments/Update	Progress
1. The Trust's quality governance arrangements are complex and were not embedded consistently below Board level	• The Trust should review its quality governance arrangements to develop and consider how it can embed these further at directorate and ward level	November 2013	Deloittes	The Trust commissioned Deloittes to undertake an independent review of the Quality Governance arrangements and advise on best practice. The review found areas of good practice and noted some areas where improvements could be made in relation to the effective governance of quality , many of which the Board are already addressing. The Board has considered the report and is progressing the actions.	
2. Systematic learning from incidents, reviews and complaints was not clearly evidenced by the Trust.	• The Trust should review how it can embed a culture of learning from incidents, RCAs, complaints and mortality reviews, including reviewing data more systematically to target improvements. • The Trust should also review its complaints process to ensure that it is fully addressing the Ombudsman's requirements and there is adequate resource to support this.	September 2013 October 2013	West Midlands Quality Network Clinical Commissioning Group Central Support Unit	A review has been undertaken and actions have been agreed. Revised procedures have been introduced. A review has been undertaken. The Trust complies with statutory requirements. An action plan is in place.	
3. The Trust's mortality review process is currently not identifying opportunities for systematic improvement	• The Trust needs to consider how it will review mortality data more systematically and use this alongside its learning from directorate reviews to target improvement actions more effectively.	October 2013		The Trust has revised the mortality review process and board report. Reporting is now comprised of mortality data, feedback from Directorate performance reviews and speciality mortality meetings. Local Speciality and Directorate level actions reflect a trust level log of ongoing actions in response to the data ,which is reviewed monthly.	

The Dudley Group NHS Foundation Trust - Our Improvement Plan – October 2013

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Comments/Update	Progress
4. The Trust has capacity challenges which its operational management procedures are not addressing fully	• The Trust's system for bed management, patient flows and discharge need to be urgently reviewed and improved to address operational effectiveness issues and improve patient experience	October 2013 **Ongoing monitoring**	Emergency Care Intensive Support Team (ECIST) to review processes NHS England	• ECIST follow up review team response agreed. Action plan being delivered •AEC unit saw 451 patients in first month •Weekly planning meeting identifies upcoming high risk (capacity) days •Directorate management teams operating manager and nurse of the day for capacity management •Improved weekend medical (GP and hospital doctor cover •Transfer nurses routinely booked for high trigger days	
5. The Board's patient experience strategy needs further development and embedding at ward level.	The Trust Board has more work to do to agree a Patient Experience Strategy with clear performance metrics, embed this and demonstrate that it is effectively monitoring performance.	• Mid July 2013 **Revised Timescale Dec 2013**	Healthwatch Clinical Commissioning Group Stakeholder Event	Information gathered at event fed back to participants. Meeting arranged with CCG and Healthwatch to discuss strategy development and metrics	
6. The Trust's nurse staffing levels/skill mix need urgent review along with some other staffing issues identified.	•The Trust should review its current staffing levels for nursing and medical staff using a nationally recognised tool; it should then action any changes required for improving both the quality and safety of care. •There is an urgent action identified to make sure that nurse staffing levels are assessed using an evidence based methodology. This should be reviewed in conjunction with the clinical teams to ensure each ward has appropriate nurse staffing levels and the appropriate ratio of registered to unregistered nurses on all wards. •The Trust should review how it can improve engagement in the national staff survey. •It should further review staff engagement in theatres, following up the external review undertaken in 2012.	• Sept 2013 **Revised Timescale TBA**	No additional support was required.	• AUKUH (Tool to measure staffing levels) Data collected. • National Database not yet available. • Use of bank and agency staff continues to cover absence and sickness. • Daily Nurse to Patient Ratio published on wards as per RCN Best practice. •The Trust runs staff focus groups relating to the national survey and has implemented changes over the past two years as a result. Staff are also given time to complete the survey. •A full review of theatres has been undertaken. *(refer also to item 9)*	

Summary of Keogh Concerns	Summary of Urgent Actions Required	Agreed Timescale	External Support/ Assurance	Comments/Update	Progress
7. A number of the Trust's processes relating to patient safety and quality were not being consistently applied at ward level.	The Trust should review its processes to ensure all equipment and safety checks are undertaken appropriately.	• July 2013	No additional support was required.	• Delivered. • In Place. • Audit now embedded.	
8. Consistency of pressure ulcer care including prioritisation of patients and access to equipment	The Trust should review its processes to provide appropriate care and equipment for patients that are high priority for pressure ulcer prevention. The Trust should also audit compliance with its pressure ulcer care bundles	• July 2013 • July 2013	No additional support was required.	The Trust has reviewed pressure ulcer care bundles and implemented bundle usage and compliance as part of a monthly audit review. Audits are now part of the Forward Audit programme.	
9. Theatre Staff engagement.	The Trust has agreed to undertake a follow up review of theatres, specifically around staffing levels and response to an earlier whistle-blowing issue.	Sept 2013	No additional support was required.	•The Theatre investigation is complete. • External advisor contacted for a scoping exercise. • Initial safety checks implemented.	

The Dudley Group NHS Foundation Trust - How we are checking that our improvement plan is working

Oversight and improvement action	Timescale	Action owner	Progress
Independent External Review of Quality Governance arrangements by External Auditors.	Delivery November 2013	Director of Finance	
Monthly progress update report on Keogh actions by Lead Directors to Board.	Monthly	Executive Directors	
Mortality & Morbidity Reports to Clinical Quality Safety and Patient Experience Committee	Monthly	Medical	
Governors holding Board to account on all aspects of quality	November 2013	Governors	
Working with a range of partners, who are providing support on a variety of areas, including mortality levels and service quality. These partners include the Emergency Care Intensive Support Team, AQuA (Advancing Quality Alliance).	From July 2013 onwards	Executive Directors	
Monthly scrutiny by the Clinical Commissioning Group through Clinical Quality Review meetings.	Monthly	Director of Nursing / Medical Director	
Local economy level consideration of whether the trust is delivering its action plan and improvements in quality of services by a Quality Surveillance Group (QSG)	Monthly	Chief Executive	
Update reports to the Dudley Health Scrutiny Committee confirming progress against the Action Plan.	When requested	Director of Nursing	
Trust Reports to the public about how our trust is improving via briefings to local media and monthly public board meetings.	Monthly	Chief Executive	

Enclosure 7

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board on 5th December 2013

TITLE:	**Francis Inquiry Table of Recommendations requiring Local Action**		
AUTHOR:	**All Directors**	**PRESENTER**	**Paula Clark Chief Executive**

CORPORATE OBJECTIVE: SGO1: Quality, safety & service transformation, reputation, SGO2: Patient Experience, SGO5: Staff commitment

SUMMARY OF KEY ISSUES:

The attached report confirms the progress made against the local actions arising from the recommendations of the Francis Inquiry Report.

Updates provided are shaded in yellow. Completed and closed actions are shown in yellow and bold.

A number of actions have been linked to the Keogh Action Plan and will be progressed through that. The remainder will be progressed as shown.

IMPLICATIONS OF PAPER:

RISK		**N**	**Risk Description:**
	Risk Register:	**N**	**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Y**	**Details:** Outcome 1 - Respecting & Involving people Outcome 4 – Care & welfare of people Outcome 7 - Safeguarding Outcome 12 – Requirements relating to workers Outcome 16 – Assessing & monitoring quality of service provision
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Compliance requirements
	Equality Assured	**Y**	**Details:** Better health outcomes for all Improved patient access and experience
	Other	**Y**	Details: Confirmation of action to DoH

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
	Y		

RECOMMENDATIONS FOR THE BOARD
The Board is requested to receive the report and note and approve the local action taken to date by Lead Directors against the outstanding recommendations contained in the Francis Report.

Report to Board December 2013 - Francis Inquiry Table of Recommendations requiring Local Action

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.					
4	Clarity of values and principles	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21	Board	Whilst the NHS Constitution underpins the core values and principles of the Trust, these will be re-visited and re-considered in light of the report and recommendations made.	**Open**
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions					
75	Enhancement of role of Governors	The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	10	Council of Governors and Chairman	The Board and Council of Governors will work together to progress these recommendations. Governors have committed to evaluate their current role in the monitoring of clinical quality within the Trust and strengthen this where necessary. This report will be produced by the Governor Development Group for consideration by the full Council in November 2013. The full report was approved by the Board of Directors and Council of Governors on 7th November 2013. A number of recommendations were agreed by both groups.	**Closed**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
76		Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	10	Council of Governors and Chairman	The Board and Council of Governors will work together to progress these recommendations. Governors attend patient safety walkabouts in ward areas. The Council of Governors Development Group undertook a review of the role of governors in Dudley, following the passing of the 2012 Act and the reviews of Sir Robert Francis QC and Sir Bruce Keogh and reported back to the full Council and Board of Directors on 7th November 2013. This recommendation was considered as part of this review.	**Closed**
79	Accountability of providers' directors	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	10	Chairman	Directors are currently required to comply with individual professional codes of practice and professional registrations. Any recommendations to comply with a prescribed code of conduct for directors that is not currently part of directors contracts will be complied with. The Government issued (July 2013) a consultation on Strengthening Corporate Accountability in Health and Social Care. This proposes a new requirement that all Board Directors (or equivalents) of providers registered with the Care Quality Commission must meet a new fitness test. This test includes checks about whether the person is of good character including past employment history, and if the individual has the qualifications, skills and experience necessary for the work or office as well as the more traditional consideration of criminal and financial matters.	**Closed**
81		Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.	11	Board		

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
84		Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	10	Human Resources/ Board Secretary	This situation has not arisen in the Trust. However should this ever be the case then the Board Secretary together with the Director of HR would make the necessary referrals. Refer to comments at Rec 81 above. The consultation document on Strengthening Corporate accountability incorporates this.	**Closed**
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings					
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13	Director of Transformation and Performance	The Health and Safety Manager role is currently vacant and is being considered as part of a restructuring of the F&E function within the Trust. Whilst arrangements for reporting RIDDOR incidents remain sound, the review of this recommendation will have to be deferred until the appointment of a new Health and Safety Manager for the Trust.	**Open**
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13	Director of Nursing	We will work with the HSE to meet any new requirements.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.					
174	Candour about harm	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	22	Medical Director	On 14th May the Medical Director advised all Consultants (inc Locums) and Trust Non-Consultant Medical Staff, of these requirements and confirmed that the Trust would not support any approach that was not consistent with these recommendations. Medical Director exploring the possibility of including a clause of openness and candour in all new medical staff contracts and retrospectively in all current medical staff contracts. The duty of candour is included in the proposed contract which is subject to negotiations. The duty of candour is included in the proposed contract which is subject to negotiations. Contractual negotiations are expected to close following the next Joint Local Negotiating Committee on 21/11/13. The Joint Local Negotiating Committee has **approved** the new contract and specifically endorsed the inclusion of the duty of candour. .	**Closed**
175		Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	22	Medical Director		

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Nursing					
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the:	23	Director of Nursing and Human Resources		
		– Possession of the appropriate values, attitudes and behaviours;			An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation.	**Open**
					Interviews for novice programme – entirely on values. A process has been agreed to include behaviours assessments for band 5 RN appointments, including newly qualified and band 2 CSW	**Closed**
		– Ability and motivation to enable them to put the welfare of others above their own interests;			To include in competencies for novices and new graduates. Customer care training is now included in both the Novice and Graduate programmes.	**Closed**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		– Drive to maintain, develop and improve their own standards and abilities;			All nursing staff/CSW have appropriate competencies and training programme, required to achieve before promotion to next grade – shortlisted for National Award 2013.	**Open**
					The new Healthcare Support Workers Code of Conduct is now integrated into all care support workers programmes.	
					Clinical Supervision re-launched during August/September 2013 Trust wide by posters sent to Lead Nurses for display in ward areas and Launch on the Hub. Training dates in September 2013 organised for staff wanting to become a supervisors	
		• Leadership which constantly reinforces values and standards of compassionate care;			Developing Appraisal questions based on "The Way We Care" and Codes of Conduct	**Open**
					The Trust runs 3 Leadership programmes • Clinical leadership in conjunction with the Hay Group aimed at CDs, MSHs and aspirant Clinical leaders. • A Trust Leadership programme which links to the NHS Leadership competency framework • A Trust Leaders Tool kit, aimed at people who are new to leading and are looking to again basis level technical skills in people management.	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		• Involvement in, and responsibility for, the planning and delivery of compassionate care;			Nursing strategy launched May 2013. 'The Way We Care' based on 6 C's and incorporating Trust Values of Responsibility, Care and Respect. KPI will be reported quarterly to Board. Quarterly updates now part of reporting process.	**Closed**
		• Constant support and incentivisation which values nurses and the work they do through: – Recognition of achievement;			Appraisals are managed as per the Trust's appraisal policy and cover both the technical part of any job together with the Trust values and the way the tasks are carried out by the employee. Recognition of good performance is made via "Committed to Excellence "and the Roll of Honour. The Trust also makes regular nominations to external awards	**Closed**
		– Regular, comprehensive feedback on performance and concerns;			Nurses referred to NMC report to be taken to the Board.	**Open**
		Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	23	Associate Director of Human Resources	An objective of the Trust is to pre screen all candidates on the Trust values, Care, Respect, and Responsibility. This was to be implemented via the revised NHS Jobs web site. However, this has now been delayed for almost 12 months and we are now pursuing and alternative IT solution to this implementation.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Caring for the elderly - Approaches applicable to all patients but requiring special attention for the elderly					
236	Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	25	Medical Director	Email from Medical Director to all CDs on 14th May 13) requesting assurance on this issue. Assurance received from multiple CDs and Medical Service Heads. Responses being chased following MD/CD/MSH meeting on 7/06/13. The Medical Director issued a further email to CDs and Medical Service Heads on 25/06/13 requesting assurance that all patients admitted to Dudley Group were at all times under the care of a named consultant and that appropriate systems were in place at directorate level to ensure this happens. 21/08/13 All specialities have confirmed. This practice is in place across the trust.	**Closed**
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25	Director of Operations	i) MDTs currently form a vital part of care at DGNHSFT. ii) A review, initially in care of the elderly, will be undertaken to ensure that the contribution of all staff involved in the care of patients is included (particularly linking different teams, PFI partners etc), and the lessons of Francis applied where appropriate	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds:	25			
		• All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors.		Director of Nursing	Matron and Lead Nurse availability will be posted on ward boards. This is being trialled in Paediatrics and will then be rolled out across the Trust.	**Open**
		• Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients		Director of Ops /Director of Nursing	Every ward has an area that is confidential to converse with patients and visitors.	
		• The NHS should develop a greater willingness to communicate by email with relatives.		Director of Ops/Medical Director /Director of Finance & Information	All e-mails from patients relatives and nurses are responded to by the Executive team. Ward level will require more process.	
		• The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered		Director of Ops/Medical Director /Director of Finance & information	The trust plans to move to an Electronic Patient Record system in the future and will include this requirement in the system specification	
		• Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.		Director of Ops/Medical Director	Care plans available at the bedside. Communication with relatives/visitors sheet being trialled on C7.	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25	Director of Operations	i) Late night discharge reports to be provided to clinical teams routinely to enable peer review and challenge ii) Review of the criteria for and protocol supporting patient moves at night as a requirement of managing bed capacity during periods of high escalation levels Discharge lounge is now appropriately staffed and furnished to provide care for patients awaiting discharge. Further work is being undertaken to improve the uptake of the service provided by the discharge lounge	**Open**
242 243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25	Director of Nursing & Medical Director/ Director of Finance & Information	Not currently possible to record electronically. This functionality is specified in a replacement EPR solution being procured by the Trust	**Open**
					Paper charts are at each bedside.	
					Compliance with charts is audited via Nursing Care Indicators.	

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
	Information					
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input.	26	Director of Finance & Information	The requirements outlined here will be considered when reviewing the electronic Patient Information Systems. Information is currently shared available via the manual systems in place across the Trust.	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
		• Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. • Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.				
255	Using patient feedback	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	26	Director of Nursing	1. New web pages for patient experience being developed. 255 Web pages complete. Presented to Clinical Quality Safety and Patient Experience Committee in Nov 2013. 2. Patient experience results posters currently displayed on wards – this are being refreshed and improved. Patient experience posters on all wards updated regularly by ward and patient experience team staff	**Closed**
256	Follow up of patients	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	26	Director of Nursing	The Friends and Family Test follows patients up on discharge/shortly after. The new website will host more online surveys – awareness will be raised via the ward leaflets Web pages with an online option for feedback are complete. Patients will be advised of this option via the ward leaflets by Jan2014	**Open**

Rec. No.	Theme	Recommendation	Chapter	Lead Director	Progress	
262	Enhancing the use, analysis and dissemination of healthcare information	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatments	26	Director of Finance and Information	The Trust had adopted robust manual information sharing arrangements. At present real time information is not available	**Closed**

Enclosure 8

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 5th December 2013

<table>
<tr><td>TITLE:</td><td colspan="3">Summary of Key issues from the Risk & Assurance Committee held on 22nd October 2013</td></tr>
<tr><td>AUTHOR:</td><td>Julie Cotterill
Governance Manager</td><td>PRESENTER</td><td>Ann Becke (NED)
CQSPE Committee Chair</td></tr>
<tr><td colspan="4">CORPORATE OBJECTIVES: SGO1: Quality , Safety & Service Transformation, Reputation
SGO2: Patient Experience , SGO5: Staff Commitment</td></tr>
</table>

SUMMARY OF KEY ISSUES:

External Reviews - Breast Screening Annual Report - 24,634 women were screened for breast cancer in Dudley and Wolverhampton in 2011/12 and 109 cancers were diagnosed. Screening outcomes were within national targets other than benign open biopsy rates. A QA visit is due in March 2014. Current issues include a lack of space for the service to expand into and difficulties working between the two stakeholder trusts, MRI requirements for screening in women at high risk, current non con-current screening practices carried out at both sites and finding new screening locations.

External Reviews - Statutory Supervision of Midwives - Review of University Hospitals of Morecambe Bay NHS Foundation Trust - The Committee received the report conducted by the Nursing and Midwifery Council (NMC) and the CQC in July 2011 following a number of concerns and complaints regarding midwifery practice and the supervisory activities at the Trust which were raised by a member of the public. The action plan was reviewed in June 2013 and was considered to be complete by Supervisors of Midwives; compliance had been agreed by the Directorate team.

West Midlands LSA Report 2012-2013 - The report describes how the Midwives Rules and Standards were met by the West Midlands LSA. The Trust had achieved the birth rate against staffing at 1:32.

External Reviews - Cancer Peer Review Serious Concerns Action Plan Update - Chemotherapy and Acute Oncology - Good progress had been made. The cancer services management team will continue to work with the relevant MDT teams to complete outstanding actions. A tender for the development of an electronic prescribing system has been progressed and the Trust IT Department is developing a Trust screensaver showing the single point of contact for patient referrals in acute oncology (metastatic spinal cord compression pathway). Training was continuing for ED and EAU Staff which now includes a session on Induction for Junior Doctors. A concern relating to the lack of an automated system to inform ED and EAU that a cancer patient has been admitted to the Trust was highlighted. A project team is progressing this.

Trauma and Orthopaedics Risk Register - the directorate is responsible for 2 wards; B1, B2, Out Patients Department and 3 theatres for Trauma and Orthopaedics. Out Patients Department and ward B1 have a good reporting culture. 3 listed risks were discussed:

- TO004 – Elective Orthopaedic Surgery no longer ring-fenced (Score 25),
- TO005 – Difficulty engaging with Trust's Orthopaedic Assessment Service (OAS) (Score 20)
- O003 – Staffing additional trauma beds on B3 station 2 (Score 15).

A further 4 risks following the Keogh review were outlined.

Corporate Risk Register - Directors are currently managing 26 corporate risks of which 9 score 20 or above and will be used in the BAF. The Committee discussed and challenged the scoring of the following and progress of mitigating actions:

- COR034 – Failure to achieve the CIP target.
- COR007 – Unable to admit emergency patients due to externally caused delayed discharge /transfer.
- COR045 -Sub-optimal management of diabetes patients
- COR039 -Patients with Learning Disabilities specific needs not being addressed as part of their care
- COR047 -Failure to achieve Monitor targets

Transformation and Estates Risk Register - There is an outstanding risk regarding the PFI partner's overarching response to utilities business continuity failures. The estates team is progressing some actions following a formal report into a water failure incident in 2010. The Deputy Director of Operations has concluded the RCA arising from the high voltage power failures of June 2013. A resolution to the practical changes that Summit and IFM need to make to return the HV system back to the expectations of the original building design and specification is awaited (due June 2013). Dr Banks (clinical champion) is working with medical staff on the introduction of the process of care changes demanded in the ECIST

Action Plan.

Operations Directorate Risk Register and CSIC - Mr Cattell outlined the work that had taken place to standardise the risk management approach at directorate level. Directorate meetings had highlighted instances where the top 5 risks do not align to Performance Accelerator. The Committee discussed risk ref VAS003 Inadequate Staffing Arrangements to support Phase 2 and beyond of the Vascular Hub reconfiguration and agreed that a detailed report was required for F & P Committee prior to Christmas.

Nursing Directorate Risk Register - the Directorate had a total of 11 risks on the register, of which 1 scored 16 or above. The Infection Control risk remained on the register as the Trust had failed CDiff figures for Quarter 2. The risk end dates would need to be extended.

Finance, Information and IT Directorate Risk Report - there were 6 risks on the Finance, Information and IT risk register and a further 2 had been closed since the last report. The Committee discussed the following:

- FO11 – Implementation of new Maternity Pathway System has resulted in increased complexity in recovering income for providing maternity care.
- IT002 - The current PFI IT service provision does not meet the Trust's business requirements.
- F010 / F003 - Failure to meet CQUIN targets leading to an income loss of up to 2.5%

Human Resources Risk Register - there were 5 risks on the register which had been previously reported. Good progress has been made with regard to mitigating actions.

Medical Directorate - there was 1 risk on the register which scored 12. "M031 - Not all Medical on-call SpR's are signed off as being competent". The Committee discussed the actions taken and confirmed that mitigating actions have reduced the risk to a score of 8.

Compliance with NPSA Safety Alerts - one alert has breached the closure date of 01/04/13. This occurred because only one provider was producing non luer needles which had delayed trials of the new equipment. As previously reported, this problem is shared with many organisations and the position has not changed since the last report.

Policy Group Recommendations - The Policy Group recommended 39 policies/guidelines for formal ratification. The full documents were available for review on the Directors shared drive prior to the meeting. The Committee **reviewed** the schedule of Policies and Guidelines and **ratified** all 39 documents listed.

Diversity Management Group held on 6th August 2013 - no major issues to report. New training sessions had been arranged to promote awareness of people with limited sight or hearing.

Health and Safety Group – The committee discussed concerns relating to a lack of specialist equipment to enable a full patient evacuation in the event of a fire, should parallel evacuation not be practicable.

***Please Note**: The full Committee minutes are available for Board members on the Directors drive.*

IMPLICATIONS OF PAPER:

RISK	Y		**Risk Description:** Committee reports ref to the risk register.
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	Y	**Details:** Outcome 1 - Respecting & Involving people , 4 – Care & welfare of people , 7 – Safeguarding, 16 – Assessing & monitoring quality of service
	NHSLA	Y	**Details:** Risk management arrangements e.g. Safeguarding
	Monitor	Y	**Details:** Ability to meet national targets and priorities
	Equality Assured	Y	**Details:** Better health outcomes for all Improved patient access and experience
	Other	Y	**Details:** Quality Report / Accounts

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
		Y	

RECOMMENDATIONS FOR THE BOARD: To note the key issues arising from the Risk & Assurance Committee held on 22nd October 2013 and refer to the full minutes for further details.

The Risk and Assurance Committee has overarching responsibility for risk and ensures that the Trust has appropriate and effective systems and processes in place to identify, record, manage and mitigate all risks (clinical and non clinical) to the provision of high quality, safe, patient centred care. The duties of the Committee include the assessment of the Trust risk

Enclosure 9

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th December 2013

TITLE:	Quarterly Quality Account Report (Second quarter July 13 - September 13)		
AUTHOR:	Derek Eaves Quality Manager	**PRESENTER:**	Denise McMahon Director of Nursing

CORPORATE OBJECTIVE:
SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.
SGO2: Patient experience - To provide the best possible patient experience.

SUMMARY OF KEY ISSUES:

The attached paper indicates the Trust's position at the end of the second quarter with the five Quality Priority target areas and the National Clinical Audits/Confidential Enquiries for 2013-14. The paper shows the actions being taken to achieve the targets. With regards to the five specific quality priority areas:-

Patient Experience - There are two hospital and two community targets for this topic, however, the latter two are based on an annual survey and so these cannot be reported on at this stage. One hospital target is on track but one isn't and so action is being taken from both the nursing and human resources perspectives, the latter to ensure that the health screening of the considerable backlog of volunteers, who can assist with feeding, is reduced in the immediate future.

Pressure Ulcers - Both the two hospital and the one community end of year targets are on track to be achieved with large reductions in grade 3 and 4 ulcers in both sectors.

Infection Control - While the MRSA target is being met so far with no bacteraemia being reported, we are over trajectory by 3 cases with the C.Difficile target at the end of September.

Nutrition/Hydration - One of the three 90% targets on these topics is being missed slightly over the first six months. The aim is to improve the score over the following months to get the score back on track and to achieve the end of year target of 93%.

With regards to the **National Clinical Audits and Confidential Enquiries -** It can be seen that staff are participating in all of those relevant to the Trust's services.

IMPLICATIONS OF PAPER:

RISK			**Risk Description:**
	Risk Register		**Risk Score:**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details**:
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** Quality Report requirements
	Equality Assured:	**Y**	**Details:** Better Health Outcomes Improved Patient Access and Experience
	Other	**Y**	**Details**: DoH Quality Account requirements

ACTION REQUIRED OF THE BOARD:

Decision	**Approval**	**Discussion**	**Other**
		✓	✓– Comment

RECOMMENDATIONS FOR THE BOARD: To note the position with regards to the quality priority targets and with regards to the national clinical audit/confidential enquiry participation at the end of the second quarter.

THE DUDLEY GROUP NHS FOUNDATION TRUST
QUALITY ACCOUNT UPDATE OCTOBER 2013

QUALITY PRIORITY 1: PATIENT EXPERIENCE. TARGETS: Hospital: a) Maintain an average score of 85 or above throughout the year for the patients who report receiving enough assistance to eat their meals. b) By the end of the year, at least 80per cent of patients will report that their call bells are always answered in a reasonable time. **Community**: a) Increase the number of patients who use their Single Assessment Process folder/Health and Social Care Passport to monitor their care from 49.4 per cent to 80 per cent by the end of the year. b) Increase the number of patients who would know how to raise a concern about their care and treatment if they so wished from 86.8 per cent to 90 per cent by the end of the year.

Planned Actions	Who	By When	Progress at end of June 2013	Progress at end of Sept 2013
Hospital				
Include the hospital patient experience quality priority in the newly developed Quality Outcome Measures Dashboard, a list of key quality indicators, to give lead nurses and matrons timely feedback	Karen Broadhouse Mandy Green	April 2013 and updated monthly	Meetings have been held with the Information Department staff to discuss the formatting and development of criteria. The Dashboard is under development. The checking of whether the Family & Friends information is available on ward notice boards will be included in the NCI's from 1st August 2013.	**COMPLETE**
Recruitment of additional nutritional support workers within Stroke & Elderly Care Dept.	Sheree Randall	Sept 2013	VAR forms have been completed. Adverts to go out within the next 2 weeks.	Interviews to take place at the end of October
Increase the number of volunteers trained to provide mealtime assistance	Mandy Green	Dec 2013	The volunteer coordinator is identifying the number of trained volunteers	Only 20 volunteers are trained as mealtime assistants. A recruitment event planned for Dec. but more importantly awaiting HR response re improving occupational health clearance time for volunteers as there is considerable delays in the health clearance system.
Include details in our patient information around the welcoming of family members to assist their relatives at mealtime if they wish to do so	Mandy Green	Next reprint – Approx Dec 2013	Added to Information Guide May 2013**.** All leaflets have been updated and ready for next reprint. Some leaflets have already been reprinted due to other changes and this update has been included.	Ongoing as leaflets are reprinted

Planned Actions	Who	By When	Progress at end of June 2013	Progress at end of Sept 2013
Pilot an improved system of call bell answering on the surgical wards, monitor its impact and roll out to other areas dependant on its success	Lesley Leddington	Sept 2013	A meeting has been held to agree posters and audit mechanisms.	A roll out of the system to Surgery and Trauma/Orthopaedics is occurring in November.
Design and trial new posters giving patients clear information on the call bell system	Lesley Leddington/ Mandy Green	Sept 2013	A meeting has been held to agree posters and audit mechanisms.	Posters have been agreed and being printed. A roll out of the system to Surgery and Trauma/Orthopaedics is occurring in November.
Introduce a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells, thereby allowing sufficient time for patients & nursing staff to adequately prepare for mealtimes.	Lesley Leddington/ Sheree Randall	Sept 2013	A meeting with the call bell supplier has occurred and the Trust has obtained the relevant information to change the system. S Randall will review options by the end August 2013	A meeting has been held with Static, the call bell company, to discuss functionality options. A review to agree further action is taking place.
Community				
Launch the new Health and Social Care Passport which is for information sharing between the patient, carers and health and social care professionals. The document will be simpler to follow and will encourage patient and carers to use to monitor their care.	Sally-Anne Osborne	Sept 2013	Document under development	Delay in finalising the folder due to changes in stakeholder leads. Changes made following GP consultation. Expected launch November 2013.
Produce a information leaflet for existing Single Assessment Process folder holders to explain to them how to use the document to monitor their care.	Sally-Anne Osborne	Sept 2013	Document under development	Plan to be completed November in line with the launch.
Extend the annual survey to try to discover the reason for patients choosing not to use the documents to monitor their care.	Sally-Anne Osborne	Quarter 3 survey		Included in the survey

Hospital

July-September 2013 data and commentary

Quality Priority hospital (a)	Apr-Jun	Jul-Sep
Maintain an average score of 85 or above throughout the year for patients who report receiving enough assistance to eat their meals	77.3	77.6

Of 429 patients interviewed in quarter two 320 reported that they did not need any help to eat their meals and 80 didn't answer the question. Five patients said that they sometimes got the help that they needed and the wards concerned are PCCU/A2/A3/B2/B3. Four patients reported that they didn't get the help they needed and the wards concerned are B2/B4/C3/C7. Twenty patients reported that they always got the help they needed. Matrons are being asked to look at how to improve this score. In addition, there is a need to improve the appointment system of volunteers as there are considerable delays in the occupational health clearance system.

Quality Priority hospital (b)	Apr-Jun	Jul-Sep
By the end of the year at least 80 per cent of patients will report that their call bells are always answered in a reasonable time	89.2	89.1

Quarterly scores of 89.2 and 89.1 are a pleasing start for this quality priority. There is no baseline for comparison as this is a new question on the survey.

Community

July-September 2013 data and commentary

No data to report for quarter two as this is an annual survey.

Operational lead: Mandy Green, Communications Manager

QUALITY PRIORITY 2: PRESSURE ULCERS: Hospital: a) Reduce avoidable grade 4 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 50 per cent in 2013/14. b) Reduce avoidable grade 3 hospital acquired pressure ulcers so that the number for 2012/13 has been reduced by 25 per cent in 2013/14. **Community:** Reduce avoidable grade 3 and 4 acquired pressure ulcers that occur on the district nurse caseload so that the number for 2012/13 has been reduced by 25 per cent in 2013/14.

Planned Actions	Who	By When	Progress at end of June 2013	Progress at end of Sept 2013
Continue to promote the "50 Day Dash campaign	C Carter	Mar 2014	The 50 Day Dash continues with Awards given for 200 days Pressure Ulcer free – next target will be 365 days.	**COMPLETE**
Tissue Viability are planning a trolley dash for the hospital to continue the message of Zero tolerance, highlight the importance of elevating patients heels off the surface with a suggestion box on the day for staff to inform the Trust how we can improve pressure ulcer prevention. This trolley dash will also be to spread the message of a different staging tool to assess the severity of pressure ulcers.	C Carter	April 2013	Several trolley dashes have been completed – this is to be completed on a regular basis to ensure that all ward areas are covered. Discussions are had with staff regarding any concerns/changes that are happening and action taken to make any improvement.	**COMPLETE**
Regular equipment sessions have been organised to inform community nursing teams about the correct use of equipment and fault finding.	L Turley	Mar 2014	Equipment sessions continue. Recruitment process in progress for 2 new nurses to support monitoring of community equipment and training	Band 6 Nurses now in post. Equipment training sessions booked.
Education sessions will continue for all trust staff.	L Turley C Carter	Mar 2014	Education sessions continue – there are sessions held for acute or community staff nearly every month.	**COMPLETE**
The team will continue to work with private care agencies and organise education sessions and updates as required.	L Turley	Mar 2014	Crib sheet for guidance for carers agreed and sent out to all agencies Dates given for future training days	**COMPLETE**
Tissue viability team to support nursing homes with the formulation of a mattress selection guide.	L Turley	July 2013	Mattress guide nearing completion. The Tissue viability team has reviewed the document completed by Karen Mcbride and decided would be better if cushions are also included. Will be completed and presented at Nursing home link nurse meeting on 26th July.	**COMPLETE**

July-September 2013 Data

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

Period	2012/13	Apr- June 13	Jul-Sep 13+	Oct-Dec 13	Jan-Mar 14
No. of stage 3	23	3	5		
No. of Stage 4	28	0	0		
Total	51	3	5		

+Please note than these figures may change dependant on the outcomes of RCA investigations as to whether reported pressure ulcers are avoidable or unavoidable.

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

Period	2012/13	Apr- June 13	Jul-Sep 13+	Oct-Dec 13	Jan-Mar 14
No. of stage 3	7	0	0		
No. of Stage 4	11	0	0		
Total	18	0	0		

+Please note than these figures may change dependant on the outcomes of RCA investigations as to whether reported pressure ulcers are avoidable or unavoidable.

July-September 2013 Commentary

The number of avoidable pressure ulcers is continuing to be low with zero stage 4 and five stage 3 pressure ulcers reported in the hospital and zero stage 3 and 4 in the community. It can be seen that so far this year the three targets are on track to be achieved.

Operational Lead: Lisa Turley, Tissue Viability Lead Nurse

QUALITY PRIORITY 3: INFECTION CONTROL TARGETS: Reduce our MRSA and *Clostridium difficile* (C*. diff*) rates in line with national and local priorities. a) MRSA Bacteraemia (blood stream infections) target is to have no post 48hr cases. b) *C.diff* is no more than 38 post 48hr cases in 2013/14.

Planned Actions	Who	By When	Progress at end of June 2013	Progress at end of Sept 2013
Revise the C. difficile care pathway in line with national guidance to include the use of fidaxomicin (Dificlir), which is associated with lower rates of relapse.	Antimicrobial Pharmacist/ Consultant Microbiologist	October 2013	Fidaxomicin has been passed through the Trust D&T Group - now awaiting Areas Medicines Management Committee approval. The care pathway in draft pending these approvals.	**COMPLETE**
Assign an Infection Control Nurse particularly to the investigation and follow up of patients with C. diff.	Infection Control Team	In Post	In post and role being embedded into clinical areas.	**COMPLETE**
Continue to develop educational programmes and improve the attendance of staff at the relevant sessions	Infection Control team	Training sessions are continually on-going	Good attendance to sessions as of end of June 2013. Many sessions are about MRSA screening and preventing C.diff and are completed via informal sessions and are ward based. Both medical and Allied Health Care professionals are targeted.	Educational sessions have been provided by the Consultant Microbiologist in the community regarding antimicrobial prescribing and a training video detailing the Clostridium difficile care pathway is complete and awaiting upload on the Hub.
Launch an online antimicrobial training package to include a competency assessment for all prescribers to supplement the existing training provision.	Dr Rees/IT Department	September 2013	Video recorded; competency questions completed. Awaiting final IT work.	IT work now complete – final version to be checked by Consultant Microbiologists /Antimicrobial Pharmacist and liaison with Communications Department regarding uploading onto the Hub in progress.
Participate in primary care educational programme for GPs to improve prescribing of antimicrobials and awareness of C. difficile.	Dr Rees	October 2013	Training dates confirmed.	Primary session complete – other sessions now booked.
Increase the rate of MRSA screening for emergency patients	Matrons/ lead nurses	July 2013	May 2013- (Compliance 92.2%, up from April 2013 at 90.7%) Contract target is 97%. Continue informal awareness sessions including feedback of results.	Figures for Jul 91.9%, Aug 93.2%, Sep 91.3%. Continue informal awareness sessions including feedback of results.

Roll out the availability of HPV service which enhances the cleaning programme across the Trust.	Infection Control team	Fogging service is operational	Fogging service is provided weekdays and service now being extended to weekends, and some evenings. More staff members have received training. Funding agreed for the service to have permanent staff therefore awaiting confirmation to advertise these posts.	Work continues to develop a planned preventative programme alongside the reactive HPV fogging of high risk side rooms.

July-September 2013 Commentary

MRSA is within trajectory for the quarter. With regards to C. diff, we are 3 over trajectory for the first two quarters. We have a improved the system to ensure samples are sent appropriately and timely by including all of the infection control team in this activity. There are also plans for the HPV service to undertake terminal cleans (presently undertaken by Interserve) prior to undertaking the 'fogging' so that a more effective service is provided to ward areas.

July-September 2013 Data

Clostridium difficile infections

Monthly number of C.diff cases

Month / Year	> 48 hrs Activity	> 48 hrs Target	% Over/Under Target	Cumulative > 48 hrs	Cumulative Target	% Over/Under Target	Trust Total	Health Economy
Apr-13	1	3	-66.7%	1	3	-66.7%	5	7
May-13	4	3	33.3%	5	6	-16.7%	10	11
Jun-13	5	3	66.7%	10	9	11.1%	6	6
Jul-13	3	3	0.0%	13	12	8.3%	9	11
Aug-13	2	3	-33.3%	15	15	0.0%	8	11
Sep-13	6	3	100.0%	21	18	16.7%	9	9
Oct-13		4			22			
Nov-13		3			25			
Dec-13		4			29			
Jan-14		3			32			
Feb-14		3			35			
Mar-14		3			38			
FY 2013-14	21	38	16%				47	55

The CCG target for Cdiff is 38 cases for the financial year. The vital signs reporting framework has indicated that samples taken during the first 48 hours of admission to hospital should not be considered as hospital acquired.
The Trust Total applies to the number of samples taken from Inpatients, including pre 48 hours.
The Health Economy figures apply to all samples processed by the Russells Hall pathology service, including GP samples.

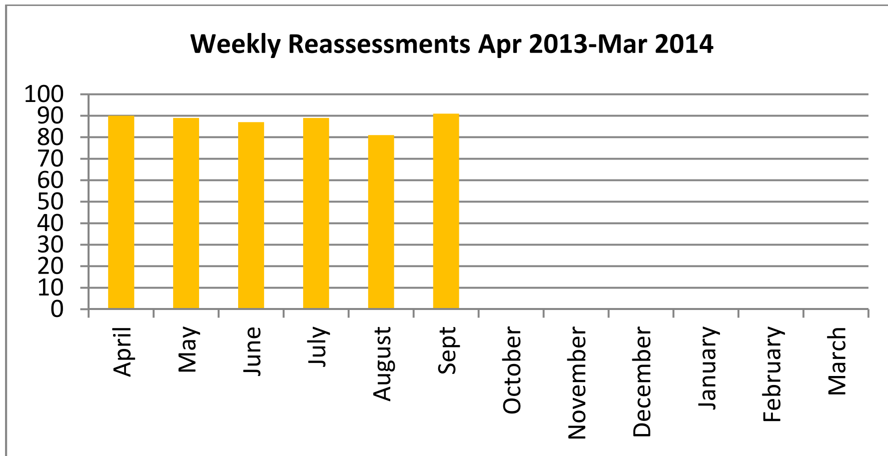
MRSA infections 0

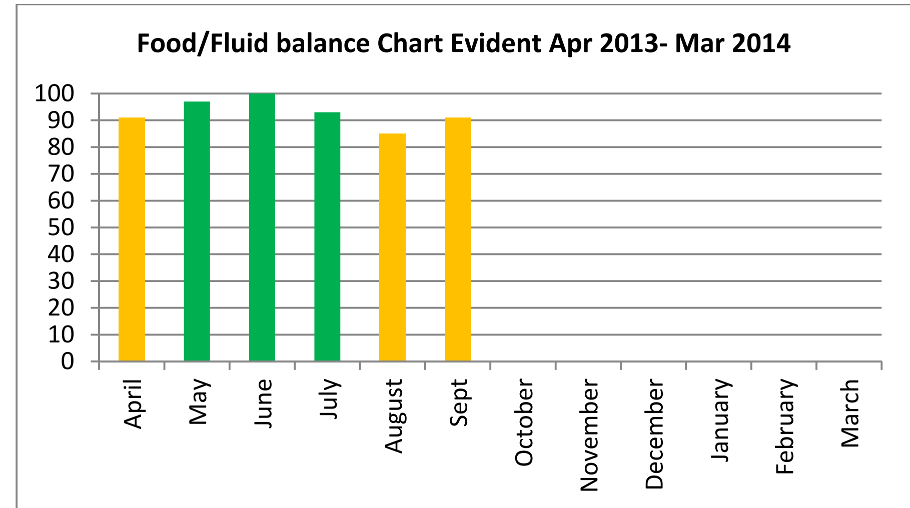
Operational Lead: Dr E Rees, Consultant Microbiologist

QUALITY PRIORITIES 4 AND 5: NUTRITION/HYDRATION: **Nutrition** a) Increase the number of patients who have a weekly risk re-assessment regarding their nutritional status. Through the year on average at least 90% of patients will have the weekly risk assessment completed and this will rise to at least 93% by the end of the year (March 2014). b) Increase the number of patients having a food recording chart and a fluid balance chart in place if the MUST score is 1 or above. Through the year on average at least 90% of patients will have the weekly risk assessment completed and this will rise to at least 93% by the end of the year (March 2014). **Hydration** Increase the number of patients who have their fluid balance charts fully completed. Through the year on average at least 90% of patients will have their charts fully completed and this will rise to at least 93% by the end of the year (March 2014).

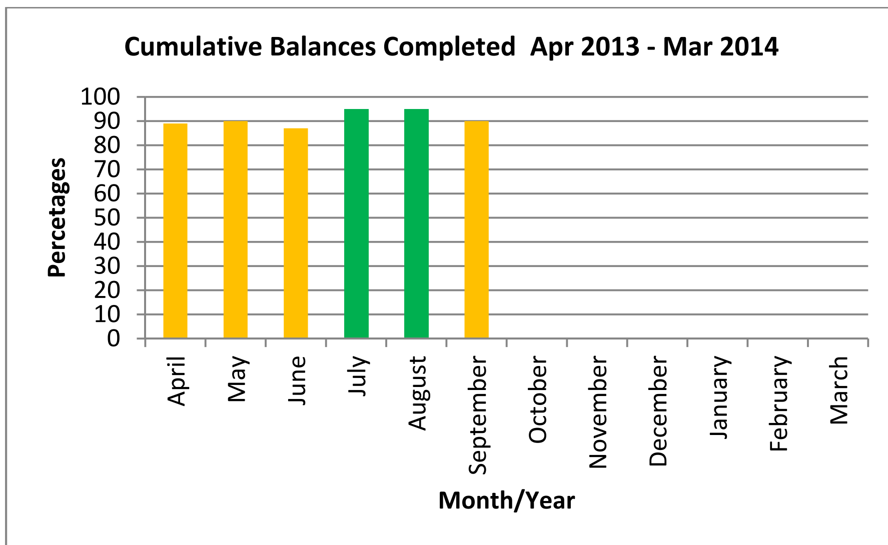
Planned Actions	Who	By When	Progress at end of June 2013	Progress at end of Sept 2013
System of monthly mealtime audits to be reviewed to have a more robust system of ensuring appropriate action is taken dependent on the audit results.	K Broadhouse	April 2013. Then quarterly reports and escalation	Following a review of the audit question wording, an area of concern has been highlighted concerning the expected level of participation for the Registered nurses during mealtimes. Changes to question to be undertaken by Sept 2013.	**COMPLETE**
Introduce a more automated system of ensuring that patients and staff are forewarned about mealtimes rather than the use of hand bells.	S Randall	September 2013	A meeting with call bell supplier has occurred and the Trust has obtained the relevant information to change the system. S Randall will review options by the end August 2013	Digby Aston has met with Static to discuss functionality options. Aw DA return from AL to review & agree further actions By end Nov 2013
Explore the introduction of an e-learning package.	A Marsh/ S Randall	April 2013	A package has been identified to source funding. S Randall to review learning package with A Marsh & K Broadhouse for suitability by the end of August 2013.	Due to competing priorities this meeting has yet to be scheduled. Action: S Randall to arrange meeting by end Nov 2013
Develop a strategy for ensuring the importance of nutrition/hydration is a priority issue by such means as further screensavers, articles in newsletters and other appropriate mechanisms	A Marsh/ S Randall	September 2013	Awaiting trust decision on any new meal supplier changes. Mealtime audit and fluid balance audit results are discussed at the bi monthly essence of care meetings.	Continue to await outcome of Trust pilot re alternative meal system (Steamplicity). End Nov 2013

July- September 2013 Data- Nutrition





July- September 2013 Data – Hydration



Key: Green – 93% and above
Amber – 92-75%
Red – 74% and less

July -September 2013 Commentary

During the 2nd quarter 2013 results for weekly reassessments of the MUST scores have been: July 89%, August 81%, September 91% which gives an average score of 87%. This means that for the first 6 months of 2013-14 the average Trust score is 87%, under the 90% target.

Food and fluid balance charts have to be instigated for all patients with a MUST score of 1 and the monthly results have been: July 93%, August 85% and September 91% giving a quarterly average score of 89%. This means that for the first six months of 2013-14 the average Trust figure is 92% and so the 90% target is presently being met.

Fluid balance results for the second quarter are July 95%, August 95% and September 90%, giving an average of 93%. This means that for the first six months of 2013-14 the average Trust figure is 92% and so the 90% target is presently being met.

All the results are discussed at the Link nurse meetings and highlighted at the Matrons meetings. A special meeting has been arranged with Lead nurses to improve these results especially in light of the end of year target of 93%.

Operational Leads: Dr S. Cooper, Consultant Gastroenterologist, Sheree Randall, Matron, Karen Broadhouse, Quality Project Lead

NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES

With regards to the National Clinical Audit Programme there are presently 32 audits that the Trust is eligible to participate in and the Trust is participating in them all. This number is not static in that the Healthcare Quality Improvement Partnership (HQIP), which co-ordinates the list, updates it on a continual basis. There is the potential that five more audits will be added to the list as no commencement dates for these audits have yet been agreed and likewise some scheduled audits may be deleted off the list if they do not actually materialise prior to March 2014. In addition, the Trust is partaking in all five Confidential Enquiries it is eligible to take part in.

Contributions from: K. Obrenovic, M. Green, S. Randall, C. Carter, E. Rees, K. Broadhouse.
Compiled by D. Eaves.
Oct 2013

Paper for submission to the Board on 5th December 2013

TITLE:	**Information: To Share or not to Share Government Response to the Caldicott Review**		
AUTHOR:	Head of Information Information Governance Manager	**PRESENTER**	Mr Roger Callender

CORPORATE OBJECTIVE:

SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation

SUMMARY OF KEY ISSUES:
What this means for organisations within health or social care

- Boards or their equivalents will make sure that their organisation has due regard for information governance.
- Employing organisations will adhere to the principles of the Caldicott Report and the NHS Constitution on data sharing in their efforts to improve care and support for the benefit of patients and people who use services.
- Employing organisations will help professionals to share information appropriately in order to help to integrate care and improve services.
- Organisations will be open and honest – explaining and apologising if a data breach happens, and taking action to prevent it happening again.
- Organisations will have a Caldicott Guardian or a Caldicott lead and will offer suitable training and education for all staff on information governance.
- Over time social care providers and commissioners will adopt more of the best practice that is already in place across much of the NHS so that the way personal information is treated is the same whether the care is provided by a GP, hospital or care home.

IMPLICATIONS OF PAPER:

RISK	**Y/N**		**Risk Description: Not applicable**
	Risk Register: Y/N		**Risk Score: Not applicable**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**Yes**	**Details:** The CQC's information governance monitoring work will focus on how well information is used and shared to support delivery of good quality care. The CQC's approach will evolve as it develops its new regulatory model across different sectors. This will encompass: • *the quality of care records;* • *how health and care providers ensure effective and consistent information governance practice;* • *the use of information across teams and within organisations;* • *and the sharing of information along care pathways and across organisational boundaries.*

			The CQC will use the Confidentiality Code of Practice http://systems.hscic.gov.uk/infogov/codes/securitycode.pdf to inform its monitoring plans for information governance in order to reassure itself that organisations are reviewing their practices and adhering to the required standards, and they will be directed towards the best practice contained in the Code of Practice.
	NHSLA	**No**	**Details:**
	Monitor	**Yes**	**Details:** **Monitor commitment:** When they next update their requirement for foundation trusts' annual reports, consider including a requirement to publish all data breaches
	Equality Assured	**Yes**	**Details:** Sharing information to support better care is one of the fundamental requirements to support many of the Secretary of State's priorities, including vulnerable older people and compassionate care. The Report's view is that good professional practice goes hand in hand with good information governance practice and the Department expects the two to become fully integrated.
	Other	**No**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		■	

RECOMMENDATIONS FOR THE BOARD /COMMITTEE/GROUP:

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

SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
SGO2.	Patient experience	To provide the best possible patient experience
SGO3.	Diversification	To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio
SGO4.	Clinical Partnerships	To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO5.	Staff Commitment	To create a high commitment culture from our staff with positive morale and a "can do" attitude
SGO6.	Enabling Objectives	To deliver an infrastructure that supports delivery

The Dudley Group NHS
NHS Foundation Trust

Information: To Share or not to Share
Government Response to the Caldicott Review

INTRODUCTION

In the past, information governance rules have prioritised systems over people. Too often they have been seen as an insurmountable obstacle and an excuse to avoid sharing information. An outline of a new approach from the government is detailed here.

This new approach will mean that frontline staff will be confident about when to share information with other members of a person's care team and how to do so safely. Frontline staff will also have much greater confidence that anyone else who shares information will do so responsibly and properly. And people will know how their care information is used and shared and how to object if they want to.

The government's response sets out how individuals and organisations should improve the way that information is used for research, commissioning and above all good care. Giving people a say in how their information is used is an essential component of a good system. Where someone is concerned about their information being shared, they have the right to make their objection heard.

Information must be held securely. Several safeguards will be put in place. They include: making sure that health and care staff are appropriately trained in information governance, responding to a data breach honestly and immediately, and having a designated leader on information governance.

The revised Caldicott principles

1. Justify the purpose(s)
2. Don't use personal confidential data unless it is absolutely necessary
3. Use the minimum necessary personal confidential data
4. Access to personal confidential data should be on a strict need-to-know basis
5. Everyone with access to personal confidential data should be aware of their responsibilities
6. Comply with the law
7. The duty to share information can be as important as the duty to protect patient confidentiality

What this means for organisations within health or social care

- Boards or their equivalents will make sure that their organisation has due regard for information governance.
- Employing organisations will adhere to the principles of the Caldicott Report and the NHS Constitution on data sharing in their efforts to improve care and support for the benefit of patients and people who use services.
- Employing organisations will help professionals to share information appropriately in order to help to integrate care and improve services.
- Organisations will be open and honest – explaining and apologising if a data breach happens, and taking action to prevent it happening again.
- Organisations will have a Caldicott Guardian or a Caldicott lead and will offer suitable training and education for all staff on information governance.
- Over time social care providers and commissioners will adopt more of the best practice that is already in place across much of the NHS so that the way personal information is treated is the same whether the care is provided by a GP, hospital or care home.

Health and care professionals must not use information governance as a reason not to share data when sharing it is in the best interests of people they are caring for. Indeed, the duty to safeguard children or vulnerable adults may mean that confidential information should be shared, even without consent, because it is in the public interest to do so. Where there is a risk of significant harm to a child, either directly through abuse or neglect, or indirectly where they live in a household where other people are suffering harm (for example, domestic violence), there may be a strong basis for sharing information to protect the child.

Perhaps the most important recommendations of the Report relate to the emphasis that should be placed upon sharing information to support direct care. The Department is calling on all organisations to examine their existing arrangements, and to lead by example.

Direct care is the term used by the Review to include clinical care, social care and public health activity relating to individuals. It also includes activity such as audit and management of untoward incidents where these are carried out by people who have a legitimate relationship for that person's care.

REPORT RECOMMENDATIONS

Recommendation 1 (section 2.4)
People must have the fullest possible access to all the electronic care records about them, across the whole health and social care system, without charge.

An audit trail that details anyone and everyone who has accessed a patient's record should be made available in a suitable form to patients via their personal health and social care records. The Department of Health and NHS Commissioning Board should drive a clear plan for implementation to ensure this happens as soon as possible.

Recommendation 2 (sections 3.3 and 3.4)
For the purposes of direct care, relevant personal confidential data should be shared among the registered and regulated health and social care professionals who have a legitimate relationship with the individual.

Health and social care providers should audit their services against NICE Clinical Guideline 138, specifically against those quality statements concerned with sharing information for direct care.

Recommendation 3 (section 3.5)
The health and social care professional regulators must agree upon and publish the conditions under which regulated and registered professionals can rely on implied consent to share personal confidential data for direct care. Where appropriate, this should be done in consultation with the relevant Royal College. This process should be commissioned from the Professional Standards Authority.

Recommendation 4 (sections 3.6 and 3.7)
Direct care is provided by health and social care staff working in multi-disciplinary 'care teams'. The Review recommends that registered and regulated social workers be considered a part of the care team. Relevant information should be shared with members of the care team, when they have a legitimate relationship with the patient or service user. Providers must ensure that sharing is effective and safe. Commissioners must assure themselves on providers' performance.

Care teams may also contain staff that are not registered with a regulatory authority and yet undertake direct care. Health and social care provider organisations must ensure that robust combinations of safeguards are put in place for these staff with regard to the processing of personal confidential data.

Recommendation 5 (section 3.10)
In cases when there is a breach of personal confidential data, the data controller, the individual or organisation legally responsible for the data, must give a full explanation of the cause of the breach with the remedial action being undertaken and an apology to the person whose confidentiality has been breached.

Recommendation 6 (section 4.6)
The processing of data without a legal basis, where one is required, must be reported to the board, or equivalent body of the health or social care organisation involved and dealt with as a data breach.

There should be a standard severity scale for breaches agreed across the whole of the health and social care system. The board or equivalent body of each organisation in the health and social care system must publish all such data breaches. This should be in the quality report of NHS organisations, or as part of the annual report or performance report for non-NHS organisations.

Recommendation 7 (section 5.5)
All organisations in the health and social care system should clearly explain to patients and the public how the personal information they collect could be used in de-identified form for research, audit, public health and other purposes. All organisations must also make clear what rights the individual has open to them, including any ability to actively dissent (i.e. withhold their consent).

Recommendation 8 (section 5.5)
Consent is one way in which personal confidential data can be legally shared. In such situations people are entitled to have their consent decisions reliably recorded and available to be shared whenever appropriate, so their wishes can be respected. In this context, the Informatics Services Commissioning Group must develop or commission:

- *guidance for the reliable recording in the care record of any consent decision an individual makes in relation to sharing their personal confidential data; and*
- *a strategy to ensure these consent decisions can be shared and provide assurance that the individual's wishes are respected.*

Recommendation 9 (section 5.9)
The rights, pledges and duties relating to patient information set out in the NHS Constitution should be extended to cover the whole health and social care system.

Recommendation 10 (section 6.5)
The linkage of personal confidential data, which requires a legal basis, or data that has been de-identified, but still carries a high risk that it could be re-identified with reasonable effort, from more than one organisation for any purpose other than direct care should only be done in specialist, well-governed, independently scrutinised and accredited environments called 'accredited safe havens'.

The Health and Social Care Information Centre must detail the attributes of an accredited safe haven in their code for processing confidential information, to which all public bodies must have regard.

The Informatics Services Commissioning Group should advise the Secretary of State on granting accredited status, based on the data stewardship requirements in the Information Centre code, and subject to the publication of an independent external audit.

Recommendation 11 (section 7.4)
The Information Centre's code of practice should establish that an individual's existing right to object to their personal confidential data being shared, and to have that objection considered, applies to both current and future disclosures irrespective of whether they are mandated or permitted by statute.

Both the criteria used to assess reasonable objections and the consistent application of those criteria should be reviewed on an ongoing basis.

Recommendation 12 (section 7.6)
The boards or equivalent bodies in the NHS Commissioning Board, clinical commissioning groups, Public Health England and local authorities must ensure that their organisation has due regard for information governance and adherence to its legal and statutory framework.

An executive director at board level should be formally responsible for the organisation's standards of practice in information governance, and its performance should be described in the annual report or equivalent document.

Boards should ensure that the organisation is competent in information governance practice, and assured of that through its risk management. This mirrors the arrangements required of provider trusts for some years. Recommendation 12 (section 7.6)

Recommendation 14 (section 9.2)
Regulatory, professional and educational bodies should ensure that:

- *information governance, and especially best practice on appropriate sharing, is a core competency of undergraduate training; and*
- *information governance, appropriate sharing, sound record keeping and the importance of data quality are part of continuous professional development and are assessed as part of any professional revalidation process.*

Recommendation 15(section 9.4.2)
The Department of Health should recommend that all organisations within the health and social care system which process personal confidential data, including but not limited to local authorities and social care providers as well as telephony and other virtual service providers, appoint a Caldicott Guardian and any information governance leaders required, and assure themselves of their continuous professional development.

Recommendation 17(section 11.2)
The NHS Commissioning Board, clinical commissioning groups and local authorities must ensure that health and social care services that offer virtual consultations and/or are dependent on medical devices for biometric monitoring are conforming to best practice with regard to information governance and will do so in the future.

Recommendation 18(section 12.8)
The Department of Health and the Department for Education should jointly commission a task and finish group to develop and implement a single approach to recording information about 'the unborn' to enable integrated, safe and effective care through the optimum appropriate data sharing between health and social care professionals.

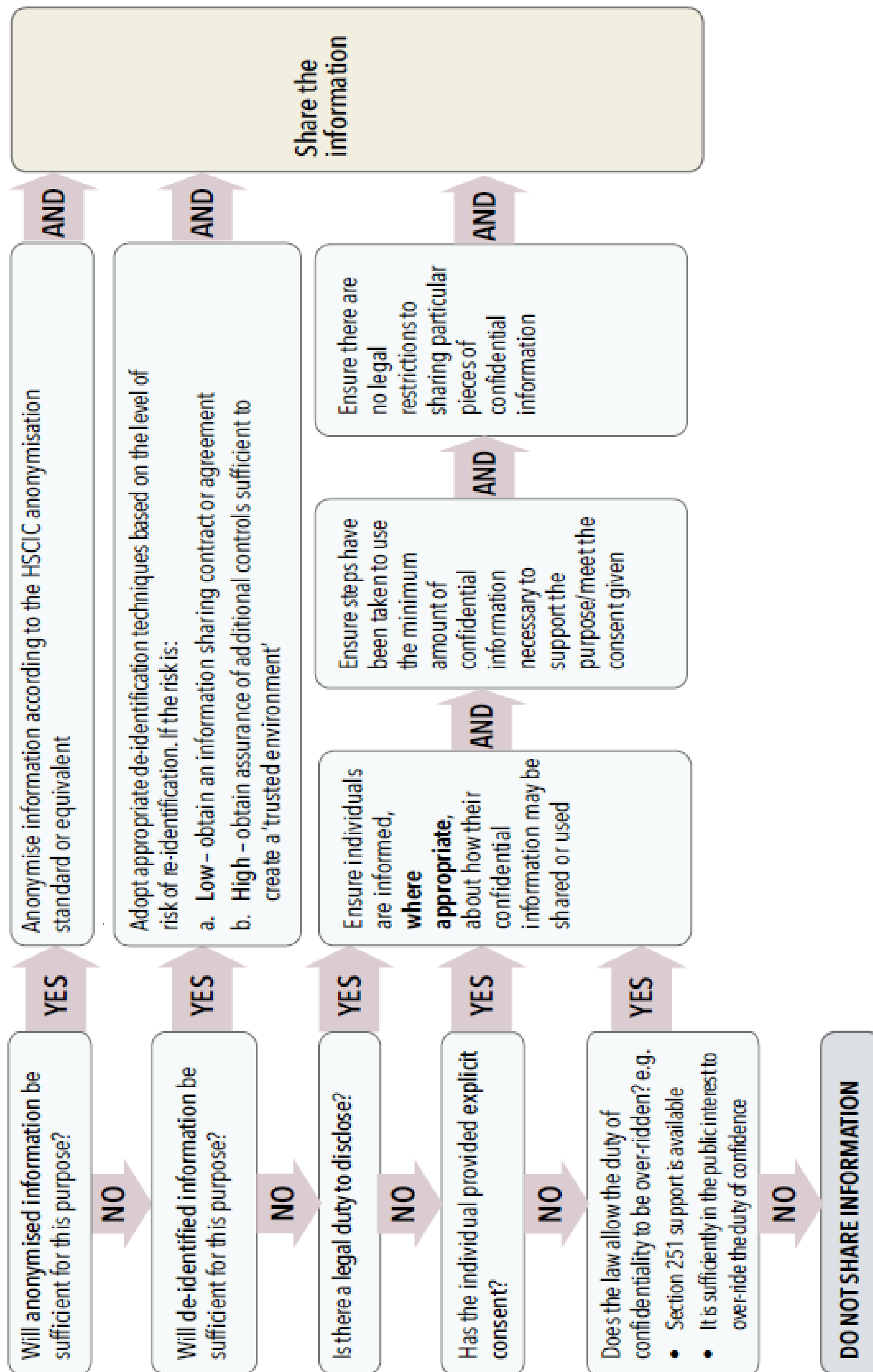
Recommendation 19(section 12.9)
All health and social care organisations must publish in a prominent and accessible form:

- *a description of the personal confidential data they disclose;*
- *a description of the de-identified data they disclose on a limited basis;*
- *who the disclosure is to; and*
- *the purpose of the disclosure.*

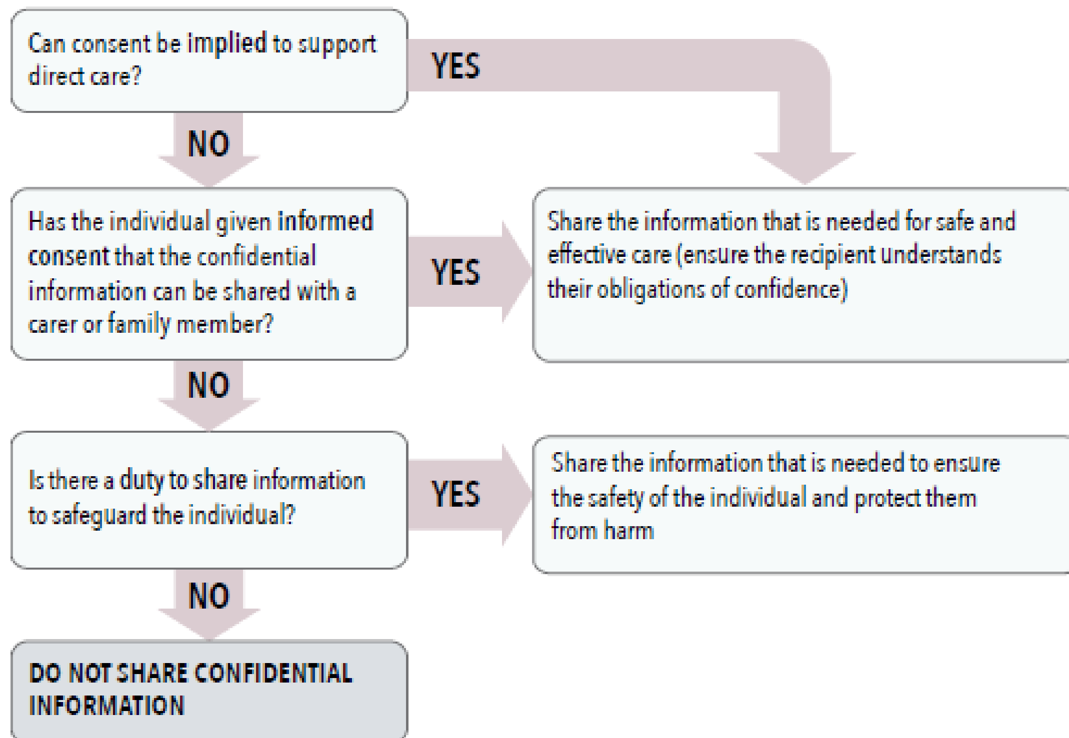
Recommendation 20(section 12.10)
The Department of Health should lead the development and implementation of a standard template that all health and social care organisations can use when creating data controller to data controller data sharing agreements. The template should ensure that agreements meet legal requirements and require minimum resources to implement.

Recommendation 25(section 14.2)
The Review Panel recommends that the revised Caldicott principles should be adopted and promulgated throughout the health and social care system.

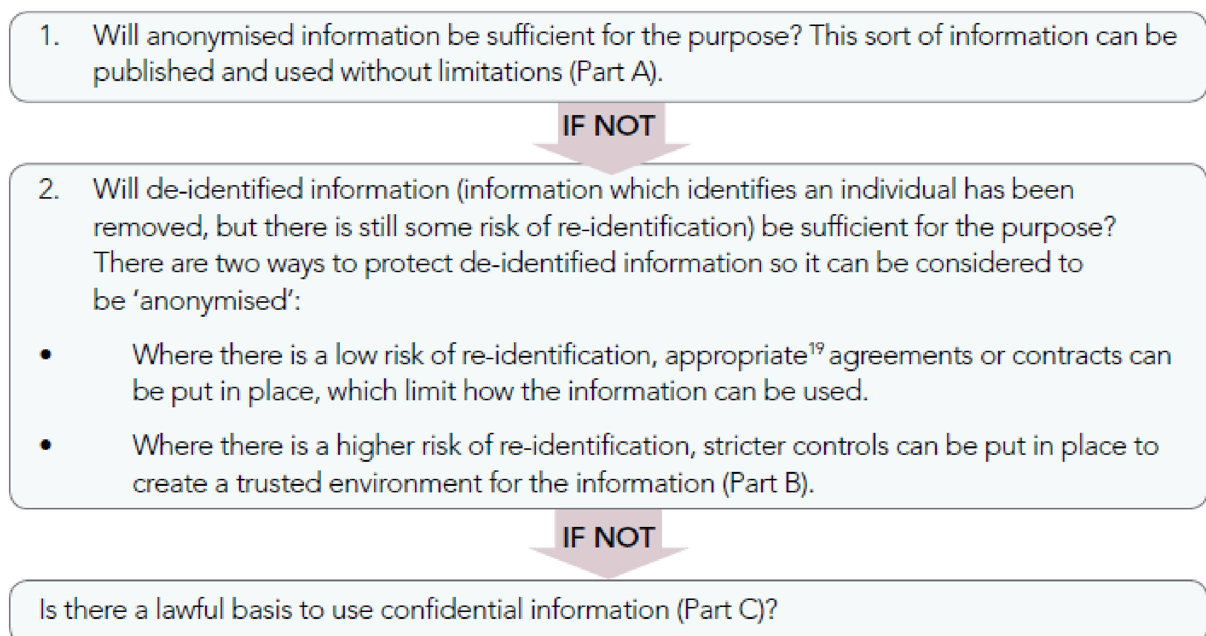
Deciding whether to share or disclose confidential information for the benefit of the community



Deciding whether to share confidential information for direct care



The guiding principles about the type of information which should be used for different purposes.



A. Generally, anonymised information can and should be used to support the improvement of care services

Effectively anonymised information can be published

Removing the individual's name, age, address and other personal identifiers[21] may not be sufficient to effectively anonymise the information. This is because it is sometimes possible to link pieces of information together which on their own would not identify an individual but when looked at together could re-identify an individual. For the same reason anonymisation is not always achieved through masking the individual's identity by using pseudonyms or coded references.

When confidential information has been anonymised in line with the HSCIC Anonymisation Standard[22] or equivalent, it can lawfully be published and used. This means it can be shared without breaching confidentiality.

B. However, sometimes anonymised information by itself is not sufficient to release benefits to the community

Sometimes anonymised information is not adequate to support important activities. Occasionally it is important to have information at service user or patient level, which allows for a differentiation between individuals. Although the information is not identifiable, there is still a risk that an individual could be identified unless appropriate controls are put in place. The controls required will be based on the risk of re-identification of an individual.

The risk is deemed to be low where personal identifiers have been removed. This risk can be controlled by data sharing agreements or contracts with appropriate liabilities and penalties included.

C. In exceptional circumstances it may be necessary to use confidential information, but this requires informed consent of the individual or another legal basis which allows or mandates the sharing

Confidential information should **only** be used in those cases where it is not possible to use anonymised or de-identified information. This is only possible where:

- there is a legal obligation to share the confidential information for a particular purpose.

  OR

- fully informed consent has been gained from the individual.

  OR

- the law allows the sharing of confidential information for a particular purpose. This can be in the public interest or through legislation.

The Dudley Group NHS Foundation Trust

Paper for submission to the Board of Directors on
5th December 2013

TITLE:	Birmingham and Black Country Stroke Transformation Programme		
AUTHOR:	**Richard Beeken, Director of Strategy, Performance & Transformation**	**PRESENTER**	**Richard Beeken, Director of Strategy, Performance & Transformation**

CORPORATE OBJECTIVE:
SG04 - To develop and strengthen strategic clinical partnerships to maintain and protect our key services

SUMMARY OF KEY ISSUES:

The previous Regional Cardiovascular Network and the NHS Midlands and East Cluster SHA co-ordinated a review of Stroke Services which concluded in 2012. Although not particularly definitive in its conclusions, the review team did state that Commissioners needed to insist on changes to the specification of the Stroke Care Pathway, particularly the Hyper-Acute Pathway, to deliver improved outcome measures and standards for stroke patients.

There has been an agreement from all the Area Teams CCG's that Sandwell and West Birmingham CCG lead the Stroke Transformation Programme and will host a CCG Led Stroke Project Board to oversee the programme of work. The decision on the future placement of hyper-acute and acute stroke unit will sit with the commissioning organisations, so it is incumbent upon all NHS providers including ourselves, to clinically influence the Project Board regarding the final solution for hyper-acute configuration and/or designation.

Whilst the aims and objectives of the programme are clear and set out in the paper from SWB CCG, it is at present unclear whether the final recommendations are likely to be around a minimum size for hyper-acute stroke units (HASUs) or the unit must be forced to assure commissioners that they are meeting designated standards.

The timetable and key milestones for the review process is also attached. The draft case for change will be appraised by the Project Board between April – June 2014 with a final decision being made by the Birmingham & Black Country CCGs in the late summer 2014. A physical re-configuration of services is required, then a 12 week formal public consultation will be necessary.

The risks to the Dudley Group NHS Foundation Trust in this process remain as they were under the previous Midlands and East sponsored review process, namely we do not in isolation, manage the kind of confirmed acute stroke volumes that one would expect of a long term HASU. Despite this, the organisation has made significant strides towards meeting most of the previous quality standards set by the Cardiovascular Network, such that in the Black Country, we are now the leading provider on some of these indicators. We will continue to stay close to the review process and continue to appraise the Board of Directors on the options available to us, which may involve collaboration with another NHS provider.

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

RISK	**Y**	**Risk Description: OP122 - Potential of Hyper Acute Stroke Services being decommissioned**
	Risk Register: Y	**Risk Score: 4x4 16**

COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Y	Details:
	NHSLA	N	Details:
	Monitor	N	Details:

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
		X	

RECOMMENDATIONS FOR THE BOARD OF DIRECTORS:
To note the programme of work on Stroke Transformation being led on behalf of the Birmingham and Black Country Local Area Team by Sandwell & West Birmingham CCG.

To note that there are risks to the Dudley Group NHS Foundation Trust should we wish to continue to be a recognised and designated provider in the future, albeit those risks have reduced in light of our medical recruitment strategy and the exceptional work of the medical directorate and stroke management teams on achieving many of the previous cardiovascular network stroke indicators

Dudley
Metropolitan Borough Council

NHS
Sandwell and West Birmingham
Clinical Commissioning Group

Agenda Item No. 7

Health Scrutiny Committee 7th November

Report of Sandwell and West Birmingham Clinical Commissioning Group

Stroke Transformation Programme

Purpose of Report

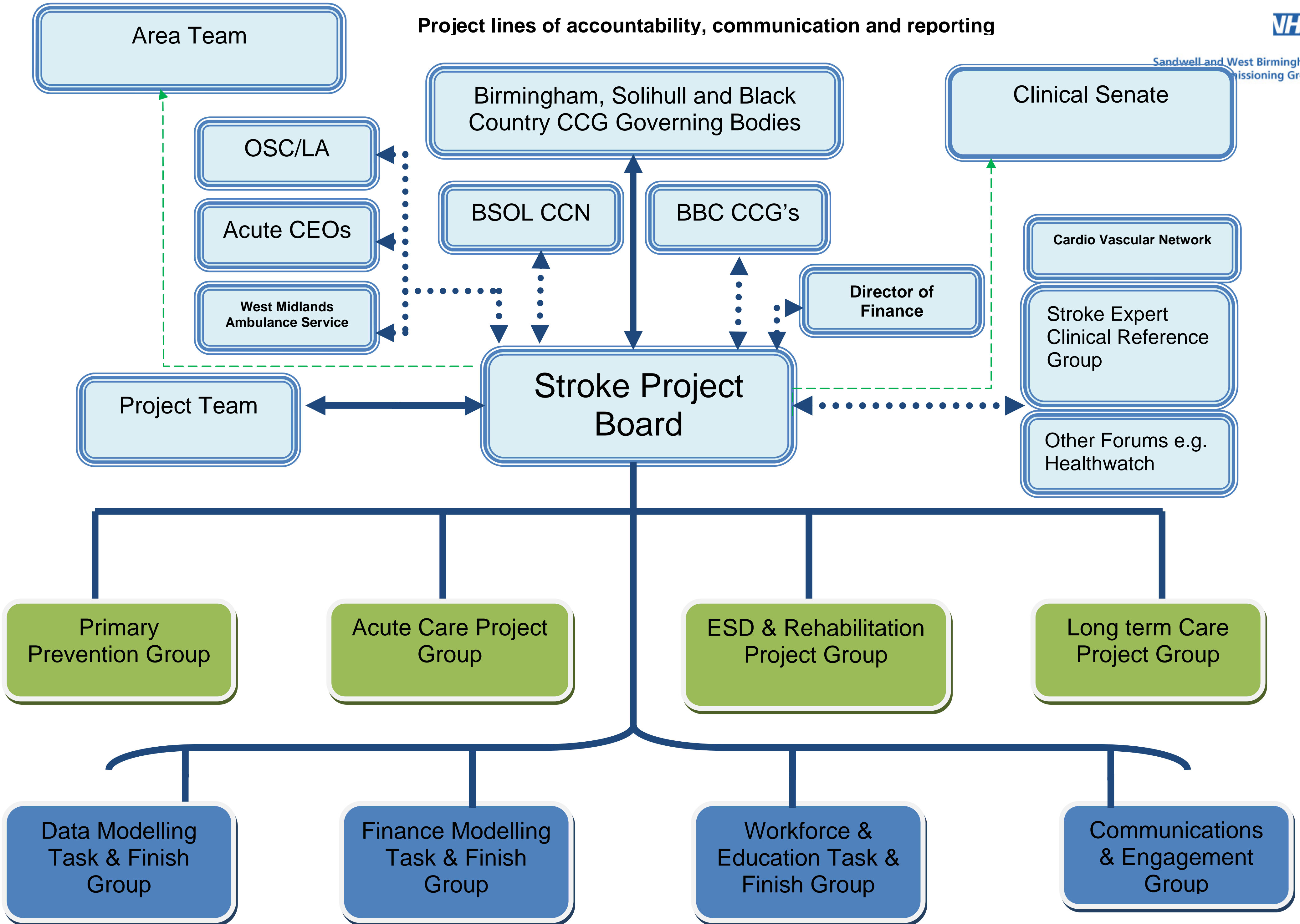
To update members on the progress Birmingham, Solihull and Black Country Stroke Transformation programme

1. Introduction:

Stroke is one of the top three causes of death and the largest cause of adult disability in England, and costs the NHS over £3 billion a year. Many people suffering strokes are left with long term disability. Although there have been significant improvements in stroke services across the region over the last three years, there remains scope for further improvement across NHS Midlands and East Review; demonstrated by the gap between the regions' performance as measured against the national Integrated Performance Measures.

The previous Cardiovascular Network and the NHS Midlands and East Cluster Strategic Health Authority coordinated a review of stroke and TIA services to identify how it could achieve a step change improvement in clinical outcomes and patient experience. The SHA and Network review concluded that there is evidence to suggest that changing the specification of the stroke care pathway in Birmingham, Solihull and the Black Country could lead to improved outcomes for patients. An important part of this relates to the hyper-acute phase of the pathway. The evidence suggests that there is a minimum best practice service specification that all hyper-acute stroke units should achieve if they are to provide optimal care to patients. This centres on the timeliness of response and requires 24/7 consultants on call as well as access to rapid scanning and thrombolysis services.

There has been an agreement from the Birmingham, Solihull and Black Country CCGs that Sandwell and West Birmingham CCG (SWB CCG) will lead the Stroke Transformation Programme and will host the Stroke CCG Project Board to provide the strategic steer for the programme. The decision on the future placement of hyper-acute and acute stroke centres will sit with respective CCG governing bodies however the role of the project board will be to advice and recommend the optimum solution for hyper-acute placement.


Project lines of accountability, communication and reporting
NHS
Sandwell and West Birmingham
Area Team
Birmingham, Solihull and Black Country CCG Governing Bodies
Clinical Senate
OSC/LA
Acute CEOs
West Midlands Ambulance Service
BSOL CCN
BBC CCG's
Director of Finance
Cardio Vascular Network
Stroke Expert Clinical Reference Group
Other Forums e.g. Healthwatch
Project Team
Stroke Project Board
Primary Prevention Group
Acute Care Project Group
ESD & Rehabilitation Project Group
Long term Care Project Group
Data Modelling Task & Finish Group
Finance Modelling Task & Finish Group
Workforce & Education Task & Finish Group
Communications & Engagement Group

2. Programme Aims:

To successfully deliver the following expected outcomes of the Stroke Transformation Programme:

- Ensure efficient, safe and equitable services that deliver the intended improvement in outcomes for patients are available and
- Ensure outputs and outcomes can be measured, in terms of patient experience and by the reduction in mortality and disability.

The Programme will be conducted in order to determine the highest quality of Service (within specified constraints) and seek the most economically advantageous service configuration for hyper-acute sites for the Birmingham, Solihull and Black Country CCGs.

2.1 Objectives:

The programme team is expected to support the Birmingham, Solihull and Black Country CCGs:

- Ensure the consistent understanding and commitment from all key stakeholders to the aims and objectives of the review including securing the support of each constituent CCG for the process and ensure that CCG boards are kept abreast of progress and emerging issues which may have local implications
- Ensure key options for delivery of the standards set out in the service specification are identified, together with the implications for commissioners as well as for both the designated and non designated providers, and so that robust and transparent decisions can be made by CCGs on future delivery, and these are built into their future commissioning/ contracting processes.
- Ensure the preferred models are future proofed and underpinned by effective prediction of changes in prevalence and also the expected impact of primary prevention programmes and that they are also in alignment with the models of service delivery across the wider West Midlands and bordering CCGs
- Support the implementation of an approach that makes best use of available fixed and human resources within the system/organisations, including identifying and managing any risks
- Ensure the NHS Area Team have confidence that the local programme will deliver its objectives

2.2 Outcomes of programme:

- Reduction in stroke mortality rates
- Reduction in average length of stay
- Reduction in stroke re-admissions
- Achievement of 90% stay on stroke ward
- Increase in the number of patients receiving thrombolysis
- Achievement of diagnosis and treatment for high risk TIA within 24hrs
- Increase in the number of patients discharged to their normal place of residency

3. Scope and Exclusions

Clinical scope

The Midlands and East Service Specification divides the pathway into eight phases and specifies the standards to be achieved in each. These are:-

- Primary prevention
- Pre-hospital
- Acute phase
  - Hyper-acute unit (HASU) services
  - Acute stroke (ASU) services
  - Transient Ischaemic Attack (TIA) services
  - Tertiary care
- In-hospital rehabilitation
- Community rehabilitation (including Early Supported Discharge)
- Long term care and support
- Secondary prevention
- End of Life

Outside scope

Tertiary care (neuro-surgical referral), and strokes occurring in children, are both outside the direct scope of the project.

Population scope

It is expected that this work will require a solution that takes in both Birmingham and Solihull and the Black Country.
Therefore the work will focus on the:-

- Population registered with GPs within the boundaries of the seven CCGs of Birmingham and Black Country (BBC)
- People who live within the 7 CCGs but who are not registered with a GP

- People who access emergency health care services within BBC either on an ad hoc basis, or based upon traditional referral flow (catchments of acute organisations)

4. Interdependencies

Successful delivery is interdependent with a number of other factors and actions. These include :

- Collaboration, agreement and support from all CCGs
- Information received from providers
- Multi-agency commitment to the review
- Recruitment of sufficient programme resource to support delivery
- Ability to agree a restructured revised payment mechanism with all providers

5. Approach and Next Steps:

It is recognised that each of the phases with the services specification will have a number of specific standards to be delivered and so will need to be treated as a specific project, with clear timescales and distinct actions and responsibilities. However it is intended these will all form part of an overall interlinked programme of work, with oversight by the Birmingham, Solihull and Black Country CCG Stroke Project Board, which will ensure overall connectivity and that an integrated pathway of care is in place.
The programme will be designed into two specific strands as follows:

5.1 Strand A:

This strand will support an options appraisal for future hyper acute and acute phase sector configuration. It is recognised will be complex and contentious and will therefore require the most capacity and focus. Areas of the project that fall into this category are the Acute Phase, where some challenging improvements within current resources need to be achieved. This phase includes:-

- Pre-Hospital Phase
- Hyper-acute services
- Acute stroke services
- TIA services

As above, it is also recognised that the programme will require a solution that takes in both Birmingham and the Black Country and also acknowledges other neighbouring economies.

In addition managing the interface between the acute phase and the rehabilitation phase, and the rehabilitation and long term care phases may also provide challenges.

Key Milestones:

Milestone	**Owner**	**Timeframe**
Agree vision, scope and outcome of programme	Stroke Project Board	October 2013
Development and implementation of Communication plan	Communication & Engagement Group	October 2013 onwards
Agree Criteria for HASU/ASU and TIA	Stroke Project Board	October-December 2013
Agree principles for options appraisal	Stroke Project Board	October-December 2013
Agree decision making process to support option appraisal	Stroke Project Board	October-December 2013
Seek expression of interest from existing providers for HASU/ASU and TIA service provision including capacity and capability to meet current services and increased volumes to support the scoping of the optimum HASU model configuration	Project team	November – January 2013
Baseline Data including Public Health and SSNAP data sets	Primary Prevention Sub-Group	October – December 2013
Activity Modelling	Modelling Sub-group	October 2013 – March 2014
Financial Modelling	Financial modelling sub-group	October 2013 – March 2014
Public and Patient Engagement	Communication and Engagement Sub-group	November 2013 onwards
Draft case for change	Project Team	April 2014
Appraisal of optimum options for HASU configuration by Project Board and Independent Clinical Advisory Team	Stroke Project Board & Independent Clinical Advisory Team	April – June 2014
Cost Benefit Analysis	Independent team	June 2014

Approve case for change and recommendation of optimum model for HASU configuration	Stroke Project Board	August 2014
Agree optimum model for HASU configuration	CCG Governing Bodies	August – September 2014
Formal Public Consultation (if a decision to reduce the HASU sites is made)	Communication & Engagement Group and Project Team	12 weeks

The programme will also be subjected to regular Department of Health Gateway Reviews to ensure that the programme has a robust framework to achieve key objectives and outcomes.

5.2 Strand B:

A review in partnership with lead CCG representatives in collaboration with the respective provider organisation to understand current service provision against the standards and criteria set out in the service specification. The role of the programme team will be to support the gap analysis and recommendation to achieve best practice. Respective funding for local service change will need to be agreed with each individual CCG and respective provider.

Stages:

- Mapping of current service delivery against the service specification and gaps for all phases:

  - A review of stroke service in partnership with each CCG and lead provider
    - Understand current service provision for each phase and support the collection of information to enable decision making process
    - Carry out a gap analysis with recommendations to achieve service specification criteria
    - Understand financial envelope for Pbr and local payment mechanism for each phase
    - Engagement with key stakeholders including OSC
    - Carry out public consultation where appropriate
    - Agree action plan to achieve services specification standards

Milestones: to be agreed with CCG leads

Finance

To be scoped as part of the programme case for change

Law

Section 111 of the Local Government Act, 1972, enables the Council to do anything, which is calculated to facilitate or is conducive or incidental to the discharge of its functions.

Health and Social Care Act 2012 provides for Local Authority members to review and scrutinise health improvement services with the particular aim of securing even better health outcomes across communities.

Equality

To be carried out as part of the programme case for change

Recommendation:

The Dudley OSC is asked to:

a) Note the scope and approach of the Stroke Reconfiguration Programme
b) Note the key project milestones

Criteria for Hyper-Acute Services Birmingham, Solihull and Black Country:

Scoring:

Score	Performance	Judgement
5	Meets the standard exactly	Excellent
4	Meets the standard well but not exactly	Good
3	Meets the standard in most respects, fails in some	Satisfactory
2	Fails standard in most aspects, meets in some	Doubtful
1	Significantly fails to meet standard	Poor
0	Completely fails to meet the standard	Not Worth Considering

Criteria Weighting:

Criteria Weighting:	**3**	**2**	**1**
Characteristic	Essential	Very Important	Desirable

Criteria	Benefit	Characteristics	Score	Weight	Weighted Score
Clinical Quality	Maintains or improves clinical outcomes; timely and appropriate services, minimises clinical risk	• Providing better health outcomes for patients; • Meets the East and West Midlands best practice service specification • Meets CQCS • Meets the National and local Stroke guidelines and protocols • Has sufficient bed capacity for hyper-acute			

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		activity and acute for patients within the local boundary area • Can demonstrate clear pathways for in-patient, community and domiciliary rehabilitation • Clear pathway for EOL for local and out of catchment area patients • Providing the best opportunity to enhance the quality of clinical services and teaching; • Facilitating modernisation, improvement and innovation in clinical practice and teaching; • Enabling new methods of providing clinical care and undertaking teaching; • Facilitating better configuration of services extending to the local health economy; • Addressing existing clinical problems; • Promoting new models for delivering services; • Promoting other national teaching and health priorities; • Flexibility to cope with future changes in service models / patterns; • Enabling better integration of services including with social and voluntary care.			
Access	Reasonable access for patients, carers, relatives and staff	• Greater responsiveness and choice in the delivery of patients' health needs (does the model align with activity and incidence according to local demographics • Ease of access to care close to people's homes • Travelling time by public and private transport for both patients and staff			

DRAFT

		• Availability of care parking / accessibility of public transport • Equality of access (different catchments, ethics and socioeconomic groups • Greater responsiveness and choice in the delivery of patients health needs •			
Improved Strategic fit	The model of care delivered will easily adapt to cope with the changes in demand for services	• Meeting strategic needs of the locality and region for clinical services; • Improving the quality of service relationships and departmental links; • Realising benefits of inter-dependence with other services, especially community and voluntary sector; • Promoting opportunities for collaboration and the development of partnerships with other local facilities and businesses in the delivery of services; • Providing flexibility to cope with changes in demand and changes in the delivery of services.			
Workforce, including meeting training, teaching and resource needs:	Has sufficient staff to deliver high quality care and provides and environment which support the recruitments/retention of staff; supports clinical staffing arrangements.	• Meets the workforce requirements of the Midlands and East best practice services specification • Making it easier to recruit staff; • Making it easier to retain staff; • Enabling the development of a clear "skills escalator" to engage all staff; • Meeting or protecting accreditation standards; • Improving productivity; .			

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Sustainability / flexibility	Able to meet current demand and future demands in activity; ability to respond to local, regional, national service change The service will ensure continued delivery of expected high standards of care with continuous improvement in care outcomes	• Meets the workforce requirements of the Midlands and East best practice services specification • Has sufficient bed capacity • Can demonstrate ability to meet Emergency care pressures comfortably • Has a contingency plan to deal with any unexpected increases in activity • Developing or providing services required by commissioners of clinical services; • Contributing to an increase in the quantity of clinical services available; • Ensuring the widest availability of services locally			
Ease of delivery:	The model can be delivered within a short time frame and does not adversely impact on other care pathways such as Urgent care.	• Practicality of delivery of physical proposals; • Practicality of delivery of service proposals; • Timescale for implementation; • Impact on other local Projects; • Acceptability to staff; • Planning workforce and estate implications, including WMAS and community rehabilitation			
Financial and Value for Money	Cost-Benefit-Analysis (there will be sufficient, people, skills, buildings and resource available to support the model)	TBC – anticipated analysis will be carried out by B'ham Uni or London Health Economics school and will complement the outcome of the option appraisal.			

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Enclosure 12

The Dud[illegible]
NHS Foundation Trust

Paper for submission to the Board on 5th December 2013

TITLE:	NHS Core Standards for Emergency Preparedness Resilience and Response(EPRR) Assurance		
AUTHOR:	Paul Oxley Emergency Planning Officer.	**PRESENTER**	Richard Beeken Director of Strategy, Transformation and Performance.
CORPORATE OBJECTIVE: **SG06 Enabling Objective " To deliver an infrastructure that supports delivery"**			

SUMMARY OF KEY ISSUES:

Context

- NHS England requires all Trusts to provide assurance that the National Core Standards for Emergency Preparedness Resilience and Response (EPRR) are being met.
- These standards will be used by the CQC in their own hospital inspection process and overall assurance system

Process

- The process is being managed locally by the NHS England Area Team for Birmingham Solihull and the Black Country utilising the attached national assurance template which has been completed for the Trust by the Emergency Planning Officer in conjunction with the Director of Strategy Transformation and Performance who is the designated EPRR Accountable Officer for the Trust.
- The Local Area team (LAT) will decide in the New Year on what further assurance is needed in terms of evidence of compliance and/or visits to Trust to assess compliance.

The Assurance Template

- Is self assessed for compliance with the core standards rated green for compliance and amber where improvements are required by the 31st December 2013. There are three areas rated as red which means that the action plan will be completed after January 2014 (see below) .The final column acts as an action plan for improvements which can be summarised as follows.
- Several straight forward additions are needed to the Major Incident Plan (MIP) and Business Continuity Plan (BCP).
- Further work is needed on On-Call Director compliance with the National Occupation Standards for Civil Contingencies.
- The Business Continuity Plan (BCP) needs significant input from the Trust's PFI Partners in relation to contingency plans in the event of water and power failures. The Board is already sighted on the risks posed in this significant area of Business Continuity as we currently do not have complete assurance from Summit and Interserve FM in this area.
- While all current and planned upgrades of the Trust's IT systems have robust Business Continuity Plans as part of the change over plan there is a need to develop BCP's for the Operations Directorate's business critical systems. It is planned to produce a framework for Directorates in 2014 and to produce a rollout plan for the remainder of the year to create BCP's for the outstanding areas (approximately 80% of IT systems)

IMPLICATIONS OF PAPER:			
RISK			Risk Description:
	Risk Register:		Risk Score: OP111 Utilities Business Continuity Plans – score 12 OPO95 Major Incident involving Chemicals – score 10 OPO96 External Major Incident(staff awareness of roles) – score 8 COR32 Failure to Implement Business Continuity Plan during an incident(including loss of IT systems) – score 12
COMPLIANCE and/or LEGAL REQUIREMENTS	CQC	Yes	Assessment is against National Core Standards – CQC Outcome 10" Safety and Suitability of Premises"
	NHSLA	No	
	Monitor	Yes	Contribution to the Governance Rating
	Equality Assured	Yes	Better health outcomes for all.
	National Standard	Yes	Monitored by NHS England.

ACTION REQUIRED OF THE BOARD:

Decision	Approval	Discussion	Other
	Approval		

RECOMMENDATIONS FOR THE BOARD

The Board are asked to

- note the areas requiring improvement by the end of December 2013
- note the areas that are rated red for improvement after January 2014(an action plan will be prepared early in the New Year to achieve compliance)
- approve the assurance template as an accurate reflection of current EPRR compliance

Assessment of EPRR Core Standards - NHS Trusts, CCGs, NHS England : Phase 1, Autumn 2013

On the following page, please insert **Organisation Name, Organisation Type** (eg mental health trust), **name of completing officer** (usually a EPO), **name of authorising officer** (Accountable Emergency Officer) and date of submission

Select dropdown menu for relevant organisation type

Filters have been provided to select only those questions relevant to each organisation type.

For example, if you represent an Acute Trust, click the down arrow for Acute trusts and check the X, this will hide the questions that are not relevant to acute trusts

If your organisation provides two types of service (eg: acute and community services, or mental health and community services) then you will need to select the appropriate columns sequentially, ensuring you have deselected the intial colum first.

For example, if you represent an Acute Trust, click the down arrow for Acute trusts and check the X and complete the relevant questions. Once completed, re-click the down arrow for acute trusts, ensure all boxes are checked, select the Community Trust down arrow, and check the X box under that field and complete any unanswered fields.

Specialist Trusts should use Acute Trust dropdown, however some areas may not be applicable to them and the option of N/A is available where this occurs.

Please note that some standards have been blanked out and will not be assessed in this round of assurance.

Select your organisation type using Autofilter dropdown arrow(s)								
Cat 1					Cat 2		Uncategorised	
Acute trusts	Ambulance trusts	NHS England	NHS England		CCGs		Community providers	Mental health

Suggested Evidence

Column U contains a list of suggested evidence that you may be asked to provide to demonstrate your self-assessment. You are not required to submit evidence in this submission, but be prepared to provide it upon request later.

Self-Assess Progress

In Column V, provide a commentary to support your self-assessment including reference to the evidence you are using to support your self-assessment. This may include evidence not listed in Column U. DO NOT SUBMIT EVIDENCE AT THIS STAGE.

Work through each core standard and self-assess your progress using the following RAG-rating:

GREEN - arrangements in place now, compliant with core standards
AMBER - draft or scheduled for completion by Dec 2013
RED - arrangements not in place or scheduled for completion after Jan 2014
N/A - Not applicable to organisation
N/R - Not rated in 2013

Actions

Column X has been provided for those trusts that wish to use it. An improvement/rectification plan is required for all NHS organisations.

Approval(s) & Submission

The completed self-assessment and accompanying action/rectification plan must be approved by the Accountable Emergency Officer (executive-level) for the organisation prior to submission by 25th October 2013.

All NHS organisations will be required to provide evidence that their assessment of their progress against Core Standards and the development of an action/rectification plan has been endorsed by their Trust Boards. This endorsement by the Trust Board must be completed before mid-December.

Dudley Group NHS FT
Acute
Paul Oxley Emergency Planning Officer
Richard Beeken Director of Strategy Transformation and Performance
Oct-13

Select your organisation type using Autofilter dropdown arrow(s)

GREEN - arrangements in place now, compliant with core standards
AMBER - draft or scheduled for completion by Dec 2013
RED - arrangements not in place or scheduled for completion after Jan 2014
N/A - Not applicable to organisation
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			Cat 1				Cat 2	Uncategorised					
		NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	**Acute trusts**	**Ambulance trusts**	**NHS England**	**NHS England**	**CCGs**	**Community providers**	**Mental health**	**Suggested Evidence**	**Commentary References to Suggested Evidence**	**Self Assessment (Red, Amber, Green, N/A, N/R)**	**Areas Requiring Improvement Actions to be Taken (including timescales)**
1	**Accountable Emergency Officer**	**All NHS organisations and providers of NHS funded care must nominate an accountable emergency officer who will be responsible for EPRR and business continuity management.**	X	X	X	X	X	X	X	Accountable officer is Richard Beeken			**NOTE**: For all the actions below the lead is the Emergency Planning Officer and target action date is end December 2013
2	**Resource contribution - 'Response'**	**All NHS organisations and providers of NHS funded care must share their resources as necessary when they are required to respond to a significant incident or emergency.**	X	X	X	X	X	X	X	Member of LHRF and LHRP			
3	**Planning in Partnership - 'Preparedness'**	**All NHS organisations and providers of NHS funded care must have plans setting out how they contribute to co-ordinated planning for emergency preparedness and resilience (for example surge, winter & service continuity) across the area through LHRPs and relevant sub-groups. These plans must include details of:**	X	X	X	-	X	X	X	Participation in LHRP			
3 . 1		director-level representation at the LHRP; and	X	X	X	-	X	X	X	Emergency Planning Officer has full powers to represent the Trust at the LHRP briefing the Accountable Officer as necessary			
4	**System Assurance for Emergency Preparedness**	**All NHS organisations and providers of NHS funded care must contribute to an annual NHS England report on the health sector's EPRR capability and capacity in responding to national, regional and LRF incidents. Reports must include control and assurance processes, information-sharing, training and exercise programmes and national capabilities surveys. They must be made through the organisations' formal reporting structures.**	X	X	X	X	X	X	X				
4 . 1		Organisations must have an annual work programme to reduce risks and learn the lessons identified relating to EPRR (including details of training and exercises). This work programme must link back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X	Work Plan for EPO			
4 . 2		Organisations must maintain a risk register which links back to the National Risk Assessment (NRA) and Community Risk Register (CRR).	X	X	X	X	X	X	X	Risk Register			
5	**Incident Response Plan - 'Preparedness'**	**All NHS organisations and providers of NHS funded care must have plans which set out how they plan for, respond to and recover from disruptions, significant incidents and emergencies. Incident response plans must:**	X	X	X	X	x	x	x				
5 . 1		be based on risk-assessed worst-case scenarios;	X	X	X	X	X	X	X	Included as a summary in MIP			
5 . 2		make sure that all arrangements are trialled and validated through testing or exercises;	X	X	X	X	X	X	X	Programme of testing and lessons learnt log			
5 . 3		make sure that the funding and resources are available to cover the EPRR arrangements;	X	X	X	X	X	X	X	• Details of agreed budget • EPRR business cases/ papers for funding, • EPLO job description showing WTE			
5 . 4		plan for the potential effects of a significant incident or emergency or for providing healthcare services to prisons, the military and iconic sites; and	X	X	-	X	-	X	X	Not applicable			
5 . 5		include plans to maintain the resilience of the organisation as a whole, so that the Estates Department and Facilities Department are not planning in isolation.	X	X	-	X	-	X	X	BCP demonstrates joint working.			
	Interoperability	**Incident response plans must be in line with published guidance, threat-specific plans and the plans of other responding partners. They must:**	X	X	X	X	X	X	X				
5 . 6		refer to all relevant national guidance, other supporting and threat-specific plans (e.g. pandemic flu, CBRN, mass casualties, burns, fuel shortages, industrial action, evacuation, lockdown, severe weather etc) and policies, and all other supporting documents that enhance the organisation's incident response plan;	X	X	X	X	X	X	X	Included in MIP			Needs adding to MIP
5 . 7		refer to all other associated plans identified by local, regional and national risk registers;	X	X	X	X	X	X	X	Included in MIP			Needs adding to MIP
5 . 8		have been written in collaboration with all relevant partner organisations;	X	X	X	X	X	X	X	Included in MIP			Clarification needed on what this means
5 . 9		refer to incident response plans used by partners, including LRF plans;	X	X	X	X	X	-	-	Included in MIP			Clarification needed on what this means
5 . 10		have been written in collaboration with PHE;	X	X	X	X	X	-	X	Included in MIP			Clarification needed on what this means
5 . 11		have been written in collaboration with all burns, trauma and critical care networks; and	X	X	X	X	X	X	-	Included in MIP			
5 . 12		define how the organisation will meet the Prevent strategy's objectives for health (1. prevent people from being drawn into terrorism and ensure that they are given appropriate advice and support and 2. work with sectors and institutions where there are risks of radicalisation which we need to address, and the wider CONTEST strategy).	X	X	X	-	X	X	X	**Not rated in 2013**	**Not rated in 2013**	N/R	**Not rated in 2013**
	Governance	**Incident response plans must follow NHS governance arrangements. They must:**	X	X	X	X	X	X	X				
5 . 13		be approved by the relevant board;	X	X	X	X	X	X	X	Approved by Board via Emergency Planning group/Risk and Assurance Committee			
5 . 14		be signed off by the appropriate Senior Responsible Officer;	X	X	X	X	X	X	X				
5 . 15		set out how legal advice can be obtained in relation to the CCA;	X	X	X	X	X	-	X				Clarification needed on what this means
5 . 16		identify who is responsible for making sure the plan is updated, distributed and regularly tested;	X	X	X	X	X	X	X				Needs adding to MIP
5 . 17		explain how internal and external consultation will be carried out to validate the plan;	X	X	X	X	X	X	X				Needs adding to MIP
5 . 18		include version controls to be sure the user has the latest version;	X	X	X	X	X	X	X				Needs adding to MIP
5 . 19		set out how the plan will be published – for example, on a website;	X	X	X	X	X	X	X				Needs adding to MIP
5 . 20		include an audit trail to record changes and updates;	X	X	X	X	X	X	X				Needs adding to MIP
5 . 21		explain how predicted and unexpected spending will be covered and how a unique cost centre and budget code can be made available to track costs; and	X	X	X	X	X	X	X				Needs adding to MIP
5 . 22		demonstrate a systematic risk assessment process in identifying risks relating to any part of the plan or the identified emergency.	X	X	X	X	X	X	X				Some risk assessments will be undertaken including Police Documentation.
	Staff Competence & Training	**Staff must be aware of the Incident Response Plan, competent in their roles and suitably trained.**	X	X	X	X	X	X	X				
5 . 23		Key staff must know where to find the plan on the intranet or shared drive.	X	X	X	X	X	X	X	Traing material available together with training logs			
5 . 24		There must be an annual work programme setting out training and exercises relating to EPRR and how lessons will be learnt.	X	X	X	X	X	X	X	Testing plan.			
5 . 25		Key knowledge and skills for staff must be based on the National Occupation Standards for Civil Contingencies. Directors on NHS on-call rotas must meet NHS published competencies.	X	X	X	X	X	X	X	training material available together with traing records			Formal assessments to be undertaken for all on-call Directors
5 . 26		It must be clear how awareness of the plan will be maintained amongst all staff (for example, through ongoing education and information programmes or e-learning).	X	X	X	X	X	X	X	training material available together with traing records			Needs adding to MIP
5 . 27		It must be clear how key staff can achieve and maintain suitable knowledge and skills.	X	X	X	X	X	X	X	training schedule			Needs adding to MIP
	Incident 'Response'	**Set out responsibilities for carrying out the plan and how the plan works, including command and control arrangements and stand-down protocols.**	X	X	X	X	X	X	X				
5 . 28		Describe the alerting arrangements for external and self-declared incidents (including trigger points, decision trees and escalation/de-escalation procedures)	X	X	X	X	X	X	X	MIP			
5 . 30		Explain how the emergency on-call rota will be set up and managed over the short and longer term.	X	X	X	X	-	X	-	On call rota			
5 . 31		Include 24-hour arrangements for alerting managers and other key staff, and explain how contact lists will be kept up to date.	X	X	X	X	X	X	X	On call arrangements			
5 . 32		Set out the responsibilities of key staff and departments.	X	X	X	X	X	X	X	MIP Action Cards			
5 . 33		Set out the responsibilities of the appropriate Senior Responsible Officer or nominated Executive Director.	X	X	X	X	X	X	X	• Page/ section references in IRP, annexes to plans or standalone plans • Action Cards			
5 . 34		Explain how mutual aid arrangements will be activated and maintained.	X	X	X	X	X	X	X				
5 . 35		Identify where the incident or emergency will be managed from (the ICC).	X	X	X	X	X	X	X	MIP and Action Cards			
5 . 36		Define the role of the loggist to record decisions made and meetings held during and after the incident, and how an incident report will be produced.	X	X	X	X	X	X	X	Action Card			
5 . 37		***Best Practice:*** Use an electronic data-logging system to record the decisions made.	X	X	-	-	-	-	-	**Not rated in 2013**	**Not rated in 2013, unless organisation provides evidence**	N/R	**Not rated in 2013**
5 . 38		***Best Practice:*** Use the National Resilience Extranet.	X	X	X	X	-	X	-	**Not rated in 2013**	**Not rated in 2013, unless organisation provides evidence**	N/R	**Not rated in 2013**
5 . 39		Refer to specific action cards relating to using the incident response plan.	X	X	X	X	X	X	X	Action Cards			
5 . 40		Explain the process for completing, authorising and submitting NHS England standard threat-specific situation reports and how other relevant information will be shared with other organisations.	X	X	X	X	X	X	X				Needs adding to MIP
5 . 41		Explain how extended working hours will apply and how they can be sustained. Explain how handovers are completed.	X	X	X	-	X	X	X				Needs adding to MIP
5 . 42		Explain how to communicate with partners, the public and internal staff based on a formal communications strategy. This must take into account the FOI Act 2000, the Data Protection Act 1998 and the CCA 2004 'duty to communicate with the public'. Social networking tools may be of use here.	X	X	X	X	X	X	X				Needs adding to MIP

		NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England	NHS England	CCGs	Community providers	Mental health	Suggested Evidence	Commentary References to Suggested Evidence	Self Assessment (Red, Amber, Green, N/A, N/R)	Areas Requiring Improvement Actions to be Taken (including timescales)
5 . 43		Have agreements in place with local 111 providers so they know how they can help with an incident	X	X	X	X	X	X	-				Needs further consideration as Police would handle most enquiries
5 . 44		Consider using help lines in an emergency. Set up procedures in advance which explain the arrangements. Make sure foreign language lines are part of these arrangements.	X	X	X	X	X	X	X				Needs further consideration as Police would handle most enquiries
5 . 45		Describe how stores and supplies will be maintained.	X	X	-	-	X	X	X	MIP and BCP			
5 . 46		Explain how specific casualties will be managed – for example, burns, paediatrics and those from certain faiths.	X	X	-	-	-	X	X	MIP and BCP			
5 . 47		Explain how VIPs will be managed, whether they are casualties or visiting others who are casualties.	X	X	-	X	-	-	X				Needs adding to MIP
5 . 48		Explain the process of recovery and returning to normal processes.	X	X	X	X	X	X	X				Needs adding to MIP
5 . 49		Explain the de-briefing process (hot, local and multi-agency)at the end of an incident.	X	X	X	X	X	X	X				Needs adding to MIP
5 . 50		Explain how to support patients, staff and relatives before, during and after an incident (including counselling and mental health services).	X	X	X	X	X	X	X	MIP			
	Surge	**Set out how surges in demand will be managed.**	X	X	X	X	X	X	X				
5 . 51		Explain who will be responsible for managing escalation and surges.	X	X	X	X	X	X	X				
5 . 52		Describe local escalation arrangements and trigger points in line with regional escalation plans and working alongside acute, ambulance and community providers.	X	X	X	X	X	X	X				
	Threat Specific	**Link the Incident Response Plan to threat-specific incidents**	X	X	X		X	X	X				
5 . 53		CBRN incidents;	X	X	-	-	-	X	X	MIP			
5 . 54		mass casualty incidents;	X	X	-	-	-	X	X	MIP			
5 . 55		pandemic flu;	X	-	X	-	-	X	X	Pandemic Flu Plan			
5 . 56		patients with burns requiring critical care; and	X	-	-	-	-	X	X	MIP			
5 . 57		severe weather.	X	X	X	-	X	X	X	BCP			
6	**Incident Co-ordination Centre - 'Response'**	**All NHS organisations must provide a suitable environment for managing a significant incident or emergency (an ICC). This must include a suitable space for making decisions and collecting and sharing information quickly and efficiently.**	X	X	X	X	X	X	X				
6 . 1		There must be a plan setting out how the ICC will operate.	X	X	X	X	X	X	X	MIP and Action Cards			
6 . 2		There must be detailed operating procedures to help manage the ICC (for example, contact lists and reporting templates).	X	X	X	X	X	X	X	Silver Command resources pack.			
6 . 3		There must be a plan setting out how the Incident Coordination Team will be called in and managed over any length of time	X	X	X	X	X	X	X	MIP and Action Cards			
6 . 4		Facilities and equipment must meet the requirements of the NHS England Corporate Incident Response Plan.	X	X	X	X	X	X	X	MIP and equipment audit by Area Team.			
7	**Service 'Resilience'**	**All NHS organisations and providers of NHS funded care must develop, maintain and continually improve their business continuity management systems. This means having suitable plans which set out how each organisation will maintain continuity in its services during a disruption from identified local risks and how they will recover delivery of key services in line with ISO22301. Organisations must:**	X	X	X	X	X	X	X				
7 . 1	SUPPORT	make sure that there are suitable financial resources for their BCMS and that those delivering the BCMS understand and are competent in their roles;	X	X	X	X	X	X	X	BCP			
7 . 2		set out how finances and unexpected spending will be covered, and how unique cost centres and budget codes can be made available to track costs;	X	X	X	X	X	X	X				Include in BCP
7 . 3	BC Strategy	develop business continuity strategies for continuing and recovering critical activities within agreed timescales, including the resources required such as people, premises, ICT, information, utilities, equipment, suppliers and stakeholders; and	X	X	X	X	X	X	X	BCP			This is a Trust with PFI Partners who provide Estates, Soft FM and IT Services. The Trust is utilising contractual levers to have the EstatesBCP strengthened in relation to loss of power or water. There is a need to develop further contingency plans in the event of the loss of IT systems.
7 . 4	BC Plans	develop, use and maintain business continuity plans to manage disruptions and significant incidents based on recovery time objectives and timescales identified in the business impact analysis	X	X	X	X	X	X	X				
	Governance	**Business continuity plans must include governance and management arrangements linked to relevant risks and in line with international standards.**	X	X	X	X	X	X	X				
7 . 5	CONTEXT OF THE ORGANISATION	Each organisation's BCMS must be based on its legal responsibilities, internal and external issues that could affect service delivery and the needs and expectations of interested parties.	X	X	X	X	X	X	X	• Page/ section references in BC arrangements			
7 . 6	LEADERSHIP	Organisations must establish a business continuity policy which is agreed by top management, built into business processes and shared with internal and external interested parties.	X	X	X	X	X	X	X	BCP approved by Board			
7 . 7		Organisations must make clear how their plan will be published, for example on a website.	X	X	X	X	X	X	X				
7 . 8		The BCMS policy and business continuity plan must be approved by the relevant board and signed off by the appropriate Senior Responsible Officer.	X	X	X	X	X	X	X				
7 . 9		There must be an audit trail to record changes and updates such as changes to policy and staffing.	X	X	X	X	X	X	X				Needs adding to BCP
7 . 10		The planning process must take into account nationally available toolkits that are seen as good practice.	X	X	X	X	X	X	X	**Will be reviewed when National Toolkit available**	**Not rated in 2013**	N/R	**Not rated in 2013**
	Organisational Knowledge	**Business continuity plans must take into account the organisation's critical activities, the analysis of the effects of disruption and the actual risks of disruption.**	X	X	X	X	X	X	X				
7 . 11	PLANNING	Organisations must identify and manage internal and external risks and opportunities relating to the continuity of their operations.	X	X	X	X	X	X	X				
7 . 12		Plans must be maintained based on risk-assessed worst-case scenarios.	X	X	X	X	X	X	X				
7 . 13	Risk Assessments	Risk assessments must take into account community risk registers and at very least include worst-case scenarios for: • severe weather (including snow, heat wave, prolonged periods of cold weather and flooding); • staff absence (including industrial action); • the working environment, buildings and equipment; • fuel shortages; • surges in activity; • IT and communications; • supply chain failure; and • associated risks in the surrounding area (e.g. COMAH and iconic sites).	X	X	X	X	X	X	X	BCP			
7 . 14	OPERATION	Organisations must develop, use and maintain a formal and documented process for business impact analysis and risk assessment.	X	X	X	X	X	X	X	BCP			
7 . 15		They must identify all critical activities using a business impact analysis. This must set out the effect business disruption may have on the organisation and how this will be overcome, including the maximum period of tolerable disruption.	X	X	X	X	X	X	X	BCP			
7 . 16		Organisations must highlight which of their critical activities have been put on the corporate risk register and how these risks are being addressed.	X	X	X	X	X	X	X	• Appropriate risk register			Needs further work to assess which risks need to go on register.
	Strategy	**Business continuity plans must set out how the plans will be called into use, escalated and operated.**	X	X	X	X	X	X	X				
7 . 17	Warning & Communications	Organisations must develop, use, maintain and test procedures for receiving and cascading warnings and other communications before, during and after a disruption or significant incident. If appropriate, business continuity plans must be published on external websites and through other information-sharing media.	X	X	X	X	X	X	X	Undertaken due to incidents.			
7 . 18		Plans must set out: the alerting arrangements for external and self-declared incidents, including trigger points and escalation procedures;	X	X	X	X	X	X	X	BCP			
7 . 19		the procedures for escalating emergencies to CCGs and the NHS England area, regional and national teams;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 20		24-hour arrangements for alerting managers and other key staff, including how up-to-date contact lists will be maintained;	X	X	X	X	X	X	X	On call rotas			
7 . 21		the responsibilities of key staff and departments;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 22		the responsibilities of the appropriate Senior Responsible Officer or Executive Director;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 23		how mutual aid arrangements will be called into use and maintained;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 24		where the incident or emergency will be managed from (the ICC);	X	X	X	X	X	X	X	BCP			
7 . 25		how the independent healthcare sector may help if required; and	X	X	X	X	X	X	X				Needs adding to BCP
7 . 26		the insurance arrangement that are in place and how they may apply.	X	X	X	X	X	X	X				Needs claryfying.
	Implementation	**Business continuity plans must describe the effects of any disruption and how they can be managed. Plans must include:**	X	X	X	X	X	X	X				
7 . 27		contact details for all key stakeholders;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 28		alternative locations for the business;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 29		a scalable plan setting out how incidents will be managed and by whom;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 30		recovery and restoration processes and how they will be set up following an incident;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 31		how decisions and meetings will be recorded during and after an incident, and how the incident report will be compiled;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 32		how the organisation will respond to the media following a significant incident, in line with the formal communications strategy;	X	X	X	X	X	X	X				Needs adding to BCP
7 . 33		how staff will be accommodated overnight if necessary;	X	X	X	X	X	X	X				
7 . 34		how stores and supplies will be managed and maintained; and	X	X	-	-	X	X	X	BCP			

		NHS Core Standards for Emergency Preparedness, Resilience & Response (EPRR)	Acute trusts	Ambulance trusts	NHS England	NHS England		CCGs	Community providers	Mental health	Suggested Evidence	Commentary References to Suggested Evidence	Self Assessment (Red, Amber, Green, N/A, N/R)	Areas Requiring Improvement Actions to be Taken (including timescales)
7 . 35		details of a surge plan to maintain critical services.	X	X	X	X		X	X	X				Needsadding to BCP
	Exercising,	**Business continuity plans must specify how they will be used, maintained and reviewed.**	X	X	X	X		X	X	X				
7 . 36	T&E	Organisations must use, exercise and test their plans to show that they meet the needs of the organisation and of other interested parties. If possible, these exercises and tests should involve relevant interested parties. Lessons learnt must be acted on as part of continuous improvement.	X	X	X	X		X	X	X	Plan used in reality for several incidents. Lessons learnt to be incorporated in revision.			
7 . 37		Plans must identify who is responsible for making sure the plan is updated, distributed and regularly tested.	X	X	X	X		X	X	X	BCP			
7 . 38	PERFORMANCE EVALUATION	Organisations must monitor, measure, analyse and assess the effectiveness of their BCMS against their own requirements, those of relevant interested parties and any legal responsibilities.	X	X	X	X		X	X	X	BCP			
7 . 39	IMPROVEMENT	Organisations must identify and take action to correct any irregularities identified through the BCMS and must take steps to prevent them from happening again. They must continually improve the suitability and effectiveness of their BCMS.	X	X	X	X		X	X	X	BCP revisions			
	Embedded in the Organisation	**Business continuity plans must specify how they will be communicated to and accessed by staff. Plans must include:**	X	X	X	X		X	X	X				
7 . 40	Training	details of the training provided to staff and how the training record is maintained;	X	X	X	X		X	X	X	Training records; staff awareness via Intra-net			
7 . 41		reference to the National Occupation standards for Civil Contingencies and NHS England competencies when identifying key knowledge and skills for staff; (directors of NHS England on-call rotas to meet NHS England published competencies);	X	X	X	X		X	X	X				Assessment needed of Director competencies .
7 . 42		details of the tools that will be used to make sure staff remain aware through ongoing education and information programmes (for example, e-learning and induction training); and	X	X	X	X		X	X	X				Needs adding to BCP
7 . 43		details of how suitable knowledge and skills will be achieved and maintained.	X	X	X	X		X	X	X				Needs further work.
8	**Acute Providers**	**NHS Acute Trusts must also include:**	**X**	-	-	-		-	-	-				
8 . 1		detailed lockdown procedures;	X	-	-	-		-	-	-	Lockdown Plan			
8 . 2		detailed evacuation procedures;	X	-	-	-		-	-	-	Follows Fire Evacuation Plan			
8 . 3		details of how they will manage relatives for any length of time, how patients and relatives will be reunited and how patients will be transported home if necessary;	X	-	-	-		-	-	-	MIP			
8 . 4		details of how they will manage fatalities and the relatives of fatalities; and	X	-	-	-		-	-	-	MIP			
8 . 5		***Best Practice:*** reference to the Clinical Guidelines for Major Incidents.	X	X	-	-		-	-	-	• Page/ section references in IRP, annexes or standalone plans	Not reviewed in 2013	N/R	Not rated in 2013
9 . 42		explain how the Mobile Privileged Access Scheme (MTPAS) and Fixed Telecommunications Privileged Access Scheme (FTPAS) will be provided across the organisation; and	X	X	-	-		X	X	X				Needs reviewing.
19		**Urgent care centres must also:**	X	-	-	-		-	X	X				
19 . 1		outline how they can support NHS organisations affected by service disruption, especially by treating minor injuries to reduce the pressure on emergency departments. They will need to develop procedures for this in partnership with local acute trusts and ambulance and patient care transport providers.	X	-	-	-		-	X	X	• Page/ section references in IRP, annexes or standalone plans • Commissioning specifications should include provisions for appropriate support			

Enclosure 13

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors on 5th December 2013

TITLE:	How to ensure the right people, with the right skills, are in the right place at the right time		
AUTHOR:	Denise McMahon Director of Nursing	**PRESENTER:**	Denise McMahon Director of Nursing

CORPORATE OBJECTIVE:

SGO1: Quality, Safety & Service Transformation Reputation - To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation

SGO2: Patient experience - To provide the best possible patient experience

SGO5: Staff Commitment - To create a high commitment culture from our staff with positive morale and a "can do" attitude

SUMMARY OF KEY ISSUES:

This is the new guidance which was published last week and has been developed by the Chief Nursing Officer with the National Quality Board and seeks to support organisations in making informed decisions about staffing levels that allow for high quality and compassionate care. The report covers 10 expectations; these are explicit requirements for Trust Boards.

ACCOUNTABILITY & RESPONSIBILITY

Expectation 1: Boards take full responsibility for the quality of care provided to patients and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. *It will be a responsibility of the Board to assure and be accountable to the public that staff levels are safe.*

Expectation 2: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis. *There must be an escalation process to inform on shortages and this must be visible to the Board.*

EVIDENCE-BASED DECISION MAKING

Expectation 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability. *Staff must be trained to use these tools but also soft intelligence.*

SUPPORTING AND FOSTERING A PROFESSIONAL ENVIRONMENT

Expectation 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns. *Staff must be supported to speak out if they can't deliver care within the staffing levels allowed.*

Expectation 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments. *This includes AHP, Clerical and Management.*

Expectation 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties. *This includes clinical, admin, leading and mentoring.*

OPENNESS AND TRANSPARENCY

Expectation 7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review.

Expectation 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift. *This must be visible to patients.*

PLANNING FOR FUTURE WORKFORCE REQUIREMENTS

Expectation 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements.

THE ROLE OF COMMISSIONING

Expectation 10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.

National Institute for Health and Care Excellence (NICE) are taking forward this guidance and

will publish it by July 2014. This will be followed by specific guidance on Accident and Emergency (A&E), Mental Health, Community and Paediatrics.

This report is welcomed to give structure to the National position on nurse staffing. As a Trust, we have undertaken much of this work already but still await results from the AUKUH Safer Staffing Tool, which at present Ruth May has instructed that a bespoke data entry should be made for us to satisfy the requirements of the Keogh inspection actions. She has suggested Ann Coley, an expert from University College London Hospital, undertakes this process for us.

I will advise the Board at the January 2014 meeting of our specific actions against each of our recommendations.

IMPLICATIONS OF PAPER:			
RISK	**Y**		**Risk Score and Description:**
	Risk Register: Y		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 be cognisant of the Board responsibilities within the new guidance and agree.
To approve the proposed actions.

How to ensure the right people, with the right skills, are in the right place at the right time

A guide to nursing, midwifery and care staffing capacity and capability

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Foreword

High quality, compassionate care is about people, not institutions. In every ward and clinic, in every hospital, health centre, community service and patient's home across the country, nursing, midwifery and care staff work to provide care and compassion to people when they need it – whether it is at the beginning, or end of their life; in times of illness or uncertainty; or as part of helping people with long term conditions to stay as healthy and live as independently as possible.

However, there have been examples of care in recent times which have been unacceptable. These have been as a result of individual and organisational failings. We must all find the provision of sub-standard and unsafe care to patients intolerable. We must do all we can to support our staff to provide high quality, compassionate care. And we must support organisations to be able to make the right decisions about their staffing needs and to create an environment within which staff are supported to care.

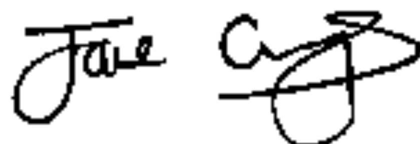
This guidance, which I have developed with my colleagues from the National Quality Board, seeks to support organisations in making the right decisions and creating a supportive environment where their staff are able to provide compassionate care. It sets out expectations of commissioners and providers in relation to getting nursing, midwifery and care staffing right so that they can deliver high quality care and the best possible outcomes for their patients. To a large extent, these expectations are about common sense and good leadership. We expect that all organisations should be meeting these currently, or taking active steps to ensure they do in the very near future.

There has been much debate as to whether there should be defined staffing ratios in the NHS. My view is that this misses the point – we want the right staff, with the right skills, in the right place at the right time. There is no single ratio or formula that can calculate the answers to such complex questions. The right answer will differ across and within organisations, and reaching it requires the use of evidence, evidence based tools, the exercise of professional judgement and a truly multi-professional approach. Above all, it requires openness and transparency, within organisations and with patients and the public. This guidance helps organisations to make those decisions by identifying tools, resources and examples of good practice. NICE will soon review the evidence and accredit evidence-based tools to further support decision-making on staffing.

Getting the right staff with the right skills to care for our patients all the time is not something that can be mandated or secured nationally. Providers and commissioners, working together in partnership, listening to their staff and patients, are responsible and will make these expectations a reality. As national organisations we pledge to play our part in securing the staffing capacity and capability you need to care for your patients.

I am grateful to my NQB colleagues for their commitment to this challenge and for working with me in setting out these expectations. I look forward to our continued work together and to seeing this guidance implemented across England for the benefit of our patients and staff.

Jane Cummings, Chief Nursing Officer for England



1 Expectations relating to nursing, midwifery and care staffing capacity and capability

Nursing, midwifery and care staff, working as part of wider multidisciplinary teams, play a critical role in securing high quality care and excellent outcomes for patients.

There are established and evidenced links between patient outcomes and whether organisations have the right people, with the right skills, in the right place at the right time. *Compassion in Practice*[1] emphasised the importance of getting this right, and the publication of the report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry,[2] and more recent reviews by Professor Sir Bruce Keogh into 14 trusts with elevated mortality rates[3], Don Berwick's review into patient safety,[4] and the Cavendish review into the role of healthcare assistants and support workers[5] also highlighted the risks to patients of not taking this issue seriously.

That is why members of the National Quality Board, which brings together the different parts of the NHS system with responsibilities for quality, alongside patients and experts – and the Chief Nursing Officer, England, have come together to set out collectively the expectations of NHS providers and commissioners in this area.

[1] *Compassion in Practice,* NHS England, December 2012. Available at http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

[2] *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry,* The Mid-Staffordshire NHS Foundation Trust Public Inquiry, February 2013. Available at http://www.midstaffspublicinquiry.com/

[3] *Review into the quality of care provided by 14 hospital trusts in England: overview report,* Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

[4] *A promise to learn, a commitment to act: improving the safety of patients in England,* Don Berwick, Department of Health, August 2013. Available at: https://www.gov.uk/government/publications/berwick-review-into-patient-safety

[5] *The Cavendish review: an independent review into healthcare assistants and support workers,* Camilla Cavendish, Department of Health, July 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

ACCOUNTABILITY & RESPONSIBILITY

EXPECTATION 1: Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Boards ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week.

Boards are actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards monitor staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-to-shift basis, versus planned staffing levels. They examine trends in the context of key quality and outcome measures. They ask about the recruitment, training and management of nurses, midwives and care staff and give authority to the Director of Nursing to oversee and report on this at Board level.

Board papers are accessible to patients and staff working at all levels, and boards seek to involve staff at all levels and across different parts of the organisation, facilitating a strong line of communication from ward to Board, and Board to ward. Boards ensure their organisation is open and honest if they identify potentially unsafe staffing levels, and take steps to maintain patient safety.

Boards must, at any point in time, be able to demonstrate to their commissioners, the Care Quality Commission, the NHS Trust Development Authority or Monitor that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient.

EXPECTATION 2: Processes are in place to enable staffing establishments to be met on a shift-to-shift basis. The Executive team should ensure that policies and systems are in place, such as e-rostering and escalation policies, to support those with responsibility for staffing decisions on a shift-to-shift basis. The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. Where staffing shortages are identified, staff refer to escalation policies which provide clarity about the actions needed to mitigate any problems identified.

EVIDENCE-BASED DECISION MAKING

EXPECTATION 3: Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability. As part of a wider assessment of workforce requirements, evidence-based tools, in conjunction with professional judgement and scrutiny, are used to inform staffing requirements, including numbers and skill mix. Senior nursing and midwifery staff and managers actively seek out data that informs staffing decisions, and they are appropriately trained in the use of evidence-based tools and interpretation of their outputs. Staff use professional judgement and scrutiny to triangulate the results of tools with their local knowledge of what is required to achieve better outcomes for their patients.

SUPPORTING AND FOSTERING A PROFESSIONAL ENVIRONMENT

EXPECTATION 4: Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns. The organisation supports and enables staff to deliver compassionate care. Staff work in well-structured teams and are enabled to practice effectively, through the supporting infrastructure of the organisation (such as the use of IT, deployment of ward clerks, housekeepers and other factors) and supportive line management.

Nursing, midwifery and care staff have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk, including raising concerns. Clinical and managerial leaders support this duty, have clear processes in place to enable staff to raise concerns (including about insufficient staffing) and they seek to ensure that staff feel supported and confident in raising concerns. Where substantiated, organisations act on concerns raised.

EXPECTATION 5: A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments. Directors of Nursing lead the process of reviewing staffing requirements, and ensure that there are processes in place to actively involve sisters, charge nurses or team leaders. They work closely with Medical Directors, Directors of Finance, Workforce (HR), and Operations, recognising the interdependencies between staffing and other aspects of the organisations' functions. Papers presented to the Board are the result of team working and reflect an agreed position.

EXPECTATION 6: Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties. Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Providers of NHS services make realistic estimations of the likely levels of planned and unplanned leave, and factor this into establishments. Establishments also afford ward or service sisters, charge nurses or team leaders time to assume supervisory status and benefits are reviewed and monitored locally.

OPENNESS AND TRANSPARENCY

EXPECTATION 7: Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review. Boards receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. At least once every six months, nursing, midwifery and care staffing capacity and capability is reviewed (an establishment review) and is discussed at a public Board meeting. This information is therefore made public monthly and six monthly. This data will, in future, be part of CQC's Intelligent Monitoring of NHS provider organisations.

EXPECTATION 8: NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift. Information should be made available to patients and the public that outlines which staff are present and what their role is. Information displayed should be visible, clear and accurate, and it should include the full range of support staff available on the ward during each shift.

PLANNING FOR FUTURE WORKFORCE REQUIREMENTS

EXPECTATION 9: Providers of NHS services take an active role in securing staff in line with their workforce requirements. Providers of NHS services actively manage their existing workforce, and have robust plans in place to recruit, retain and develop all staff. To help determine future workforce requirements, organisations share staffing establishments and annual service plans with their Local Education and Training Board (LETBs), and their regulators for assurance. Providers work in partnership with Clinical Commissioning Groups and NHS England Area Teams to produce a Future Workforce Forecast, which LETBs will use to inform their Education Commissions and the Workforce Plan for England led by Health Education England (HEE).

THE ROLE OF COMMISSIONING

EXPECTATION 10: Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract. Commissioners specify in contracts the outcomes and quality standards they require and actively seek to assure themselves that providers have sufficient nursing, midwifery and care staffing capacity and capability to meet these. Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability pose a threat to quality, commissioners use appropriate commissioning and contractual levers to bring about improvements. Commissioners recognise that they may have a contribution to make in addressing staffing-related quality issues, where these are driven by the configuration of local services or the setting of local prices in contracts.

2 Introduction and purpose of this guide

In recognition of the ever increasing focus on nursing, midwifery and care staffing capacity and capability as a key determinant of the quality of care experienced by patients, the Chief Nursing Officer in England, members of the National Quality Board, and a cross-sector professional steering group have come together to set out system-wide expectations of providers and commissioners in this area. This 'How to' guide outlines these expectations and considers each one in detail, outlining why it is important, and providing some practical advice on how it can be met. This guidance has been written with providers and commissioners of NHS funded acute services, maternity, mental health, learning disabilities and community services, in mind.

Meeting the expectations outlined in the guide will go a long way to ensuring that organisations have nursing, midwifery and care staffing capacity and capability that is consistent with the provision of high quality care. However, establishing and maintaining adequate staffing capacity and capability is an inherently challenging process, and we recognise that not all organisations will be meeting the expectations set out in this document at the moment. Where this is the case, we expect organisations to have discussions at Board level as a matter of urgency about the actions that could be taken to meet these expectations. Chapter 9 – Next Steps, sets out how national regulatory and oversight organisations will take account of this guidance.

In the longer term, this guidance will be built upon by the work of the National Institute for Health and Care Excellence (NICE). NICE will be reviewing the evidence in this area, and will produce further guidance, and accredit tools to support staffing capacity and capability that is commensurate with high quality care.

There is no 'one size fits all' approach to establishing nursing, midwifery and care staffing capacity and capability, and this guide does not prescribe the 'right way', or a single approach, to doing so. Similarly, the guide does not recommend a minimum staff-to-patient ratio. It is the role of provider organisations to make decisions about nursing, midwifery and care staffing requirements, working in partnership with their commissioners, based on the needs of their patients, their expertise, the evidence and their knowledge of the local context. Rather, this guide aims to support providers and commissioners in meeting the expectations of people using their services by:

- suggesting some practical steps that organisations can take to meet the expectations and providing examples of good practice;
- signposting readers to existing tools and resources; and
- outlining the individual roles and responsibilities of different professionals involved in establishing and maintaining nursing, midwifery and care staffing capacity and capability.

In order to ensure that the nursing, midwifery and care staffing workforces can deliver the best care possible, a range of factors must be considered – simply having the right numbers of staff in place is not enough. To maximise the effectiveness of the workforce, organisations need strong and effective leadership, and to foster a culture that encourages people to take pride in their work. Staff need adequate training and development, and the organisation needs to support them to maintain their health and wellbeing. At a time when finances remain constrained, yet demand and public expectations of the health system are rising, it is vital that organisations look at how they use their available resources and workforce, and consider how things can be done more efficiently. Whilst this guide focuses on staffing capacity and capability, the importance of other factors in supporting a capable and effective workforce must not be overlooked.

Though this guide is focussed on nursing, midwifery and care staffing capacity and capability – following recent reports that identified particular issues with these professional groups – the principles outlined in this guide are applicable when assessing the appropriateness of clinical staffing in its broadest sense. Nurses, midwives and care staff make a unique and vital contribution to high quality patient care – but they are part of a much wider clinical team, and staffing needs must be considered in the round to ensure high quality care is delivered.

Throughout this guide, the following certain terms are frequently used:

- **High quality** – the accepted definition of 'quality' in the NHS comprises three components; care that is safe, care that is clinically effective; and care that provides as positive an experience for the patient as possible.

- **Wards** – we recognise that care is delivered in a variety of settings, such as wards, departments, clinical services, community settings. Throughout this document we have used the term 'ward' to denote all settings.

- **Capacity** – by this we mean the ability of staff present on any ward at any one time to provide care to patients.

- **Capability** – here we mean the skills, experience, knowledge and training of those staff present providing care to patients.

- **Care staff** – this includes assistant/associate practitioners, healthcare support workers, healthcare assistants, nursing assistants, auxiliary nurses and maternity support workers.

3 Accountability and responsibility for staffing capacity and capability

Expectation 1

Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability. Boards ensure there are robust systems and processes in place to assure themselves that there is sufficient staffing capacity and capability to provide high quality care to patients on all wards, clinical areas, departments, services or environments day or night, every day of the week.

Boards are actively involved in managing staffing capacity and capability, by agreeing staffing establishments, considering the impact of wider initiatives (such as cost improvement plans) on staffing, and are accountable for decisions made. Boards monitor staffing capacity and capability through regular and frequent reports on the actual staff on duty on a shift-to-shift basis, versus planned staffing levels. They examine trends in the context of key quality and outcome measures. They ask about the recruitment, training and management of nurses, midwives and care staff and give authority to the Director of Nursing to oversee and report on this at Board level.

Board papers are accessible to patients and staff working at all levels, and boards seek to involve staff at all levels and across different parts of the organisation, facilitating a strong line of communication from ward to Board, and Board to ward. Boards ensure their organisation is open and honest if they identify potentially unsafe staffing levels, and take steps to maintain patient safety.

Boards must, at any point in time, be able to demonstrate to their commissioners, the Care Quality Commission, the NHS Trust Development Authority or Monitor that robust systems and processes are in place to assure themselves that the nursing, midwifery and care staffing capacity and capability in their organisation is sufficient.

Why is this important?

- Boards of organisations are ultimately responsible for the quality of care they provide, and for the outcomes they achieve. The impact of nursing, midwifery and care staffing capacity and capability on the quality of care experienced by patients, and on patient outcomes and experience has been well documented, with multiple studies linking low staffing levels to poorer patient outcomes, and increased mortality rates.

- One study estimated that an increase of 1 registered nurse full time equivalent per patient day could save 5 lives per 1000 patients in intensive care, 5 lives per 1000

medical patients, and 6 per 1000 surgical patients.[6] In Prof. Sir Bruce Keogh's review of 14 hospitals with elevated mortality rates, he found a positive correlation between in-patient to staff ratios and higher hospital standardised mortality ratios (HSMRs)[7]

- Staffing capacity and capability can have a profound impact on patient safety - Don Berwick's recent review into patient safety emphasised the role of Boards and leaders of provider organisations in relation to staffing capacity and capability, stating that they should take responsibility for ensuring that clinical areas are adequately staffed in ways that take account of varying levels of patient acuity and dependency, and that are in accordance with scientific evidence about adequate staffing.[8]

- Patients need care every day of the week – not just Monday to Friday. Evidence shows that the limited availability of some services at weekends can have a detrimental impact on outcomes for patients, including raising the risk of mortality.[9] Appropriate nursing, midwifery and care staffing capacity and capability, together with other clinical staff, needs to be sustained 24 hours a day, 7 days of week, to maintain patient care and protect patient safety.

What does this mean in practice?

Board reporting

- **Boards request and receive papers on establishment reviews.** Carried out at least every six months, establishment reviews are critical to ensuring that the right people, with the right skills, are in the right place at the right time. They provide the opportunity to evaluate staffing capacity and capability over the previous six months, and to forecast the likely staffing requirements of wards for the next six months, based on the use of evidence based tools, and a discussion with ward, service and team leaders. Boards should sign off establishments for all clinical areas, articulate the rationale and evidence for agreed staffing establishments, and understand the links to key quality and outcome measures.

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[6] Kane RL, Shamliyan TA, Mueller C, Duval S, Wilt TJ. *The association of registered nurse staffing levels and patient outcomes: systematic review and meta-analysis*. *Med Care.* Dec 2007;45(12):1195-1204

[7] *Review into the quality of care provided by 14 hospital trusts in England: overview report,* Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

[8] *A promise to learn, a commitment to act: improving the safety of patients in England,* Don Berwick, Department of Health, August 2013. Available at: https://www.gov.uk/government/publications/berwick-review-into-patient-safety

[9] N Freemantle, M Richardson, J Wood, D Ray, S Khosla, D Shahian, WR Roche, I Stephens, B Keogh and D Pagano, *Weekend hospitalization and additional risk of death: An analysis of inpatient data. Journal of the Royal Society of Medicine, February 2012 vol. 105 no. 2 74-84.* Available at: http://jrs.sagepub.com/content/105/2/74

Papers to the Board on establishment reviews should aim to be relevant to all wards and cover the following points:

- the difference between current establishment and recommendations following the use of evidence based tool(s) (further detail provided under **expectation 3);**
- what allowance has been made in establishments for planned and unplanned leave (further detail provided under **expectation 6);**
- demonstration of the use evidence based tool(s) (further detail provided under **expectation 3**);
- details of any element of supervisory allowance that is included in establishments for the lead sister / charge nurse or equivalent (further detail provided under **expectation 6);**
- evidence of triangulation between the use of tools and professional judgement and scrutiny (further detail provided under **expectation 3**);
- the skill mix ratio before the review, and recommendations for after the review (further detail provided under **expectation 3);**
- details of any plans to finance any additional staff required (further detail provided under **expectation 9**)
- the difference between the current staff in post and current establishment and details of how this gap is being covered and resourced;
- details of workforce metrics - for example data on vacancies (short and long-term), sickness / absence, staff turnover, use of temporary staffing solutions (split by bank / agency / extra hours and over-time); and
- information against key quality and outcome measures - for example, data on: safety thermometer or equivalent for non-acute settings, serious incidents, healthcare associated infections (HCAIs), complaints, patient experience / satisfaction and staff experience / satisfaction.

The paper should make clear recommendations to the Board, which would be considered and discussed at a public Board meeting. Actions agreed by the Board should be detailed in the minutes of the meeting, and evidence of sustained improvements in the quality of care and staff experience should be considered periodically.

- **Regular updates to the Board** on staffing capacity and capability. Published monthly, these updates should provide details of the actual staff available on a shift-to-shift basis versus planned staffing levels, and the impact that this has had on relevant quality and outcome measures. These reports would highlight those wards where staffing capacity and capability frequently falls short of what is required to provide quality care to patients, the reasons for the gap, the impact and actions being taken to address it and to improve care.

Evaluating the risks

- Ensuring that adequate staffing capacity and capability is maintained can be a challenging and complicated process, and there will inevitably be times when it falls short of what is needed to provide high quality care to patients. Even where there appears to be enough staff, the skills of the workforce must be considered: a very dilute skill mix of registered nurses/midwives to care staff can compromise patient safety. In Professor Sir Bruce Keogh's review of 14 hospitals with elevated mortality rates, an over-reliance on non-registered staff and temporary staff was reported as a particular problem, and there were often restrictions in place on the clinical tasks temporary staff could undertake.[10]

- Boards should seek assurance that there are processes in place to highlight risks to patient care caused by insufficient staffing capacity and capability. They should seek assurance that escalation policies and contingency plans are in place for those times where staffing capacity and capability falls short of that required to provide a high quality service to patients. Further detail on the use of escalation policies is provided under **expectation 2.**

- Organisations should actively encourage all staff to report any occasions where any lack of suitably trained or experienced staff could have, or did, harm a patient. Because we know that staff under pressure are more liable to make errors, these locally reported incidents should be considered as patient safety incidents rather than solely staff safety incidents, and be routinely uploaded to the National Reporting and Learning System[11].

Being able to take decisive action

- Boards should ensure that the Executive Team is supported and enabled to take decisive action when necessary. Where potentially unsafe staffing capacity and capability is identified, escalation policies are important in outlining mitigating actions as part of contingency plans. In those situations where all potential solutions are exhausted, Directors of Nursing and the Executive Team should have the knowledge and expertise required to form a judgement on the course of action that best protects the safety of patients in their care. The closure of a ward or suspension of services as a final resort should always be carefully considered with alternative arrangements for patients identified as a priority.

[10] *Review into the quality of care provided by 14 hospital trusts in England: overview report,* Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

[11] More information on how to report incidents can be found at: http://www.nrls.npsa.nhs.uk/patient-safety-data/

CASE STUDY 1: **University College London Hospitals (UCLH)**

At UCLH the Executive Board receives regular updates about nursing and midwifery staffing and patient care.

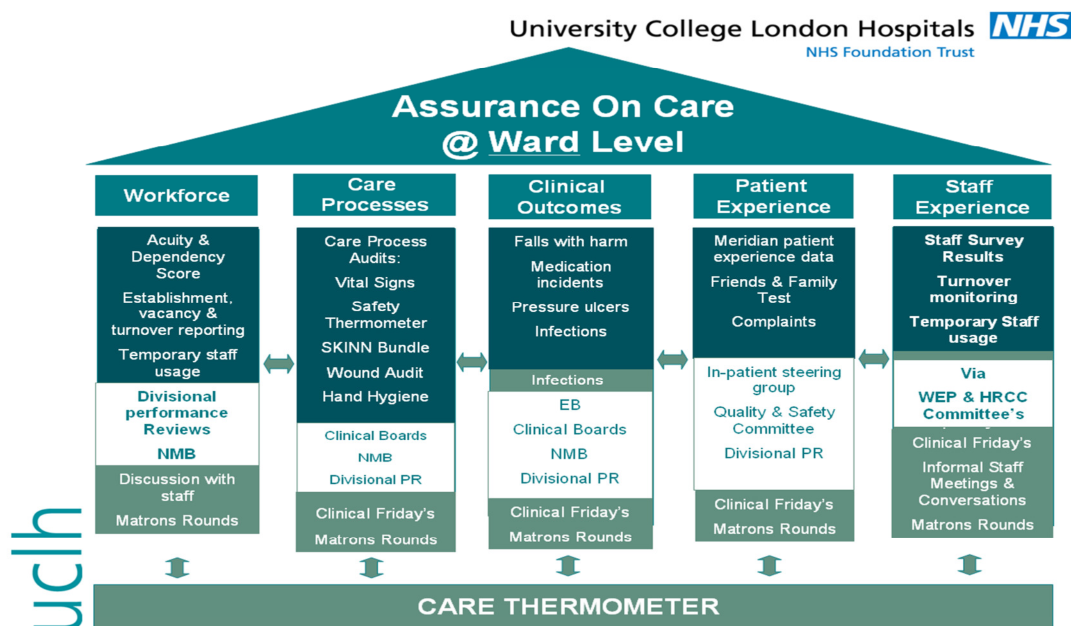
Ward establishments are set through a process agreed by the trust board and which utilises the Safer Nursing Care Tool to ensure that staff numbers are based on evidence based assessment of acuity and dependency.

Data are collected three times per year which is followed by a review of the data by the Head of Nursing, Head of Finance, Head of Workforce and Divisional Manager. This review triangulates professional judgement and ensures that the establishments are set at the right level for a particular ward.

Where an adjustment to the establishment is required this is then reflected in the following year's ward budget and is updated on the e-rostering system.

Staffing numbers are measured at the beginning of each shift and are displayed on the ward quality board at the entrance to each ward. Where the number of staff on duty is more than 1 nurse less that rostered, or each nurse has more than 7 patients to care for, the nurse in charge follows a standard escalation procedure which includes escalation to the chief nurse or one of her deputies over the full 24 hour period.

Nurse sensitive outcomes are measured and monitored via the care thermometer which is challenged at monthly meetings of the matrons and the nursing and midwifery board. This mechanism allows the leadership team to monitor process and outcomes measures that are sensitive to nurse staffing levels and provide assurance that the mechanisms for setting establishments are robust and effective.



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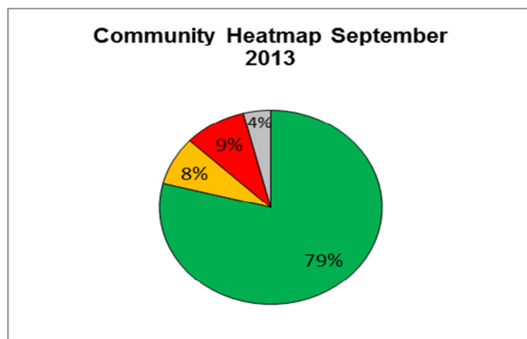
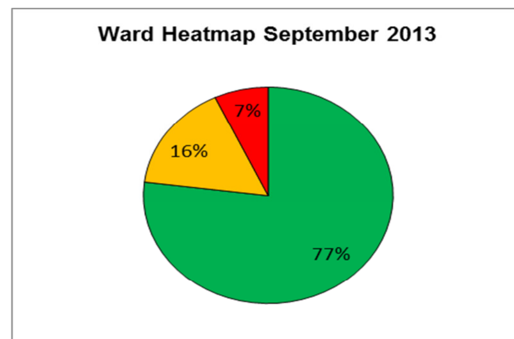
CASE STUDY 2: **Lincoln Partnership NHS Foundation Trust**

Board Reporting - Use of a Heat Map, Cultural Barometer and Staffing Benchmarks'

For the last 18 months Lincolnshire Partnership NHS Trust has been developing and using a set of indicators that pull together reporting against CQC standards, patient experience, staff experience, and more recently the benchmarking of staffing. These indicators cover all clinical services (including wards and community services) and are in use from the ward to the Board. The 'Heat Map' report informs the Board and all staff within the organisation of the performance of the wards and community services utilising both pictorial and written methods. The report acts as an early warning tool and complements an *'under the skin'* approach to support services that need support and is also used to highlight improvement and exemplary practice.





Key: Outcome met Outcome mostly met Risk of outcome not being met no data

Underpinning the Heat Map the Trust uses the framework of the Provider Compliance Assessment (PCA) tool developed by the CQC. The Trust measures compliance across 16 outcomes which includes staffing measures which are presented to the Board and throughout the organisation using both pie charts and tables, showing compliance across individual outcomes for each ward/clinical area. Recently this internal regulation approach has been enhanced by the use of an internal cultural barometer, including questions about support, leadership, staff development and satisfaction, whether people feel able to raise concerns and transparently reported staffing ratios.

The report and approach highlights the requirement for listening to patients, staff and the public, a culture of open and honest communication, leadership at every level and not relying on one single process of assurance about care standards and quality. The approach supports the Board level requirement to monitor the quality of its services, to challenge poor performance and variation, and to incentivise high quality and performance improvement. Its use has supported the leadership development at all levels that is required to underpin good governance and high quality care.

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Expectation 2

Processes are in place to enable staffing establishments to be met on a shift-to-shift basis. The Executive team should ensure that policies and systems are in place, such as e-rostering and escalation policies, to support those with responsibility for staffing decisions on a shift-to-shift basis. The Director of Nursing and their team routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage immediate implications and identify trends. Where staffing shortages are identified, staff refer to escalation policies which provide clarity about the actions needed to mitigate any problems identified.

Why is this important?

- Agreeing staffing establishments is the first part of an important process. Ensuring that establishments are met on a shift-to-shift basis is a vital step in ensuring that there is sufficient capacity and capability to care for patients on wards.

- Professor Sir Bruce Keogh highlighted this as a particular problem in his recent review into hospitals with elevated mortality rates; whilst staffing establishments in organisations appeared adequate in many instances, there were occasions when establishments were not met on wards on a shift-to-shift basis, compromising patient care.[12]

- Temporary staff form a key part of the nursing, midwifery and care staffing workforces. Using temporary staffing solutions when establishments cannot be met on a shift-to-shift basis can be an effective way of maintaining patient care, where the skills and capabilities of temporary staff match the requirements on the ward. However, an over reliance on temporary staffing can be costly, and lead to a lack of continuity in patient care. Ideally, substantive staff should be recruited to establishments, with temporary staffing solutions used to fill short term gaps only.

What does this mean in practice?

- **Daily reviews of the actual staff available on a shift-to-shift basis versus planned staffing levels** should occur between Sisters, Matrons and Heads of Nursing (and equivalent posts). Where shortages are identified, they work together to seek a solution – such as the pooling of staff from other clinical areas, or the deployment of bank or agency staff.

[12] *Review into the quality of care provided by 14 hospital trusts in England: overview report,* Prof. Sir Bruce Keogh, NHS England, July 2013. Available at: http://www.nhs.uk/NHSEngland/bruce-keogh-review/Documents/outcomes/keogh-review-final-report.pdf

- **E-rostering policies** can be an effective way of making the most of existing resources. NHS Employers has produced guidance that provides all the information an organisation will need to successfully implement an e-rostering system, which will allow them to embrace efficient and safe staffing by releasing more time for staff to deliver higher quality services, as well as helping to reduce expenditure on temporary staffing. E-rostering brings together management information on shift patterns, annual leave, sickness absence, staff skill mix and movement of staff between wards. This enables managers to quickly build rotas to meet patient demand. Employees are able to access the system to check their rotas and make personal requests, which should be balanced with service requirements. The guidance explains why e-rostering is beneficial, and explains how organisations can secure agreement to and implement an e-rostering programme.

  The guidance can be found at: http://www.nhsemployers.org/planningyourworkforce/flexible-workforce/agencyworkers/reducingagencyspend/e-rostering/Pages/e-Rostering.aspx

- **Using escalation policies and contingency plans** can provide a source of clarity at times of increased pressure (for example, when there are unusually high workloads, a particularly high level of patient dependency, exceptionally high staff sickness levels, or unfilled vacancies), and when staffing capacity and capability cannot be met on a shift-to-shift basis. Staff should be aware of the escalation policies in place, flag where they think staffing capacity and capability falls short of what is required (further detail is provided under **expectation 4**), and be able and prepared to use the escalation policies in place.

- Escalation policies should outline actions to be taken, the people who should be involved in decisions, in short, medium and long term staffing shortages, and outline the contingency steps where capacity problems cannot be resolved. Escalation policies are helpful in flagging capacity problems at an early stage, allowing organisations to adopt a proactive rather than a reactive response to problems identified.

4 Evidence-based decision-making

Expectation 3

Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability. As part of a wider assessment of workforce requirements, evidence-based tools, in conjunction with professional judgement and scrutiny, are used to inform staffing requirements, including numbers and skill mix. Senior nursing and midwifery staff and managers actively seek out data that informs staffing decisions, and they are appropriately trained in the use of evidence-based tools and interpretation of their outputs. Staff use professional judgement and scrutiny to triangulate the results of tools with their local knowledge of what is required to achieve better outcomes for their patients.

Why is this important?

- Determining nursing, midwifery and care staffing requirements is a complex process, requiring input from all levels within the nursing and midwifery staffing structure. Using an evidenced-based tool is a critical part of making staffing decisions, and will ensure that these decisions are based on patient care needs and expert professional opinion.

- Using such tools is only one part of an approach to making staffing decisions; professional judgment and scrutiny is critical in evaluating the results from evidence-based tools, in light of patients' needs and knowledge of the local context.

- Simply determining the number of nurses, midwives or care staff required is only one part of the equation. The skill mix of the workforce should reflect patient care needs and local requirements, considering the experience and capabilities of the workforce employed. Evidence suggests that where there are lower levels of registered nurses, there are higher rates of errors in care[13, 14] and care is more likely to be 'left undone' when there are fewer registered nurses on a ward.[15,16]

- The right number and skill mix of staff alone will not ensure that high quality patient care is delivered; this depends upon a range of other factors, such as the leadership of an organisation, the management culture, the culture and team working on the ward, the

[13] McGillis Hall L, Doran D, Pink GH. *Nurse staffing models, nursing hours, and patient safety outcomes*. Journal of Nursing Administration. Jan 2004;34(1):41-45

[14] Blegen MA, Goode CJ, Reed L. *Nurse staffing and patient outcomes*. Nurse Researcher. Jan-Feb 1998;47(1):43-50.

[15] Kalisch B, Tschannen D, Lee H. *Does missed nursing care predict job satisfaction?* Journal of Healthcare Management. Mar-Apr 2011;56(2):117-131; discussion 132-113.

[16] Kalisch BJ, Tschannen D, Lee KH. *Do staffing levels predict missed nursing care?* International Journal for Quality in Health Care. Jun 2011;23(3):302-308.

level of education and training available to staff, and the organisational environment. Further detail is given under **Expectation 4.**

What does this mean in practice?

- **Using evidence-based tools** - there are a range and variety of tools available for use at present. Some of the tools that are currently in use, and a guide as to their use, is given in the table below. This is not intended to be a comprehensive list of the tools in use, and in the longer term, NICE will be reviewing the evidence base and accrediting tools in this area.

ACUTE SETTINGS

Safer Nursing Care Tool ™

The SNCT was originally developed in conjunction with the Association of UK University Hospitals (AUKUH), when it was known as the *AUKUH Patient Care Portfolio*. It has been widely used across the NHS, private sector and in some overseas hospitals. The Shelford Group commissioned a review of the tool and it has recently been relaunched as the *Safer Nursing Care Tool* (SNCT). It is available on the Shelford website at: http://shelfordgroup.org/resource/chief-nurses/safety-nursing-care-tool

The tool comprises two parts:

- An Acuity and Dependency Tool – this has been developed to help acute NHS hospitals measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce. The tool sets out how to measure acuity and dependency of patients in a ward, what rules to follow to ensure that data are captured accurately, how to use this information to calculate total staff needed in a particular ward using nursing multipliers, and provides an example database which organisations can adapt for their own purposes.

- Nurse Sensitive Indicators (NSIs) – these have been identified as quality indicators of care with specific sensitivity to nursing intervention or lack of intervention. They can be used alongside the information captured using the Acuity and Dependency Tool to develop evidence-based workforce plans to support existing services or the development of new services. The Safer Nursing Care Tool demonstrates how NSI outcome data can be used alongside acuity and dependency information. If the SNCT and NSIs are used concurrently then it will be possible to relate ward staffing and nursing outcomes.

Work is underway to develop Safer Nursing Care tools for children's in-patient wards, acute assessment units, elderly acute care and elderly rehabilitation.

MATERNITY SETTINGS

Birthrate Plus®

Birthrate Plus® is the only national tool available for calculating midwifery staffing levels. It was developed 24 years ago and has now been applied in the majority of NHS Trusts in the UK and Ireland, being modified and developed to reflect changing models of care and working patterns.

- Using Birthrate Plus® enables individual Trusts to calculate their staffing requirements based on their specific activity, case mix, demographics and skill mix.
- It enables commissioners to compare the staffing, skill mix and models of care in their local providers with neighbours or units of a similar size.
- It provides workforce planners with robust data on which to commission student midwife numbers and advise on workforce establishments.

At its simplest Birthrate Plus® can provide any given service with a recommended ratio of clinical midwives to births in order to assure safe staffing levels. The methodology is based on an assessment of clinical risk and the needs of women and their babies during labour, delivery and the immediate post-delivery period. From these quantifiable needs of women Birthrate Plus® provides insights and intelligence to inform decisions about staffing numbers, staff deployment, models of care and skill mix.

Birthrate Plus® is available at http://www.rcm.org.uk/college/policy-practice/joint-statements-and-reports/

PAEDIATRICS

Great Ormond Street Hospital Paediatric Acuity and Nursing Dependency Assessment tool (PANDA) ™

Developed by Great Ormond Street Hospital, the PANDA tool measures patient dependency and calculates nursing staff requirements based on the actual acuity and dependency of children.

Previously paper based, the new PANDA software version has been supported by NHS Innovations London and developed by Genisys Group.

It is available at: http://rfdesign-uk.com/testsite/panda/

CLINICAL NURSE SPECIALISTS PROVIDED SERVICES

Cassandra™

Cassandra™ allows specialist advanced practice nurses to draw on a representative sample of their work and was a response to diary care exercise/time and motion studies in common use which did not adequately capture the complexity of the work. The Cassandra ™ tool was developed by Dr Alison Leary by clustering data from a more complex dataset (Pandora). It has been used in several national studies and is now free to download as a spreadsheet from www.alisonleary.co.uk

Alexa Caseload Tool™

The Alexa Caseload tool™ was developed by Dr Alison Leary with the National Cancer Action Team (NCAT) quality in nursing group. It is used to determine the optimum caseload of a specialist nurse against best practice. It is based on the work of lung Clinical Nurse Specialists but the methodology can be applied to Clinical Nurse Specialists who manage patients with other long term conditions. It uses previously modelled activity and national data to calculate a recommended caseload.
It is available at: www.alisonleary.co.uk or www.cancertoolkit.co.uk

ACUTE AND MENTAL HEALTH IN-PATIENT SETTINGS

Nursing Hours per Patient Day (NHPPD) ™

Developed in Western Australia the Nursing Hours per Patient Day tool is a nursing workload monitoring and measuring system that provides a guide to the number of nurses required for service provision in a specific clinical area. The model relies on clinical judgement to assess adequate staffing to deliver care on a day-to-day basis. The model is used to calculate the number of direct nursing hours required to provide patient care and can offer a framework to develop a nursing roster.

It can be found at: http://www.nursing.health.wa.gov.au/planning/workload_man.cfm

ACUTE, MENTAL HEALTH, LEARNING DISABILITIES AND COMMUNITY SETTINGS

Tools developed by Dr Keith Hurst - Dr Keith Hurst has developed a variety of tools to determine nursing requirements:

Professional Judgement Software™

A quick and easy method: an expert group (clinical, workforce and finance) decides each ward’s team size and skill mix using local intelligence.

Ward Staff Per Occupied Bed™

Another quick and easy method; ward managers draw relevant staff to occupied ratios from the national database and multiply occupied beds in their wards by the staffing multiplier. Separate multipliers are available for nurses and healthcare support workers. This method does not consider patient dependency/acuity.

Patient Dependency / Acuity Specialty Specific Tool™

Ward managers assess every patient at least daily for two weeks using the ADL dependency criteria. Daily averages are entered into software (selected according to clinical speciality). Ward staffing, therefore, reflects a clinical speciality's current workload and can be adjusted at any time. The software covers 28 clinical specialties. Managers also conduct an activity analysis and service quality audit. Ward workload index, staffing recommendations, ward staff activity and service quality can be benchmarked against same-specialty wards in the UK.

A community nursing tool with community care levels and multipliers is also available for use.

The software is available from keithhurst.research@yahoo.co.uk

A list of professional guidance is provided at **Appendix A.**

Evidence-based tools for mental health, learning disabilities and community settings

- The evidence base in relation to workforce planning and safe and effective staffing within mental health, learning disability and community settings is less established than that for acute care settings. Work is under way through *Compassion in Practice* Action Area Five to understand what workforce planning tools exist for these care settings and to pilot these tools or develop new tools.

    - **Mental Health -** A critical issue in mental health services is the therapeutic relationship and skilful interaction between staff and individual patients. The ethos, models of care and philosophy are also important factors in determining staffing establishments in mental health. The composition of the multi-professional team in mental health settings, for example the presence of occupational therapists and psychologists, will have a direct impact upon nurse staffing requirements.

- The guiding principles of workforce planning are applicable for all care groups, and some tools, for example the methodology developed by Dr Keith Hurst, are applicable to mental health services. Work is underway to pilot the Mental Health tool developed in NHS Scotland alongside Dr Keith Hurst's mental health / learning disabilities tool in mental health in-patient settings in England.

- **Learning Disabilities -** A UK-wide review of learning disabilities nursing supported by the four Chief Nursing Officers in the UK published in 2012[17] made recommendations related to workforce planning. Subsequent to this report a number of work streams and actions have commenced across the UK to influence workforce planning and education commissioning decisions in relation to learning disability nursing. All of the work streams report to the UK steering group chaired by Dr Ben Thomas. The Centre for Workforce Intelligence also undertook a strategic review of the learning disability nursing workforce.

- Through *Compassion in Practice* Action Area Five work is underway to pilot the NHS Scotland mental health tool and Dr Keith Hurst's tool for mental health and learning disabilities in learning disability in-patient settings. It is however recognised that the vast majority of learning disabilities care takes place in the community and work is also being taken forward to develop a tool for use in community settings. This work will consider the close working relationship between the nursing and social care workforce.

- **Community services -** The Community Nursing Strategy Programme brings together multiple organisations, including NHS England, the Department of Health, Health Education England, Public Health England and Queens Nursing Institute within a national programme led by the Chief Nursing Officer for England. Within the next two years, it aims to:

    - strengthen innovation;
    - support the workforce and improve commissioning practice for community, district and general practice nursing that enables care to be delivered closer to home; and
    - improve the outcomes for people with long term conditions, whilst simultaneously improving the experience of patients, carers and staff.

- The Queen's Nursing Institute is undertaking a review of workforce planning tools in community settings which is due to report at the end of December 2013.

[17] *Strengthening the commitment, The Report of the UK Learning Disabilities Nursing Review,* 2012, available at: http://www.scotland.gov.uk/Resource/0039/00391946.pdf

Interpreting results of tools and using professional judgment and scrutiny

- **Triangulation of results** from evidence-based tools is a vital step in establishing safe nursing, midwifery and care staffing capacity and capability. Staff should use professional judgement and scrutiny to interpret results from evidence based tools, taking account of the local context and patient needs. Some factors which can affect staffing requirements include:

    - The layout and design of the ward. For example, wards with multiple single rooms or bays may require higher staffing capacity and capability;
    - The number of ward clerks/ housekeepers and other support staff available;
    - Employing ward clerks and housekeepers on wards can reduce the pressure on nurses, midwives and care staff in undertaking administrative tasks;
    - Any travel requirements. For example, in community settings, staff may have distances to travel between visits. Establishments should include a proportion of time allocated to travel where necessary. Clinical visits should be planned to make most effective use of travel time;
    - The technological support available on wards. The adoption of new technological solutions can reduce the amount of time that nurses, midwives and care staff spend on paperwork, freeing them up to focus on direct caring duties;
    - The dependency and acuity of patients. High patient dependency will require higher capacity and capability of registered nurses and midwives; and
    - Patient throughput is another factor which needs to be considered when planning nursing, midwifery and care staff establishments.

- Professional judgment and knowledge of the local context and patient needs should also inform the **skill mix** of staff. Simply determining the numbers of staff required for each ward is not sufficient – it is important that the skill mix between registered and non-registered staff reflects the likely workload and skills required to care for patients locally. Healthcare Support Workers, Maternity Support Workers and Assistant / Associate Practitioners are key members of the nursing and midwifery team, and the skill mix used should maximise the potential contributions of all parts of the workforce. The considerations outlined above are equally relevant when considering the skill mix of staff.

- Employer organisations should have robust systems in place to govern the practice of all members of the nursing and midwifery workforce, including the accountabilities of Registered Nurses and Midwives in relation to the appropriate delegation of care. It is essential that all members of the nursing and midwifery team receive training for their role.

- Healthcare Assistants[18]/Support workers now make up around a third of the caring workforce in hospitals, and research suggests that they now spend more time than nurses at the bedside.[19] Health Education England (HEE) is leading work nationally to maximize the capabilities and contribution of Healthcare Assistants/Support Workers, which includes:.
    - establishing minimum training standards for Healthcare Assistants / Support Workers
    - progression routes for Healthcare Assistants / Support Workers to enter nurse training
    - increasing the number of healthcare apprentices

- The Royal College of Midwives has published guidance on the role and responsibilities of Maternity Support Workers available at: http://www.rcm.org.uk/college/your-career/maternity-support-workers/roles/

CASE STUDY 3: **Hertfordshire Partnership University Trust - 'Safe Staffing: Managed entry and exit policy for acute mental health services'**

Hertfordshire Partnership University NHS Foundation Trust acute mental health services updated its managed exit and entry policy, focusing on correct and safe staffing on acute admission wards for Informal patients entitled to leave the unit and Formal patients detained under the Mental Health Act.

The policy introduced the following principles:

- All service users admitted are screened and risked assessed for their potential to abscond from the unit based on their status under the Mental Health Act and their profile risk is combined with clinical judgement.
- 'Patient Status' at a glance boards for high risk absconders are utilised at handover and team meetings.
- A range of evidence-based tools interventions are available for use to assess acuity and risk, enabling staffing needs to be adjusted, these include including the Nursing Observed Intensity Sickness Scale and the Brøset Violence Checklist.

Early feedback suggests this policy is leading to safer services for both service users and staff.

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[18] Some organisations use the terms Nursing Auxiliaries, Nursing Assistants, Healthcare Support Workers and Healthcare Assistants.

[19] *The Cavendish review: an independent review into healthcare assistants and support workers,* Camilla Cavendish, Department of Health, July 2013. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf

***CASE STUDY 4*: Derbyshire Community Health Services NHS Trust - 'Staffing for Quality: Joint Review of Community Nursing on behalf of Derbyshire Community Health Services NHS Trust and North Derbyshire CCG'**

A review was established between Derbyshire Community Health Services DCHS and North Derbyshire CCG (NDCCG), as lead commissioner, to assess community nurse staffing levels following the publication the Francis Inquiry report, and in light of national and local priorities in relation to community nursing and the delivery of integrated care models.

In March 2013 following a review of staffing levels in their community hospitals, the DCHS Board approved increased funding. The review 'Staffing for Quality' was undertaken utilising an evidence-based tool (Hurst) and assessed against recent recommendations by the Royal College of Nursing (RCN) and national reports on the provision of elderly care.

A locally developed tool based on a model used in Central Essex to determine community nursing workload and dependency has been in use within DCHS for a number of years. Currently it is mainly used by the District Nursing sister to manage the weekly and daily work load of their teams (planned and urgent work), matching skills/competency to patient need. In some localities the Integrated Team Leaders use it across a number of teams to ensure efficient use of resources and manage their workforce. Recent development work has supported linking the tool with electronic patient records. DCHS is developing this further, linking with a Hurst review process, and e-rostering, system which will include a patient acuity tool.

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***CASE STUDY* 5: Cumbria Partnership NHS Foundation Trust - 'Safer Nursing Care Tool: Community Hospital Review and Disrict Nurse Services Review'**

In Summer 2012 the tBoard requested a review of two Community Hospital in-patient units which resulted in a recommendation to undertake a review across all 14 in-patient units. It was also agreed that the District Nursing team should be reviewed.

This review was commissioned in November 2012. The Safer Nursing Care Tool was used for the inpatient review and the audit results were benchmarked against 145 comparable best practice wards within England. In April 2013 all forty-six district nursing teams were audited.

The results of the reviews has enabled the Trust Board to understand the dependency and acuity of patients on each ward and in the community, the quality of care delivered and the staffing numbers, skill mix and competency required to care for the patient mix compared with the actual staffing levels. This has provided the Board and clinicians with an evidence base against which to allocate resources and has resulted in Ward Managers becoming supervisory and a Band 5 Registered Nurse post appointed on each ward in replacement (13 in total); there have also been additional Health Care Assistant's and Band 6 Registered Nurse roles appointed.

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CASE STUDY 6: Staffordshire and Stoke on Trent Partnership NHS Trust - 'Workforce Planning Toolkit'

Staffordshire and Stoke on Trent Partnership NHS Trust has developed an innovative Workforce Planning Toolkit to support its strategic workforce planning and operational deployment. Using a bottom up approach, it enables managers to work through an integrated workforce planning methodology in a systematic way using population/demographic demand, competency frameworks to match demand and a caseload management tool.

Features of the toolkit include a triangulation of multiple methods to establishing demand, and include business tools to link workforce planning with the Trust's overall strategic direction, as well as indications for improvements to the current deployment of staff and possibilities for workforce redesign.

The development of robust competency frameworks across the Trust is a key enabler to this toolkit which will ensure that staff are appropriately placed with the right skills, knowledge and competences to deliver the Trust's person-centred model.

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CASE STUDY 7: 'The Role of Maternity Support Workers

The Royal College of Midwives (RCM) describes Maternity Support Workers (MSW) 'as any non-registered employee providing support to a maternity team, mothers and their families who work specifically for a maternity service' and who, with training and supervision, can provide information, guidance and support.

In Wrightington, Wigan and Leigh NHS Foundation Trust (WWL) MSW's deliver one to one practical parenting support and education to the 2% most vulnerable pregnant women and their families as part of the Integrated Health Service Team. These pregnant women can have complex needs, which may include safeguarding or mental health concerns. Support commences early in pregnancy and continues both on the maternity ward and for six weeks post natal. The MSWs provide training and support across a range of areas including baby bathing, breastfeeding, artificial feeding and associated sterilisation and safe sleep.

At Southend University Hospital Foundation Trust Infant Feeding MSWs are trained and empowered with the skills and knowledge to support women to continue to breastfeed for as long as possible. The MSWs were trained in the UNICEF Baby Friendly Initiative Breastfeeding Management and provide post-delivery support of up to six weeks by making contact with breastfeeding mothers upon transfer to the community. Within three months of introducing MSWs the continuation rate for breastfeeding had improved.

Although MSWs do not make clinical judgments their input under the direction of the midwife supports mother and baby.

5 Supporting and fostering a professional environment

Expectation 4

Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns. The organisation supports and enables staff to deliver compassionate care. Staff work in well-structured teams and are enabled to practice effectively, through the supporting infrastructure of the organisation (such as the use of IT, deployment of ward clerks, housekeepers and other factors) and supportive line management.

Nursing, midwifery and care staff have a professional duty to put the interests of the people in their care first, and to act to protect them if they consider that they may be at risk, including raising concerns. Clinical and managerial leaders support this duty, have clear processes in place to enable staff to raise concerns (including about insufficient staffing) and they seek to ensure that staff feel supported and confident in raising concerns. Where substantiated, organisations act on concerns raised.

Why is this important?

- In general terms, the more positive the experience of staff within a Trust, the better the outcomes for patients and the organisation. Staff engagement has many significant associations with patient satisfaction, mortality, and infection rates. The proportion of staff working in well-structured teams, receiving well-structured appraisals and experiencing supportive leadership from line managers are all linked to patient mortality.[20]

- A key part of supporting staff is ensuring that the organisational culture encourages them to perform their job to the best of their abilities. For example, advances in technology can have a huge impact on the workload of nursing, midwifery, and care staff, enabling them to deliver effective care and freeing up their time to care for patients. Embracing such developments will allow staff the opportunity to fulfill roles to their maximum potential, and could affect the staffing establishments required.

- Being listened to, respected, and treated with the compassion and dignity they deserve has a huge impact on patients' experience of care, and contributes to higher quality care. It is vital that leaders and managers at every level create supportive, caring cultures, within teams and within organisations as a whole. As outlined in *Compassion in Practice,*

[20] Michael A West, Jeremy F Dawson. *Employee engagement and NHS performance*, 2012. Available at: http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

nurses, midwives and care staff have a responsibility to demonstrate six key values – the 6Cs - in everything they do. These are care, compassion, competence, communication, courage and commitment.[21]

What does this mean in practice?

Supporting staff

- **Organisational culture** is key to ensuring that staff feel supported and enabled to fulfill their role to their maximum potential, and are able to raise concerns where necessary. Those with line management responsibilities seek to ensure that staff are managed effectively, with clear objectives set, constructive appraisals carried out, resulting in a workforce that feels valued. Teams should be well-structured, with supportive line management at every level of the organisation.

- The adoption of technological advances can enable nurses and midwives to deliver care more effectively, and can free up staff time to focus on delivering patient care. The Nursing Technology Fund has been established with this aim - £100 million of funding over two years will be available uniquely for new technology that will support safe, effective care. The new technology could include digital pens and other handheld mobile devices that allow staff to access the latest information about a patient's treatment whenever, wherever they are. These technologies will enable a swifter, more comprehensive understanding of a patient's care and conditions, reducing the time spent on form filling and bureaucracy, freeing up time for face-to-face patient care and contributing to safer care and better outcomes.

Ensuring staff are able to speak up

- Nurses, midwives and care staff are under a professional duty to put the needs of their patients first, and to speak out when they have concerns. This is made clear in the Nursing and Midwifery Council's (NMC) code. The Code is the foundation of good nursing and midwifery practice, and a key tool in safeguarding the health and wellbeing of the public. It highlights that the people in the care of Registered Nurses and Midwives must be able to trust them with their health and wellbeing, and that to justify that trust, nurses and midwives must:
    - make the care of people their first concern, treating them as individuals and respecting their dignity;
    - work with others to protect and promote the health and wellbeing of those in their care, their families and carers, and the wider community;
    - provide a high standard of practice and care at all times; and

[21] *Compassion in Practice,* NHS England, December 2012. Available at http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

- be open and honest, act with integrity and uphold the reputation of their profession.

The code continues to apply to operational managers who keep their nursing or midwifery registration. The code is available at: http://www.nmc-uk.org/Nurses-and-midwives/Standards-and-guidance1/The-code/

- The NMC has also recently refreshed and re-launched guidance on raising concerns. This provides guidance for nurses and midwives on raising concerns, setting out broad principles that will help them think through the issues and take appropriate action in the public interest. The new edition includes information on recent legislation that offers protection to whistleblowers as well as updated information on where nurses and midwives can go to for further information. It is available at http://www.nmc-uk.org/Nurses-and-midwives/Raising-and-escalating-concerns

- **Whistleblowing policies** should be in place within providers of NHS services, supporting staff to raise concerns as and when they arise. NHS Employers provides guidance to support employers to implement and develop policies and procedures that are targeted at enabling NHS staff to report concerns appropriately. NHS Employers work closely with the National Whistleblowing Helpline launched in December 2011 which provides free, independent advice and support to staff within the NHS and Social Care.[22] The Helpline can be reached by calling 08000 724 725.

- Organisations should be open and honest when things go wrong. All providers of NHS services must adhere to **Duty of Candour requirements,** which require organisations to publish an annual declaration of a commitment to telling patients if something has gone wrong with their care.[23] The Duty of Candour has also been strengthened in the recently published Government response to the Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry, available at: https://www.gov.uk/government/publications?departments[]=department-of-health

- **Staff side representatives** working in organisations can provide support in ensuring that staff views are considered, for example through staff survey feedback, and can support them in raising concerns – including concerns around staffing capacity and capability. They can act on behalf of staff and represent staff views and concerns during regular meetings with the organisation's management team.

[22] Guidance produced by NHS Employers can be found at: http://www.nhsemployers.org/employmentpolicyandpractice/ukemploymentpractice/raisingconcerns/pages/whistleblowing.aspx

[23] Guidance on the Duty of Candour can be found at: http://www.nhsemployers.org/EMPLOYMENTPOLICYANDPRACTICE/UKEMPLOYMENTPRACTICE/Pages/DutyofCandourconsultation.aspx

CASE STUDY 8: The Royal Wolverhampton Hospitals NHS Trust - 'SafeHands' Programme supports safer staffing levels using real time information

SafeHands is a Department of Health part-funded innovation project using Real time locating software (RTLS) to improve patient safety.

RTLS uses infra-red and radio-frequency technology to monitor and measure real time patient and staff interaction based on RTLS badge co-location. It provides real time locating and visibility of patients with on screen alerts and audible alarms when a patient is leaving the ward unaccompanied or alone in an isolated area and can generate a live bed state. The hospital can understand the true dependency of patients allowing staff to prioritise and improve individual patient care.

The RTLS also monitors Hand Hygiene index (similar to compliance) by ward and real time locating of equipment across the Trust ensuring planned equipment gets to the patient in a timely manner allowing prompt commencement of treatment.

All of the data can be reported on including hours of care given to individual patients, by individuals or groups of staff and triangulated with patient condition, acuity, falls risk etc. This will support accurate costing of service provision, predicting and planning for future staffing levels and informed dialogue with commissioners.

The programme is being rolled out across all in-patient areas of the hospital.

"Virtual walls" mark out individual bed spaces to identify real time locations of badges.

The Badges attach to patients, staff, hand gels, soaps and equipment to track location, movement, interaction, passage of time and hand hygiene compliance.

Staff, patient, gel and equipment badges send radiofrequency signals indicating their current location to the virtual walls. Messages are sent to the software which interprets the messages and triggers rules and reports including patient staff interaction, equipment tracking and patient "Last Seen" timer.

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CASE STUDY 9: Stockport NHS Foundation Trust - Stockport District Nursing and the Dominic System (Domiciliary in the Community Care System)

In 2010 the District Nursing Service in Stockport moved forward to produce an electronic scheduling system tailor made to staff requirements. The system, later called 'Dominic', was initially developed to reduce medication errors, duplication of visits, ensure continuity of visit by the right nurse with the right skills and promote visits at the patient's choice of time

The system was fully launched in 2012, and all caseloads are visible to all staff. It can now:

- schedule visits weeks in advance;
- enable management of workload pressures by moving staff;
- predict peaks in demand enabling managers to forecast pressures;
- monitor the performance of the service by measuring outcomes for CQUINS/KPIs and local targets;
- reduce the amount of bank required; and
- introduce improved skill mix resulting in efficiency savings.

Further development in 2014 will include incorporating the Specialist Nursing Team so that communication and referrals are fully electronic.

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CASE STUDY 10: King's College London - 'Culture of Care Barometer'

Caroline Alexander, Chief Nurse, NHS England (London) is leading the work on Action Area 4 of Compassion in Practice and the Culture of Care Barometer is part of this work. The National Nursing Research Unit at King's College London have been commissioned to develop and pilot the tool.

The Barometer aims to:

- be short and quick to complete;
- complement, not duplicate, other measures or quality programmes;
- allow "ward to board" communication;
- act as an early warning system to identify care culture problems; and
- prompt reflection, to help identify actions required.

The Barometer is a short survey which captures staff views of resources to deliver quality care, support needed to do a good job. It aims to gauge whether the culture of care in different parts of an organisation is conducive to delivering compassionate patient centred care, signalling where there are opportunities to develop and improve.

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CASE STUDY 11: University Hospital Southampton NHS Foundation Trust - 'A Staff Compact: Roles and Responsibility Discussions'

The Director of Nursing and Organisational Development has developed with staff a compact which sets out her own responsibility to staff and their responsibility within the organisation and to the nursing profession.

The staff compact is utilised to stimulate discussions in training sessions around professional behaviours and how every action or intervention with a patient should reflect their role as a caring and compassionate nurse or midwife. It also sets out a clear commitment that the Director of Nursing and Organisational Development will champion high quality patient care from Board to Ward.

A Moment In Time Every Time

My Responsibility To You

- I will continually champion high quality patient care from Board to Ward
- I will continue implementing our strategies to fill our vacancies, enable Ward Leaders to be fully supernumerary and ensure there are regular staffing reviews
- I will support anyone who has the courage to escalate concerns
- Working with you, I will ensure nursing and midwifery is valued and is high profile in the organisation
- I want to actively listen to new ideas and your views on how the nursing, midwifery and carer workforce can feel fully engaged in the Quality Improvement agenda

Judy Gillow, Director of Nursing and Organisational Development

A Moment In Time Every Time

Your Responsibility To Your Profession and the Organisation

- Remember every action/intervention/communication you undertake with patients, should reflect your role as a caring, compassionate nurse/midwife, and as a member of UHS
- At every level you should be a role model in behaviour and practice and demonstrate pride in your job
- You are the advocate for patients and must ensure they are receiving the best care
- You should act professionally at all times and treat your colleagues with respect

Contact: Judy Gillow, Director of Nursing and Organisational Development - Judy.gillow@uhs.nhs.uk

***CASE STUDY 12*: Maidstone and Tunbridge Wells NHS Trust - 'Safer Staffing; Changes made to a respiratory ward following the use of the Safer Staffing methodology'**

Key quality indicators are reviewed monthly at performance meetings and at the Clinical Governance Overview Committee utilising the Quality, Effectiveness and Safety Trigger Tool (QuESTT). Two consecutive low QuESST scores, along with a further infection case, instigated an internal review of Whatman ward, a 28 bedded medical ward focused on respiratory care and providing non-invasive ventilation support (NIV), using the CQC Dignity And Nutrition Inspection methodology. The review included a matron external to the Directorate and a patient representative.

Demand for NIV support had increased and had not been reflected in staffing levels. Discussions with operational management resulted in one bay (6 beds) being closed; staffing levels were adjusted to improve the Registered Nurse:Patient ratio. A bespoke training programme ensured all staff were competent and confident with NIV management.

Data from Safer Staffing was reviewed daily and progress was monitored weekly by the Directorate, the Infection Prevention Committee, Chief Nurse and up to the Board via the Quality & Safety Committee. A Risk Summit chaired by the Chief Executive allowed the Directorate to identify what Corporate/Organisation level support was required.

Improvements include a decrease in the number of complaints, improved patient satisfaction and a reduction in the number of incidents. There has also been a reduction in staff sickness and turnover. All of these improvements have been sustained over the last 6 - 9 months.

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Expectation 5

A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments. Directors of Nursing lead the process of reviewing staffing requirements, and ensure that there are processes in place to actively involve sisters, charge nurses or team leaders. They work closely with Medical Directors, Directors of Finance, Workforce (HR), and Operations, recognising the interdependencies between staffing and other aspects of the organisations' functions. Papers presented to the Board are the result of team working and reflect an agreed position.

Why is this important?

- There are many complex interdependencies between nursing, midwifery and care staffing capacity and capability, and other parts of an organisation's structure and functions. A multi-disciplinary approach to reviewing and establishing staffing capacity and capability will help to identify these interdependencies and to ensure that decisions are not taken in isolation.

- Whilst responsibility for nursing, midwifery and care staffing capacity and capability resides with Directors of Nursing (or equivalent), other Directors – such as Workforce (HR), Finance, Operations and Medical – also have responsibilities in this area. For example, it is important to ensure that the impact on nursing, midwifery and care staffing of changes to the provision of medical care are discussed between the Medical Director, the Director of Nursing and Director of Operations before being implemented. It would also be important to consider the impact of issues such as medical, allied health professional or pharmacy vacancies on the nursing, midwifery and care workforce, together with the use of administrative staff to support the non-clinical aspects of the workload.

What does this mean in practice?

- Staff should be clear on individual **roles and responsibilities** in terms of nursing, midwifery and care staffing capacity and capability. Whilst recommendations on staffing capacity and capability presented to the Board should be the result of joint working and joint ownership of the issues, there are some distinct roles and responsibilities for different parts of the organisation involved in the staffing process, as outlined below. These are not intended to be comprehensive and will also change as innovation occurs and new roles develop.

NON-EXECUTIVE DIRECTORS OF THE BOARD

- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Review data on workforce, quality of care and patient safety on a regular basis and hold Executive Directors to account for ensuring that the right staff are in place to provide high quality care to patients
- Ensure that decisions being taken at a board level, such as implementing cost improvement plans, have sufficiently considered and taken account of impacts on staffing capacity and capability and key quality and outcomes measures
- Understand the principles which should be followed in workforce planning, and seek assurance that these are being followed in the organisation

CHIEF EXECUTIVE

- Ensure that the organisation has the right number of staff with the required knowledge and skills to provide safe and effective patient care
- Ensure that there is an agreed nursing and midwifery establishment for all clinical areas
- Ensure there are robust systems and processes in place across the organisation to make informed and accurate decisions concerning workforce planning and provision.
- Ensure that appropriate escalation policies are in place and action is taken when staffing falls below that expected
- Ensure workforce plans are clinically and financially viable, and that they inform education commissioning process in place through the Local Education and Training Board (LETB) and Health Education England (HEE)
- Ensure that the Executive Team have SMART objectives (specific, measurable, achievable, realistic, timely) aligned to staffing and that these are reviewed and performance tracked regularly.

EXECUTIVE BOARD MEMBERS

- Report to the Board on nursing, midwifery and care staffing capacity and capability, highlighting concerns and making recommendations where necessary. Workforce data should be triangulated with data on quality of care
- Where staffing capacity and capability is insufficient to provide safe care to patients and cannot be restored, undertake a full risk assessment and consider the suspension of services and closure of wards in conjunction with the Directors of Operations, Chief Executive and Commissioners
- Foster a culture of openness and honesty amongst staff, supported by nursing and midwifery leaders, where staff feel able to raise concerns, and concerns are acted upon

DIRECTOR OF NURSING

Develop the nursing and midwifery leadership team to ensure that they understand the principles of workforce planning and can use evidence based tools informed by their professional judgement to develop workforce plans and make staffing decisions on a day to day basis

Assure the Board that there are nursing and midwifery workforce plans in place for all patient care areas/pathways

On a monthly basis, report workforce information to the Board on expected vs actual staff in post on a shift-to-shift together with information on key quality and outcome measures

Ensure there is an uplift in planned establishments to allow for planned and unplanned leave and ensure absence is managed effectively

DIRECTOR OF WORKFORCE (HR)

Ensure that human resources support and policies are available to secure sufficient staffing capacity and capability to provide high quality care to patients

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, staff movements, training and turnover to inform decisions on workforce planning

Develop and implement policies that support all staff working within areas of competence

Develop and implement a strategic recruitment plan to provide the required resources and fill current and future vacancies

CHIEF OPERATING OFFICER/DIRECTOR OF OPERATIONS

Ensure that the management of the organisation supports delivery of the workforce plan and there is sufficient staffing capacity and capability to provide high quality care to patients

Ensuring that there are systems and processes in place to capture accurate data on quality of care, patient pathways and volume to inform decisions on workforce planning

DIRECTOR OF FINANCE

Ensure that finance decisions which could have an impact on staff capacity and capability and patient outcomes are taken with consideration of staffing and workforce planning implications, and that these are reflected in any advice provided for decision to the Board, linking proposals to patient outcomes and quality

Ensure there are staff recruitment and retention strategies in place, and regularly review the effectiveness of these

Ensure that there are systems and processes in place to capture accurate data on establishment, staffing levels and skill mix, to inform decisions on workforce planning

NURSING LEADERS: HEAD OF NURSING / MATRON / SENIOR MIDWIFE

- Review and approve rosters submitted from wards
- Reallocate staff and authorise the use of temporary staffing solutions if necessary and where required
- Continuously review and monitor nursing, midwifery and care staffing capacity and capability across areas of responsibility
- Produce data / information to inform the Board and management of the organisation, and to inform workforce planning
- Hold Service Managers to account for having appropriate staffing capacity and capability on a shift to shift basis, and following escalation procedures where necessary

SISTER / CHARGE NURSE/TEAM LEADER

- Produce and manage safe and efficient staff rosters
- Measure quality of care and outcomes achieved for patients and the capacity and capability of staff on a ward-to-ward basis
- Respond in a timely manner to unplanned changes in staffing, changing patient acuity / dependency or numbers, including the request for and use of temporary staffing where nursing/midwifery shortages are identified
- Escalate concerns to line manager where staffing capacity and capability are inadequate to meet patient needs
- Understand the evidence based methodology used to determine the nursing and/or midwifery staffing in your area of responsibility

OTHER HEALTH AND CARE STAFF

- Complete data returns where requested about the staffing in your workplace to inform workforce planning decisions
- Participate in discussions and decisions regarding staffing in your clinical area
- Understand the agreed staffing capacity and capability are for your clinical area on a shift by shift basis
- Raise concerns regarding staffing and/or the quality of clinical care within your organisation when they arise

These roles and responsibilities only seek to cover responsibilities related to nursing, midwifery and care staffing capacity and capability, and are not exhaustive. They are not mandatory and should be read in the context of each organisation and its governance and management structures. It is important to empower ward Sisters/Charge Nurses to take responsibility for their clinical areas with delegated authority to act, supported by their organisations.

Roles will, over time, evolve and change as new innovations come into practice and these guidelines will need to be updated to take this into account.

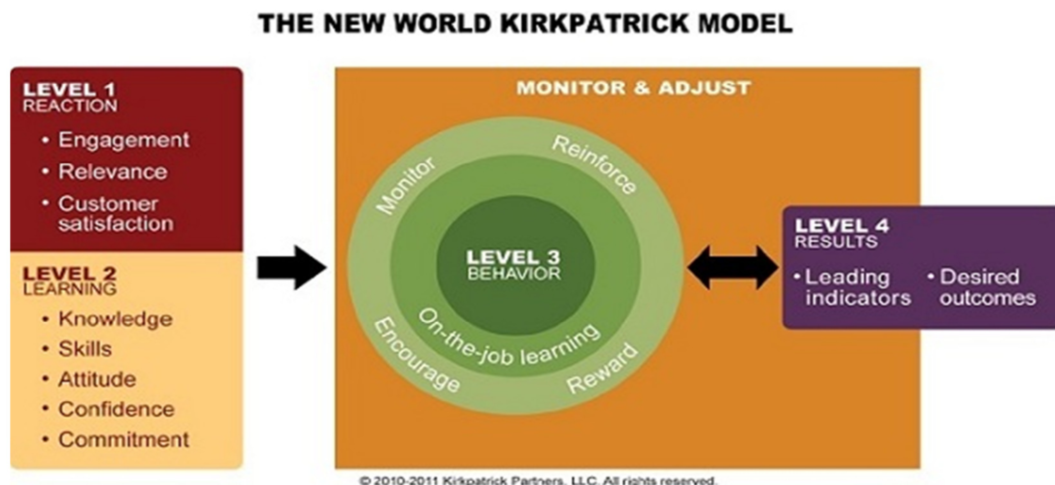
CASE STUDY 13: **NHS England – North - 'Investing in Behaviours'**

The 'Investing in Behaviours' programme was funded by the Health Foundation for the North East of England and is being taken forward as part of Action Area 3 of the Compassion in Practice Programme, which is led by Gill Harris, Chief Nurse, NHS England (London)

Conceived in July 2012, it is a product of the need to address issues raised by the Francis Inquiry; to underpin safety and quality improvement work with actions that address Human Factors and Behaviours.

During the 3 year improvement programme, 'Safer Care North East' clinicians leading improvement work recognised that focussing on systems and processes alone could only deliver improvements to a point – there was a need to address the fact that human error exists. A faculty of Human Factors was established and clinical teams worked with pioneers from the airline industry to develop the knowledge base of human factors in patient safety. It includes a new perspective on working as part of a team; the benefit this can have in terms of leadership, patient focus and utilisation of staff. Funded by the Health Foundation, an educational package was published in March 2013 including e-learning, workbook and trainers manual.

'Investing in Behaviours' has two elements; firstly it is underpinned by the Kirkpatrick evaluation model, which ensures that any action, intervention or training, delivered to support improvement, delivers behaviour change rather than just the acquisition of a technical or theoretical skill. The Kirkpatrick evaluation model is shown below:



Secondly individuals and clinical teams are supported with 'Insights Discovery – Discovering Investing in Behaviours', a programme that delivers self-awareness and facilitates changes in individuals, in teams and organisations, focusing on engaging 'hearts and minds'.

The programme involves an assessment of organisational culture and Quality Indicators and identification of area(s) to change; Board Level expectations are set as a result of this and a multi-disciplinary corporate team leading the implementation of an improvement plan based upon Kirkpatrick model and facilitated by Human Factors awareness and 'Insights Discovery (Discovering Investing in Behaviours)' workshops. A reassessment of leading indicators during and following implementation to measure impact is undertaken.

There are currently eight acute organisations involved in the ‘Investing in Behaviours’ programme and they are seeing improvements in their projects.

Board level Insights ‘Discovery (Discovering Investing in Behaviours)’ workshops allow Boards to see that differences in individual personalities can lead to constructive as well as destructive behaviours in the Board room, which can impact on patient care.

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Emma Nunez. Quality and Safety Manager, NHS England (North) emma.nunez@nhs.net

Expectation 6

Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties. Staffing establishments take account of the need to allow nursing, midwifery and care staff the time to undertake continuous professional development, and to fulfil mentorship and supervision roles. Providers of NHS services make realistic estimations of the likely levels of planned and unplanned leave, and factor this into establishments. Establishments also afford ward or service sisters, charge nurses or team leaders time to assume supervisory status and benefits are reviewed and monitored locally.

Why is this important?

- Undertaking continuous professional development is a key part of developing staff capability. It can improve the quality of care provided to patients, as staff who undertake continuous professional development are more likely to have up to date knowledge, skills and judgement. In order to maintain registration with the Nursing and Midwifery Council (NMC), nurses and midwives need to declare that they have completed:

  - 450 hours of registered practice in the previous three years; and
  - 35 hours of learning activity (continuing professional development) in the previous three years.[24]

- Fulfilling supervision and mentorship roles effectively is key to training the next generation of nursing, midwifery and care staff, and ensuring that student nurses and midwives are adequately supported throughout their training.

- Allowing staff the time to undertake these activities, whilst not compromising patient care, is likely to contribute to an increase in staff engagement and productivity. Patient and organisational outcomes are better where staff engagement is higher.[25]

- Strong and clear nurse leadership is central to the delivery of high quality care, and to ensuring that staff are well led and motivated. Allocating time for the Lead Sister/Charge Nurse/Senior Midwive/Community Team Leaders to assume supervisory

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[24] Further information about staying on the NMC's register can be found at: http://www.nmc-uk.org/Registration/Staying-on-the-register/

[25] Michael A West, Jeremy F Dawson. *Employee engagement and NHS performance*. . Available at: http://www.kingsfund.org.uk/sites/files/kf/employee-engagement-nhs-performance-west-dawson-leadership-review2012-paper.pdf

status can help to ensure that leaders have sufficient time to co-ordinate activity on the ward, manage and support staff, and ensure standards are maintained.

What does this mean in practice?

- **Establishment uplifts** should reflect a realistic expectation by the organisation of the impact on staffing requirements of a range of factors:

  - **staff training and development**: the amount of time that staff may reasonably be expected to be absent from direct caring responsibilities to undertake mandatory training and continuous professional development;

  - **supervision and mentorship roles**: the amount of time that staff would realistically need to spend fulfilling mentorship roles (for example, of students) or supervision roles. Where new staff are recruited, or new/bank agency staff are used, time should be allowed for permanent staff to conduct a thorough induction;

  - **planned and unplanned leave**: based on the number of staff in post and the annual leave, maternity and paternity leave entitlements, realistic estimations of the number of staff likely to be absent at any one time should be made and reflected in establishment figures. Establishments should also have flexibility to allow for unplanned leave, such as sickness absence and carer leave; and

  - a realistic assessment of the time required by the lead sister / charge nurse or team leader to assume **supervisory status.** Many trusts have supported these staff to be supervisory full time. The NHS Trust Development Authority provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow – and they expect that the lead sister, charge nurse or team leader should spend a minimum of two shifts per week assuming supervisory status. Cost Improvement Plans and other initiatives should enable the lead sisters/charge nurses or team leaders time to assume supervisory status.

CASE STUDY 14: Heart of England NHS Foundation Trust - 'Introducing Supervisory roles'

At Heart of England NHS Foundation Trust Sam Foster, Chief Nurse has undertaken a review of the ward sister/charge nurse role. A paper was shared with the Board setting out options for nursing including the creation of the ward sister/charge nurse supervisory role. This was endorsed by the Board who supported investment of £1.4m, creating and additional nurses of 60.48 full time equivalent(FTEs) which allowed for the ward sister/charge nurse to become supervisory.

To support the transition new job descriptions were produced and a training needs analysis was undertaken with ward sisters/charge nurses with a complementary development programme introduced to provide them with the skills required to undertake their roles.

In order to be able to measure success Key Performance Indicators (KPIs)were agreed and each ward sister/charge nurse is expected to report against these, the head nurses hold monthly performance meetings whereby the delivery of these are monitored.

Supervisory Ward Sister/ Charge Nurse

- KPI 1: 1% Reduction in short term sickness
- KPI 2: Implementation of e- JONAH and discharge CQUIN
- KPI 3: 100% Compliance with ADTs
- KPI 4: 0% Prevalence of hospital acquired pressure sores
- KPI 5: Demonstrable improvement in patient experience
- KPI 6: Sustained achievement of > 95% for nursing metric scores
- KPI 7: Implementation of nursing quality review bundle
- KPI 8: Sustained nursing staffing to agreed levels
- KPI 9: 100% Compliance with Infection Control policies and procedures
- KPI 10: To be set for each clinical area around Harm Free Care Reduction

The extensive preparation which has led to 'go live' in October 2013 is already yielding results – for example doctors are more engaged with ward sisters/charge nurses about the management of their patients creating a 'team' around the patient and the ward sisters/charge nurse feels more confident in challenging operational aspects to ensure they support best patient care.

Contact: Sam Foster, Chief Nurse sam.foster@heartofengland.nhs.uk

6 Openness and transparency for patients and the public

Expectation 7

Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review. Boards receive monthly updates on workforce information, including the number of actual staff on duty during the previous month, compared to the planned staffing level, the reasons for any gaps, the actions being taken to address these and the impact on key quality and outcome measures. At least once every six months, nursing, midwifery and care staffing capacity and capability is reviewed (an establishment review) and is discussed at a public Board meeting. This information is therefore made public monthly and six monthly. This data will, in future, be part of CQC's Intelligent Monitoring of NHS provider organisations.

Why is this important?

- Transparency should be at the heart of the NHS, and is a key mechanism for holding organisations to account for the outcomes they achieve with their available resources. As outlined in **expectation 1,** Boards are accountable for the patient outcomes they achieve with the staffing capacity and capability in place.

- As outlined earlier in the document, meeting establishments on a shift-to-shift basis can present difficulties at times of increased pressure. Boards are ultimately responsible for staffing capacity and capability, and must ensure that there are systems in place to regularly assure themselves that there is sufficient nursing, midwifery and care staffing capacity and capability on a shift-to-shift basis.

What does this mean in practice?

Board level discussions

- As outlined in **expectation 1**, establishment reviews should be carried out every six months. Components of papers to the Board on the establishment reviews were also set out under expectation 1.

- At least twice per year, all nursing, midwifery and care staffing levels, and key quality and outcomes measures should be discussed at Trust Board level in a public meeting.

This recommendation was made in *Compassion in Practice*[26], published in December 2012, so we expect Trusts to be doing this already. Where they are not, we expect them to start this process by April 2014 and discuss at a Public Board meeting by June 2014 at the latest.

Monthly reporting

- As outlined in **expectation 1,** on a monthly basis, the Board should receive a report on workforce information, outlining the actual staff available on a shift-to-shift basis versus planned staffing levels. The report should outline areas where there are gaps between these figures, the impact of this, and the steps being taken to address the issue. This report should be published in a form accessible to patients and the public.

- By summer 2014 this data will be collated alongside an integrated safety dataset that will provide information down to ward level where appropriate. This will be available via a single website covering the key aspects of patient safety and in a form accessible to patients and the public.

- Information published in this way will provide close to real time information of staffing at organisational level. It is not intended to replace established statistical publications by the Health and Social Care Information Centre on a monthly, quarterly and annual basis, which are official statistics that go through a rigorous validation process.

[26] *Compassion in Practice* is available at http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf

CASE STUDY 15: Avon and Wiltshire Mental Health Partnership Trust - 'Board to Ward Quality Information System'

The Avon and Wiltshire Mental Health Partnership Trust (AWP) has created a 'Ward to Board' quality information system, known as 'IQ'. Every ward and team completes a monthly self-assessment on key quality indicators which includes compliance with Care Quality Commission standards including a declaration on the 'suitability of staffing' outcome. Although minimum staffing requirements are known, managers are asked to assess against their professional judgement and to declare compliance or not.

The IQ system is accessible by every part of the Trust, including all Board members, and is reviewed in real time every fortnight by the Senior Management Team. Staffing issues are visible and addressed as required.

Contact: Hazel Watsons, Director of Nursing, Hazel.watsons@awp.nhs.uk

CASE STUDY 16: Guy's and St Thomas' NHS Foundation Trust - 'Board Update on Safe Staffing

In April 2013 the Chief Nurse and Director of Patient Experience presented a paper to the Board of Directors. It highlighted previous Board reports, the need to report 6 monthly on nursing and midwifery levels and whether they are adequate to meet patient acuity and dependency.

The Board paper set out the approach to assuring safe staffing levels in acute adult wards and Evelina Children's Hospital using both professional judgement and a range of tools including:

- Safer Nursing Care tool
- RCN guidance 'Defining Staffing levels for Children's and Young People's Services'
- Paediatric Intensive Care services.
- Birth-rate plus tool (for maternity services)

Directorate teams were asked to provide an assurance statement to the Chief Nurse that staffing levels were safe. In addition the Chief Nurse met all ward sisters/charge nurses individually to discuss staffing, their concerns and whether what was being reported to the Board was accurate.

The Board paper also details how the Trust utilises its staffing resource effectively and the Board of Directors was asked to assure itself that staffing levels were robust, recognise that further work relating to the community workforce was to take place and the recruitment challenges.

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CASE STUDY 17: NHS England – North - 'Open and Honest Care: Driving Improvement'

'Open and Honest Care: Driving Improvement' uses data on quality of care, such as the Safety Thermometer and Friends and Family Test. It enables an organisation to understand what data is telling them about clinical safety and patient experience. Initially launched in the North West as the 'Transparency pilot' in September 2011 following a challenge by Jane Cummings (then Chief Nurse, North West) to a group of Directors of Nursing: 'What can nursing do to further improve quality, safety and patient experience and justify pride in the profession?'.

The transparency pilot measured the quality of nursing care delivered together with patient and staff experience in the area where harm occurred. The incidence of harm was published monthly together with the action taken to prevent a recurrence. This collaborative work identified pressure ulcers and falls as areas where an immediate, lasting impact could be made.

Nurses recognised that publishing the data they collected on pressure ulcers and patient falls would bring even stronger focus on patient safety, resulting in staff and patients in open, honest conversations about the quality of care. It offers the opportunity to make further improvements, by looking at things differently; enabling the organisation to be open and honest about care and how they are working to improve the quality of services provided.

The 'Open and Honest Care: Driving Improvement' process begins with a Trust Board signing a compact that endorses its involvement and commitment to openness; an agreement that it will use common data definitions and reporting templates, publish data in agreed formats at agreed times and proactively share with stakeholders (internal and external) and that the publication will form part of routine quality reporting in Part One of Trust Board meetings. There is also a commitment to publish further metrics as developed and agreed and to focus on the capacity and capability for improvement, not to apportion blame.

On a monthly basis there is a publication on the Trust website utilising a standardised template that has been designed with service users. Staff views about the harm events are collected and a future ambition is to identify the staffing levels that should have been deployed at the time compared with actual staff available. The first publication of Open and Honest Care: Driving Improvement takes place in November 2013.

Organisations involved in the transparency pilot have been able to demonstrate a reduction in pressure ulcers and falls. In addition they have demonstrated that this framework can easily shift to new priority areas.

Contact: Teresa Fenech Deputy Director: Quality Assurance NHS England North (t.fenech@nhs.net)

Hazel Richards, Programme Director. Hazel.Richards1@nhs.net

Expectation 8

NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift. Information should be made available to patients and the public that outlines which staff are present and what their role is. Information displayed should be visible, clear and accurate, and it should include the full range of support staff available on the ward during each shift.

Why is this important?

- In other industries, it is common practice for the people serving customers to be visible. If you travel on an aeroplane, you are clear that there is a pilot in charge of flying the plane, and a first officer there to assist the pilot. Air stewards and stewardesses introduce themselves, and make their role in serving passengers, and protecting their safety, known.

- When people use the NHS, they are often at their most vulnerable stage in life. By the very nature of healthcare, patients, their families, friends and carers place trust in the professionals looking after them, and rely on them to put their interests first. There is a strong argument that, in this unique environment and at the time of greatest need and vulnerability, transparency should be more important than in any other setting.

- Displaying information about the staff present on each ward on each shift is part of the broader agenda around improving transparency in health care. Other actions underway include displaying the name of the lead clinician and nurse in charge of patients' care above their beds, and ensuring that people outside of hospitals have a named clinician who is responsible and accountable for the care of that patient.

What does this mean in practice?

- Providers should have information on staffing on a shift-to-shift basis that is available, and accessible to patients. Organisations should display the numbers of staff in post on a shift-to-shift basis, piloting an approach to this. Plans should be implemented subject to evaluation of pilots.

- The information displayed should be helpful and accessible to patients, and could include: the numbers of staff present on the ward, department, service or setting; who is in charge; and what the different roles and responsibilities of staff on the ward are.

- It may be helpful to outline additional information that is relevant locally, for example, the significance of different uniforms worn by staff, and titles used, mean.

Case study 18: #Hellomynameis

During 2013, Dr Kate Granger, a senior registrar specialising in the care of older people, and who is also terminally ill, was an in-patient in NHS care and she noticed that only some members of the healthcare team looking after her introduced themselves. Kate wondered why this fundamental element of good communication (the introduction) seemed to have failed. She noted how members of healthcare staff know much about the patients in their care, but that this is not always reciprocated, and she pointed out that this tends to push the balance of power in favour of the healthcare worker. Given that people receiving treatment and care often feel vulnerable already, this imbalance creates an unhelpful and unfortunate gap.

Kate shared her views via twitter and suggested that getting to know people's names is the first rung on the ladder towards providing compassionate care. It is getting the simple things right that means that the more complex things follow more easily and naturally. As a result, the idea of #hellomynameis was born.

Since then people have taken steps in all manner of ways to ensure that this key bit of compassionate care; the introduction, happens. Some organisations have created name boards in their clinical areas headed 'Hello My Name Is…' and others have used it as they start their speeches at conferences and other events or placed it on name badges.

There is further work to do however. As Kate has pointed out, the NHS employs many, many people and a significant number of these people interact directly or indirectly with patients at some level. Influencing practice in this small way could have a major impact on the outcomes of care and treatment, especially the patient's experience of that care.

CASE STUDY 19: 'Implementing Safe Nurse Staffing Salford Royal NHS Foundation Trust'

At Salford Royal NHS Foundation Trust (SRFT) the Safer Nursing Care tool is used to determine nursing establishments to deliver safe quality care. The qualified nurse to patient ratio at SRFT of 1:8 is never breached. Sub specialty wards have a ratio higher than this. All wards in addition have a nurse in charge on all shifts.

The Safe Staffing Steering Group considers how SRFT shares information with patients and families in an open and transparent way, including the numbers of nursing staff on wards at each shift. To support this staffing boards have been introduced onto every ward/department.

The board identifies the coordinator for the area and the numbers of registered and non-registered nurses that the ward should have and the numbers they actually have for the shift. The board is displayed at the entrance to every ward and visible to patients/family and carers.

A senior nurse teleconference is held daily at 8.30am, chaired by the Deputy Director of Nursing to address any nurse staffing concerns. To support this, a daily nursing rota is produced and staffing is discussed at capacity meetings held four times daily.

SRFT will expand the project to look at staffing with community nursing.

Contact: Elaine Inglesby, Executive Nurse Director – elaine.inglesby@srft.nhs.uk

CASE STUDY 20: Wrigthington, Wigan and Leigh NHS Foundation Trust (WWL) – 'Using Staffing Display Boards'

An element of WWL's Nursing and Midwifery Strategy includes the need for transparency, and white boards at the entrance to wards have been introduced. These boards display the funded staffing establishment and the actual staffing levels on each shift and are visible to patients and visitors.

An escalation process means that should staffing levels fall below establishment this is picked up by the Ward Sister and Matron immediately. Two wards 'buddy' each other and will work together to resolve the staffing issue initially across the two wards with Matron reviewing all nurse staffing across the directorate. The Duty Matron has access to staff across the organisation and will move nursing staff as appropriate to ensure safe levels in all areas, in addition to securing additional nurses by utilising bank and agency.

Board papers include details of any staffing breaches to ensure the team are aware of issues and actions taken, offering an opportunity for further challenge and support.

Contact: Pauline Jones, Director of Nursing, pauline.m.jones@wwl.nhs.uk

7 Planning for future workforce requirements

Expectation 9

Providers of NHS services take an active role in securing staff in line with their workforce requirements. Providers of NHS services actively manage their existing workforce, and have robust plans in place to recruit, retain and develop all staff. To help determine future workforce requirements, organisations share staffing establishments and annual service plans with their Local Education and Training Board (LETBs), and their regulators for assurance. Providers work in partnership with Clinical Commissioning Groups and NHS England Area Teams to produce a Future Workforce Forecast, which LETBs will use to inform their Education Commissions and the Workforce Plan for England led by Health Education England (HEE).

Why is this important?

- It is first and foremost an employer responsibility to ensure they have enough staff to provide a safe and high quality service for current and future patients. As outlined in this document, providers are required to produce establishment reviews and Annual Service Plans which set out the number and mix of staff that providers intend to employ that year, (including fill and vacancy rates and planned spend on temporary staffing). It is an employer responsibility to ensure that they have robust plans in place to recruit, retain and develop their staff, as well as managing and planning for any potential loss of staff through, for example, turnover, retirement and maternity leave.

- In order to make services sustainable, organisations have a key role to play in determining future workforce demands. It can take fifteen years to train a Consultant, and three years to train a nurse – so the NHS has to plan not just for the needs of patients today, but the needs of patients tomorrow.

What does this mean in practice?

Managing the current workforce

- It is the responsibility of Health Education England to secure the future supply of workforce through commissioning education and training places. The workforce plans that HEE will publish later this year will result in nurse training places commencing in September 2014, completing in 2017. It is then the responsibility of the providers of health care services to ensure they have sufficient supply (nurses and midwives) to meet patient demand. As well as recruitment, this requires providers to have effective

strategies in place to retain and develop the staff they employ, in order to reduce the numbers of qualified staff who leave the service. Without effective employment strategies in place, providers are forced to demand yet more supply (either from other parts of the UK or abroad), which takes time and money to produce. This is potentially an inefficient use of taxpayers' money, and a poor use of the investment we have made in people who have expressed a desire to work with patients.

Shaping the future workforce

- Each provider of NHS services is required to be a member of, or be represented on, their Local Education and Training Board, (LETB) which are committees of Health Education England. It is the role of the Governing Body of LETBs to ensure that education and training commissions reflect local need and national priorities, by directly involving employers and commissioners in these decisions. In order to enable LETBs to ensure that their plans reflect local needs, employers need to:

    - Share establishment reviews with their LETB so that they have a sound understanding of the current situation upon which to base any future investments, and with regulators (NTDA, Monitor and CQC) for assurance; and

    - Produce a future workforce forecast that sets out their anticipated needs, which will form the basis of LETBs education and training commissioning plans and strategies. These forecasts should be developed in partnership with local commissioners to ensure that they reflect local visions for services, and submitted to LETBs as set out in HEE's Workforce Planning Guidance. Further information is available at: http://hee.nhs.uk/work-programmes/workforce-planning/

    - Local LETBs will assess and aggregate the forecasts submitted by local providers, triangulate with local partners including commissioners and Health and Well Being Boards and submit to Health Education England; and

    - Health Education England will assess and aggregate the 13 investment plans from its LETBs and develop a Workforce Plan for England, ensuring that the £5 billion pounds that is spent on workforce reflects both local and national priorities as set out in by their Mandate.

8 The role of commissioning

Expectation 10

Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.
Commissioners specify in contracts the outcomes and quality standards they require and actively seek to assure themselves that providers have sufficient nursing, midwifery and care staffing capacity and capability to meet these. Commissioners monitor providers' quality and outcomes closely, and where problems with staff capacity and capability pose a threat to quality, commissioners use appropriate commissioning and contractual levers to bring about improvements. Commissioners recognise that they may have a contribution to make in addressing staffing-related quality issues, where these are driven by the configuration of local services or the setting of local prices in contracts.

Why is this important?

- Commissioners are responsible for ensuring that they commission high-quality services. The impact that nursing, midwifery and care staffing capacity and capability can have on patient safety has been well documented and should therefore be a key focus for commissioners. Commissioners should continually hold providers to account for ensuring that they deliver high-quality services, ensuring that they maintain sufficient staffing capacity and capability to do this at all times.

- Commissioners must commission high-quality care whilst also delivering value for public money. Where prices for the services they commission are set through local negotiations, rather than by national tariffs, commissioners have a responsibility to ensure that the local prices agreed mean that provision of safe, effective services remains viable.

What does this mean in practice?

- Commissioners set clear standards for quality and outcomes in their contracts, through services specifications and incorporating quality standards.

- As outlined in *Everyone Counts: Planning For Patients 2013/14*,[27] commissioners actively review and discuss the cost improvement programmes proposed by their major

[27] *Everyone Counts: Planning for Patients 2013/2014* is available at: http://www.england.nhs.uk/everyonecounts/

providers, ensuring that these have clinical ownership within the provider and do not threaten service quality.

- Commissioners have mature discussions with providers about local prices and efficiency requirements so that commissioner financial constraints do not inadvertently encourage providers to operate unsafe staffing levels.

- Commissioners monitor service quality and outcomes, alongside expenditure and activity levels, using the monitoring information which providers are required to supply under the NHS Standard Contract; this covers quality standards, complaints, serious incidents and Never Events, infections rates, clinical audit reports and patient and staff surveys. Commissioners maintain a constant and close dialogue with providers about any issues relating to service safety and staffing levels.

- Commissioners triangulate this data on service quality with provider reports on actual staff available on a shift-to-shift basis versus planned staffing levels. The NHS Standard Contract for 2014/15 is expected to set out new requirements on providers to report on this to commissioners.

- In liaison with regulators and NHS England Area Teams through Quality Surveillance Groups, commissioners use the levers set out in the NHS Standard Contract to address any provider issues with service quality and safe staffing. These levers include the ability to:

    - require remedial action plans to be agreed and implemented
    - report formally to the provider’s Board and levy financial sanctions where such actions plans are not implemented
    - suspend services temporarily or terminate them permanently.

- In deciding whether to suspend or terminate services, commissioners balance risks and benefits carefully and work closely with providers to ensure that sufficient service provision can be maintained and that delivery of the normal service can be re-established as soon as possible, if necessary through a new provider.

- Commissioners share information and intelligence with their local commissioning and regulatory partners through their Quality Surveillance Group.

9 Next Steps

This document has set out expectations of providers and commissioners in respect of nursing, midwifery and care staffing capacity and capability and how those expectations can be met. Similar guidance may need to be developed for other parts of the health and care workforce.

This chapter sets out how the different organisations with responsibilities for regulating and supervising the system will reflect these expectations as they discharge their statutory responsibilities. This guidance has been developed in advance of further, evidenced based work which is being taken forward by NICE, more detail on which is set out at the end of chapter.

Leadership in provider organisations

These expectations are designed to support providers in taking the complex and difficult decisions that they must take to secure safe staffing to care for their patients and service users.

We would expect that each provider organisation would consider these expectations explicitly, and have a board discussion to assure itself that the systems and processes within the organisation met these expectations.

Establishing and maintaining adequate staffing capacity and capability is an inherently challenging process, and we recognise that not all organisations will be meeting the expectations set out in this document at the moment. Where this is the case, we expect boards to identify as a matter of urgency the actions that could be taken to meet these expectations.

Care Quality Commission (CQC)

The **CQC** is the regulator of the quality of health and care services in England. It is currently developing a new approach to monitoring, inspecting and rating providers. Staffing capacity and capability will be central to this new approach, and the expectations set out in this guide will be used to inform the development of their new approach to inspections, and subsequently, to inform their judgements and ratings for providers.

Monitor
Monitor is the sector regulator for health services in England. Their role is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. They have the ability to exercise a range of powers in relation to the licences issued to NHS-funded providers.

Monitor expects that NHS foundation trusts and aspirant foundation trusts should have the right people, with the right skills, in the right place at the right time. They should take the necessary steps to assure themselves and others that they do so. Monitor will act where the CQC identifies any deficiencies in staffing levels for foundation trusts.

NHS Trust Development Authority
The NHS Trust Development Authority (NHS TDA) provides support, oversight and governance for all NHS Trusts on their journey to delivering what patients want; high quality services today, secure for tomorrow. As part of this drive for sustainable quality across all NHS trusts the NHS TDA will support trusts to develop a constructive approach towards meeting the expectations set out in this guide.

Trusts will also be encouraged to continue to work in a transparent manner in sharing data and to liaise with Commissioners in the delivery of the expectations.

NHS England
NHS England has a dual role in respect of staffing capacity and capability: it is a commissioner of certain services (specialised, primary care, health and justice and veterans care); and it oversees the local commissioning system, supporting Clinical Commissioning Groups to meet their statutory responsibility for improving the quality of services and delivering the best possible outcomes for their communities.
NHS England will reflect relevant elements of these expectations in the NHS Standard Contract which is used by all commissioners for contracts with providers (other than for primary care services). In relation to its own commissioning, NHS England will design and commission services with a view to meeting the expectations in this guide, and particularly in line with expectation 10 on commissioning. Through assurance, NHS England will ensure that both statutory duties and delivery plans are being met by CCGs with challenge through evidence and agreed support where improvement is found to be required.

National Institute for Health and Care Excellence (NICE)

NICE will shortly begin work to develop evidence-based guidance that sets out safe staffing capacity and capability for the NHS. This guidance will be for use within NHS provider organisations, and to inform any practical tools that help calculate staffing capacity and capability.

It will begin by reviewing the evidence-base underpinning existing products, plus any new or additional relevant evidence, to develop staffing guidance. This guidance will enable existing tools and related products used in the NHS in England to be updated, if required.

By June 2014, NICE will have produced guidance on safe staffing in adult in-patient settings, including its view of existing staffing tools. This initial phase will be followed by further work to develop full accreditation of staffing tools against the evidence based guidance, and work on safe staffing in other settings, including maternity, A&E non-acute settings such as mental health, community services and learning disabilities settings. The focus of the work will be nursing and maternity staffing levels, but it will also take into account the wider context of other workforce groups and the importance of multi-disciplinary working in modern healthcare.

This guidance has set out some core expectations of providers and commissioners in respect of getting nursing, midwifery and care staffing right. They are based on available evidence, good practice and common sense. They aim to support and reinforce the ability and judgement of healthcare professionals and managers in making what are difficult decisions both on a daily basis, and with a longer term perspective. In using this guidance, working in the NHS, we must recognise that the roles staff perform, and the capacity and capability of staffing needed to provide care, like any other components of healthcare delivery, can and should be components for constant innovation. Across the NHS we must make sure that current approaches to staffing do not stifle bold ideas and innovation, such as the development of new healthcare professional roles; new forms of delivery of care that might significantly alter the patterns of needs and staffing requirements; and new ways to empower patients and carers to use their own skills and expertise to improve their care. Similarly, we must constantly look to the future, understanding how we can improve our care through the skills and expertise of our staff, not just those we currently employ, but the young professionals in training and as they enter their careers.

Appendix A: Professional Guidance

Below is a list of some known professional guidance on nursing, midwifery and care staffing capacity and capability. This list is not intended to be definitive or exhaustive.

The British Association of Critical Care Nurses (2009): *Standards for nurse staffing in critical care***.** Available at:
http://www.baccn.org.uk/about/downloads/BACCN_Staffing_Standards.pdf

The Paediatric Intensive Care Society Standards for the Care of Critically Ill Children (4th ed) 2010. Available at:
http://www.ukpics.org.uk/documents/PICS_standards.pdf

The Association for Peri-operative Practice (2008): Available at:
http://www.afpp.org.uk/books-journals/books/book-119

BAPM Service Standards for Hospitals Providing Neonatal Care 3rd edition (2010). Available at:
http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf

RCN Guidance

RCN (2006) *Setting appropriate ward nurse staffing levels in NHS acute trusts*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0007/287710/setting_appropriate_ward_nurse_staffing_levels_in_nhs_acut.pdf

RCN (2010a) *Guidance on safe nurse staffing levels in the UK*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0005/353237/003860.pdf

RCN (2010b) *RCN policy position: evidence based nurse staffing levels.* Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0007/353239/003870.pdf

RCN (2012a) *Safe staffing for older people's wards: RCN full report and recommendations*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0009/476379/004280.pdf

RCN (2013) *Defining staffing levels for children and young people's services*. Available at: http://www.rcn.org.uk/__data/assets/pdf_file/0004/78592/002172.pdf

The Dudley Group NHS Foundation Trust

Paper for submission to the Board on 5.12.13

TITLE:	**Diabetes mandatory training**		
AUTHOR:	**Annette Reeves Associate director for HR**	**PRESENTER**	**Annette Reeves Associate Director for HR**

CORPORATE OBJECTIVE:

SGO5.	Staff Commitment	To create a high commitment culture from our staff with positive morale and a "can do" attitude

SUMMARY OF KEY ISSUES:

Diabetes Training is not a mandatory training subject and falls outside the criteria of the Trust to be mandatory. However CQSPE took the decision to include it in the tracking for mandatory training as Diabetes Management is on the Trust Risk Register and scores 25.

The training started in this financial year and is currently 40.6% compliant. As this is clinical training the Diabetes team own and run the sessions, HR report the figures. It was agreed that the Diabetes team would achieve 80% compliant by March 2014, however on current performance it is more realistic that this would be 50% compliant.

The Trust is holding the annual review of Mandatory training and will be looking at a all subjects including Diabetes training to look at the training contents and progress against target.

IMPLICATIONS OF PAPER:

RISK	**Y**		**Risk Description: as on register**
	Risk Register: Y		**Risk Score: 25**
COMPLIANCE and/or LEGAL REQUIREMENTS	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**N**	**Details:**
	Equality Assured	**Y**	**Details:**
	Other	**N**	**Details:**

ACTION REQUIRED OF COMMITTEE:

Decision	Approval	Discussion	Other
			x

RECOMMENDATIONS FOR THE BOARD

For information as requested

Enclosure 15

The Dudley Group NHS
NHS Foundation Trust

Paper for submission to the Board of Directors

On the activities of the Finance & Performance Committee

TITLE	**Finance & Performance Committee meetings held on 28th November 2013**		
AUTHOR	**Paul Assinder**	**PRESENTER**	**David Badger**
CORPORATE OBJECTIVE: S06 Enabling Objective			

SUMMARY OF KEY ISSUES:

- **The Trust has generally continued to perform well against the long list of access and waiting target set by the NHS nationally and locally.**
- **However for the Quarter to date, the A&E 4 Hours target is being missed and Cdiff numbers exceed trajectory.**
- **Financially the Trust has performed poorly in recent months. In October against a forecast surplus of £1m, a £47,000 surplus was recorded.**
- **The Committee noted with some concern some further slippage on CIP schemes and two General Managers presented recovery plans to the Committee.**

IMPLICATIONS OF PAPER:

RISKS	**Risk Register**	**Risk Score** **Y**	**Details:** **Risk to achievement of the overall financial target for the year** **Failure to achieve the 4 hours A&E target in Q4 & Q1 and risk for Q3** **Risk to C. Diff target** **Financial deficit now forecast**
COMPLIANCE	**CQC**	**N**	**Details:**
	NHSLA	**N**	**Details:**
	Monitor	**Y**	**Details:** **Monitor has rated Trust at 'Amber/Green' for Governance & '3' (good) for Finance at Q2. The Trust remains on quarterly monitoring by Monitor.**

	Other	N	Details: Significant exposure to performance fines by commissioners

ACTION REQUIRED OF BOARD:

Decision	Approval	Discussion	Other
			X

NB: Board members have been provided with a complete copy of agenda and papers for this meeting.

RECOMMENDATIONS FOR THE BOARD:

The Board is asked to note the Committee's intention to refer the increase in C Difficile numbers in Q2 and Mortality for consideration by the Clinical Quality Safety and Patients Experience Committee.

The Dudley Group NHS
NHS Foundation Trust

Report of the Director of Finance and Information to the Board of Directors

Finance and Performance Committee Meeting held on 28th November 2013

1. Background

The Finance & Performance Committee of the Board met on 28th November 2013. The Committee considered in some detail the performance of the Trust against its financial, access, waiting and other clinical and operational targets and standards for the period and considered forecast year end performance reports. The Committee noted in particular the following matters:

2. Performance Management Framework

The Committee considered a report of the most recent round of Directors performance management sessions with clinical directorates. Some 90 action points had emerged of which 13 related to registered risks.

The Committee noted that, in line with the Deloittes report recommendations, a performance dashboard summary will be presented at future Board meetings.

3. AMU Business Case – Post Implementation Review

Mrs Hanson presented a post implementation report. Total investment in this case was £1.3m and of this sum all had been committed except delayed consultant post appointments. The Plan to close GP Beds in the Unit had not been achieved, due to exceptional capacity pressures, even though the length of stay gains forecast had been realised.

The Committee requested a further up date in 6 months.

4. Cost Improvement Programme – Directorates of Surgery & Trauma and Orthopaedics

The Committee considered a detailed report on the Trust's £12.4m Cost Improvements Programme (CIP). To date savings of £7.7m have been actioned. However, £2.8m has yet to be identified. Particular problem areas are the Directorate of Surgery, where savings have not yet been identified; Trust wide schemes, where declared schemes are not delivering savings to timescale; and Medicine, where schemes have been declared but have a high risk of failure due to workload

pressures. There has also been delay in approving schemes due to the unavailability of the medical and nursing directors (who have to personally 'sign off' schemes).

The Committee received a presentation from the General Manager of Surgery on that Directorate's CIP Programme, totalling £1.4m. This is currently forecasting a shortfall of £739,000.

Directorate projects have been developed to generate additional margin on new activity to recover this position.

The Committee received a further presentation from the same General Manager in respect of Trauma & Orthopaedics on that Directorate's CIP Programme, totalling £0.4m. This is currently forecasting a shortfall of £245,000.

The Committee noted and agreed a rectification plan to recover this position.

5. Emergency Medicine Directorates Financial Position

The Committee received a report from the General Manager of this Directorate on the significant deterioration in financial performance. Schemes were outlined to further reduce expenditure in 2013-14 by £105,000.

The Director of Finance warned the Committee that increasingly Directorates were identifying 'notional or qualitative' benefits as CIP. This did not lead to cash releasing savings (eg since despite reduced Length of Stay wards never closed) and since the Government was actively reducing provider cash by 4% every year through deflation of the tariff the Trust would soon face real solvency issues.

6. Investment Panel

The Committee resolved to establish an Investment Panel, as a sub group of F&P. This Group will examine proposals for investments and disinvestments in detail and advise F&P accordingly.

7. Workforce KPIs

The Committee received a report from the Director of Human Resources, noting the following:

a. Absence
   The Trust absence rate for the month of September is 3.64 % (3.84% in June) and was 4.02% in 2012. The 2013-14 target is 3.50% and YTD performance is 3.7%.

b. Turnover
Turnover continues to remain consistent and within target at 7.82% (7.80% in Aug)

c. Pre-employment Checks
Pre-employment checks managed through the Centralised Recruitment Department perform at 100%, together with 93% for Medical Workforce recruitment.
Staff bank also performed at 87.5% (75% previously).

d. Mandatory Training and Appraisals
The compliance rates for Mandatory Training has shown a small increase on previous months to 70.7%.
Appraisals have increased again this month to 84.72% (85.6% in Aug).

e. Professional Registration
100% of Professional registrations checks have been performed.

f. Vacancies
The current live vacancy rate has increased significantly to 233 FTE due to widespread nurse recruitment to the graduate and novice programmes.

g. Employment Tribunal Summary
The Committee noted that the Trust had 3 live ET cases submitted during the year.

8. Facilities Assurance Report

Mr Graves presented his report for Q2. The Committee noted a transfer of Summit shareholding from Sir Robert McAlpine to Dalmore Capital a London based investment house. SRM will retain building defect liability.

Relations between Summit, the Trust and Interserve were said to be strained by the transfer of Steve Taylor by IFM to its Leicester site

The Trust will extend the lease on essential properties on Pensnett Trading Estate.

Mr Graves expressed concern about the forthcoming market testing exercise, particularly the involvement of PFI partners who were crucial to identifying savings opportunities.

Major capital schemes for the Simulation Suite and Hybrid Theatre were discussed.

The Committee requested a time scaled report on inflationary pressures v CIP contributions from the PFI service set.

9. Financial Performance for Month 6 – September 2013

The Trust made a small trading of £27,000 in September but this was £1m below plan. Major problems were the level of pay expenditure, particularly agency spending.

For the 6 months period in total the Trust is now recording a small deficit of £192,000.

The forecast for the year in total is now for a deficit of £500,000 although a recovery plan has been agreed between Directors and Directorates to seek to restore balance.

Principle factors are:

- Continued confusion in the NHS commissioning landscape with outstanding sign off of additional payment for extra activity still outstanding. An annual loss on Maternity services of c£1m is now forecast.
- Significant slippage on the Trust's CIP programmes delivery.
- A significant worrying trend in the 'run rate' of Trust spending, particularly on bank and agency nurses.

The Trust's balance sheet and liquidity position remains strong, however the Committee noted, with concern that NHS debtors had increased significantly this year due to major changes to commissioner organisations. The Committee asked that where contractually available, interest should now be charged on the late payment of outstanding amounts.

Capital spending is now below phased plans due to slippage on IT and medical equipment programmes and a revised profile has been submitted to Monitor.

10. Performance Targets and Standards

The Committee noted the following matters:

a) A&E 4 Hour Waits

The percentage of patients who waited under 4 hours within A&E for October was 91.5% and for Quarter 3 it is a cumulative 92.7% against a 95% target.

b) Diagnostic 6 week waits

The Trust has achieved this performance target in October

c) Never Events

The Trust had no 'never events' in October.

d) C Difficile Infections

The Trust had 2 C. Diff infections in August and is within trajectory. The Committee has expressed concern about the ambitious nature of this target in 2013-14 and wishes to refer the increase in C Difficile numbers in Q2 for consideration by the Clinical Quality Safety and Patients Experience Committee.

e) Referral to Treatment target waits (18 weeks)

The Committee heard that unusually there had been 2 RTT 18 week breaches in the specialty of Neurology and the Director of Operations was asked to investigate and report back to the Committee on this issue.

f) Mortality Indices

The Committee noted that all current reported mortality indices are within expected ranges:

Standardised Hospital Mortality Indicator (Dept of Health)	1.11
Hospital Standardised Mortality Ratio (Dr Foster/HED)	99
CHKS Risk Adjusted Mortality Index (CHKS)	96

The Committee noted that the Medical Director will prepare detailed reports on mortality to the Board and Clinical Quality Committees and the Committee requested that the deterioration in SHMI be investigated.

g) C Difficile

The Trust has reported 26 incidents against a trajectory of 22. The Committee referred the matter to CQSPE Committee to investigate causes and mitigation.

11. **Matters for the attention of the Board of Directors or other Committees**

The Board is asked to note the Committee's intention to refer the increase in C Difficile numbers in Q2 and the increase in mortality indices (SHMI to March 2013) for investigation by the Clinical Quality Safety and Patients Experience Committee.

PA Assinder
Director of Finance & Information
Secretary to the Board

Board of Directors Members Profile.

Paula Clark – Chief Executive

As the Chief Executive, Paula leads the Executive Team to ensure that effective management systems are in place and that Directors and Senior Managers have clear objectives and are assigned well-defined responsibilities in line with the Trust's strategy and organisational objectives.

As a leader Paula provides visible examples of a positive culture for the Trust and drives the Trust Management executive to reflect a positive culture in their behaviour and decision making to continuously improve the Patient Experience within the Trust.

John Edwards – Chairman

Johns ensures that the Board and its committees function effectively and in the most efficient way: discharging their role of collective responsibility for the work of the Trust. John decides: on committee membership; ensures they have the correct Terms of Reference, assigns the appropriate committee's to deal with the key roles in running the Trust and ensures the Committee chairs report accurately to the Board in line with the relevant committees meeting cycle. John is also Chair of the Council of Governors and Chairs the Transformation Committee and the IT Project Board.

Paul Assinder – Director of Finance and Information

Paul provides strategic financial and business advice to the Board of Directors. He has lead responsibility for statutory accounts and audit as well as informatics, information technology, contracting, procurement and supplies. Paul is also Secretary to the Board of Directors and key liaison director for the FT regulator, Monitor.

Richard Beeken – Director Strategy, Performance and Transformation

Richard is responsible for developing the Trusts Long Term Strategy and for driving transformational change programmes within the organisation and local health economy. He provides leadership of the facilities and estates function via the PFI contract, in addition to security and health and safety management. In his role he also leads Emergency Planning and Business Continuity Planning for the Trust.

Denise McMahon – Director of Nursing

Denise provides professional leadership, management and direction for: Nursing and Midwifery Strategy, Education and Professional Conduct; Infection Prevention and Control and Integrated Governance. Denise also has collective corporate responsibility for strategic and operational performance as an Executive Director and member of the Trust Board.

Paul Harrison – Medical Director

Paul provides professional medical leadership for the organisation, including the role of Responsible Officer for revalidation. He contributes to the Boards strategic discussions by bringing perspective on clinical issues as a practising clinician. He is responsible for medical education, research and development and medical workforce issues. Paul and is also lead on Mortality and Morbidity issues.

Richard Cattell – Director of Operations

Richard is Executive Lead for operational management and delivery in clinical services on a day to day basis. He is responsible for the successful delivery of all national and local performance targets and quality standards, via each of the organisation's clinical directorates. Negotiation of and adherence to the contract the Trust has with our CCG commissioners is a vital part of his role.

Annette Reeves – Associate Director of Human Resources

Annette provides leadership and strategic management for the Human Rescources Directorate and gives advice to the Board on issues relating to functions under her control and their impact on the wider service issues to the Trust. She is responsible for developing strategies which meet NHS/legislative/best practise requirements and the needs of the Trust. She participates in the corporate management of the Trust, ensuring the Trust's strategic and operational objectives are met to facilitate the highest quality of services for patients.

David Badger – Non Executive Director, Deputy Chairman and Chair of the Finance and Performance Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act. David is Deputy Chair of the Trust and also Chair's the Finance and Performance Committee.

David is also responsible for the following:
Member - Clinical Quality Safety and Patient Experience Committee
Member - Risk and Assurance Committee
Member - Remuneration Committee
Member - Nominations Committee
Member - Transformation Programme Board
Member and link to Trust Board - Organ Donation Committee
NED liaison - Council of Governors
Assigned - Governor Development Group
Assigned - Governor Membership Engagement Committee
Attendee - Governor Appointments Committee
Board representative - Contract Efficiency Group

David Bland – Non Executive Director and Chair of the Clinical Quality, Safety and Patient Experience Committee

As a Non Executive Director it is David's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

David is also responsible for the following:
Chair of the Clinical Quality, Safety and Patient Experience Committee
Non Executive Director Lead for Patient Experience
Non Executive Director Lead for Patient Safety
Member of Risk and Assurance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Member of Charitable Funds Committee
Member of Council of Governors Committee
Member of the Dudley Clinical Services Limited (subsidiary of the Trust

Jonathan Fellows - Non Executive Director and Chair of the Audit Committee

As a Non Executive Director it is Jonathans responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Jonathan is also responsible for the following:
Chair of Audit Committee
Member of Finance and Performance Committee
Member of Charitable Funds Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Assigned to the Governors Governance Committee
Board representative - Contract Efficiency Group

Richard Miner – Non Executive Director and Chair of the Charitable Funds Comittee

As a Non Executive Director it is Richard's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Richard is also responsible for the following:
Chair of the Charitable Funds Committee
Non Executive Director Lead for Security Management
Member of Finance and Performance
Member of Audit Committee
Assigned to the Governors Governance Committee
Member of the Remuneration Committee
Member of the Nominations Committee
Chair of the Dudley Clinical Services Limited (subsidiary of the Trust)

Ann Becke – Non Executive Director and Chair of the Risk and Assurance Committee

As a Non Executive Director it is Ann's responsibility to challenge and support the Board to develop its strategy to address the challenges set out in the Health and Social Care Act.

Ann is also responsible for the following:
Chair - Risk and Assurance Committee
Member – Audit Committee
Member – Clinical Quality, Safety and Patient Experience Committee
NED Lead for Safeguarding
Board Representative – Dudley Children's Partnership
Non Executive Director Liaison for West Midlands Ambulance Service
Member – Remuneration Committee
Member – Nominations Committee
Member – Arts and the Environment Panel

Assigned – Governor Sub Committee Membership Engagement
Assigned – Governor Sub Committee Strategy
Member – Dudley Clinical Education Centre Charity